Virginia

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/01/2025 4.14.51 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	Virginia Department of Behavioral Health and Developmental Services
Organizational Unit	Office of Adult Community Behavioral Health
Mailing Address	P. O. Box 1797
City	Richmond
Zip Code	23219-1797

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Nicole
Last Name	Gore
Agency Name	Virginia Department of Behavioral Health and Developmental Services
Mailing Address	P. O. Box 1797
City	Richmond
Zip Code	23219-1797
Telephone	804-219-7531
Fax	804-786-9248
Email Address	nicole.gore@dbhds.virginia.gov

State CMHS Unique Entity Identification

Unique Entity ID

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Virginia Department of Behavioral Health and Developmental Services
Organizational Unit	Office of Adult Community Behavioral Health
Mailing Address	P.O. Box 1797
City	Richmond
Zip Code	23218-1797

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Nelson
Last Name	Smith
Agency Name	Virginia Department of Behavioral Health and Developmental Services
Mailing Address	PO Box 1797
City	Richmond
Zip Code	23218
Telephone	(804) 786-5682
Fax	(804) 371-6638
Email Address	nelson.smith@dbhds.virginia.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Virginia

Name of Chief Executive Officer (CEO) or Designee: Janet Kelly

Signature of CEO or Designee[1]: Janet V. Kelly

Title:

Date Signed: 7.23.25

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 06/15/2023 Expires: 06/30/2026

Footnotes:

COMMONWEALTH of VIRGINIA

Office of the Governor

Glenn Youngkin
Governor

July 21, 2025

Art Kleinschmidt, PhD, MBA
Principal Deputy Assistant Secretary
Office of the Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
U.S. Department of Health & Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Kleinshmidt:

I am delegating responsibility for the administration of Virginia's Mental Health Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) to the Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, VA 23218
Telephone: (804) 786-3921

I am also authorizing the Secretary of Health and Human Resources for the Commonwealth, to sign the required certifications and assurances required for application to the Substance Abuse and Mental Health Services Administration of the MHBG and SUPTRS Block Grants for this and subsequent years of my administration.

Sincerely,

Glenn Youngkin

Patrick Henry Building • 1111 East Broad • Richmond, Virginia 23219
(804) 786-2211 • TTY (800)828-1120
www.governor.virginia.gov

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
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    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

COMMONWEALTH of VIRGINIA

Office of the Governor

Glenn Youngkin
Governor

July 21, 2025

Art Kleinschmidt, PhD, MBA
Principal Deputy Assistant Secretary
Office of the Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
U.S. Department of Health & Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Kleinshmidt:

I am delegating responsibility for the administration of Virginia's Mental Health Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) to the Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, VA 23218
Telephone: (804) 786-3921

I am also authorizing the Secretary of Health and Human Resources for the Commonwealth, to sign the required certifications and assurances required for application to the Substance Abuse and Mental Health Services Administration of the MHBG and SUPTRS Block Grants for this and subsequent years of my administration.

Sincerely,

Glenn Youngkin

Patrick Henry Building • 1111 East Broad • Richmond, Virginia 23219
(804) 786-2211 • TTY (800)828-1120
www.governor.virginia.gov

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2025

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57

Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Janet Kelly

Signature of CEO or Designee[1]: Janet Kelly

Title: Health and Human Services, Secretary

Date Signed: 7.23.25

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 3rd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the third allotment. The proposal should also explain any new projects planned with the third allotment and describe ongoing projects that will continue with the third allotment. The performance period for the third allotment is from September 30th, 2024, to September 29th, 2026, and the proposal should be titled "BSCA Funding Plan 2025". The proposed plans are due to SAMHSA by September 1, 2024.

OMB No. 0930-0168 Approved: 06/15/2023 Expires: 06/30/2026

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

   Please see attached Step 1: Step 1: Assess the strengths and organizational capacity

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

   Please see attached Step 1: Step 1: Assess the strengths and organizational capacity

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

   Please see attached Step 1: Step 1: Assess the strengths and organizational capacity

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 1: Assess the strengths and

organizational capacity of the service

system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Contents

General Overview of Virginia's Public Behavioral Health System 4

State Hospital System 5

The Community Services Board (CSB) System 6

Local Interagency and Regional Planning 7

Local governments continue to collaborate with DBHDS in most cases through the CSBs in order to develop plans and create a sustainable system of care not just within their own locality but within their identified region of the Commonwealth as well. 7

Right Help Right Now Overview and Updates to Implementation 7

STEP VA Overview and Updates to Sustainment ..... **Error! Bookmark not defined.**

Medicaid Behavioral Health Services Redesign 10

Virginia Implementation of Federal Criteria for State Behavioral Health Services 13

Mental Health Services Criteria 13

addressed in MHBG plans. The criteria are defined below with accompanying overviews: 13

Criterion 1: Comprehensive Community-Based Mental Health Service Systems for Individuals with Serious Mental Illness (SMI) including Co-occurring MH/SUD 13

Adult Community Mental Health Services 13

Crisis Services 17

Recovery Support Services for Mental Health 19

Housing Services for Mental Health 21

Criterion 2: Mental Health System Data Epidemiology 21

Criterion 3: Children's Services 22

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults 24

Criterion 5: Management Systems 26

Virginia Implementation of Federal Criteria for State Substance Use Services 27

Substance Use Disorder Services Criteria 27

Criterion 1: Statewide Plan for Substance Use Primary Prevention, Treatment and Recovery Services for Individuals, Families and Communities 27

Criterion 2: Primary Prevention 31

Criterion 3: Pregnant Women and Women with Dependent Children 33

Criterion 4: Persons Who Inject Drugs 38

Criterion 5: Tuberculosis Services 39

Criterion 6: Early Intervention Services Regarding the Human Immunodeficiency Virus 40

Criterion 7: Group Homes for Persons in Recovery from Substance Use Disorders 40

Criterion 8: Referrals to Treatment and Coordination of Ancillary Services 42

Criterion 9: Independent Peer Review 43

Criterion 10: Professional Development 44

Services System Partnerships that Comprise Integrated System of Care .... **Error! Bookmark not defined.**

Partnerships with Private Providers: 30

Peer/Recovery Support Services: ..... **Error! Bookmark not defined.**

Services for Populations of Interest ..... **Error! Bookmark not defined.**

Cultural, Racial/Ethnic and Language Minorities ..... **Error! Bookmark not defined.**

Planning Steps 1: Assess Strengths and Needs

General Overview of Virginia's Public Behavioral Health System

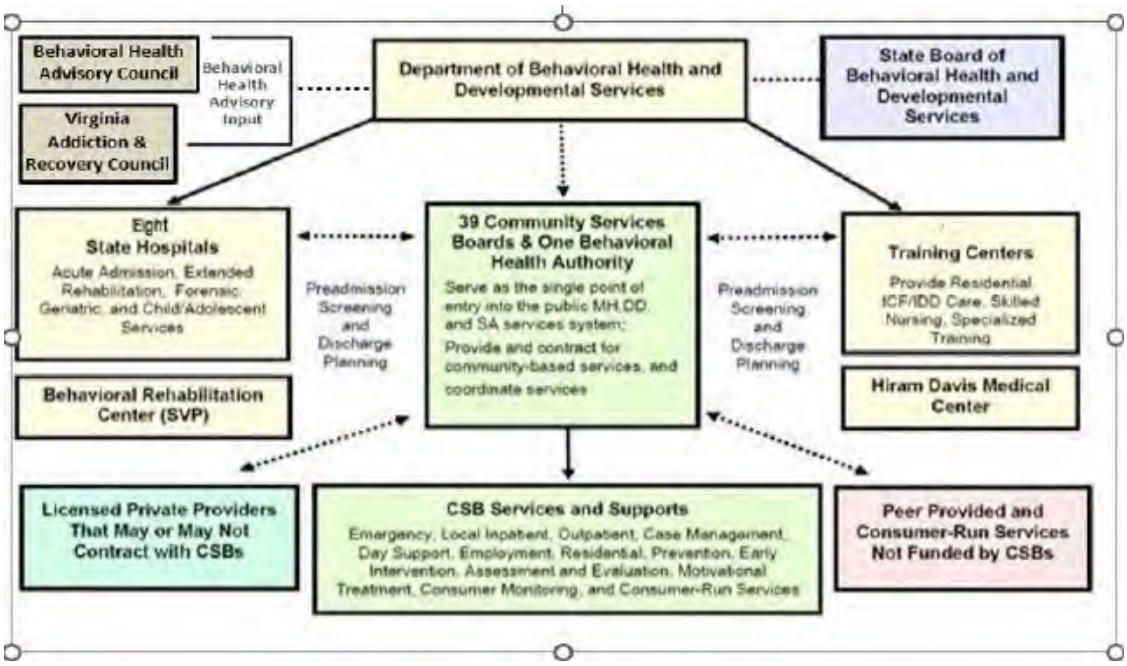
The Department of Behavioral Health and Developmental Services (DBHDS) is tasked with providing public behavioral health (mental health and substance use disorders) as well as developmental and intellectual disability services in Virginia. Title 37.2 of the Code of Virginia establishes DBHDS as the state authority for Virginia's public behavioral health and developmental services system, thus designating the agency as the Single State Alcohol and Drug Agency (SSA) and State Mental Health Authority (SMHA).

Virginia operates 12 facilities: eight behavioral health hospitals for adults, one training center, a behavioral health hospital for children and adolescents, a medical center, and a center for behavioral rehabilitation. State facilities provide highly structured, intensive services for individuals with mental illness, intellectual disability or are in need of substance use disorder services. The Commonwealth Center for Children and Adolescents (CCCA) in Staunton remains the only state hospital for children with serious emotional disturbance. Community Services at the local level are provided by 39 community services boards and 1 behavioral health authority (referred to as CSBs). Local governments that provide services directly to consumers or through contracts with private providers across the Commonwealth have established these CSBs. Maps of CSB service areas and the locations of state facilities are included in this section of the application.

The State Board of Behavioral Health and Developmental Services is a policy board comprised of nine nonlegislative citizens from across the Commonwealth appointed by the Governor and confirmed by the General Assembly. The State Board has the statutory authority for the establishment of policy for the Department including its facilities, and community services boards and behavioral health authorities (collectively "CSBs").

The Behavioral Health Advisory Council (BHAC), which is the mental health block grant mandated planning council, and the Virginia Addiction and Recovery Council (VARC) advise DBHDS on block grant planning and state behavioral health services. BHAC is a peer-led council which also includes state agency representatives, providers, and advocates and shares needs and concerns as well as recommendations on the mental health and substance use & recovery block grants as well as the state behavioral health plan. VARC is comprised of gubernatorial appointees made up of state agency leadership, subject matter experts, and advocates and provide advisory input to DBHDS, Virginia General Assembly, and the Governor's office regarding matters related to substance use disorder treatment, prevention, and recovery.

The following diagram illustrates the relationships among these services system components. Solid lines depict a direct operational relationship between the entities involved (e.g., DBHDS operates state facilities). Broken lines represent non-operational relationships (e.g., policy direction, contract, licensing, or coordination).



DBHDS' central office provides leadership and service to support and improve Virginia's system of quality treatment, prevention services, as well as supports for individuals and families whose lives are affected by mental health or substance use disorders or developmental disabilities. The DBHDS Central Office seeks to promote a culture of recovery, self-determination, and wellness in all aspects of life for these individuals.

Responsibilities of DBHDS include:

- Providing leadership that promotes strategic partnerships between and between CSBs, state facilities, and the central office and effective relationships with other agencies and providers.
- Providing services and supports in state hospitals (civil and forensic) and training centers.
- Supporting the provision of accessible and effective evidence based behavioral health and developmental services and supports provided by CSBs and other providers.
- Assuring that public and private providers of behavioral health or developmental services and supports adhere to licensing standards; and
- Protecting the human rights of individuals receiving behavioral health or developmental services.

State Hospital System

DBHDS operates eight state mental health hospitals for adults across Virginia. The hospitals are Catawba Hospital in Salem, Central State Hospital in Petersburg, Eastern State Hospital in Williamsburg, Piedmont Geriatric Hospital in Burkeville, Northern Virginia Mental Health Institute

in Falls Church, Southern Virginia Mental Health Institute in Danville, Southwestern Virginia Mental Health Institute in Marion, and Western State Hospital in Staunton. The Commonwealth Center for Children and Adolescents, the only state hospital for children and adolescents with serious emotional disturbance, is located in Staunton. State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing support, and ancillary services. Specialized programs are provided to older adults, children and adolescents, and individuals with forensic status.

DBHDS has made strides towards operating the 12 state facilities as one healthcare system to support efficient and effective operations and to ensure quality service delivery for individuals with behavioral health needs and developmental disabilities. DBHDS continues to work with the community service boards and other stakeholders, to address the qualification and training needs of the emergency custody and preadmission screeners. Other improvements include updated communications infrastructures between the courts and behavioral health care providers. DBHDS has established contracts with private providers and agreements with CSBs to provide residential supports that fill a service gap. These contracted residential supports target individuals who are in state hospitals and are clinically ready to be discharged but need a particular level of supervision and support in the community. DBHDS has developed teams to assist individuals with their transition from hospital to community, see that they have the proper services, and provide consultation regarding the care needs of individuals with mental illness to their residential providers.

The Community Services Board (CSB) System

The 133 local governments in Virginia, pursuant to Chapters 5 and 6 of Title 37.2 of the Code of Virginia established CSBs. CSBs may serve single or multiple jurisdictions. CSBs provide services directly to consumers within their catchment area, as well as through contracts with private providers. Private providers are identified as partners who play an important role in delivering behavioral health and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services. It is important to note discharge planning for individuals leaving state facilities is also performed at the CSB level. They function as advocates for individuals who are receiving services and those in need of services. In addition, CSB staff act as community educators, organizers, and planners through community outreach. In some cases, they educate and advise their local governments about behavioral health and developmental services and needs.

While not part of DBHDS, CSBs are key operational partners with DBHDS and its state facilities in

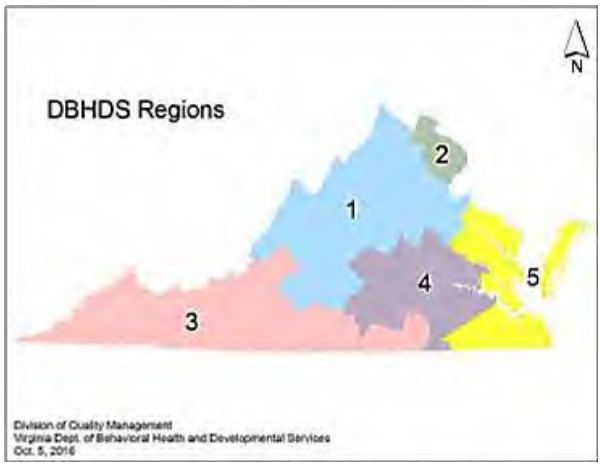
Virginia’s public behavioral health and developmental services system. The relationship between DBHDS and the CSBs involves the community services performance contract, provisions of Title 37.2 of the Code of Virginia, State Board policies and regulations, and other applicable state or federal statutes or regulations. DBHDS contracts with, provides consultation to, funds, monitors, licenses, and regulates CSBs.

Local Interagency and Regional Planning

Local governments continue to collaborate with DBHDS in most cases through the CSBs in order to develop plans and create a sustainable system of care not just within their own locality but within their identified region of the Commonwealth as well.

At the local level, CSBs maintain critical interagency partnerships with local agencies, including school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies include Medicaid rehabilitation services, waiver services, and auxiliary grants for assisted living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Some local agencies also participate in Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Five regional partnerships including one region with two sub-regional partnerships (Region 3) have been established to facilitate regional planning for services system transformation and promote regional utilization management. These partnerships provide forums to address regional challenges and service needs and collaboratively plan and implement regional initiatives. Partnership participants include CSBs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family members, advocates, and other stakeholders. Each regional partnership has established a regional utilization review team or committee to manage the region's use of inpatient beds and funds allocated to purchase local inpatient psychiatric crisis care and residential substance abuse treatment, including state general funds as well as federal Community Mental Health Services (CMHS), and Substance Abuse Prevention and Treatment (SAPT) block grant monies. The following map depicts the five regional partnership areas.



CSB Performance Contract

DBHDS contracts with Community Services Boards (CSBs) to provide a range of behavioral health and developmental disability services across the Commonwealth. These performance contracts outline specific expectations, performance measures, and accountability requirements for the CSBs. DBHDS

monitors CSB performance against these contracts and provides funding, guidance, and oversight. The contracts are regularly reviewed and revised to ensure they effectively measure outcomes and align with state priorities, such as STEP-VA. The contracts detail specific services, deliverables, timelines, and responsibilities for both DBHDS and the CSBs. Performance contracts include specific measures to assess the quality and effectiveness of services provided by CSBs. These measures are regularly reviewed and updated to ensure they accurately reflect outcomes.

Title 37.2 of the Code of Virginia, establishes DBHDS, to support delivery of publicly funded community mental health (MH), develop mental (DD), and substance use (SUD), services and supports and authorizes the Department to fund those services.

Sections 37.2-500 through 37.2-512 of the Code require cities and counties to establish community services boards for the purpose of providing local public mental health, developmental, and substance use disorder services; §§ 37.2-600 through 37.2-615 authorize certain cities or counties to establish behavioral health authorities that plan and provide those same local public services. Section 37.2-500 or 37.2-601 of the Code requires the CSB to function as the single point of entry into publicly funded mental health, developmental, and substance use disorder services. The CSB fulfills this function for any person who is located in the CSB's service area and needs mental health, developmental, or substance use disorder services. Sections 37.2-508 and 37.2-608 of the Code and State Board Policy 4018, establish the contract as the primary accountability and funding mechanism between the Department and the CSB, and the CSB is applies for the assistance provided under Chapter 5 or 6 of Title 37.2 by submitting the contract to the Department.

The CSB exhibits, addendums, appendices, Administrative Requirements and Processes and Procedures, CCS Extract, Core Services Taxonomy, and Partnership Agreement documents are incorporated into and made a part of the contract. The documents may include or incorporate ongoing statutory, regulatory, policy, and other requirements that are not contained in this contract. The CSB must comply with all provisions and requirements.

Right Help Right Now Overview and Updates to Implementation

Governor Youngkin's Right Help, Right Now plan continues to transform mental health care in Virginia. This three-year plan strengthens the care continuum, ensuring Virginians have someone to call, someone to respond, and a place to go. Built on six pillars addressing pre-crisis, crisis, and post-crisis care, the second year completed in 2024 has achieved:

Pillar One: Ensure same-day care for behavioral health crises

- Launched a statewide campaign promoting the 988 Suicide and Crisis Lifeline and expanding outreach with targeted materials for diverse communities
- Exceeded the year two goal of 70 publicly funded mobile crisis teams; Virginia now has over 100 operating statewide 24/7/365 with an average response time of under 50 minutes
- Significantly built out crisis services, with 663 units across crisis receiving centers, stabilization units, and therapeutic homes, up from 216 prior to Right Help, Right Now

Pillar Two: Reduce law enforcement burden and behavioral health criminalization

- Launched a pilot program in southwest Virginia allowing hospital security staff to be credentialed as Special Conservators of the Peace (SCOPs) to manage custody during involuntary assessments, reducing law enforcement involvement and creating calmer, more supportive environments for patients in crisis
- Provided training for CSB staff on informed consent, violence risk assessment, and advanced directives

Pillar Three: Expand system capacity, emphasizing community-based services

- Expanded care integration through the launch of the Adult Psychiatric Access Line (APAL) in October for adults struggling with substance use disorder (SUD)
- Increased youth behavioral health support through expansion of the Virginia Mental Health Access Program (VMAP) across the Commonwealth, and early intervention and maternal health services
- Provided funding for all 3,440 Priority One Developmental Disability waiver slots, growing provider capacity, and access to quality care support

Pillar Four: Strengthen support for substance use disorders and overdose prevention

- Extended comprehensive SUD services to pregnant and parenting women in underserved areas by supporting two new Project LINK sites, bringing the statewide total to 14 sites
- Significantly increased the peer workforce for Certified and Registered Peer Recovery Specialists by 60% and 152%, respectively, vastly exceeding goals
- Expanded Kinship Navigator Program with wraparound for caregivers of children orphaned by overdoses
- Partnered with Public Safety on Operation FREE, leading to the seizure of over 600 pounds of illicit fentanyl and a total of over 36,000 pounds of narcotics

Pillar Five: Prioritize the behavioral health workforce, especially in underserved areas

- Created new career pathways: Behavioral Health Technician Assistant, Behavioral Health Technician, and Master's Psychology Practitioner. Simplified the Qualified Mental Health Professional (QMHP) pathway
- Launched BeTheChange.Virginia.gov, an online campaign showcasing behavioral health career pathways and resources to support those going into the behavioral health workforce Pillar Six: Innovate services and close gaps in prevention, crisis care, and recovery
- Expanded mandated benefits to cover crisis services (mobile, residential stabilization, and receiving center), ensuring comprehensive insurance coverage, balance billing protection, and improved access
- Established the Reclaiming Childhood Task Force via Executive Order 43 to empower parents to increase positive youth mental health outcomes Governor Glenn Youngkin Announces Key

Accomplishments and Continued Investments in Virginia's Right Help, Right Now Plan

Since its creation in 2022, the Commonwealth has invested $1.4 billion in new funding to support the initiatives outlined in the six pillars of Right Help, Right Now. To build on these historic investments,

Governor Glenn Youngkin is committing an additional $70 million which includes the following state behavioral agency priorities:

- $3.5 million to reimburse law enforcement for Temporary Detention Order transportation
- $4.3 million to support the readiness and implementation of an 1115 Serious Mental Illness (SMI) Waiver
- $1.5 million to expand the Adult Psychiatric Access Line (APAL), a program designed to provide psychiatric consultation and care navigation for primary care physicians treating adults with substance use disorders (SUDs) and co-occurring mental health issues
- $1 million to enhance mental health literacy among youth aged 12–18 and address the impacts of substance use, social media, and excessive screen time
- $15 million reallocated for school-based mental health services
- $4.3 million to ensure compliance with state and federal developmental disability waiver requirements and fund administrative costs to monitor waiver slots
- $1.2 million to fund crisis co-response programs
- $1.5 million to increase access to long-acting injectables for Serious Mental Illness in a hospital setting
- $777,000 to establish a sustainable entry-level youth mental health workforce in Virginia by creating and training Youth Support Partners (YSPs)
- $560,000 to improve care coordination for at-risk youth transitioning from psychiatric residential treatment facilities (PRTFs) by maintaining their managed care enrollment
- $500,000 to offer an interactive program that educates teens on the impact of dangerous behaviors, such as drug and alcohol use
- $100,000 to support the completion of the Opioid Impact Reduction Registry

Medicaid Behavioral Health Services Redesign

Redesigning behavioral health services in Medicaid is just one component of the Right Help Right Now Plan and its vision is: to keep Virginians well and thriving in their communities, to ensure the right help is available at the right time, that no Virginian is turned away in a time of crisis and to shift our system's focus on restrictive, high acuity services to a more recovery and wellness oriented system of care that provides earlier inter rehabilitative, and long-term recovery supports. Redesigned services will emphasize earlier access to care and recovery orientation, updates to align with the managed care service delivery system, evidence-based and trauma-informed interventions, and alignment with behavioral health workforce initiatives such as new Department of Health Professions regulations for Qualified Mental Health Professionals (QMHP) and Behavioral Health Technicians.

As developments occurred with the Right Help Right Now Plan, initiatives to redesign Medicaid legacy community mental health rehabilitative services (CMHRS) emerged as significant needs within the system. CMHRS legacy services include:

- Intensive In-Home
- Therapeutic Day Treatment
- Mental Health Skill Building
- Psychosocial Rehabilitation
- Mental Health Case Management for both adults and youth

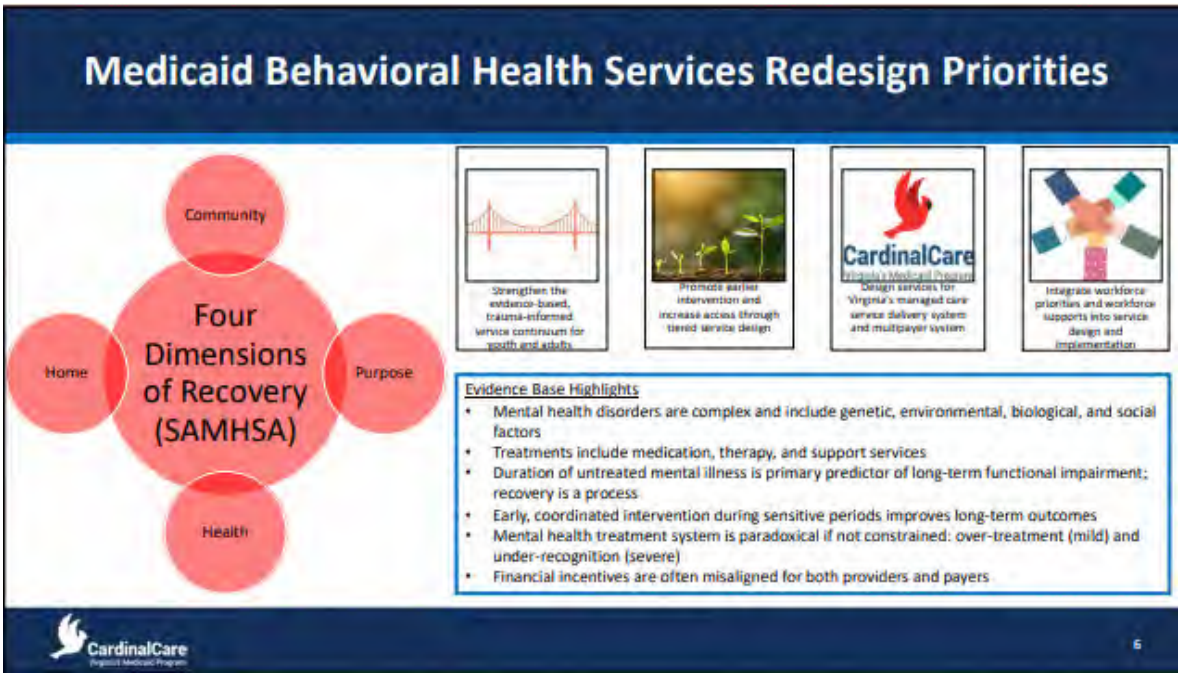
The current 2024-2026 biennium budget includes Item **288, XX** which provides the Department of Medical Assistance Services (DMAS) the authority to replace the CMHRS services and case management service. In collaboration with the Department of Behavioral Health and Developmental Services and the Department of Health Professions, DMAS launched a two-year project (July 2024-June 2026) to replace the CMHRS services and case management service.

As part of the Redesign DMAS, in coordination with DBHDS, DHP and DMAS health plans, is employing an integrated and comprehensive approach to address rate service, and workforce/provider roles for Medicaid over the next two years.

The project seeks to redesign DMAS' youth and adult legacy services by replacing them with evidence-based trauma-informed services.

Priorities of the Redesign include:

- Strengthening the evidence-based, trauma-informed service continuum for youth and adults
- Promoting earlier intervention and increasing access through tiered service design
- Designing services for Virginia's managed care service delivery system and multi-payer system
- Integrating workforce priorities and workforce supports into service design and implementation



Updates to the Medicaid Behavioral Health Redesign can be seen below:

Additionally, between July 2024- February 2025, the framework for Community Psychiatric Support and Treatment (CPST) was advanced through the Redesign process with rate assumptions completed. CPST is a multicomponent service that consists of therapeutic interventions such as counseling, as well as functional supports. Activities provided under CPST are intended to assist the individual and family/caregivers to achieve stability and functional improvement in daily living, personal recovery and/or resilience, family and interpersonal relationships in work, school and community integration. The long-term goal is to require minimal ongoing professional intervention and optimal community integration.

In March of 2025, a rate study was completed for all potential replacement to legacy services. The following June, a fiscal impact study was completed and the implementation plan developed with a "go-live" date for implementation of new services set for July 2025.

During year 1 from July 2024-June 2025,

Finance Model Change

In July 2022, DBHDS changed its federal funding model for Community Services Boards (CSBs) from advance payments to a reimbursement model. This was to align more closely with federal award terms and ensure comprehensive document review in the agency's standard for sub-recipient pass through grants.

In 2023, DBHDS rolled out WebGrants which is an online grant management system designed to streamline and automate the entire grant lifecycle for organizations. It manages the process from application submission and review to awarding, servicing, and reporting on grants and loans. The system provides features for budget management, claims management, reporting, and compliance, with role-based security and automated alerts.

The intended benefits of using WebGrants for DBHDS:

- **Increased Efficiency:** Automating the grant management process saves time and resources.
- **Improved Transparency:** All grant information is stored in a central system, making it easy to track progress and access data.
- **Enhanced Accountability:** WebGrants helps organizations meet compliance requirements and track grant spending.
- **Better Communication:** The system facilitates communication between applicants, reviewers, and grant managers.
- **Reduced Errors:** Automated workflows and data validation help minimize errors.

Virginia Implementation of Federal Criteria for State Behavioral Health Services

Mental Health Services Criteria

Section 1912(b) of the Public Health Act (42 USC § 300x-1) establishes five criteria that must be addressed in MHBG plans. The criteria are defined below with accompanying overviews.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems for Individuals with Serious Mental Illness (SMI) including Co-occurring MH/SUD

Adult Community Mental Health Services

An integral part of DBHDS' Strategic Plan and core of Virginia's Mental Health and Substance Use continuum of care is System Transformation Excellence and Performance (STEP-VA). This initiative seeks to improve Virginia's public mental health system by building a set of core services, referred to as STEPS, that will be consistent across all 40 Community Services Boards (CSBs) throughout the Commonwealth. Based on the Certified Community Behavioral Health Clinic (CCBHC) model, a national best-practices model for behavioral health services, STEP-VA creates a roadmap to consistent, comprehensive, high-quality community-based services for those facing mental health and substance use issues. CSBs serve as the primary point of entry into Virginia's public mental health system and are the primary provider of services and supports to individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED). Written into the Code of Virginia in 2018, STEP-VA increased the number of mandated services from two to nine, with an overall goal of building out a more comprehensive system of community based behavioral health services with improved access, quality, consistency, and accountability. Since its inception in 2018, STEP-VA has undergone a phased implementation, which now includes implementation of all nine steps.

The nine core services in STEP-Virginia are:

1. **Same Day Access (SDA)** – creates a way for Virginians to engage in an initial assessment for intake and treatment services the same day they contact their local CSB.
2. **Primary Care Screening** – collecting key data to identify health risks and coordinate with

medical care providers for individuals with SMI and SED.

3. **Outpatient Services** – considered the core of behavioral health services, this includes both mental health and substance use therapy for adults and children, as well as psychiatry services.
4. **Crisis Services** – builds out a comprehensive crisis system situated to provide the right service at the right time to individuals nearing crisis, experiencing crisis, or stabilizing after a crisis.
5. **Peer and Family Services** – incorporates certified professionals with lived experience into the full array of behavioral health services.
6. **Service Members, Veterans, and their Families (SMVF)** – requires that all clinical staff of CSBs have SMFV training, in addition to identifying Virginians with a connection to military service, at entry to public mental health services, and offers referrals to appropriate services and resources.
7. **Psychiatric Rehabilitation**– services that build or rebuild the skills and supports necessary for successful life in the community for individuals with SMI and SED.
8. **Targeted Case Management (TCM)** – a comprehensive service that coordinates and links key resources and care planning for individuals with SMI and SED.
9. **Care Coordination** – person-centered, holistic care planning that connects resources and services across the continuum of care for all individuals served by the CSBs.

The implementation of STEP-VA services continues to improve access, increased quality, build consistency and strengthened accountability across Virginia's public behavioral health system. Also, STEP-VA services are intended to foster wellness among individuals with behavioral health disorders in everyday life to prevent crises before they arise. Additional outcomes include fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system. These are also core outcomes of DBHDS' Strategic Plan and the current Governor's initiative, Right Help Right Now.

Each step is intended to serve both those individuals with mental health disorders as well as substance use disorders, but also both children and adults. Each step and related definition are a broad interpretation; specific services fall under each step which are more closely aligned to the particular population. For instance, Outpatient Services and Psychiatric Rehabilitation Services are clinically very different across populations, and even service areas. To account for this, the state has allowed a menu of options from which entities can choose. For example, the following is a list of Evidence Based Practices for the Outpatient step recognized by the state of Virginia under STEP-VA.

STEP-VA Requires that each CSB offer, at a minimum, the following Evidence Based Practices for psychotherapy:

- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)

And the following Evidence Based Practices for psychiatry:

- Medication Management
- Long-Acting Injectable Psychotropic Medications

And at least one EBP selected from the list provided below which meets the needs identified by the Community Needs Assessment in the community served by the CSB

- Acceptance and Commitment Therapy
- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Functional Family Therapy (FFT)
- Hi-Fidelity Wraparound (HFW)
- Integrated Treatment for Co-Occurring Disorders
- Living in Balance
- Medication Assisted Treatment (MAT)
- Moral Resonation Therapy
- Motivational Enhancement Therapy
- Multi-Systemic Family Therapy (MFT)
- Parent Child Interaction Therapy (PCIT)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Seeking Safety
- Solution Focused Brief Therapy
- Trauma Focused CBT (TF-CBT)
- Effective but underutilized medications for SUD treatment

The following is a list of options for services under Psychiatric Rehabilitation Services. As noted above, many are population specific, such as Psychosocial Rehabilitation Services for adults. Virginia is working to leverage Supported Employment across the Commonwealth. The state boasts four CSB's with Individual Placement and Support (IPS) certifications. However, there are vast disparities across the Commonwealth as it pertains to what employment services are offered.

- MH/SUD IOP
- Assertive Community Treatment
- MHSUD Supported Employment
- MHSUD Supervised Residential
- MHSUD Supervised Intensive Residential
- MHSUD Supervised Highly Intensive Residential
- Intensive In-home Services
- TDT
- Coordinated Specialty Care
- Mental Health Skill Building
- Psychosocial Rehabilitation Services
- Clubhouse Model/Fountain House

- Permanent Supportive Housing
- High Fidelity Wraparound
- Parent Child Interaction Therapy
- MHSUD peer support
- MHSUD group peer support
- Illness Management and Recovery
- Social Skills Training
- Cognitive Behavioral Therapy for Psychosis

Virginia utilizes a braided funding approach to leverage STEP-VA; the initiative is funded with state general funds, federal funds such as the Block Grant, locality matches, as well as insurance reimbursement (both public and private). No constituent is to be turned away from services based on inability to pay due to this extensive braided funding commitment. Similarly, should a constituent be in need of a service not offered by their local CSB, referrals to licensed private providers are expected to be made. Funding lines also provide financial resources to reduce this potential barrier. Medicaid expansion has greatly improved the access to mental health and substance use services within the Commonwealth of Virginia. It is an expectation of all CSB's to utilize federal funding and state general funds, as funding of last resort. During regular site visits, DBHDS regularly monitors and discusses the importance of insurance reimbursement, offering technical assistance where applicable to ensure programs are properly aligned to offset federal and state funding with insurance reimbursement. Virginia also heavily invests in Assertive Community Treatment through state general funds, as well as some Coordinated Specialty Teams. Virginia has several of these teams across the Commonwealth.

Outside of STEP-VA, as it pertains to adult services and an important Right Help Right Now initiative, Virginia has heavily invested state general funds towards the Adult Psychiatric Access Line (APAL). APAL is a statewide consult and care navigation program designed for providers treating adults struggling with substance use disorders. APAL supports providers with access to specialized mental health services and prepares primary care and emergency clinicians with the behavioral health needs of their patients through trainings and education. Despite sizable investments at the state and federal level, Virginia's capacity is constrained across the Commonwealth's continuum of behavioral health care. There are not enough specialized healthcare providers to meet patient demand for behavioral and mental health services. Virginia faces significant challenges in developing specialized solutions to reduce adverse health outcomes related to substance use disorders. With the support and resources provided by APAL, healthcare providers, particularly those in primary care and emergency settings, will have the tools and knowledge to help effectively diagnose, prescribe, and assist patients in navigating substance use recovery care. APAL's care model is based on three components: Provider education program on screening, diagnosis, management, and treatment of SUDs; access to telephonic consultations via regional hubs comprised of addiction medicine specialists and psychiatrists, psychologists, social workers, and/or prescribing providers; and care navigation assistance to help identify additional regional mental health services and resources. The APAL model is also a grant recipient of SAMHSA's Promoting Integration of Primary and Behavioral Healthcare: Collaborative Care Model grant, beginning in 2024 through 2029. The Commonwealth intends to continue investing in APAL in order to expand across several populations such as Geriatrics, Young Adults, and general mental health.

Despite the tremendous investment in services, barriers still exist across the Commonwealth. Virginia is a very diverse state, both demographically and financially. This serves to be a challenge to the state as DBHDS works to align services to STEP-VA and ensure there are services available to those in need. For instance, many families live long distances from points of treatment access and may not have reliable broadband or financial resources to access the internet. Several areas across the Commonwealth are considered provider shortage areas. Virginia has also heavily invested in a new data system which will greatly improve the data quality and availability across the system. Virginia has also set goals to ensure not only that constituents receive which services they are clinically in need of, but that these services are of quality. For instance, all ACT programs are now expected to undergo fidelity reviews which impact their levels of reimbursement. It is the ongoing intention to also ensure that if services are not available to constituents, that CSB's are appropriately referring and financing clinically appropriate care with private providers. As Virginia works to closely align STEP-VA to CCBHC, and therefore improve STEP-VA services, the above considerations are continuously taken into account.

Crisis Services

Virginia's crisis system is a statewide, regionalized model designed to ensure 24/7 access to behavioral health crisis services for all residents. The system includes crisis contact centers, mobile crisis response, and crisis receiving and stabilization services.

DBHDS is actively working to reduce the criminalization of individuals with Serious Mental Illness (SMI) through a multi-pronged crisis response system that diverts individuals from the criminal justice system and ensures timely access to behavioral health care. Key components of this system include the Marcus Alert system, 988 Suicide & Crisis Lifeline, Mobile Crisis Teams, and Crisis Intervention Team (CIT) Assessment Sites.

Marcus Alert System:
Virginia's Marcus Alert system was established to enhance the way communities respond to individuals experiencing behavioral health crises. It promotes the use of specialized behavioral health teams rather than relying solely on law enforcement. The system ensures coordination between 911 emergency services, regional crisis call centers, and local behavioral health teams. Each participating locality develops local protocols to ensure that individuals in crisis are connected with the right services at the right time. Additionally, the Marcus Alert system includes public education and outreach efforts to reduce stigma and improve community understanding of behavioral health needs. By emphasizing clinical responses over law enforcement engagement, the Marcus Alert system plays a central role in preventing unnecessary arrests and promoting recovery-oriented care.

988 Suicide & Crisis Lifeline:
The statewide 988 system was implemented to provide a simplified and accessible entry point for individuals experiencing a behavioral health crisis. The goal is to ensure that individuals are connected quickly and effectively to regional crisis call centers that can triage, stabilize, and dispatch mobile crisis services without involving law enforcement when it is not clinically necessary. This model ensures that individuals are routed to behavioral health professionals who can provide immediate support and help determine the most appropriate next steps.

Mobile Crisis Teams:
Fully funded mobile crisis teams serve as a cornerstone of Virginia's effort to divert individuals with SMI from the criminal justice system. These teams consist of licensed clinicians, qualified mental health

professional, and trained peers who respond in the community to individuals experiencing behavioral health emergencies. Mobile crisis teams provide assessment, de-escalation, and linkage to ongoing services, often resolving the crisis in the community without law enforcement involvement. Mobile teams serve as the lead responders for behavioral health support, ensuring that individuals receive care rather than face arrest or hospitalization when not necessary. Currently, there are 98 Mobile Crisis Teams operating across the state, with the goal of providing 24/7 response to behavioral health emergencies in all five regions.

While more urban and populous regions are consistently able to meet 24/7 response expectations, rural areas such as Regions 1 and 3 face persistent challenges in maintaining staffing levels to support full 24/7 coverage. The Department continues to work with providers in these areas to strengthen workforce capacity and expand equitable access to timely crisis response statewide.

Crisis Intervention Team (CITAC) Assessment Center:
CITAC Assessment Centers offer law enforcement officers a safe and efficient location to transport individuals in crisis for behavioral health assessment. Upon arrival, Individuals are screened for potential hospitalization, further behavioral health support, or placement in a Crisis Stabilization Unit (CSU). The CITAC model allows officers to quickly return to patrol duties while ensuring that individuals in crisis receive care in a therapeutic setting. These sites serve as a vital link in diverting individuals from jails and emergency departments, helping to reduce the criminal justice footprint for individuals with SMI.

Together, these components form a comprehensive Crisis Continuum that reflects Virginia's commitment to building a more just, humane, and clinically appropriate system for individuals in crisis. By embedding behavioral health professionals at key decision points and strengthening community-based resources, the Commonwealth is significantly reducing the risk of criminalization and improving outcomes for individuals with SMI.

Crisis Contact Centers

Virginia has two contracted crisis contact centers that support the Commonwealth's 988 and regional mobile response operations. HopeLink Behavioral Health serves Regions 1, 2, 4, and 5, while Frontier Behavioral Health covers Region 3. Frontier also functions as the backup contact center for HopeLink to ensure a smooth rollover during high volume. These centers handle triage, risk assessment, service registration in Virginia Crisis Connect (VCC), and dispatch mobile crisis teams.

Crisis Receiving and Stabilization Centers

Virginia is actively increasing access to facility-based crisis care. Currently, there are 10 Crisis Receiving Centers (CRCs) operating across the state, with more centers in various stages of development to enhance regional capacity. Additionally, the Commonwealth has 20 Crisis Stabilization Units (CSUs) offering short-term residential care for individuals in crisis. Of these, 7 are specifically dedicated to serving individuals with Intellectual and Developmental Disabilities (ID/DD), providing tailored support for those with unique needs.

Together, these services are integrated through Virginia's technology platform, Virginia Crisis Connect, to provide a coordinated, data-informed, and person-centered response to behavioral health crises across the state.

Recovery Support Services for Mental Health

Virginia's public behavioral health system provides recovery support and peer services in many forms, utilizing over $12M in federal and state dollars. Both block and state general funds are vital for boosting recovery support efforts and bridging the gap in recovery services across the Commonwealth. Programs and services include hiring peer staff in mental health and substance use disorder outpatient settings and services, crisis receiving center, crisis stabilization units, opioid use disorder services, intensive outpatient settings, emergency departments, inpatient facilities, hospital settings, mobile response, and assertive community treatment teams.

Block grant funding has been essential in establishing peer drop-in and resource centers, providing adequate compensation, warm line support, education, introductions to multiple recovery pathways, and internship programs that offer the 500 hours of experience required to gain certification in the state as a certified provider. The Recovery Service team extends scholarships to applicants seeking to become certified peer recovery specialists (CPRS) who have met the criteria to sit for the exam. The scholarship opportunities are accessed via the DBHDS partnership with the Virginia-based IC&RC entity, the Virginia Certification Board (VCB). DBHDS's advanced a strategic goal to increase the certified peer workforce by 10% by the end of 2023. That objective was reached within 6 months of its initiation.

Federal dollars have supported a staggering increase from 863 to over 1580 Certified Peer Recovery Specialists (CPRS) in Virginia's workforce. As internship opportunities in CSBs for peer providers increased, the behavioral health system's billing of Medicaid for this service became a priority. A $3M funding allocation via an ARPA RFP was made available to CSBs to enhance the billing infrastructure within the public system to reimburse for these services. Each of the 40 CSBs employs at least one DBHDS-funded peer or family support partner position.

COVID Supplemental dollars elevated recovery supports across the Commonwealth with the creation of four Regional Recovery-Oriented Services Coordinator positions. These positions became the DBHDS liaison in four of the state's five health planning regions. The Regional Coordinators were the training and education hubs for recovery education, resources, and community program linkages. These roles provided education system navigation and offered free and accessible training in domains such as the 72-Hour PRS, Integrated Forensic PRS, Certified Older Adult PRS, and Crisis settings.

The Recovery Leadership Academy (RLA) in Virginia is a ten-session professional development program designed to empower Certified Peer Recovery Specialists (CPRS) and Family Support Partners (FSP) with the leadership skills necessary to influence behavioral health systems and services. Launched in 2021 through a collaboration between the DBHDS Recovery Services team and Virginia Commonwealth University's Department of Rehabilitation Counseling, the RLA aims to cultivate a pipeline of peer leaders who can drive systemic change and promote recovery-oriented practices across the Commonwealth.

Participants in the RLA engage in a comprehensive curriculum that combines educational experiences, mentorship, and a team-building capstone project. The program focuses on enhancing organizational leadership competencies, strategic thinking, and advocacy skills. To be eligible, applicants must be certified peer professionals with at least two years of experience, demonstrate leadership potential, and commit to full participation, including serving as mentors for future cohorts. Since its inception, the RLA

has graduated multiple cohorts, contributing to the development of a robust peer leadership infrastructure within Virginia's behavioral health system. By fostering the growth of peer leaders, the RLA supports the integration of lived experience into service delivery, policy development, and organizational governance, thereby enhancing the effectiveness and responsiveness of recovery services statewide.

The ARPA funding established support for five additional recovery community organizations: McShin Foundation, Family Support Partners of Virginia, Chris Atwood Foundation, Strength in Peers, and Robin's Hope. Recovery Community Organizations (RCOs) have become vital pillars in Virginia's response to the substance use crisis, offering peer-led, community-rooted support that complements traditional treatment systems. Organizations like the McShin Foundation and Strength in Peers offer peer-to-peer recovery services, transitional housing, and educational programs, enabling individuals to sustain long-term recovery through their own lived experiences and mutual support. Initiatives like Recovery Corps, which launched in 2022, have placed Recovery Navigators and Project Coordinators across the state to expand access to services and reduce overdose-related emergency visits. In Northern Virginia, the Chris Atwood Foundation unites stakeholders to coordinate and provide comprehensive harm reduction, prevention, and recovery efforts, fostering a unified community response. Research indicates that participation in RCOs is associated with improved recovery capital, including housing stability and employment, as well as reduced emergency department visits and substance use recurrence. By reducing stigma, building recovery networks, and empowering individuals through peer leadership, RCOs are reshaping Virginia's recovery landscape into one that is more inclusive, sustainable, and community driven.

Virginia's recovery support continues to identify deficits in understanding the roles of peer and family support partners and how they differ from other disciplines. The Recovery Services team has developed a training module for the public behavioral health system to support the development of this crucial level of understanding throughout the system. The expectation is to take the training on the role of a peer provider at the onboarding of new direct service and peer supervisory staff working in MH/SUD programs. The training is provided on a tri-annual basis after orientation.

Compensation for Virginia's peer workforce remains at the poverty level, leading to unfilled positions across the system. It is noted that the passion for the work is prevalent; however, the lived and living experience workforce often leaves or forgoes applying for a peer position due to the inability to cover living expenses with low pay amid the rising cost of living.

Barrier crimes continue to hinder employment in the behavioral health field and block well-educated and trained individuals from positively impacting the field and modeling the power of recovery. In Virginia, the number of licensed staff available to conduct waiver screenings for peer staff eligible for this process totals two in the state. Thereby, furthering the process to gain employment in the BH more elusive.

Family Support Partners positions across the public behavioral system remain challenging. Filling Family Support Partner (FSP) positions in Virginia remains a persistent challenge due to a combination of systemic, financial, and structural issues. FSPs, who are trained caregivers with lived experience navigating the child behavioral health system, play a vital role in supporting families facing complex emotional and mental health challenges. However, recruitment and retention are hampered by low starting salaries. Thus, impacting the ability to attract and retain qualified candidates, especially when compared to higher-paying roles or private sector opportunities. High turnover rates and vacancy levels in many localities further strain the workforce. The emotional demands of the role, exposure to secondary trauma, and limited support contribute to burnout, making long-term retention difficult. Virginia's steps to enhance

training, supervision, and cultural competency are steps in the right direction, but without competitive compensation and systemic reforms, filling FSP roles will likely remain a significant hurdle.

Housing Services for Mental Health

Since 2016, DBHDS has been successful in securing nearly $90 million in state general funds to provide Permanent Supportive Housing (PSH) to individuals with SMI (nearly 3,000 slots among 30 providers) and Pregnant or Parenting Women with SUDs (300 slots, 6 providers). In FY25, 93% of PSH participants remained stably housed one year after they moved in, and state hospital costs were reduced by 76% after one year in PSH. A needs assessment released in 2023 identified that 7,220 individuals with SMI in Virginia needed PSH. DBHDS's Strategic Plan includes a goal to address 60% of that need by 2026 (KR-4C). DBHDS supports and monitors providers to ensure adherence to contract terms as well as fidelity to the Evidence-Based Practice standards for PSH. PSH providers receive support and technical assistance from the DBHDS Office of Community Housing to establish policies and procedures and build relationships with key community partners including the homelessness Continuum of Care (CoC), state and local hospitals, and jails. After the first year, programs undergo a PSH fidelity assessment and work with their DBHDS Housing Coordinator and expert coaches to improve fidelity in identified domains.

PSH funding recipients are largely CSBs, non-profit supportive housing providers, and public housing authorities who manage one or more of the key components of PSH: long-term rental assistance or tenancy support services. Prioritization criteria are applied to ensure that individuals experiencing long-term homelessness or institutionalization are afforded access to long-term rental assistance and tenancy support services that PSH provides. DBHDS's PSH programs are demonstrably successful in both prioritizing highly vulnerable individuals and ensuring their housing stability.

Criterion 2: Mental Health System Data Epidemiology

Contains a state-level estimate of the incidence and prevalence of SMI among adults and SED among children; and includes quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

CSBs provide a wide array of mental health services to children and adults. In State Fiscal Year (SFY) 2024, an unduplicated 121,950 individuals received CSB mental health services. Services include: Outpatient Services, Case Management, Assertive Community Treatment, Day Treatment/Partial Hospitalization, Ambulatory Crisis Stabilization, Rehabilitation, Sheltered Employment, Individual and Group Supported Employment, Residential Crisis Stabilization Services, Highly Intensive and Intensive Residential Services, and Supervised and Supportive Residential Services. A significant number of these individuals have severe mental illness; of the individuals receiving mental health services in SFY2024 68% of all adults served had a serious mental illness and 71% of all children served had or were at risk of having a serious emotional disturbance. Between SFY 2008 and SFY 2024, the number of individuals receiving CSB mental health services increased from 101,796 to 121,950, an increase of about 19%.

Any quantitative targets to be achieved in implementation of system of care outside of those listed in Planning Tables: Table 1

- i.e. BH dashboard, STEP VA measures, RHRN that correspond with services listed in Criterion 1

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include social services; child welfare services; educational services, including services provided under the Individuals with Disabilities Education Act; juvenile justice services; substance use disorder services; and health and mental health services.

DBHDS has prioritized engaging youth in primary settings, focusing on building school-based partnerships and pediatrician offices as main areas to support children in need of care.

DBHDS partners with the Department of Education (DOE) to support collaborative activities between schools and the behavioral health and developmental services system. In State Fiscal Years 2023 and 2024, the Virginia General Assembly allocated funding ($2.5 and $7.5 million respectively) for a school-based mental health pilot project which provided grants to school divisions to contract for mental health services/training as well as programmatic technical assistance. DBHDS has partnered with the DOE to provide technical assistance and currently partners with Old Dominion University to continue these efforts. In the 2025 State Fiscal Year, $15 million was awarded to DBHDS in order to establish school clinics throughout Virginia. Additionally in 2025, mental health block grant funds currently support 19 school divisions in contracting with either public or private agencies to provide mental health services and/or training in schools.

For children birth to three, DBHDS is the lead agency for the services under Part C of the Individuals with Disabilities Education Act. DOE is involved with all state initiatives focused on Part C services, including the state Virginia Interagency Coordinating Council for Part C. For the school age population, DBHDS and DOE work closely on a variety of interagency initiatives to improve in-school support for school-age children with behavioral health problems and improve outcomes for Virginia's children. This includes intensive efforts to keep children in their homes and community schools. In addition, DOE holds a designated seat on the Virginia Behavioral Health Advisory Council.

The Virginia Mental Health Access Program (VMAP) is a statewide initiative that increases access and improves mental, behavioral, and emotional health and development by providing education, consultation, and care navigation to medical providers of infants, children, adolescents, young adults, and pregnant & postpartum people. This program was first implemented regionally in 2020 through support from the General Assembly and due to its early successes continues to receive funding and has expanded over the years. The VMAP Line offers same-day consultation for PCPs regarding patients 21 & under. Virginia PCPs can call to connect with experts like:

- Child & Adolescent Psychiatrists
- Developmental Pediatricians
- Licensed Mental Health Professionals

Providers can also access care navigation to help their patients connect with local mental health resources and referrals.

VMAP offers a variety of expert-led pediatric and perinatal mental health trainings. VMAP core provider education offerings are held in partnership with the Virginia Chapter of the American Academy of Pediatrics. Education sessions are tailored for Virginia prescribers and are designed to equip providers with skills to identify mental health disorders, manage psychopharmacology, and adopt evidence-based care into their practice.

In addition to the core VMAP, there are several expansion projects that are connecting more providers and specialized populations to mental and behavioral healthcare. VMAP for Moms+ was developed for Virginia prescribers who provide care to pregnant and postpartum individuals and/or their children, including:

- OB/GYNs

- Primary Care Clinicians
- Midwives
- Pediatricians
- Psychiatrists

VMAP's early childhood expansion added a full staff of specialists on the VMAP line including:

- Early childhood psychiatrists
- Developmental/behavioral pediatricians
- Early childhood psychologists
- Early childhood care navigators

VMAP's early childhood expansion also added education programs specific to early childhood including ECHO Systems of Care of Kids, Triple P (Positive Parenting Program) and ECHO STAT (Autism Diagnosis).

Additionally, the Virginia Mental Health Access Program (VMAP) is utilizing funds to establish and implement a Virginia Youth Screening, Brief Intervention, and Referral to Treatment (VA YSBIRT) Project called Rise Above SUD. This is a statewide initiative this is developing and implementing a sustainable model to increase access to evidence-based screening, early intervention, and treatment for substance use and co-occurring problems for youth up to age 21. This program will be implemented in pediatric and primary care practices and will be integrated within the existing VMAP model of care.

DBHDS and the Department of Social Services (DSS) collaborate through a variety of programs and services to help individuals cope with and recover from the effects of poverty, abuse, or neglect and achieve self-sufficiency. This includes services to families who are TANF recipients, to families confronting child custody issues, and to substance-exposed infants and their families.

In 2022 the Governor of Virginia launched the Safe and Sound task force to ensure safe placements for children in foster care. This task force continues to bring together state and local government agencies, all three branches of government, private providers, health networks, advocacy groups, the faith community and other community partners, the task force works to find solutions for safe and appropriate placements for children in foster care.

CSB Level Overview of Services

Mental Health Block Grant dollars are provided to every CSB/BHA in Virginia to support the local system of care. The purpose of these funds is to provide community-based services to youth (up to age 18), who have serious emotional disturbance with the goal of keeping youth in the community and reducing reliance on out-of-home placements. Services may include assessments and evaluations, outpatient or office-based treatment, case management, community-based crisis services, intensive community-based supports, community-based home services, and special populations of youth with SED such as juvenile justice, child welfare, and/other under-served populations. Services cannot be used for residential or inpatient care.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adult

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services for older adults.

Homeless Individuals & Families

Virginia's 2024 Homeless Point in Time (PIT) count identified 1,298 heads of household with SMI and 701 with a substance use disorder (individuals may be counted in both categories simultaneously). DBHDS collaborates to address homelessness at the state level with the Department of Housing and Community Development, the state agency lead for homeless services and policy. The homelessness trends for these two populations (SMI and SUD) are heading in different directions. Between 2015 and 2024, the PIT count of individuals experiencing homelessness with a SUD dropped by 36% (from 1,103 to 701) while the SMI homeless count actually *increased* by 20% (from 1,079 to 1,298). While housing affordability remains the most significant driver of homelessness, the reduction in access barriers to housing resources for individuals with SUD is largely credited with the reduction in homelessness for that population.

DBHDS also administers the federal PATH (Projects for Assistance in Transition from Homelessness) program, and a related national project called SOAR (SSI/DI Outreach, Access and Recovery). PATH has operated in Virginia since 1991 and funds direct street outreach and shelter in-reach services to connect individuals with SMI who are homeless or at risk of homelessness to access treatment, income, and housing. In 2024, Virginia's fourteen PATH providers contacted 1,766 individuals and enrolled 1,011. PATH services remain critical to connect some of the most vulnerable individuals with SMI to the array of community resources that can improve mental health, substance use, and housing outcomes.

SOAR is a SAMHSA training and technical assistance initiative developed to improve access to disability income for homeless individuals with SMI - has been implemented in Virginia since 2005. Virginia's SOAR project is a collaboration between DBHDS, the Social Security Administration (SSA), and regional Disability Determination Services (DDS) Professional Relations Officers (PROs). The PROs role is to track submitted SOAR-assisted claims, assign them to SOAR analysts, and provide technical assistance work to facilitate claims processing. Virginia's SSA/DDS partners join in monthly regional meetings, gathering with SOAR workers to troubleshoot process and technical issues and offer direct access to SOAR workers for immediate assistance. Virginia's SOAR program implements a Local Lead structure and has trained fifteen Local Leads through the SAMHSA SOAR TA Center's Leadership Academy thereby providing local leadership and support for the SOAR initiative in regional communities.

The Virginia SOAR project, in collaboration with the SOAR TA Center and regional SSA and DDS Directors, has implemented pre-release agreements between local state psychiatric hospitals and SSA offices. This process addresses barriers to discharge for individuals with serious mental illness and chronic homelessness, while also reducing hospital census and the use of Discharge Assistance Planning (DAP) funding and increasing successfully linkage to PSH programs. Additionally, Virginia SOAR has trained all Forensic Discharge Planning (FDP) staff within the 15 regional jails to utilize the SOAR pre-release process.

Overall, Virginia's state SOAR efforts have remained fruitful. Virginia continues to achieve a high approval rating with a 76% initial approval rate (with average days to decision 161) for initial SOAR applications in 2023, well above the national average of 66%.

Virginia's Permanent Supportive Housing (PSH) programs for individuals with SMI or Pregnant or Parenting Women with SUDs operate in all regions of the state with a much more expansive geographic footprint for the PSH SMI programs. DBHDS PSH, described fully in other sections of this application, is an important community resource for these populations, helping to address homelessness and provide an affordable and accessible housing option for rural, urban, and suburban communities – all of whom face affordable housing shortages whether due to lack of infrastructure (rural) or rapidly escalating housing costs (urban, suburban). Additionally, DBHDS funds tenancy support services as a core component of its PSH programs. These service providers are an important resource for communities, helping individuals to navigate both housing and supportive services systems and directly providing services that help individuals secure and maintain housing. In FY24, 93% of PSH participants remained stably housed for at least one year after their initial move in.

Rural Population

Since the pandemic, Virginia, like most states, has seen a significant increase in the use of telehealth. This has been an extremely important resource to those constituents accessing mental health and substance use services in rural areas of the state who may have otherwise been isolated from care. Due to the rural nature of many parts of Virginia, accessing face-to-face care is sometimes impossible due to lack of access to transportation (both public and personal), as well as time resources. Other resources listed above, such as APAL, target the scarcity of resources in rural areas and within particular demographics (such as geriatrics) utilizing telehealth and established regional relationships in order to improve access to services.

Virginia is comprised of five regions, most of which have some CSB's impacted by rurality. However, one region (Region 3) in particular is considered very rural. Each region enjoys partnerships with other CSB's in their region where they are able to consult and discuss resources particular to their catchment areas. A frequent topic of Region 3 is the impact of rurality on SMI treatment, and creative approaches to reduce this barrier.

Mobile Crisis Response in Rural Virginia

DBHDS is prioritizing the expansion and accessibility of Mobile Crisis Response (MCR) services in rural areas. Recognizing the unique challenges faced by individuals in these communities, DBHDS is actively

implementing targeted strategies to enhance service delivery and public awareness.

A core component of this effort includes the focused marketing and promotion of the 988 Suicide & Crisis Lifeline across rural regions. Through localized outreach campaigns, DBHDS is working to ensure that individuals in rural communities are aware of and can access immediate behavioral health crisis support via the 988 line, which serves as a central point of connection to Mobile Crisis services.

Additionally, DBHDS has prioritized recruitment and workforce development efforts aimed at expanding the availability of qualified Mobile Crisis Response team members in rural areas. This includes outreach to educational institutions, promotion of career pathways in behavioral health, and the development of partnerships with community stakeholders to support sustainable staffing models.

Despite these efforts, a significant barrier to full implementation remains the ongoing workforce shortage, particularly in rural regions where the pool of licensed or credentialed behavioral health professionals is limited. DBHDS continues to explore innovative solutions to address these gaps, including telehealth integration, incentive programs, and cross-agency collaboration to build a more robust and regionally distributed crisis response workforce.

Older Adults

Any targeted services for SMI: Nearly 46% of individuals in PSH SMI in 2024 were 55 or older and nearly 14% were 65 or older. Homelessness is rising among older adults in Virginia, and DBHDS's PSH resources can assist older adults experiencing homelessness or exiting institutional settings.

As it pertains to STEP-VA services, there is no age limit for service appropriateness. For instance, all EBP's under Outpatient and Psychiatric Rehabilitation Services are to be tailored to any demographic and/or MHSUD diagnosis. Some CSB's, particularly those with higher populations of geriatrics, have particular set-asides for programming and training devoted to the geriatric population. As noted above, it is a goal of the Commonwealth to expand APAL into the geriatric population, as providers are aware that MHSUD treatment for geriatrics should be tailored to their particular needs. As is true with other services across the Commonwealth, there are vast differences in which services are offered and how staff are trained. It is the intention of the Commonwealth to create, implement and monitor programs and trainings specific to geriatric services due to the specific needs of this population, as well as continual specific population growth.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Virgina's system of care is funded through several different means. Funding comes from state, local, and federal resources, as well as self-pay on a sliding scale of individuals and the use of managed care for those who are insured. Our system has both locally driven community services boards as well as private providers who work to engage and offer services to those in need. DBHDS uses state and federal funds to provide training to our community services board workforce related to changes in the evolving field of care. Some training from this past two-year period includes peer recovery, ASAM trainings, Clinical

supervision training for those licensed, EBP support and training as DBHDS work toward a more standard level of care for all Virginians. Going forward, DBHDS plan to expand our EBP training to support providers in implementation and workforce retention and recruitment. DBHDS plan to continue to provide training and support to our emergency services partners as well as crisis services along the continuum of care specific to those in need of additional supports. There are changes pending in our assessments used statewide and quality measures which will need training provided to those using these tools.

Virginia Implementation of Federal Criteria for State Substance Use Services

Section 1932(b) of the PHS Act (42 U.S.C. § 300x-32(b)) established the criterion that must be addressed in the State Plan.

Substance Use Disorder Services Criteria

Criterion 1: Statewide Plan for Substance Use Primary Prevention, Treatment and Recovery Services for Individuals, Families and Communities

The Substance Use Services team serves as the substance use administrative and programmatic arm of DBHDS. The team provides oversight of state and federal substance use funding and serves as the lead systematic design for the delivery of substance use services throughout the Commonwealth. In addition, the team is responsible for oversight of substance use treatment programing and the expansion of substance use services throughout the Commonwealth.

Virginia offers a range of treatment programs for substance use disorders, including medication-assisted treatment (MAT), medication management and withdrawal, outpatient, inpatient, peer, and intensive services, and support for individuals with substance use and co-occurring disorders. These programs are available through Community Services Boards (CSBs), private clinics, and other organizations.

Virginia has enacted legislation to address substance use through treatment programs related initiatives. Highlighted programs include Virginia Opioid Reduction, STEP-VA, Student Education to Prevent Overdose, and the expansion of Maternal Health quality reviews related to substance use. Virginia continues to expand its use of evidence-based interventions, including educational programs, skills training, and community-based programs, to prevent substance use.

Need for SUD services

There has been an increase in the number of individuals that are receiving substance use disorder services. One more CSB has begun providing medication assisted treatment. Services included: Inpatient Services, Community-Based SA Medical Detox Inpatient Services, Outpatient Services, Intensive Outpatient Services, Case Management Services, Medication Assisted Treatment, Day Treatment/Partial Hospitalization, Rehabilitation, Individual Supported Employment, Highly Intensive Residential Services, Residential Crisis Stabilization Services, Intensive Residential Services, Supervised Residential Services, Supportive Residential Services and Prevention Services. In SFY 2024, an unduplicated 24,285 individuals received substance use disorder services from CSBs. Alcohol and opiates were reported as the primary drug of abuse for 27.9% and opiates for 27.9% of these individuals, marijuana/hashish for 13.2% and methamphetamines for 14.6%. Thirty of the 40 CSBs provided medication assisted treatment (methadone or buprenorphine),

either directly or through a contract with a local private provider, serving 5220 individuals in SFY 2024. In SFY 2023, an unduplicated 24,008 individuals received substance use disorder services from CSBs. Opiates were reported as the primary drug of abuse for 27.3% of these individuals, alcohol for 27.6%, marijuana/hashish for 13.4% and methamphetamines for 15.4%. Twentynine of the 40 CSBs provided medication assisted treatment (methadone or buprenorphine), either directly or through a contract with a local private provider, serving 4953 individuals in SFY 2023.

Virginia's "Right Help, Right Now" initiatives aim to address the state's behavioral health crisis by providing immediate support before, during, and after a crisis, specifically in relation to substance use disorders and overdoses. A primary goal is to improve treatment and recovery services for substance use disorders, reducing barriers to recovery, and addressing the fentanyl overdose crisis.

Measures to address substance use disorders and overdose include the development, implementation and expansion of various substance-use related programs and services. Such initiatives include the following:

- Expansion Virginia’s Suicide & Crisis Lifeline (988), to provide those in struggles with substance use, mental health and co-occurring disorders 24/7 access to trained crisis workers that provide crisis intervention, emotional support, resource referral, safe planning and follow up supports.
- Fentanyl Focus: The initiative recognizes the prevalence of fentanyl overdose deaths and aims to wage a "war on fentanyl overdoses" by investing additional funding and resources, including a public awareness campaign.
- Reducing Barriers to Recovery. The initiative aims to reduce barriers to recovery and re-entry for individuals struggling with substance use disorders.
- Increased Access to Naloxone: Efforts are underway to increase access to naloxone, an opioid overdose reversal medication, which is part of the plan to address the overdose crisis.
- Funding: A portion of the opioid settlement fund is being designated for fentanyl initiatives, demonstrating the state's commitment to addressing the crisis.

The First Responder Naloxone Program (VACP) increases access and distribution of naloxone to all first responders in the Commonwealth of Virginia, increases participation in the REVIVE! for First Responders training program, and in-creases the number of REVIVE! FR Trainers and Master Trainers. VACP is managed by the Virginia Association of Chiefs of Police (VACP) for the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

The Safe Housing and Warming Program (SHAW) provides unhoused individuals with emergency inclement weather supplies for extreme weather conditions in areas designated with:

- High substance uses and overdose rates
- Highly populated underserved
- Underinsured, and uninsured individuals
- Limited resources to include by not limited to closed shelters
- Overcrowded shelters

- No comprehensive harm reduction site within reasonable proximity
- A large population of individuals with a substance use disorder are also a part of the unhoused community

A primary outcome for the DBHDS Strategic Plan is to decrease the overdose rate by 20% by the end of the year 2025. The overdose rate in 2021 was initially chosen as the baseline year for measuring change in overdose mortality rates. However, after reviewing the data obtained from 2021 to present, it is determined that a true analyzation cannot be completed utilizing this timeframe as it does not allow for the effective measure of a directional slope for the overdose rate prior Covid, neither does it effectively measure the impact of implemented strategies targeted to reduce the overdose mortality rate. To present a more complete narrative when looking at recent overdose trends, a new baseline date of 2019 is preferable and will allow DBHDS to infer possible correlations between the overdose rate and intervention practices such as:

- risk Reduction
    - Risk Reduction Efforts: Increased access to treatment and recovery support services may have contributed to the decline.
- Naloxone Saturation
    - Increased Naloxone Availability: Wider availability and distribution of naloxone (Narcan), a medication that can reverse opioid overdoses, have likely played a role in reducing fatalities.
- The expansion of Revive and law enforcement training
- Substance Use community funds
- Recovery residences
- The acceleration of licensing substance use programs
- OTP flexibilities
- Community-based substance use awareness campaigns
- Mobile substance units
- Public Awareness Campaigns:
    - Initiatives like "It Only Takes One" and "One Pill Can Kill" aim to educate people about the dangers of fentanyl and counterfeit pills.
- Law Enforcement Efforts:
    - Initiatives like Operation FREE focus on disrupting the drug trade and seizing illicit substances.

Understanding that DBHDS are not able to measure the true impact of our statewide interventions, DBHDS can however see if there is a relationship between those efforts (and their timing) and the overdose rate. DBHDS can, with high confidence, put forth the argument that these efforts served to stop the tragic rise in overdose deaths that occurred between 2019 and 2021, and to not only 'flatten the curve' but to produce a percentage decrease in the number of overdoses throughout the Commonwealth. Currently, Virginia's overdose rate has had a significant decrease.

Peak and Decline of Overdose Deaths

Drug overdose deaths in Virginia peaked in 2021 at 2,622 deaths and have been decreasing

since then.

- 2023 Data: There were 2,463 drug overdose deaths in Virginia in 2023, a 1% decrease from 2022.
- Fentanyl-Related Deaths: Governor Youngkin announced a 44% decrease in fentanyl-related overdose deaths year-over-year and a 46% decrease from the peak in 2021, according to the Governor of Virginia (.gov).

Preliminary data from 2024 indicates a significant decrease in overdose deaths, potentially as high as 43% from 2023, though this data is still subject to change. Virginia experienced one of the largest decreases in overdose deaths in the nation between 2023 and 2024.

Related to the drop in overdose deaths, as of 2019, all 40 Community Services Boards provided some level of MAT services either directly or through formal agreements with other providers. Funding allocations now provide support for all CSBs to directly provide MAT services to clients. Funds allocated to the CSBs are used to support both staff and the purchase of FDA approved medications, such as oral and injectable buprenorphine, Sublocade, Methadone, for the treatment of substance use in carceral settings.

The ARPA funding was used to implement STEP-VA. The STEP-VA initiative is an integrated care model where primary care providers and behavioral health specialists work collaboratively. STEP-VA is also focusing on improving Same Day Access for the CSBs across the state by providing technical assistance and regulations. It was also utilized to increase the engagement and retention of SU services for all patients at 14 of the Commonwealth's CSBs. One CSB was given funding for a SU facility reinvestment.

There are still many treatment desert areas in the state and expansion of substance use and addiction services to those areas need to be a priority. DBHDS and the State Opioid Treatment Authority (SOTA) are also focusing on providing Technical Assistance for companies/agencies that want to open OTPs in the desert areas.

Partnerships with Private Providers

The private sector remains an important partner with CSBs in serving people with behavioral health needs. In addition to serving many individuals through varied contracts with CSBs across populations, private providers can also serve other individuals directly. Private providers are an especially important resource for substance use disorder treatment for persons with an opioid use disorder (OUD). Individuals receiving treatment for an OUD often include injection drug users (IDUs). Contractual agreements with private providers allow individuals to be referred for methadone or other medication-assisted treatment. These private OTPs continue to expand treatment access statewide. Virginia has 47 OTPs statewide assisting individuals in need of MOUD.

Quality Assurance for SUD Block Grant Funds

DBHDS has the responsibility of Quality Assurance to ensure through funding allocations and monitoring that block grant funds are used for its intended purposes.

Block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medi-caid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.
- Substance use disorder (SUD) treatment and recovery support services to individuals and families impacted by SUDs.

Criterion 2: Primary Prevention

The Behavioral Health Wellness team leads a comprehensive, statewide effort to prevent and reduce substance use across the Commonwealth. These efforts are funded through the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and supports all 40 Community Services Boards (CSBs) in planning, implementing, and evaluating evidence-based prevention strategies.

Virginia's substance use prevention system is grounded in proven frameworks—SAMHSA's Strategic Prevention Framework (SPF), Resiliency Theory, and the Socio-Ecological Model—and is built on the core principles of resilience, community engagement, and equity. Key services delivered through this system include coalition-building, community mobilization, suicide prevention (e.g., Lock and Talk, Mental Health First Aid, QPR), Adverse Childhood Experiences (ACEs) education, youth-focused tobacco and cannabis prevention, problem gambling outreach, and capacity-building for data-driven evaluation.

At the state level, the Behavioral Health Wellness team plays a vital leadership role in shaping Virginia's prevention infrastructure. It conducts statewide needs assessments, guides evaluation planning, and provides ongoing technical assistance, training, and strategic direction to CSBs. In 2024, the Behavioral Health Wellness team conducted a comprehensive statewide needs assessment to identify progress, gaps, and emerging trends in substance use and mental health; the findings from this effort are directly informing the upcoming 2025–2030 strategic plan.

The Behavioral Health Wellness team leads key data and evaluation initiatives through partnerships, including oversight of the Virginia Social Indicator Summary (VASIS) dashboard and the State Epidemiological Outcomes Workgroup (SEOW). These tools enable data-driven decision-making and enhance transparency and impact. In FY2024, the Behavioral Health Wellness team launched a re-platformed VASIS.org site with expanded real-time data access, integrated youth and young adult behavioral health surveys, and partnerships with new stakeholders such as the Department of Veterans Services to broaden data availability.

The Behavioral Health Wellness team ensures accountability and performance monitoring across the state through the Performance-Based Prevention System (PBPS), aligning local implementation with state and federal priorities and maintaining a strong focus on outcome measurement, sustainability, and equity.

Virginia's "Right Help, Right Now" initiative is a central value reflected in numerous prevention efforts. Through Lock and Talk, a statewide suicide prevention initiative, the Behavioral Health

Wellness team and CSBs disseminated over 31,000 safety devices (e.g., lock boxes, cable locks) and reached over 5.5 million people through awareness campaigns. CSBs also trained over 12,800 individuals in mental health awareness and suicide prevention curricula in FY24, creating stronger networks of early intervention and crisis response. The alignment of these strategies ensures community members receive timely, lifesaving support and resources—especially in high-risk areas.

Workforce development and retention remain critical priorities for sustaining a high-quality, community-based prevention system. To address ongoing challenges with recruitment, retention, and equity in compensation, a comprehensive salary study is being undertaken to evaluate current pay structures across the prevention workforce within Community Services Boards (CSBs). This study aims to assess competitive salary benchmarks, identify pay disparities, and develop recommendations for standardizing compensation to better reflect the scope and impact of prevention roles. By aligning salaries with industry standards and recognizing the specialized skills required for prevention work—including data analysis, community engagement, and evidence-based program implementation—Virginia can strengthen workforce stability, improve morale, and reduce turnover. These efforts will ultimately ensure continuity of services, protect institutional knowledge, and enhance the effectiveness of statewide prevention initiatives

The 2025–2030 Virginia Substance Use Prevention Strategic Plan, developed by the Behavioral Health Wellness team, provides a forward-thinking, integrated blueprint for the next funding cycle. It aligns interventions across shared risk and protective factors, enhances data equity, and simplifies CSB implementation to maximize impact.

The plan identifies seven core risk and protective factors: Active Parenting, Ease of Access, Healthy Coping Skills/Resilience, Perceptions of Risk, Social Isolation, Social Supports, and Trusted Adults/Mentors. Prevention strategies are categorized by socio-ecological level (individual, interpersonal, community, societal), with CSBs required to implement five evidence-based strategies—including Counter Tools, Lock and Talk, and Mental Health First Aid—while choosing additional strategies based on local needs.

This plan streamlines prevention work, strengthens evaluation of upstream outcomes, and supports trauma-informed, culturally competent service delivery across the Commonwealth.

Virginia’s 40 CSBs are the engine of prevention service delivery. They lead over 70 active coalitions, conduct thousands of merchant education visits, and provide tailored strategies addressing local behavioral health needs.

Key services implemented by CSBs in FY24 include:

- Mental health training for 12,844 individuals
- 370 ACEs trainings reaching over 5,000 participants
- Cannabis prevention campaigns (26 CSBs) reaching 2.8 million people
- Problem gambling outreach (31 CSBs) with a reach exceeding 10 million
- Retailer education through 4,000+ site visits using the Counter Tools platform

CSBs also expanded coalition engagement, youth involvement, and trauma-informed care networks. These

local innovations align with the Behavioral Health Wellness team's statewide goals while addressing unique regional challenges.

Block Grant (BG) funding remains the primary resource supporting core prevention activities, workforce capacity-building, evaluation, and strategy implementation. CSBs use BG dollars to implement required strategies (e.g., Synar, Lock and Talk, etc.) and tailor local interventions based on identified needs.

ARPA and COVID Supplemental funding have been crucial in sustaining services disrupted by the pandemic, expanding outreach to underserved communities, and addressing heightened mental health needs. Funds were used to enhance staffing, increase access to suicide prevention tools, and broaden the reach of prevention messaging during a time of unprecedented stress and behavioral health risk.

Despite these efforts, CSBs reported several persistent challenges. Staffing shortages and limited financial resources were among the most significant barriers, with 26 CSBs indicating they lacked enough personnel or funding. Other challenges included community-wide lack of awareness about substance use risks, cultural norms that favor substance use, limited transportation in rural areas, and high poverty rates. Resistance to prevention messaging and systemic mistrust of public institutions also hindered progress. Moreover, mental health indicators—particularly youth suicide attempts and related distress—have worsened, underscoring the urgent need for continued and expanded prevention services. The Behavioral Health Wellness team and CSBs are actively addressing these concerns through expanded evaluation, coalition engagement, and culturally responsive programming—but continued investment and innovation are essential.

Criterion 3: Pregnant Women and Women with Dependent Children

DBHDS participated in the National Governors Association, Improving Maternal and Child Health (MCH)in Rural America team 2024-2025. The MCH Learning Collaborative Virginia team included DBHDS, the Department of Health, and the Department of Medical Assistance (DMAS). Likewise, the Virginia team was placed in the NGA Substance Use and Behavioral Health track. The state received technical assistance on effective models of perinatal substance use disorder programs from SAMSHA, Learning Collaborative Cohort teams (Pennsylvania and Illinois) and the Association of Maternal and Child Health Programs (AMCHP) Virginia selected and identified goals for the state based upon the Governor's Executive Order 32 which reestablished the Maternal Health Data Quality Task Force and will compile a final report December 2025. Additionally, Executive Order 11 includes the creation of Maternal and Child Health dashboards and a central resource hub or website to provide family resources and other parent resources. DBHDS Women's Services and Specialty Population Manager represented Virginia at the MCH Learning Collaborative and Healthcare Workforce Policy Academy Closeout Convening (Tempe, Arizonia), in December 2025, and provided updates on perinatal addiction and goals for the state.

DBHDS remains an active member and serves as a maternal addiction subject matter expert on the Virginia Maternal Mortality Review Team, Office of the Medical Examiner's Office, Virginia Department of Health. Twenty percent of maternal mortality in the state of Virginia is attributed to substance use (accidental overdose) and behavioral health issues. DBHDS Women's Services was the team lead for recommendations for the 2024 Maternal Mortality Review report, which includes availability of NARCAN at WIC, libraries, and other public entities that women frequent.

DBHDS, Project LINK sites, and the Virginia Department of Social Services, Child Fatality Prevention, partnered to reduce child fatality as a result of unsafe sleep practices. Project LINK sites provided training on safe sleep and educated parents on safe sleep practices via, "Sleep Baby Safe and Snug" board books during home visits and group therapy. The goal is to continue this initiative after the conclusion of the VDSS grant.

Project LINK

Since its launch in 1992 with five sites, Project LINK has continued to expand steadily. As of 2025, it operates across 14 Community Services Boards (CSBs) in regions 1, 3, 4, and 5 of the Commonwealth. In FY2024, the program was funded through the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Substance Use Services team, and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Women's Set-Aside.

Project LINK remains a vital and innovative program that supports women and families affected by substance use disorders, co-occurring conditions, and trauma. The program specifically serves pregnant and postpartum women, parenting women with dependent children, and women of childbearing age. As one of the few gender-specific initiatives in Virginia, Project LINK provides access to comprehensive, trauma-informed substance use disorder services.

Project LINK's **mission** is to remove barriers to treatment, prevention, and recovery for women affected by substance use and their children. This mission is realized through service coordination, stakeholder education, and the expansion of holistic offerings.

The **targeted population** for Project LINK includes the following:

1. Pregnant women impacted by substance use disorder are a priority population and are admitted into services within 48 hours
2. Postpartum women who deliver Substance Exposed Infants (SEI)
3. Parenting women with dependent children (0-18 years old) or seeking reunification with dependent children
4. Women of childbearing age (12-45 years), including pregnant and parenting adolescents, diagnosed with SUDs or co-occurring disorders
5. Target case management services for children (0-7 years old) for programs that employ children and adolescent case managers

The **goals** of this program include the following:

1. Decrease the incidence of alcohol, tobacco, and other substance use among pregnant, postpartum, parenting, and "at-risk" women.
2. Increase early identification, referrals, and follow-up of women and children
3. Enhance the availability and accessibility of prevention, early intervention treatment services, and recovery services.
4. Optimize the healthy growth and development of infants born to Project LINK mothers
5. Strengthen the family unit, promote positive parenting, and support the optimal social, emotional, and physical development of the children in the family unit
6. Increase interagency service collaboration

The **strategies** to achieve the program's goals:

1. Intensive case management services
2. Home and community visits
3. Recovery and family-based activities
4. Evidence-Based programs:
    a. Nurturing Parenting for Families in Substance Abuse Treatment and Recovery program
    b. Trauma programs such as Seeking Safety, Healing Trauma, or Eye Movement Desensitization and Reprocessing (EMDR)
5. Linkage to Medication Opioid Use (MOUD) Services
6. Peer Recovery Support Services
7. Gender-specific clinical services such as individual psychotherapy, group therapy, co-occurring treatment, Intensive Outpatient (IOP), residential programs, or other services as deemed necessary per ASAM criteria.
8. Child development screenings (Ages and Stages) or referral to Early Intervention Services
9. Partnerships with local obstetricians and gynecologists, midwives, pediatricians, birthing hospitals, the Local Department of Social Services (LDSS), community colleges, vocational programs, and other community programs that serve families in their respective planning districts.

The mandatory **staffing requirements** for Project LINK include:

1. Program Manager
2. Case Manager and or
3. Clinician

It is important to note that service availability and staff vary by program.

The number of individuals served increased by **36.2%** in FY2024, primarily due to the implementation of two new Project LINK programs, Alleghany Highlands CSB and Highlands CSB, in FY2023. The target for FY2026 is a 15% increase, supported by changes in program admission criteria. All programs will admit women with children aged 0-18 years old.

Population Data

Fiscal Year	Number Served	Number of Home Visits
2023	1,024	2,156
2024	1,395	2,460

The **Blue Ridge Behavioral Healthcare** Project LINK program is celebrating 33 years of services and is implementing a "Perinatal Program" that includes case management services for mother and infant, individual therapy, and a dedicated group therapy room that has rocking chairs, a refrigerator, tummy time mat, sleeper swings, age-appropriate toys, and rocking chairs. This perinatal therapy room is designed for mothers to participate in treatment and care for infants simultaneously.

The **Horizon Behavioral Healthcare** Project LINK program is housed in the "Project LINK" cottage, which includes a child-minding room, family-centered therapy rooms, and a back porch for mothers and children

to enjoy the scenery. This program partners with local hospitals, doulas, and medical providers to ensure that this population receives family-based services.

Region Ten CSB Project LINK program provides gender-specific Intensive Outpatient Services and the implementation of a 12-room residential program for the PPW population.

Monitoring and Oversight

Addiction, Recovery, and Wellness Office, Women's Services and Specialty Populations Managers oversee Project LINK, providing technical assistance, training, and policy updates to ensure compliance with SAMHSA regulations. Project LINK Managers meet quarterly to address challenges, share best practices, and collaborate on regional strategies.

1. Each site must submit two "Service Delivery and Outcomes at Discharge" reports annually:
    a. Mid-Year Report: Covers October 1 – March 30 (due April 30)
    b. Annual Report: Covers October 1 – September 30 (due November 1)
2. These reports include narratives, data summaries, and financial documentation.

Looking ahead, DBHDS aims to secure additional federal funding to launch two new Project LINK programs by 2028.

The Right Help Right Now Plan- Initiative #1929-Project LINK expansion included the following goals that were funded via CAA and APRA block grant pregnant women set aside funds:

1. Implementation of Two Additional Project LINK programs. Highlands CSB and Alleghany Highlands CSB Project LINK programs were implemented in FY22 and fully staffed in FY23. These programs were funded via Pregnant and Parenting Women (PPW) Set Aside Funds for the SABG CAA and APRA federal grants that were time-sensitive for expenditures. As of July 1, 2024, both programs will receive the base Project LINK ongoing funding of $100,000.00 from the SUBG Women's Set Aside.

2. VT Contract for Best Practices for Substance Use Disorder Treatment for the Maternal Population. Women's Services partnered with VT Workforce Development, Dr. Dace Svikis, Deputy Director of the VCU Institute for Women's Health in the School of Medicine and Director of Addiction and Women's Health: Advancing Research and Evaluation), Dr. Caitlin Martin, Director of OBGYN Addiction Services, OB Motivate Clinic VCU Health and clinical team for a 90 minutes webinar: "Best Practices for Substance Use Disorder Treatment for the Maternal Population. 498 professionals attended this webinar.

3. Project LINK Manual. The manual was edited by an outside contractor.

    Virginia's 40 Community Services Boards serve more than 95 counties and 38 independent cities. SUBG Women's Set-Aside and state general funds support a range of services for pregnant, postpartum, and parenting women with dependent children, including:

1. Substance Use Outpatient Services
2. Case management
3. Medication-assisted treatment

4. Psychiatric Services
5. Medical and detoxification services
6. Intensive residential treatment
7. Peer Recovery Services
8. Day treatment and partial hospitalization

The Department utilizes the following guidelines to monitor CSBs' compliance with the required SUBG women's set-aside funds and services for the PPWDC population:

1. **Programs must treat the family as a unit and admit both women and their children into services if appropriate.** CSBs provide clinical services to women and the children in their custody. Therapeutic services for children 0-3 years old may include developmental screenings and assessments as well as early intervention services. Behavioral health services provided to children address such issues as mental illness, behavioral issues, and or related clinical issues related to child abuse, neglect, or trauma via CSBs, children/family services, or referred to appropriate community providers. Additionally, children have the option of school-based mental health services provided by some CSBs.
2. **Gender specific services that address specific women's issues, such as the role of relationships, parenting, sexual abuse, and trauma.** Specialized treatment groups, intensive outpatient programs, and individual therapy are offered internally or through referrals to community providers. The CSBs offer evidence-based trauma treatment modalities.
3. **Primary medical care.** Clients' medical needs are assessed at intake, quarterly, and annually. Case management services ensure that women are linked and referred to the Department of Social Services for medical insurance, local health departments, or Federally Qualified Health Centers (FQHCs) for obstetrical, prenatal, postnatal, reproductive health, and overall physical health services. Children are connected to case management services for linkage to pediatricians
4. **Transportation and Childcare.** Transportation continues to remain a barrier to individuals accessing treatment services in rural areas. The funding of vehicles and drivers would enable access for families to attend treatment and recovery services. As a result of the Pandemic, Virginia is experiencing a decrease in affordable and licensed childcare facilities. Additionally, block grant funding to assist CSBs with developing child-minded services would increase access to treatment.
5. **Street Outreach.** The CSBs advertise services via websites, brochures, and community events.
6. **Interim Services.** The CSBs provide counseling and education to clients on HIV, tuberculosis and Hepatitis C, as well as referrals to the local health department for services as needed. Additional interim services include the following: risk of needle sharing, transmission of sexually transmitted infections to infants and partners, and potential risk of using alcohol and illicit substances on the developing fetus. Clients are referred to prenatal and medical services, offered peer support, case management, individual psychotherapy, or Medication Opioid Use Disorder (MOUD) services until an appropriate level of services are available.

According to Virginia Code §32.1-127 B6, CSBs are responsible for care coordination and discharge planning for women who give birth to substance-exposed infants.

Additional funding for women's services would enable CSBs to train and hire staff who specialize in maternal mental health to improve outcomes for families and decrease maternal morbidity and mortality.

The Adult Community Behavioral Health team and Adult Behavioral Health Coordinators conduct site visits and block grant reviews.

Criterion 4: Persons Who Inject Drugs

DBHDS partners with the Virginia Department of Health regarding comprehensive harm reduction and syringe services. Virginia implements the Cumberland Plateau and LENOWISCO Harm Reduction Program is part of a comprehensive public health strategy, that is evidence-based, to prevent the spread of HIV/AIDS, hepatitis C, and other bloodborne pathogens among injection drugs users, their families, and the larger community. Comprehensive Harm Reduction (CHR) for persons who inject drugs includes, but is not limited to, provision of sterile hypodermic needles and syringes and collection of used hypodermic needles and syringes. CHR, also called needle exchange, syringe services, or syringe access, can decrease the spread of HIV and hepatitis.

Comprehensive Harm Reduction

Program Goals

- Reduce incidence of substance-related health and social harms, including transmission of blood-borne pathogens (infections) through substance abuse.
- Provide safe disposal of used needles.
  Raise awareness about the risk of drug overdoses and associated fatalities.
- Promote and facilitate referrals to primary health care, mental health, and substance use treatment services.
- Reduce stigma and discrimination against people who use drugs.
- Ensure full and equitable reach of Comprehensive Harm Reduction services and education to all who use substances.

Services Available

- Services are anonymous
- Exchange used syringes for clean ones
- Safe injection supplies
- Wound care supplies
- Safer sex supplies
- Risk reduction counseling
- Overdose prevention & Naloxone (Narcan®)
- Testing for hepatitis, HIV, STDs, and TB
- Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post Exposure Prophylaxis (nPEP)
- Referrals to medical care, insurance enrollment, mental health, alcohol and drug treatment, and medication assisted treatment.
- Referrals to other community programs and services needed.

Additionally, regarding DBHDS specific programs, please see information under Criterion 10 about REVIVE! and Curb the Crisis regarding support for individuals who inject drugs

Furthermore, CSBs are required to comply with Exhibit G of the performance contract which pertains to the initiation of treatment for individuals whose route of use is intravenous in compliance 45 CFR 96.131(a) as seen below:

- SUPTRS funds are to be the funds of last resort. Medicaid and private insurance, if available, must be used first. Target and priority populations are pregnant and parenting women and intravenous (IV) drug users. Any treatment services provided with SUPTRS funds must follow treatment preferences established in 45 CFR 96.131(a):
    - Pregnant injecting drug users
    - Pregnant substance abusers
    - Injecting drug users
    - All others

Criterion 5: Tuberculosis Services

TB rates are increasing both nationally and within Virginia as recent data shows an increase between 2022 rates and 2023 rates. This change is an increase from 2.3 cases per 100,000 people to 2.4 cases per 100,000 individuals. Research indicates these rates may have increased due to relaxing of social distancing in communities.

Outpatient Treatment Providers (OTPs) are licensed by DBHDS and are required to be in compliance with 12VAC30-130-5050 which includes the following provision:

- Onsite screening or the ability to refer for screening for infectious diseases such as human immunodeficiency virus, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors and the ability to provide or refer for treatment of infectious diseases as necessary.

At the state level, the Virginia Department of Health (VDH), Division of Disease Prevention, Tuberculosis Control and Prevention Program, acts as a liaison between the different entities involved in the implementation of the Virginia TB control laws (e.g., local health directors, private physicians, the State Health Commissioner, etc.) and coordinates all actions taken under the enforcement of these laws. The Division of Disease Prevention, Tuberculosis Control and Prevention Program provides necessary guidance and technical assistance.

Virginia's TB control laws address the need for specific and detailed TB control measures, as the likely consequences of failure to deliver successful treatment are drug resistance, continued transmission of Mycobacterium tuberculosis, and potentially increasing organ damage and death. These TB control measures are intended to:

- Effectively identify cases of active TB disease as quickly as possible
- Implement appropriate and immediate treatment for cases of active TB disease
- Establish legal guidelines under which TB treatment is followed and completed
- Establish guidelines for timely and efficient reporting of TB cases and lab results
- Prevent the development and spread of drug-resistant TB. To meet these goals, the Virginia TB control laws empower health authorities to:
- Activate protocols to address the possible threat of TB to the public health
- Provide appropriate resources to help people with active TB disease follow and complete the prescribed treatment regimen
- Restrict the movements of persons with active TB disease who are unable or unwilling to follow instructions and orders issued by VDH and/or a private physician in the event that prior legal

measures to protect public health have failed.

Criterion 6: Early Intervention Services Regarding the Human Immunodeficiency Virus

12VAC30-130-5050 addresses that the OTPs must evaluate for indication of infectious disease testing for diseases such as HIV; hepatitis A, B, and C; syphilis; and tuberculosis at treatment initiation and then annually or more frequently, depending on the clinical scenario and the patient's risk. Those who test positive shall be treated either on site or through referral. For individuals without immunity to the hepatitis B virus, vaccination, either on site or through referral, shall be offered. For individuals without HIV infection, pre-exposure prophylaxis to prevent HIV infection, either on site or through referral, shall be offered. Pregnancy testing for women of childbearing age, and contraceptive services, either on site or through referral, shall be offered. Through review of records and data compliance these are tracked.

Additionally, at the state level, there are a variety of options for testing. VDH-funded testing is usually free or low-cost. Testing for STDs, HIV, mpox, and viral hepatitis is available throughout the state. This includes:

- local health departments,
- healthcare clinics,
- community-based organizations,
- and pharmacies.

Criterion 7: Group Homes for Persons in Recovery from Substance Use Disorders

DBHDS certifies and regulates Recovery Residences, which are peer-run, supportive housing environments for individuals recovering from substance use disorders. CSBs may use the funding they have received from DBHDS to assist with housing for individuals in recovery.

Changes made in the 2025 Virginia General Assembly now require recovery residences to be certified in order to remain active and legally operate in coordination with state agencies. To support independent operators in meeting this requirement, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) has established a Conditional Certification process, allowing time to achieve full accreditation through a DBHDS-recognized certifying body.

Key Highlights:

- **Tiered Certification Structure**
  - **Tier 1:** Initial conditional certification for 6 months
  - **Tier 2:** One-time 90-day extension (based on demonstrated progress)
  - **Not Certified:** Termination of certification due to insufficient progress
- **Progress Monitoring**
  - Applicants must provide documentation, as requested, showing meaningful steps toward full accreditation through an approved body (e.g., VARR, Oxford House).
  - A 5-month check-in will assess progress and determine eligibility for continuation or extension.
- **Enforcement**
  - Operating without certification may be subject to penalties, including a Class 1

misdemeanor under Virginia law.

Certified Recovery Residences in Virginia

A recovery residence is a housing facility that provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders that does not include clinical treatment services.

Oxford House is a 47-year-old model for democratically self-governing, financially self-supporting recovery residences for individuals with substance use disorders. They are gender-specific homes with no time limit on residency which allows for the development of long-term recovery. They operate in compliance with the requirements of the Oxford House Charter and System of Operations found in the Oxford House Manual. Oxford Houses do not have resident staff managing the individual houses however the model includes training and oversight from the local network of houses and state association, along with technical assistance from Virginia Oxford House outreach workers. The system encourages the development of leadership skills and self-efficacy and allows residents to learn or relearn values and responsible recovery behavior. Oxford House's uniquely peer-supportive model has a long record of requiring its houses to meet high-quality standards.

All Oxford Houses operate as Level One residences (see below).

VARR presents a collaborative voice for recovery residences throughout our Commonwealth and works to ensure that everyone in recovery is able to access programs that offer high quality recovery residences.

VARR's mission is to set high levels of standards for quality recovery residences in Virginia and accredit residences that meet such rigorous criteria in order to support persons in recovery with information and access to recovery residences bound together by the core principles of standards, ethics, and unity.

VARR approved houses demonstrate adherence to a rigorous set of standards. Compliance is affirmed through submission of extensive documentation, annual onsite inspections, participation in sponsored training, data tracking, and events and responsiveness to all reported concerns and/or grievances. VARR approved houses demonstrate adherence to a rigorous set of standards that is produced at the National level through NARR. National Standards can be reviewed at NARRonline.org.

Level One Houses – Peer Run

- Self- Governed
- Minimal Staff involvement
- Focuses on peer support and community integration

Level Two Houses – Monitored

- Also offer involvement in self-help services and peer run groups
- Could possibly be apartments or other dwelling types
- Have at least one compensated person

Level Three Houses – Supervised

- Also offer in-house service hours and life skills development emphasis
- Vary in housing type and residential setting
- Have a facility manager and certified staff or case managers

Level Four Houses – Service Provider

- Also offer in-house clinical services and programming
- Are various in type and may be a more institutional environment
- Have a credentialed staff

The Lists of Recovery Certified Residences are maintained by the Department of Behavioral Health and Developmental Services (DBHDS)

The Code of Virginia § 37.2-431.1 provides that no person shall advertise, represent, or otherwise imply to the public that a recovery residence or other housing facility is a certified recovery residence unless it has been certified by the Virginia Department of Behavioral Health and Developmental Services ("DBHDS"). In accordance with the DBHDS regulation, Certified Recovery Residences [12VAC35-260], each location that an entity seeks to operate as a certified recovery residence must be accredited by or hold a charter from an accrediting entity and be credentialed by and included on the certification list maintained by DBHDS. The two accrediting entities are:

1. Oxford Houses of Virginia
2. Virginia Association of Recovery Residences (VARR)

Criterion 8: Referrals to Treatment and Coordination of Ancillary Services

In Virginia, person-centered planning in substance use treatment is identified within the administrative regulations governing behavioral health services. Specifically, code section 12VAC30-50-491, outlines substance use case management services, which include developing a person-centered Individual Service Plan (ISP). This allows the services to be tailored to the person's needs and goals. Additionally, 12VAC30-130-5010 establishes coverage for treatment for substance use disorders, aligning with the American Society of Addiction Medicine (ASAM) Criteria.

Virginia implements Screening, Brief Intervention, and Referral to Treatment (SBIRT) which is an evidence-based public health approach for the early identification and early intervention of substance misuse and co-occurring problems. As an upstream approach, the SBIRT model aims to identify substance misuse as it emerges so that an appropriate intervention can be offered to assist people in decreasing their risk of developing a substance use disorder (SUD) and decrease the impact of negative consequences linked to substance use.

- **Screening** is the first step. Where possible, this includes universal screening of all people in a given setting. Substance use screening can include alcohol, drugs, and/or tobacco and nicotine. Given the high co-occurrence between substance use and mental health symptoms, screening for mental health often includes depression, anxiety, post trauma reactions, and/or suicide.
- **Brief Interventions** are offered to people identified in the mild, moderate, or severe risk

categories.

- **Referral to Treatment** involves an active and collaborative approach to the referral process. This may include planning around the facilitators and barriers to accepting the referral, developing relationships with common referral sites to streamline the transition, and instituting follow-up as a standard of care.

Virginia has actively embraced the SBIRT model as a key strategy to address substance use and mental health concerns within the state.

Here are some key updates and initiatives related to SBIRT in Virginia:

- Expanded Reach: The Virginia SBIRT Project, initially funded by a five-year SAMHSA grant (2016-2021) and managed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) in partnership with George Mason University, has significantly broadened the implementation of SBIRT in various healthcare settings across the state.
- Positive Outcomes: Data from the Virginia SBIRT Project demonstrates positive results in reducing risky alcohol and drug use, as well as addressing depression symptoms among those receiving interventions. According to George Mason University, after receiving an SBIRT intervention, 50% of people were drinking at significantly lower levels 6 months later, and 1 in 3 people using drugs were abstinent 6 months later.
- Youth SBIRT: Building on the success of the adult SBIRT project, the Virginia Youth SBIRT (VA YSBIRT) Project (2021-2026) focuses on integrating SBIRT into settings serving adolescents and young adults (ages 12-21), including pediatric primary care, schools, and community mental health clinics, particularly in Northern Virginia and the Eastern Shore regions.
- Regulatory Streamlining: The DBHDS has been actively involved in streamlining oversight and easing the administrative burden on licensed behavioral health providers by enacting regulatory amendments. These changes, taking effect in June 2025, reflect a broader state effort to eliminate regulations deemed obsolete or unnecessarily prescriptive.
- Ongoing Implementation and Training: The VA-SBIRT team, in collaboration with DBHDS, continues to support the integration of SBIRT into healthcare and other settings through hands-on consultation and training for providers.

Criterion 9: Independent Peer Review

The purpose of Independent Peer Reviews is to continuously improve the quality and appropriateness of treatment services through independent peer review (IPR); address Federal requirements; and, by acquainting providers with the key processes and underlying theoretical principles of IPR, generate interest and encourage participation in upcoming reviews.

Federal IOR Requirements

- States are required, as a condition of receiving the mental health and substance use block grants, to “provide for independent peer review to assess the quality, appropriateness and efficacy of treatment services provided in the State with a focus on treatment programs and the substance abuse service system rather than on the individual practitioners” (45 CFR 96.136). IPR must be conducted annually, include at least five percent of the treatment providers funded under the SAPT Block Grant, and comply with patient record confidentiality rights and requirements as defined in Federal regulations (42 CFR Part 2 and 45 CFR Parts 160 & 164).

Additionally:

- Independent peer reviewers must have expertise in the field of chemical dependence treatment, be representative of the type of service under review and be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

- The IPR must include a review of a representative sample of patient records to determine quality and appropriateness of treatment services and specifically, examine admission criteria; intake processes; assessments; treatment planning, including appropriate referral; documentation of implementation of treatment services; discharge and continuing care planning; and indications of treatment outcomes.

- Practitioners and providers cannot, under IPR, review their own programs or programs in which they have administrative oversight.

- There must be a separation of peer review personnel from funding decision-makers.

- IPR cannot be conducted as part of the licensing/certification process.

Since tracking data became available in 2005, all Virginia CSBs have participated in the IPR process partnering to evaluate each other's mental health and substance use treatment programs. CSBs are paired and required to select one program that CSB staff from each CSB will evaluate. The criteria for pairing CSBs is based on geographic location and populations as the information learned from the peer review is more valuable if the CSBs have similar demographics and catchment areas.

Criterion 10: Professional Development

DBHDS Substance Use Services team works with Virginia Tech on two separate projects. The first project is with the ASAM training being conducted across the Commonwealth. ASAM Criteria is a tool that assists with standardizing the assessment process of diagnosing and finding the appropriate level of care for people with SUDs. This includes recognizing where OTPs would benefit the population with OUD. ASAM also promotes collaboration between all levels of care, allowing for a more holistic approach to substance use treatment. The second is a Judicial Training project that is engaging with the Supreme Court, VA Tech, and OAA. This training is focused on providing educational materials to the Specialty Dockets, specifically Recovery Court, on addiction and various evidence-based practices for treatment.

DBHDS continues to assist with finding solutions for the Opioid and Fentanyl Crisis through various programs. One Pill Can Kill is a campaign that brings awareness to the fentanyl crisis and is a collaboration across many state agencies including DBHDS. The REVIVE! program continues to operate by providing education and supplies to combat opioid overdose. Approximately 235 people have been trained in the rural areas through the REVIVE! program. REVIVE! and the Virginia Department of Health (VDH) work together to provide free training and free naloxone nasal spray (Narcan). VDH will also provide brief training for people who come to the department requesting naloxone.

The First Responder Grant is working to ensure that first responders are also trained with the REVIVE! knowledge and carry Naloxone to assist with opioid overdose emergencies. Curb The Crisis is also a program to assist in the opioid crisis. It is a program that provides education and resources for treatment for individuals. DBHDS continue to enhance learning on MAT and MOUD through the sponsoring of training scholarships sponsored by the Opioid Treatment Association, the Virginia Association of

Medication Assisted Recovery Programs, as well as to the annual meeting of the American Association for the Treatment of Opioid Dependence. All conferences are Evidence-based practice (EBP) training aim to educate and empower healthcare professionals with the knowledge and skills to implement EBP in their delivery service that include MAT and MOUD. Ultimately, the goal is to improve patient care, enhance healthcare quality, and contribute to the decrease in the overall opioid overdose rate.

DBHDS provides technical assistance to the Supreme Court of Virginia Drug Treatment Court Administrator in the use of MAT (extended-release naltrexone) as several drug treatment courts received funding to support the use of this medication.

Updates to Additional Program Areas and Partnerships Comprising Virginia System of Care

DBHDS partners with other state agencies and organizations that are involved in the provision of services and supports to or interact with individuals who have behavioral health, intellectual or other developmental disabilities, or co-occurring disorders. These relationships allow for additional supports to individuals in need and to help raise awareness of the needs and challenges of individuals receiving behavioral health and developmental services face. They also provide opportunities for coordinating state-level policy direction provisions of guidance to Virginia's local services systems and support statewide and community-based initiatives that promote access to and continuity of needed services and supports across populations.

Below are some updates to linkages that contribute to the development of and provide ongoing guidance for DBHDS' strategic plan, along with state-level advocacy organizations and persons with lived experience:

Criminal Justice and Juvenile Justice Services:

Crisis Services and Collaboration with Law Enforcement

The Commonwealth of Virginia, through its Right Help, Right Now initiative, has implemented targeted activities to reduce disparities in access to behavioral health services and outcomes for individuals with mental health or substance use disorders (M/SUD), particularly those involved in or at risk of involvement in the criminal justice system. The Department of Behavioral Health and Developmental Services (DBHDS) has been instrumental in the successful implementation of these efforts, leading key system reforms and investments to ensure more equitable and effective behavioral health responses across the Commonwealth. Two pillars of this initiative are especially aligned with this objective:

1. Offering Same-Day Care for Behavioral Health Crises

Virginia is making a historic investment to ensure equitable, same-day access to behavioral health crisis care through the implementation of a Crisis Continuum based on the Crisis Now model, full funding of mobile crisis response teams, and the statewide expansion of the 9-8-8 crisis hotline. These services are designed to:

- Provide rapid, community-based behavioral health care for individuals experiencing crisis, regardless of race, ethnicity, insurance status, or geographic location.

- Reduce the likelihood of arrest or emergency room utilization by ensuring that individuals, especially in historically underserved communities, are connected to care rather than the criminal justice system.

- Utilize mobile crisis teams that are trained in de-escalation and trauma-informed care, and that respond without law enforcement whenever appropriate, minimizing the potential for racially biased interactions and escalation.

This approach promotes early intervention and helps reduce disparities in outcomes certain populations who are disproportionately impacted by criminal justice involvement due to behavioral health crises.

2. Relieving Law Enforcement Burdens and Reducing the Criminalization of Mental Health

To address health disparities and reduce the criminalization of mental illness, Virginia is:

- Streamlining the discharge process for individuals under Temporary Detention Orders (TDOs) by allowing attending physicians to discharge when clinically appropriate.

- Funding in-hospital monitoring alternatives to reduce law enforcement presence in healthcare settings.

- Reducing law enforcement involvement in behavioral health response overall, helping mitigate the disproportionate policing and incarceration of racially and ethnically diverse individuals with M/SUD.

These efforts reduce unnecessary law enforcement contact and promote a clinical, rather than punitive, approach to behavioral health care, thereby directly addressing racial disparities in justice system involvement.

These pillars represent a systemic shift toward equitable, accessible, and culturally responsive crisis services. By diverting individuals from law enforcement response and criminal justice entry, and by expanding access to timely behavioral health care, Virginia is actively working to reduce disparities in service receipt and outcomes among individuals with M/SUD, particularly those at risk of justice system involvement.

Forensic Services

DBHDS supports numerous programs or initiatives targeting the needs of individuals with behavioral health disorders who are involved in the criminal justice system. Services include mental health evaluations and screenings, treatment of individuals with mental illness in jail, case management and restoration of competency to stand trial. In addition, DBHDS develops and implements programs and services for individuals at risk for involvement in the criminal justice system to attempt to create diversion alternatives (when appropriate) and/or to improve access to behavioral health services for those who enter the criminal justice system. Below is a list of various initiatives driven by DBHDS focused on this population:

1. Forensic evaluation for the courts – DBHDS provides support to Virginia criminal courts through

its Forensic Evaluation Oversight program. Virginia Code establishes DBHDS as the entity to determine evaluator eligibility to perform court-ordered evaluations and provides technical assistance and quality reviews to evaluators, ensuring that competency and sanity evaluations are performed to professional standards. DBHDS also develops and coordinates required training for forensic evaluators in partnership with the University of Virginia.

2. Mental health screening and Mental Health Treatment Standards in jails – DBHDS was instrumental in crafting legislation that requires the jail to conduct an initial screening for mental illness at the point of jail intake. The use of a standardized tool for identification of individuals with behavioral health needs was a first step in securing appropriate treatment in the jails. Subsequent to implementation of this requirement, additional funding was secured to supply each jail with a qualified mental health professional. Those funds are managed by the State Compensation Board, but DBHDS was a critical partner in advocating for expanded funding for mental health in jails. In addition, DBHDS created recommendations for minimum standards for mental health treatment in jails, which have since been adopted by the Board of Local and Regional Jails.
3. Jail Diversion initiatives come in a variety of forms, but all essentially strive to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification), divert individuals away from the criminal justice system (or from penetrating more deeply, if identified after arrest/incarceration), and connect individuals to meaningful services and treatment (as early as possible, but often during initial court appearance, during incarceration, or upon release from jail). Currently the Department funds 15 local CSBs to provide jail diversion programming in their localities but works with all 40 CSBs to identify mechanisms for early diversion or jail-based interventions that can be implemented without DBHDS grant funding.
4. Forensic Discharge Planning from Jails - DBHDS provides grant funding to local CSBs who work in partnership with their jails to serve individuals with Serious Mental Illness (SMI) in Virginia Jails by providing re-entry planning and intensive case management up to 90 days post-release, to ensure proper linkages to outpatient services. In FY24, 21 CSBs are providing forensic discharge planning services in 26 local or regional jail facilities in the Commonwealth.

1. Behavioral Health Dockets - DBHDS partners closely with the Office of the Executive Secretary (OES) of the Virginia Supreme Court on the development of statewide standards and has provided training in conjunction with OES to the Courts, CSBs, and local and state probation and parole on implementation and best practices. DBHDS provides partial funding to 6 of the operating Behavioral Health Dockets to support staffing and treatment services. These dockets strive to identify individuals for whom the traditional criminal justice process may not be effective at resolving the underlying issues that drive criminal offending. The dockets provide an alternative case processing that builds in a treatment and supervision component, with a team of providers and court staff to support participants as they satisfy the program requirements.

2. Outpatient Competency Restoration – DBHDS provides training and technical assistance to the local CSBs, who are designated as outpatient restoration providers for individuals found incompetent to stand trial. These programs ensure that individuals are served in the lowest restrictive setting possible, preventing unnecessary hospital admissions. The Department also reimburses the CSBs for these services.

3. Not Guilty by Reason of Insanity – DBHDS has established policies and procedures for the management of individuals who have been found NGRI by criminal courts. Supervision and treatment in DBHDS inpatient hospitals include forensic evaluation and reporting to the courts, clinical treatment, psychoeducation, and a demonstration model for individuals to progress from the hospital to the community. DBHDS also provides training and technical support to CSBs when they are working with acquittees in the community.

In Virginia, adult criminal defendants have access to a variety of treatment and diversion options, depending upon locality (various funding streams exist but do not support the same services in every locality). In terms of DBHDS-sponsored initiatives involving populations experiencing health disparities, there are various programs (including Specialty Dockets, Jail Diversion, Forensic Discharge Planning programs) that target individuals with behavioral health needs in the criminal justice system. These programs have clearly established criminogenic and clinical criteria that attempt to remove any subjective decision-making in regard to eligibility and enrollment in services. In all cases, these programs seek to address the underlying behavioral health symptoms that are increasing the likelihood of recidivism through prompt connection to treatment and, where appropriate, diversion from jail. In addition to these programs, there are also various training initiatives for law enforcement/corrections staff that are collaborations between state agencies, which provide education on identifying individuals in crisis and de-escalation. There are similar training initiatives in the juvenile justice arena, training for police officers (School Resource Officers and other Law Enforcement) on behavioral health-related topics and de-escalation. These training initiatives indirectly addresses the issue of health disparities by helping law enforcement better understand youth as individuals and thus decreasing inherent biases (reducing criminalization of mental illness/Pillar 2) and (pre-crisis and crisis intervention/Pillar 6) of the Right Help Right Now Plan.

Juvenile Justice

There are various inter-agency collaborations that exist to address a multitude of process or policy issues related to individuals with behavioral health needs in the criminal justice setting. DBHDS partners regularly with Dept. Of Medical Assistance Services (DMAS), Dept. Of Corrections (DOC), Dept. of Juvenile Justice (DJJ) and others on specialized workgroups, taskforces, or committees. There is no one single advisory board that addresses criminal justice issues, however, as most committees or workgroups are designed to address specific topics/service areas/barriers. For instance, the Governor recently established the DOC Re-Entry Task Force to address systemic issues with re-entry planning from DOC facilities for individuals with mental health needs – this workgroup included DBHDS staff and was intended to address gaps in communication and develop processes to address those gaps. Similarly, for juvenile justice related issues there is no one inter-agency coordinating committee for all juvenile justice related topics, but DBHDS is involved in various state level working groups or advisory boards addressing behavioral health needs of youth and juvenile justice issues.

Providing access to appropriate and effective mental health services for all youth under the agency's care is a strategic goal for the Department of Juvenile Justice (DJJs) and is outlined in their Transformation Plan 2023 Update. DJJ uses a Regional Services Coordination model for direct service provision. This ensures youth and families have access to continuous and consistent residential and community-based services to divert youth from further involvement with DJJ. The RCS's assist with building a more robust statewide continuum of evidence-informed services. In FY 2022 36.5% of referrals to the RSCs were for clinical services. In May 2023, DJJ established a Pre-Release Problem Solving Team with the goal of creating a well-defined process to ensure all youth have access to and receive services prior to their release from a

direct care placement. The DBHDS participated in the sub-workgroup on mental health services transition planning (MHSTP).

The Office of Child and Family Services participates in a workgroup that is related to Juvenile Justice. The workgroup is described below:

Workgroup Name	Convening Agency	Workgroup Purpose
Advisory Council for Juvenile Justice and Prevention	Department of Criminal Justice Services (DCJS)	Advises the Board, the Executive Branch, and localities on matters related to the prevention/treatment of juvenile delinquency and the administration of the juvenile justice system; reviews grant applications for Juvenile Justice & Delinquency Prevention (JJDP) Act and Juvenile Accountability Block Grant funds (when federally funded), as well as other juvenile justice-related grant applications, and makes recommendations on them to the Board.

DBHDS has strong collaborative relationships with Department of Corrections (DOC), Department of Criminal Justice Services (DCJS), Department of Social Services (DSS), Department of Juvenile Justice (DJJ), Department of Medical Assistance Services (DMAS), Department of Veterans Services (DVS), State Compensation Board (SCB), State Board of Local and Regional Jails, Virginia Association of Regional Jails and other state agencies as well as with local entities such as CSBs, community corrections agencies, police and sheriffs offices, and other local and statewide organizations and individual stakeholders, on issues pertaining to persons with behavioral health disorders and intellectual disabilities with criminal justice involvement. Specific collaborations impacting individuals reentering from prison or jail include the statewide expansion of Crisis Intervention Teams, Jail Diversion, Jail Forensic Discharge Planning, and Behavioral Health Docket programs, as well as the Mental Illness in Jails Annual Report and the Annual Crisis Intervention Team Conference and Training.

Other specific efforts include:

1. Memorandum of Understanding between Department of Corrections, Department of Behavioral Health & Developmental Services, and local CSBs that outlines responsibilities for post-release coordination of care and services for individuals with behavioral health needs coming out of state prisons.
2. DBHDS participates in the Governor's Re-Entry Optimization workgroup focusing on improving re-entry outcomes for individuals on state probation. This workgroup, comprised of various state agencies including DBHDS and Department of Corrections, was established in May 2023 with the goals of increasing cross-agency collaboration to improve outcomes related to employment, housing, mental health, substance use, appropriate supervision level, and health insurance status/benefits enrollment. The Re-Entry Optimization workgroup established several pilot projects and initiatives to improve mental health and substance use services to state-responsible offenders in the community.

3. Crisis Intervention Team (CIT) Statewide Expansion – This project is a collaborative effort among Dept. Of Criminal Justice Services, Department of Behavioral Health & Developmental Services, local CSBs, police, sheriff, consumers, and other service agencies. These trainings aim to provide law enforcement or other first responders with techniques for identifying and de-escalating a mental health crisis. They represent a significant amount of collaboration at the local and state level.
    a. There are now 38 local CIT initiatives developed and supported through Federal, State, and local funding.
    b. 36 programs operate 37 CIT Assessment sites throughout the Commonwealth
4. DBHDS-funded Jail Diversion Initiatives are a partnership between DBHDS and local CSBs. These grant programs serve individuals with behavioral health needs across all stages of the criminal justice process, from initial booking to re-entry planning. There are currently 15 program sites across Virginia that receive funding from DBHDS to provide services that divert individuals from the criminal justice system and into treatment.
5. DBHDS also provides funding to local CSB partners for Forensic Discharge Planning from Jails. These grants are intended to serve individuals with Serious Mental Illness (SMI) in Virginia Jails by providing re-entry planning and intensive case management up to 90 days post-release, to ensure proper linkages to outpatient services. In FY24, 21 CSBs are providing forensic discharge planning services in 26 local or regional jail facilities in the Commonwealth.
6. DBHDS partners closely with the Office of the Executive Secretary (OES) of the Virginia Supreme Court on the development of statewide standards and has provided training in conjunction with OES to the Courts, CSBs, and local and state probation and parole on implementation and best practices. DBHDS provides partial funding to six of the operating Behavioral Health Dockets to support staffing and treatment services.
7. DBHDS and the State Compensation Board (SCB) collaborate on an annual point-in-time survey of all Virginia local and regional jails. The survey gathers data around the rate of mental illness in Virginia jails, as well as data on the types of services and costs of services to individuals with mental illness in jail.
8. DBHDS partners with the Department of Criminal Justice Services to implement training for law enforcement agencies to help officers better understand and more effectively respond to youth in both crisis and routine encounters. This includes assistance in the school resource officer training program that is mandatory for all public safety officers serving in that role, and other training to assist officers working outside the school setting.
9. DBHDS provides training and consultative support to local detention centers and DJJ regarding re-entry, community supervision, and addressing mental health needs of detained juveniles.
10. DBHDS funds several behavioral healthcare programs for juveniles in detention.

Military Personnel and Their Families

Virginia has the sixth highest veteran population in the United States with more than 670,000 veterans residing in the Commonwealth. According to the US Department of Veteran Affairs, veterans are more likely to have PTSD and are at greater risk of suicide than the civilian population. It is a priority of the Commonwealth of Virginia to care for this incredibly high-risk population, which is why there is a step within STEP-VA (referenced above) dedicated to the Service Members, Veterans, and their Families (SMVF) population.

Per the Code of Virginia, core services provided by Community Service Boards shall include mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility.

As one of the nine required services for System Transformation Excellence and Performance (STEP-VA), the purpose of the Service Members Veterans and Families (SMVF) step is to ensure SMVF receive needed mental health and supportive services in the most efficient and effective manner available. Services shall be high quality, evidence-based, trauma-informed, culturally competent, and accessible.

Over the past two years, Virginia has demonstrated measurable progress in advancing suicide prevention initiatives for Service Members, Veterans, and their Families (SMVF), directly aligning with SAMHSA's priority of strengthening behavioral health systems and addressing high-risk populations. With the support of existing federal and state investments, including SAMHSA-backed initiatives, Virginia has taken a cross-sector approach to suicide prevention integrating public behavioral health systems, peer support, crisis response, and Veteran-specific services. A cornerstone of these efforts is Virginia's ongoing participation in the Governor's Challenge to Prevent Suicide Among SMVF Populations, which provides a structured framework for implementing evidence-informed practices.

As a result, Virginia developed and executed a statewide action plan centered on three pillars: identifying SMVF individuals at risk, promoting protective factors and connectedness, and enhancing access to care. This work has been supported by the Virginia Veteran and Family Support (VVFS) program, housed within the Virginia Department of Veterans Services (DVS), which provides coordinated care and peer-led outreach to Veterans at risk of suicide, including those not engaged with VA healthcare. With the implementation of the 988 Suicide & Crisis Lifeline, and its dedicated "Press 1" option for Veterans, Virginia has bolstered immediate access to crisis services. SAMHSA block grant/STEP VA funding has supported training, coordination, and infrastructure improvements among Community Services Boards (CSBs) to ensure smooth linkages between local 988 call centers and the Veterans Crisis Line. This includes warm handoffs, follow-up procedures, and the integration of trauma-informed and Veteran-informed care practices across the behavioral health system.

In parallel, Virginia has expanded the Marcus Alert system, a statewide initiative designed to enhance behavioral health crisis response and reduce law enforcement involvement during mental health emergencies. Several regions have prioritized the development of Level I and II crisis response protocols, including mobile crisis teams trained in military culture, suicide risk identification, and de-escalation techniques for SMVF individuals. Workforce development has been a critical component of these efforts. CSBs and local partners have received SAMHSA-supported training in ASIST (Applied Suicide Intervention Skills Training), and Military Cultural Competency, improving the system's capacity to intervene early and effectively with at-risk Veterans. Partnerships with community organizations, such as PsychArmor, have also enabled community-wide awareness efforts and prevention education. Despite this progress, persistent barriers remain particularly in rural areas such as a shortage of behavioral health providers with military cultural competence, limited access to specialized services for Veterans with co-occurring conditions, and lingering stigma around mental health. These gaps highlight the urgent need for expanded SAMHSA block grant funding to enhance infrastructure, support mobile crisis teams, strengthen peer services, and develop data-driven strategies to improve SMVF outcomes.

Despite these advancements, several needs and barriers continue to impact service delivery for this population. Veterans with SMI often face difficulties navigating between VA and non-VA systems, leading to confusion about eligibility, service duplication, or gaps in care. Access to services remains a significant concern in rural and underserved areas, where there is a shortage of psychiatrists, therapists, and other behavioral health providers trained in military culture and trauma-informed care. Housing instability is another major issue; veterans with SMI frequently face homelessness or precarious housing, making it difficult to maintain consistent treatment. The lack of supportive and transitional housing options further

exacerbates this challenge. System fragmentation and inconsistent program implementation across regions contribute to disparities in care. Additionally, stigma particularly among older male veterans continues to hinder engagement with mental health services, as many fear being perceived as weak or worry about losing VA benefits if they disclose their symptoms. Lastly, workforce limitations persist, as many CSBs lack staff with adequate training in co-occurring disorders and military-specific behavioral health care. Addressing these challenges through expanded funding, improved coordination, and continued investment in culturally competent, peer-driven care will be critical to meeting the needs of veterans with SMI in Virginia.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

   Please see attached Step 2 with SAMHSA Changes- Identify the Unmet Service Needs and Critical Gaps

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

   Please see attached Step 2 with SAMHSA Changes- Identify the Unmet Service Needs and Critical Gaps

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

   Please see attached Step 2 with SAMHSA Changes- Identify the Unmet Service Needs and Critical Gaps

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s).

This narrative should describe your state's needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths, and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include the use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Substance Use and Mental Health Services Survey (N-SUMHSS), the Behavioral Health Barometer, Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support

services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

DBHDS works with various business partners such as JBS International, Inc., the OMNI Institute and Cansler Collaborative Resources, LLC., community partners, and other state and local agencies to assist with statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention service by assessing the need of Virginians for publicly funded behavioral health services (BHS) through assessing current capacity of the Commonwealth of Virginia's BH system to meet the BH needs of Virginians across the continuum of prevention, treatment, and recovery, as well as community based, crisis and facility care provided throughout the Commonwealth.

Assessments include surveys, focus groups, expert consultants, site visits, interviews, DHP Behavioral Health Workforce Data, Medicaid Data. Information from the assessment(s) are used to guide system improvements and to proactively prepare for future system change with the implementation of Medicaid Expansion, Medicaid managed care, BH Redesign, and Virginia Behavioral Health System's System Transformation Excellence and Performance (STEP-VA). The assessment(s) is also designed to include an analysis of existing Department of Behavioral Health and Developmental Services (DBHDS) funding sources and how funds are allocated, as well as DBHDS BH data sets and DBHDS' performance management infrastructure.

A mixed-method data collection approach is used that incorporates a variety of quantitative and qualitative data sources to best understand the capacity of the system and the unmet needs. Several existing data sources are utilized to describe individuals

currently being served as well as several national surveys to describe the prevalence of behavioral health needs within Virginia. Collection of data from providers is conducted through a site survey as well as onsite visits.

In the past, needs assessments were often conducted separately by program area which often led to siloed data and challenges with creating system wide change utilizing common themes from the various assessments. Sufficient funding in 2026 has been set aside to do a comprehensive system needs assessment through the use of state general funds earmarked for STEP VA which will aid in strategically looking at how to improve STEP VA services. DBHDS has identified it as a priority to consolidate assessment and data collection efforts for the purpose of modernizing the information and metrics that can be leveraged for system wide change.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

As shared above, DBHDS continues to consolidate its needs assessment process to reduce silos and increase uniformity in assessing unmet needs and service gaps across programs. Below are common themes in terms of needs/gaps that were identified across several different needs assessments:

Common Themes

- **Workforce Shortages:** Severe provider shortages, especially in rural areas, youth services, and bilingual roles. High caseloads, turnover, and lack of training in culturally responsive, trauma-informed care.
- **Limited Access:** Transportation barriers, long waitlists, language access issues, and limited telehealth infrastructure. Limited qualified providers and options of treatment modalities available in rural areas.
- **Inadequate Prevention:** School-based programs dominate but are inconsistently applied, underfunded, and often outdated. Few community-wide or environmental prevention strategies.

- **Youth Service Gaps:** Most CSBs lack adolescent-specific services; youth are often grouped with adults. Families report difficulty accessing timely, relevant care.
- **Health Disparities:** Disparities in service access and outcomes persist for certain demographics and in various geographic catchment areas particularly rural populations. For certain populations, stigma and lack of interpreter services worsen these gaps.
- **Housing Instability:** Supportive housing programs fall short in tenant choice, location, integration, and clinical support. Many operate below fidelity standards.
- **System Fragmentation:** Disconnected behavioral health/substance use services, justice, education, and housing systems hinder coordinated care and early intervention.

Root Causes

- **Structural Lack of Uniformity in Service Delivery:** Longstanding economic and geographic disparities are embedded in system design along with other factors measured at the state level and not with federal dollars.
- **Stigma:** Youth and adults avoid care due to shame, fear, or past negative experiences. Families report blame or disengagement.
- **Underfunded Infrastructure:** Many services rely on short-term grants or are under-resourced to implement models like STEP-VA or PSH at scale.
- **Lack of Consumer Voice:** Little collaboration between schools, health systems, juvenile justice, housing, and behavioral health. Screenings and referrals are often missed or delayed.
- **Insufficient Data Collection:** Few programs consistently collect key demographics, or outcome data, limiting measure of accountability on uniformity in service delivery across populations.

Below are some findings from population specific needs assessments that were completed and contracted by DBHDS. Some assessments including The Virginia Behavioral Health Needs Assessment completed by JBS International in 2020 are a few years old and will be updated utilizing state general dollars that have been set aside for system needs assessment as mentioned in the response to the first prompt.

Adult Community Behavioral Health

Virginia Behavioral Health System Needs Assessment Final Report – March 31, 2020

Key Takeaways

- Workforce shortages are a statewide crisis, especially in rural areas and among youth-serving providers.
    - Recruitment, retention, and burnout are major obstacles to delivering behavioral health services.
- STEP-VA is progressing unevenly—many CSBs lack the resource and staff to fully implement its pillars, especially in prevention and peer support.
    - Youth and families were not fully engaged in the rollout.
- Prevention is underfunded and undervalued.
    - Most programs remain school-based, with little support for community or environmental prevention work.
    - Staff are stretched thinly and often assigned to tasks outside their core skill set.
- Navigation across systems is disjointed, with clients and providers alike struggling to understand how to access services or transition between care types.
    - Referral services are unclear or duplicative.
- Health disparities cannot be addressed without better data
    - Many programs do not collect key demographics limiting the ability to monitor and close service gaps.
- Families and youth feel disengaged from behavioral health services, describing them as overly clinical, adult-centered, and inaccessible.
    - Parents report being left out of the support process.
- Structural and historical inequities—including systemic racism, rural isolation, and fragmented funding—are driving many of the unmet needs across the system.

Child and Family Services

Virginia Statewide Needs Assessment on Adolescent Substance Use – Final Report (2022)

Key Takeaways

- Adolescent substance use services in Virginia are fragmented, under-resourced, and developmentally misaligned.
- There is an urgent need for dedicated youth programs, not just adaptations of adult models.
- Prevention efforts are inconsistent across regions and lack centralized support.
- Stigma and family disengagement are major obstacles to early intervention.
- Special populations—including LGBTQ+, BIPOC, rural youth, and justice-involved youth—face compounded barriers.
- Stronger screening, workforce training, cultural competency, and system collaboration are essential for change.

Special Populations Highlighted

- **Youth across different demographics:** Higher risk of use and mental health challenges but face structural issues and lack of access to appropriate care.
- **Youth in Rural Areas:** More limited access, fewer providers, longer travel times.
- **Non-English-Speaking Families:** Language barriers + low availability of translated materials = huge access gap.
- **Youth in Juvenile Justice System:** High prevalence of use, often unmet treatment needs post-release.

Prevention

The State of Behavioral Health and Wellness in Virginia – 2024 Prevention Needs Assessment Findings

Key Takeaways

- A shared risk and protective factor model are recommended to replace siloed, substance-specific approaches.
- Shifting this model improves impartiality in service delivery, efficiency, and impact, and reduces stigma in programming.
- Protective factors like mentorship, connection, parental engagement, and skill-building need to be centered and resourced.

Identified Unmet Needs

Overextended Prevention Workforce

- CSBs are stretched thin with increasing topic areas (e.g., OTC misuse, cannabis, problem gaming & gambling).
- Staff pulled into non-core duties (e.g., media campaigns, graphic design).
- Burden to meet training quotas—even when attendance is low.

Lack of Focus on Upstream Prevention

- Current strategies are often reactive, focused on crisis issues.
- Missed opportunity to invest in long-term protective factors and community resilience.

Underfunded Youth & Family-Based Initiatives

- Programs supporting parental involvement, self-esteem, and prosocial youth activities are under-resourced or excluded from state priorities.

Limited Data on Root Causes

- Data focuses on outcomes (e.g., depression, use rates), not underlying factors like coping skills or emotional regulation.
- Lack of data hinders program evaluation for newer prevention strategies.

Barriers to Community Engagement

- Stigma around substance usage makes it hard to reach vulnerable populations.
- Lack of culturally appropriate and wellness-framed programming limits participation.

Gaps in Coordination

- Insufficient inter-agency collaboration and limited CSB role in advocacy/policy change

Substance Use Disorders

2024 Virginia Young Adult Survey (YAS) Report – Findings from a Statewide Survey on Young Adult Substance Use and Behavioral Health

Key Takeaways

- Young adults in Virginia are highly impacted by mental health and substance use challenges but are not adequately connected to care.
- Stigma, accessibility, and service mismatch are often barriers.
- Efforts should focus on:

- Culturally competent, youth-designed programs
- Increasing awareness and access to services
- Building protective factors like connection, belonging, and coping skills

Identified Unmet Needs

Mental Health Crisis Among Young Adults

- 56.7% reported experiencing depression, anxiety, or other emotional distress in the past year.
- 17.6% seriously considered suicide in the past year.
- The majority did not access mental health services, citing stigma, lack of time, affordability, or not knowing where to go.

Substance Use Concerns

- High rates of alcohol, cannabis, and vaping:
  - 66.5% reported alcohol use.
  - 32.2% used cannabis.
  - 18.3% reported vaping nicotine.
- Many see little to no risk with regular cannabis or alcohol use.

Stigma & Barriers to Help-Seeking

- Over 40% of respondents did not seek help due to stigma.
- Others lacked knowledge about available services or didn't think their issues were "serious enough."

Lack of Youth-Friendly, Culturally Relevant Services

- Services often don't reflect youth values, identities, or lived experience.
- Certain demographics for young adults experience higher distress and lower access to support.

Low Social Connectedness

- 1 in 5 reported rarely or never feeling connected to their community.
- Disconnection linked to higher rates of distress and substance use.

Housing

Estimate of Need for Permanent Supportive Housing (PSH) for Virginians with Serious Mental Illness – Presentation (2023)

Key Takeaways

- Major PSH gap exists for people with SMI, especially those in crisis.
- Housing + support services = better outcomes, lower public costs.
- Scaling PSH + improving data tracking = priority action steps.
- Uniformity in service delivery can't be addressed without more complete data.

Identified Unmet Needs

Insufficient Permanent Supportive Housing (PSH) Units

- Estimated need: 7,220 units statewide.
- Includes:
    - Homeless (1,791)
    - Incarcerated populations (638)
    - Assisted Living Facilities (693)
    - High system utilizers (4,098)

Affordable Housing

- Rent exceeds Supplemental Security Income (128%-132% of monthly income).
- 71% of VA renters are severely cost-burdened.

Staffing & Capacity

- CSBs report waitlists and lack capacity despite open "slots."

Mental Health & SUD Services

- Long waits for outpatient mental health and substance use treatment.
- State hospitals are at or near capacity.

Outreach Limitations

- Reliance on Projects for Assistance in Transition from Homelessness (PATH) programs with limited reach.
- Undiagnosed individuals are ineligible for PSH requiring SMI diagnosis.

Data Gaps

- Missing race/ethnicity and diagnosis data for incarcerated, ALF, and homeless populations.

Housing

Virginia Fidelity Assessment System Report (2023)

Key Takeaways

- Most Virginia PSH programs operate below high-fidelity standards, particularly in areas of **housing choice, integration, and voluntary services.**
- **Access to safe, affordable housing remains limited,** especially for those with SMI or substance use history, exacerbated by landlord discrimination or low housing inventory.
- Tenants frequently **lack meaningful choice or voice** in their housing or services, reducing long-term engagement and success.
- Many PSH programs are under-resourced and disconnected from **behavioral health providers,** creating **gaps in clinical and peer support services.**
- **Workforce training is inconsistent,** and staff need greater support in trauma-informed, harm reduction, and equity-focused models.
- The PSH system must shift toward **more person-centered, integrated, and equity-aware practices—**backed by sustainable funding and fidelity monitoring.

Identified Unmet Needs

Inconsistent Adherence to PSH Fidelity Standards

- Low or moderate fidelity was common across the assessed programs, particularly in:
    - Choice of Housing - tenants are often placed where units are available, not necessarily based on preference.
    - Integration – units located in areas lacking access to transportation or community resources.
    - Services – limited assertive engagement, clinical supports not consistently available.

Housing Affordability & Availability

- Clients struggle to find housing due to:
    - Low housing stock

    - Discrimination against voucher holders
    - Tight rental markets, especially in urban regions
- Many programs depend on a single landlord or small pool of units.

Limited Consumer Choice & Voice

- In many programs:
    - Tenants have little input into unit location or program design.
    - Participation in services is perceived as required, rather than voluntary.
    - Lack of tenant advisory councils or structured client feedback mechanisms.

Insufficient Service Integration

- PSH teams often lack:
    - Consistent access to mental health clinicians, substance use specialists, or peer support
    - Shared data systems for coordination with CSBs, hospitals, or justice system partners
- Some sites report service gaps during evenings/weekends, when crises are more likely to occur

Workforce Capacity & Training Gaps

- Staff report:
    - Limited training in harm reduction, trauma informed care, and cultural competence
    - High caseloads reduce ability to offer personalized or community-based supports

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

DBHDS is committed to continuous quality improvement (CQI), which is an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes. CQI helps to address and build upon processes to address behavioral health (BH) needs identified in needs assessments to ensure continual growth in access to services as well as the quality of the services received.

DBHDS' QMS fully integrates a culture of quality in every aspect of BH operations and programs. DBHDS' organizational structure allows for improved efficiency and accountability. The BH QMS captures the high-quality work completed throughout DBHDS and identifies opportunities for ongoing improvement. The BH QMS has grown in its focus as it strives to describe its achievement towards established performance goals and outcomes.

DBHDS draws on multiple quality frameworks to include the Institute of Medicine's six dimensions of quality, the Substance Abuse and Mental Health Services Administration (SAMHSA) quality framework, and the Centers for Medicare & Medicaid Services (CMS) Home and Community Based Services (HCBS) in the implementation of the DBHDS BH QMS.

DBHDS QMS incorporates the nationally recognized quality principles and programs. The system's infrastructure is supported through the organization's leadership who is:

- Committed to the success of the QMS
- Supportive of the organizational culture of quality improvement (QI)
- Prepared to designate resources for critical support mechanisms
- Willing to give authority to staff to make changes
- Person and family-centered
- Characterized by employees and providers who are continuously learning and empowered as innovative change agents
- Effective in utilizing data for ongoing quality improvement
- Sustainable and continuous

The goal is a system of quality services that allows individuals to direct their own lives to access and fully participate in their community and balances risk, health, safety, and well-being. An effective quality/risk management (RM) structure includes quality assurance (QA), RM, and QI processes.

The DBHDS BH QMS includes:

- Division of Provider Management- The DBHDS Division of Provider Management provides a quality assurance function for the agency, establishing basic requirements for provider organizations through regulation, determining the extent to which these standards/regulations are met, and taking progressive

action to remedy specific problems or concerns that arise. The DBHDS Division of Provider Management includes the Offices of Licensing, Human Rights, and Regulatory Affairs.

- Division of Facilities Services- The DBHDS Division of Facilities Services directs, monitors, and strengthens QI in the DBHDS state facilities. Each facility ensures the coordination and integration of QI activities aimed at the delivery of safe, high-quality care in its facility. The goal is to maintain a systematic facility-wide approach to safety and performance improvement across three overlapping areas of focus: accreditation and regulatory compliance; incident management and risk reduction; and systematic and sustainable performance improvement.
- Division of Crisis Services- Formed FY 2023, Crisis Services is focused on the development and implementation of an integrated continuum of community-based crisis intervention services. Over the past year, Crisis Services has grown by nine staff and undergone considerable re-organization. This includes the creation of two offices, one focused on the operational infrastructure and systems of the integrated continuum, and the other focused on the support and monitoring of service providers.

  The division of crisis services includes the Office of Crisis Services and the Office of Crisis Operations. The Office of Crisis Services manages: Mobile Crisis Response (MCR), Crisis Receiving Centers and Crisis Stabilization Centers, Community Services Board Emergency Services, REACH (Regional, Education, Assessment, Crisis Services, Habilitation). The Office of Crisis Operations manages: Regional Crisis Call Centers, Alternative Transportation and Custody, Virginia Crisis Connect (VCC) (formerly the Crisis Data Platform), Marcus Alert/Co-Responder Program, and the Crisis Intervention Team
- Division of Behavioral Health Services- In collaboration with its state and community partners, the DBHDS Division of BH Services plans, develops, directs, funds and monitors the delivery of comprehensive behavioral health services throughout the Commonwealth of Virginia. To ensure the delivery of coordinated services to mutually served populations, DBHDS provides liaison services to state and community agencies that interact with the public behavioral health services system. DBHDS is involved in design, development and implementation of evaluation processes, data reporting standards and measures used to analyze the delivery of mental health services, and also operates nine acute care state psychiatric facilities, including one for children.

  The Division of BH Services manages Virginia’s community services boards which are (CSBs) the primary point of entry into the Commonwealth’s public behavioral health and developmental services system. CSBs provide treatment

for mental health issues, substance use and addiction, and intellectual and developmental disabilities. There is a CSB that serves every county and city in the state.

- Division of Clinical and Quality Management- The Division of Clinical and Quality Management provides cross-disability quality management and technical expertise and support across all program areas of the agency to aid in leading system-wide transformation and enhance cross-disability collaboration. The aim of the Division is to support the agency in ensuring that all individuals receive high quality care and service providers integrate mortality review, infection control, pharmacology, quality assurance and improvement best practices, and use data to drive decision-making, behavioral health policy development and enhancement, and the identification of the need for improvement and the development of strategies to drive change. The Division is comprised of the following offices: Pharmacy Services, Mortality Review, Clinical Quality Management, Community Quality Improvement, Quality Assurance and Healthcare Compliance, and Infection Prevention.

DBHDS Quality Improvement Process Description

Each office and division involved with the BH QMS engages in root cause analysis and the development of quality improvement initiatives (using the Plan-Do-Study-Act quality improvement model depicted below) as well as other quality improvement activities.

Quality improvement is a continuous process, rather than a one-time activity, and connects with the agency's mission and vision. This process involves:

- Development of quality outputs and outcomes
- Data collection

- Data analysis
- Evaluating the effectiveness of the overall system
- Determining findings and conclusions
- Identifying trends that need to be addressed
- Identifying corrective actions, remedies, or quality improvement initiatives as needed
- Implementing quality improvement initiatives, corrective actions, or remedies; and
- Evaluating the effectiveness of implemented corrective actions, remedies, and/or quality improvement initiatives.

As DBHDS uses these QA, RM and QI processes in its BH QMS operations and engages in CQI activities, key areas are targeted for improvement (known as Path Forward).

Data reliability and validity are key components for the BH QMS and the development of quality improvement initiatives. Processes to evaluate and improve data quality are integrated throughout the BH QMS, which include use of i.e. accepted benchmarks, inter-rater reliability tools, use of standardized tools and measures, internal validation processes, and updating and enhancing existing sources of data.

Path Forward

Through program evaluation, DBDHS determines the path forward, for targeted improvement for the coming year. DBHDS may include other Path Forward items based on strategic planning and associated priorities, external audit findings, or emerging needs.

As a subcommittee of the Department of Behavioral Health and Developmental Services (DBHDS) Behavioral Health Quality Improvement Committee (BH QIC), the Behavioral Health Key Performance Area Committee (KPAC) is charged with responsibilities associated with collecting and analyzing valid and reliable data; facilitating measure development; and evaluating measures related to the established Community Behavioral Health (CBH) Key Performance Areas (KPA), across the lifespan of Behavioral Health programs (provided by the offices of Adult Community Services, Behavioral Health Wellness, Child and Family Services, Crisis Services and Emergency Services, Housing Services, and Recovery Services).

The established BH Key Performance Areas (BH KPAs) and their intended outcomes are as follows:

- Health, Safety, and Wellbeing
  - Individual: People being served are safe, receive routine, preventative healthcare, and holistic, person-centered behavioral health services and supports.
  - Engagement of Communities: Communities work together to address health-related issues, identified and prioritized by DSBHDS, as indicated through the mechanisms such as Behavioral Health Index and others, to promote well-being to achieve positive health impact and outcomes through the provision of training opportunities, support for coalition capacity-building, and leveraging community resources to enact environmental changes that support the social, emotional, spiritual, and physical well-being of individuals served.
- Recovery and Resiliency
  - People with mental health and/or substance use challenges have access to the resources, tools, and skills to live fully ensuring that they have the necessary information to make informed choices that support physical and emotional well-being; access to safe and stable housing; opportunities to engage in employment and other meaningful daily activities and opportunities to establish and maintain relationships and social networks.
- Access to Care
  - Providers are knowledgeable and trained to meet the needs of the population served.
  - The populations served have equitable access to affordable, high-quality care.
  - There are enough providers to ensure access to care.

DBHDS will continue to enhance its ability to utilize data in driving decision-making, in identifying service gaps, and in identifying QI efforts, including statewide initiatives.

In SFY25-26, The BH KPA Committee is committed to:

- Evaluating the four BH KPAs at the systems level.
- Reviewing data and identifying trends/gaps in the available data (system-level and provider level, as applicable)
- Facilitating the review and discussion of Performance Measure Indicator data with program SMEs to inform Quality Improvement Initiatives (QIIs)
- Facilitating the development of performance measures following the completion of the BH Measure Development Process

- Establishing benchmarks for performance measures based on baseline data and national standards
- Reviewing progress towards meeting established benchmarks
- Ensuring technical assistance/support is provided related to performance against BH QMS performance measures
- Evaluating whether a performance measure benchmark needs to be adjusted and establishing a specific action plan for revising benchmarks
- Assessing performance measures annually and based upon analysis and collaboration with program SMEs, revising or retiring performance measures in accordance with continuous quality improvement practices
- Ensuring communication and opportunities for feedback around performance measures occurs with applicable stakeholders in accordance with DBHDS' BH Measure Development and Review Process
- Receiving reports from and providing consultation to other DBHDS programs and workgroups that are reviewing BH surveillance data
- Recommending Performance Measure Indicators to BH QIC for approval

Through data collection, data reviews, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, program SMEs in collaboration with BH KPAC identify areas for development of quality improvement initiatives (QIIs).

A QII may be recommended by program SMEs to the BH QIC. The BH QIC maintains authority to approve, defer, or reject the proposed QII.

On a quarterly basis, DBHDS staff assigned to implement approved QIIs will report data related to the QIIs to the BH KPAC to enable the committee to track implementation.

DBHDS Strategic Plan Initiatives

Through the quality improvement process outlined above, DBHDS has identified several initiatives to improve outcomes across program areas including initiatives that receive in some part block grant dollars or at one point received ARPA block grant dollars (highlighted in bold with populations served identified in parentheses).

Facility New Hire Retention	Increase one-year retention rates to 65% for all DBHDS facilities by December 2024

Peer Impacts **(Peers serving SMI/SED, SUD TX, PWID, PPW)**	Define, measure, and enhance the impact of peers on the publicly funded behavioral health system in Virginia as evidenced by the implementation of high-fidelity Peer Respite services, the expansion of settings utilizing peers, and the continual growth of the CPRS roster across the Commonwealth
Employee Professional Development	Double the number of Professional Skills Development actions (within current SAP) issued by each facility over the next 9 months
Training and Role-Based Competencies	Establish and incorporate role-based and level-based clinical and non-clinical competency requirements associated with positions and roles within both Central Office and the Facilities. Assess for and implement an HRIS-compatible LMS to support these competencies.
Vacancy Rate of Prioritized Service Positions	Reduce average vacancy rate of DBHDS prioritized service positions to less than 20% by December 2023
Assess Public System Workforce Capacity	By July 2023, work with Community Service Boards (CSBs) to develop metrics, baseline, and a plan to assess workforce capacity for prioritized positions
Provider Administrative Burden	Eliminate all documentation and reporting requirements placed upon CSB direct care staff that are not essential to ensuring consumers receive effective and timely services by Dec 2025
Provider Licensure Process	Re-configure process for high priority/high need services with focus on maintaining health and safety, and quality applications to continue to meet the target of 85% of applicants licensed withing 90 days; balancing KR: % of providers that progress from a conditional license to an annual license
Annual Inspection Compliance	Align resources, policies, and workflows to balance inspection operations to ensure 100% of providers receive annual inspections within a 12-month period

Human Rights Compliance	New KR in development to ensure providers funded by DBHDS that have requirement to abide by human rights in their contract are compliant
Virginia Mental Health Access Program- VMAP **(Children w/ SED)**	Increase the call volume among registered VMAP providers by 15% by December 2024. Additionally, the number of registered providers shifts to a KPI (also will track trajectory for easy reference).
School-Based Mental Health (SBMH) Services **(Children w/ SED)**	Increase access to mental health services for students in an integrated school setting by: (1) increasing the number of students who receive School-Based Mental Health (SBMH) services by 300% by December 2024; (2) increasing the number of youth served through screenings, functional behavioral assessments, and intervention services by 15% each year through 2025; and (3) demonstrating an increase in the number of established partnerships to provide SBMH services within schools across the 40 Community Services Boards (CSBs) / Behavioral Health Authorities (BHAs) each year through 2025
Teen Substance Use **(SUD TX, PWID)**	Plan and implement an intervention to reverse the trend of increasing prescription pain medication abuse in teens. Because this is an HHR KR, the rates for the other substances will be continually monitored
Lapses in Care for Transitioning Students	Reduce lapses in care for people with disabilities by connecting transitioning students to additional resources - as measured by individuals receiving a Developmental Disabilities (DD) waiver, connecting to employment or connecting to higher education. Establish baseline of need and aim to impact by 5% by 2025
Permanent Supportive Housing (PSH) **(Adults w/ SMI)**	Meet 60% of the need for permanent supportive housing among serious mental illness (SMI) population by June 2026
Priority 1 Waiver Waitlist	In Development

Waiver Employment	Increase employment for adults on the Developmental Disabilities (DD) waiver and waitlist, to 25% by the end of 2025
Coordinated Specialty Care (CSC) **(FEP/ESMI)**	Increase the percentage of individuals receiving their first CSC service within two years of their first episode of psychosis by 2% each year (from the initial baseline) through 2025 to improve early intervention of behavioral health services
Assertive Community Treatment (ACT) **(Adults with SMI)**	Demonstrate an improvement in Assertive Community Treatment (ACT) outcomes, within each of the next 3 fiscal years (SFY 2023-2025), as measured annually by a reduction in: 1) state hospital bed days utilized; 2) local hospital bed days utilized; and 3) total days in confinement (incarceration) for individuals accessing ACT services
Adult Psychiatric Access Line (A-PAL) **(SUD Tx for PWID & PPW)**	Adult Psychiatric Access Line (A-PAL) Register X providers with the APAL program by February 2025.
Opioid-Related Deaths **(SUD Tx and Prevention)**	Decrease in opioid-related deaths by 20% by December 2025
Behavioral Health Quality Management System	Continue to complete the buildout of the BH QMS, assess and refine measures to identify core measures that: 1) measure outcomes for individuals served 2) measure access or lack of services across VA 3) measures that actually assess achievement of program intent. STEP-VA benchmark establishment is a priority, and the team will collaborate to develop a plan by October 2024 outlining the activities required to revise all BH measures.
Source-System Validation	Resource and activate source-system validation processes for DOJ and non-DOJ-related source systems by July 1, 2024, for inclusion into an analysis and report by September 1, 2024

STEP-VA Measure Development	Complete the plan for the measure development process with provisional benchmarks for each of the steps in STEP VA by October 15, 2024, and compile the measures, benchmarks, and supporting data into a report by October 1, 2025.
Crisis Services Delivery **(Crisis Set-Aside, Adults with SMI, Children w/ SED)**	Within 120 days, develop Crisis Service Delivery quality outcome measures in collaboration with select CSBs and DHBDS Quality Management Team (note: This KR is still in development)
Crisis Services Awareness **(Crisis Set-Aside, Adults with SMI, Children w/ SED)**	Expand crisis service awareness throughout Virginia by increasing the 988 and regional call center usage rate by 15% and increasing the in-state answer rate to 94% or higher by December 2025
Crisis Services Access **(Crisis Set-Aside, Adults with SMI, Children w/ SED)**	Expand access to same-day crisis care for all Virginia residents through the following goals: (1) Mobile Crisis Teams (MCTs): At least 70 MCTs are staffed at or above minimum standard by December 2023; (2) Crisis Stabilization Units (CSUs): Establish 2 Crisis Stabilization Units (CSUs) by December 2025; (3) Crisis Receiving Centers (CRCs): Sites to expand statewide capacity by 104 chairs are identified by August 2023, new CRC breaking group by December 2023
Temporary Detention Order (TDO) Volume	Reduce the volume of Temporary Detention Orders (TDOs) by 20% by July 2024 and eliminate the TDO waitlist by July 2024
Virginia Crisis Connect **(Crisis Set-Aside, Adults with SMI, Children w/ SED)**	Establish all components of the Virginia Crisis Connect platform including the following milestones: (1) ensure state hospital waitlist is functional for provider usage by December 2023; (2) ensure full bed registry is functional in Virginia Crisis Connect by January 2024; (3) support full integration of all Virginia hospital bed management systems into Virginia Crisis Connect to fully automate the hospital bed registry by January 2025; and (4)

	launch app to dispatch mobile providers by January 2025
Children's Crisis Services **(Crisis Set-Aside, Children w/ SED)**	Expand pilot program to provide child psychiatry and children's crisis response services as measured by the following milestones: (1) award proposals for Children's Crisis Stabilization Services by November 2023; (2) begin implementation of expanded Children's Community Crisis Stabilization Services by January 2024; (3) activate all sites in pilot by December 2024; and (4) collect initial outcomes from pilot by December 2025
Crisis Services Infrastructure **(Crisis Set-Aside, Adults with SMI, Children w/ SED)**	Within 120 days, develop Crisis Service Delivery quality outcome measures in collaboration with select CSBs and DHBDS Quality Management Team
Structural Improvement	Complete the measure development process with provisional benchmarks for each of the steps in STEP VA by October 15, 2024.
Customer Satisfaction	Design and deploy a customer satisfaction tool for Community Service Boards (CSBs) and providers by January 2023 and attain an average score of 90% satisfaction by January 2025

Enterprise Policy Management	Implement a sustainable system to evaluate, develop, and implement policies, processes, and procedures including the following milestones: (1) establish a governance structure and enterprise policy management system by January 2024; (2) revise and approve policy on policies by March 2024; and (3) pilot system to address at least 1 critical priority policy/process by July 2024
Interagency Structural Planning	Design and deploy the apparatus required to participate meaningfully in the Behavioral Health Services Redesign process that is being led by DMAS and execute fully on all agency obligations within that project until its completion in Dec of 2025
CSB Performance Management	Design and deploy a CSB Performance Management paradigm inclusive of FY26 and ongoing Performance Contract changes and the continued development of the CSB Performance Dashboard. Plan to be briefed to ELT by 1 September 2024
Behavioral Health Provider Availability	Complete geographic analysis of behavioral health provider availability (top 3 underserved areas), as informed by the BH Redesign Continuum of Care effort by December 2024
Electronic Health Record Adoption	Improve adoption of Cerner Electronic Health Records (EHR) Platform through standardized workflows to support care safety/quality, clinical staff effective and efficient use, and regulatory/cost savings opportunities AEB: (1) improve clinical staff effective and efficient EHR use, with focus on providers, for a 10% reduction in applicable opportunity metrics by June 2024; (2) assimilate and/or automate applicable paper and / or manual clinical processes into standardized EHR workflows by June 2024 (10% by March 2024, 5% by June 2024); and (3) improve and control 3 key EHR specific adoption and safety metrics (CPOE greater than or equal to 92%, Patient ID and Medication Barcode Scanning greater than or equal to 95%, Medication

	Reconciliation greater than or equal to 99%) by June 2024
Facility Efficiency	Improve effectiveness and efficiency of facility business operations: (1) establish a facilities governance framework (RACI, decision-rights, communication plan) to standardize business processes necessary to evaluate and prioritize technology solutions by June 2024 and (2) adopt at least 2 enterprise technology solutions and/or processes by June 2024
Facility Financials & Operations	Improve financials and operations for all facilities: (1) identify 2-3 areas to demonstrate cost savings and improved efficiency by June 2023, including operations, procurement, and personnel, to be implemented by the end of June 2024; (2) enhance critical processes to enable reimbursements, increasing revenue by 5% by December 2023 (completion of advanced training by December 2023; replacement of Avatar by Q2 ‘25); and (3) enhance clinical documentation within the EHR system to demonstrate a 95% authorization approval rate by June 2024
New Facility Certification	Achieve certification for Piedmont Geriatric Hospital (PGH) by June 2024 to enable reimbursements

Data Warehouse	Create a single behavioral health and developmental disabilities enterprise data warehouse by December 2024
Data Exchange	Establish a platform for the exchange and management of Community Service Boards (CSBs) and DBHDS data to improve data collection and reporting by December 2024
Data Governance Compliance	All data source systems feeding the Enterprise Data Warehouse comply with established data governance policies and procedures by December 31, 2025; all other data sources owned by the Agency will comply with data governance by December 2026
Data Analytics	Provide comprehensive data analytics for the continuum of care and reduce administrative burden on provider reporting by December 2025
Admission Dynamics	Identify the top 8 CSB and jail outliers regarding TDO use, determine the cause driving the trend, and provide technical assistance to normalize TDO use across the Commonwealth.
Discharge Dynamics: Facility Ops	Decrease the length of time individuals spend ready for discharge (on average) before leaving state hospitals by 10%* by 7/1/25.
Discharge Dynamics: Community Ops	Develop a funding/service governance structure to include PSH, ACT, and DAP and other community-based funding sources, in order to enhance timely pathways for state hospital discharge, that is fully operational by 7/1/25.
Forensic Services **(Adults w/ SMI, SUD)**	Implement at least three initiatives/programs that prevent and/or reduce overutilization of state hospitals by patients requiring forensic services, by 7/1/25.
Alternative Custody	Double the number of monthly law enforcement hours saved by 1 July 2025.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Initiation in Community Substance Use (SUD) Treatment Services

Priority Type: SUP, SUT

Population(s): PWWDC, PP, PWID, TB

Goal of the priority area:

Provide adequate intervention services to individuals receiving community SUD treatment services to decrease the likelihood of the need of more intensive services.

Strategies to attain the goal:

1. Encourage providers to utilize Cognitive Behavior evidence-based practices such as Contingency Management, harm reduction, mindfulness, and medication-assisted treatment (MAT) where appropriate, and provide training/guidance to providers in this practice.
2. Encourage and provide support to providers to use engagement strategies such as Motivational Enhancement Therapy, Motivational Interviewing techniques, peer support services by provider training on these evidence-based practices.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In the last 12 months, percentage of adults and children who are 13 years or older with a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD service within 14 days of the new SUD diagnosis (numerator).

Baseline measurement (Initial data collected prior to and during 2026): 72%

First-year target/outcome measurement (Progress to the end of 2026): 75%

Second-year target/outcome measurement (Final to the end of 2027): 76%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Data will track individuals who have been diagnosed with SUD and are quickly receiving their first service within 14 days. Indicator aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from provider via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Indicator #: 2

Indicator: In the last 12 months, percentage of intravenous substance users requesting admission into a substance use program that were admitted and provided substance user services within 14 days of the request for admission.

Baseline measurement (Initial data collected prior to and during 2026): None

First-year target/outcome measurement (Progress to the end of 2026): 75%

Second-year target/outcome measurement (Final to the end of 2027): 76%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Data will track individuals individuals who are identified as intravenous substance users and are quickly receiving their first service within 14 days.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from provider via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Indicator #: 3

Indicator: In the last 12 months, percentage of intravenous substance user requesting admission into a substance use program that were not admitted into substance use services within 14 days of the request for admission and did receive interim services within 48 hours and did not stay on the waitlist for more than 120 days.

Baseline measurement (Initial data collected prior to and during 2026): None

First-year target/outcome measurement (Progress to the end of 2026): 75%

Second-year target/outcome measurement (Final to the end of 2027): 76%

Data Source:

Provider survey; DBHDS Enterprise Data Warehouse

Description of Data:

Data will track individuals who did not receive their first SUD service within 14 days of request but did receive interim services within 48 hours and did received services within 120 days of request.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from provider via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Indicator #: 4

Indicator: In the last 12 months, percentage of individuals who completed TB risk assessment within 30 days of after being admitted to SUD treatment services in order to identify those individuals who are at high risk of becoming infected.

Baseline measurement (Initial data collected prior to and during 2026): 37%

First-year target/outcome measurement (Progress to the end of 2026): 38%

Second-year target/outcome measurement (Final to the end of 2027): 39%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

total # of individuals who received TB screenings (numerator) after SUD Tx Program admission/ total # of individuals admitted to SUD Tx Program (denominator)

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from provider via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 2

Priority Area: Increasing initiation and engagement of pregnant and parenting women in SUD services.

Priority Type: SUT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Increasing initiation and intensity of engagement of pregnant and parenting women in SUD services provided by the Community Services Boards (CSBs) in Virginia

Strategies to attain the goal:

1.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In the last 12 months, percentage of pregnant women and women with dependent children with a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD service within 14 days of the new SUD diagnosis (numerator).

Baseline measurement (Initial data collected prior to and during 2026): 76%

First-year target/outcome measurement (Progress to the end of 2026): 77%

Second-year target/outcome measurement (Final to the end of 2027): 78%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Data will track pregnant women and women with dependent children who have been diagnosed with SUD and are receiving their first service within 14 days. Indicator aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Indicator #: 2

Indicator: In the past 12 months, percentage of pregnant women and women with dependent children with a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD service within 14 days of the new SUD diagnosis and who received two or more additional SUD services within 30 days of the first service (numerator)

Baseline measurement (Initial data collected prior to and during 2026): 63%

First-year target/outcome measurement (Progress to the end of 2026): 69%

Second-year target/outcome measurement (Final to

the end of 2027):

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Data will track pregnant women and women with dependent children who have received services within 30 days of being admitted into the SUD services program. Aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 3

Priority Area: Adherence to the standard that pregnant women receive priority admission for SUD services being seen within 48 hours of their request for services.

Priority Type: SUT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Increasing percentage of pregnant women in Virginia who are receiving priority admission for SUD services at the Community Service Boards (CSBs).

Strategies to attain the goal:

-Evaluation and Research Analyst will query the data in EDW to extract percentage.
-Evaluation and Research Analyst, Block Grant State Planner and SUD Director will meet to evaluate the results
-If targets are not met, BG Specialists will meet with CSBs to determine appropriate responses which will include education, training, and technical assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In the last 12 months, percentage of pregnant women seen within 48 hours of their request for a valid SUD service.

Baseline measurement (Initial data collected prior to and during 2026): 76%

First-year target/outcome measurement (Progress to the end of 2026): 78%

Second-year target/outcome measurement (Final to the end of 2027): 78%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

The data compares the data an individual who identifies as pregnant requests SUD services and the date the first appointment was held.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 4

Priority Area: Increase Peer Support Services

Priority Type: SUP, SUT, SUR, ESMI

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Increase peer services and support in the public behavioral health system.

Strategies to attain the goal:

Increase the number of peer support specialists in Virginia's public behavioral health system through inclusion of peer support as a Medicaid reimbursable service.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of peer staff offering recovery support services in substance use disorder service settings.

Baseline measurement (Initial data collected prior to and during 2026): 193

First-year target/outcome measurement (Progress to the end of 2026): 195

Second-year target/outcome measurement (Final to the end of 2027): 200

Data Source:

Data to be collected by DBHDS from CSBs.

Description of Data:

Data is the number of FTE peer support specialists providing recovery support services in CSBs SUD treatment programs

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Number of peer staff offering mental health peer support services in mental health treatment settings.

Baseline measurement (Initial data collected prior to and during 2026): 301

First-year target/outcome measurement (Progress to the end of 2026): 305

Second-year target/outcome measurement (Final to the end of 2027): 314

Data Source:

Data collected by DBHDS from CSBs and state hospitals.

Description of Data:

The number FTE mental health peer support specialists reports by CSBs and state hospitals.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 3

Indicator: Increase the number of available certified Peer Recovery Specialists to better meet demand

within the public, private and non-profit sectors.

Baseline measurement (Initial data collected prior to and during 2026): 1403

First-year target/outcome measurement (Progress to the end of 2026): 1410

Second-year target/outcome measurement (Final to the end of 2027): 1411

Data Source:

Virginia Certification Board

Description of Data:

The number of peers certified to provide services throughout Virginia

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 5

Priority Area: Engagement in Community Substance Use Disorder (SUD) Treatment Services

Priority Type: SUT, SUR

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Maintain engagement level of individuals' engagement in community SUD treatment services.

Strategies to attain the goal:

1. Work with Community Service Boards (CSBs) to establish guidance concerning service capacity that supports adequate frequency of treatment services.
2. Work with providers to ensure that current resources are used efficiently.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In the last 12 months, percentage of adults and children who are 13 years with a new episode of substance use disorder (SUD).

Baseline measurement (Initial data collected prior to and during 2026): 58%

First-year target/outcome measurement (Progress to the end of 2026): 58%

Second-year target/outcome measurement (Final to the end of 2027): 59%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Data will track individuals who have received services within 30 days of being admitted into SUD Services. Indicator aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 6

Priority Area: Engagement in child mental health outpatient services

Priority Type: MHS, ESMI

Population(s): SED, ESMI

Goal of the priority area:

Increase child and family engagement in mental health outpatient services.

Strategies to attain the goal:

1. Monitor access to a uniform array of children's behavioral health services using the System Transformation Excellence and Performance (STEP-VA) model.
2. Focus on strategic initiatives to fill gaps in the STEP-VA array of services for children through the implementation of the outpatient services step of STEP-VA.
3. Continue to expand workforce development initiatives. There is an extreme shortage of licensed professionals in CSBs to meet the challenging needs of children with behavioral health problems. Workforce development initiatives from DBHDS provide continuing education for the children's behavioral health workforce. This training is provided free of charge to assist clinicians in getting licensed or maintaining current licenses. (This strategy is currently implemented with federal funding.)
4. Improve DBHDS quality management and quality assurance and oversight capacity for child and adolescent behavioral health services. Additional resources are needed for this initiative. (This strategy is contingent on state funding.)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of children admitted to mental health services during the previous 12 months who received one hour of outpatient services within 30 days of admission (denominator) who received at least two additional hours of outpatient services within 60days of admission (numerator).

Baseline measurement (Initial data collected prior to and during 2026): 71%

First-year target/outcome measurement (Progress to the end of 2026): 72%

Second-year target/outcome measurement (Final to the end of 2027): 73%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Data will track children who received services within 30 days of admission into the mental health services program.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 7

Priority Area: Address the housing needs of individuals with mental health and/or substance use disorders

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Address the housing needs of individuals with behavioral health disorders to support a secure and stable recovery.

Strategies to attain the goal:

1. Continue participation in cross-secretarial and interagency activities to leverage housing resources and create affordable housing options for individuals receiving public behavioral health services.
2. Continue providing training and consultation to service providers to increase affordable housing and appropriate supports by leveraging housing resources and
implementing supportive housing models.
3. Continue including housing stability of individuals receiving CSB behavioral health services as a Performance Contract goal and responsibility, and track outcomes on a regular basis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals receiving SUD treatment services housed in Permanent Supportive Housing programs through DBHDS.

Baseline measurement (Initial data collected prior to and during 2026): 850

First-year target/outcome measurement (Progress to the end of 2026): 875

Second-year target/outcome measurement (Final to the end of 2027): 900

Data Source:

DBHDS Permanent Supportive Housing Database; DBHDS Enterprise Data Warehouse

Description of Data:

Data are total number of individuals housed since the inception of the DBHDS Permanent Supportive Housing Initiative.

Data and Evaluations Coordinator will receive individual list from PSH database and do a cross-match with individuals in EDW to identify SMI.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Individuals who receive SUD treatment services who are supported by the PSH program and remain stably housed for at least 12 months.

Baseline measurement (Initial data collected prior to and during 2026): 96%

First-year target/outcome measurement (Progress to the end of 2026): 96%

Second-year target/outcome measurement (Final to the end of 2027): 97%

Data Source:

DBHDS Permanent Supportive Housing database

Description of Data:

A rolling number of persons, who receive SUD treatment services and identified in the PSH database and remain housed for at least 12 months.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 3

Indicator: Number of individual receiving SMI mental health services housed in Permanent Supportive Housing programs through DBHDS

Baseline measurement (Initial data collected prior to and during 2026): 2516

First-year target/outcome measurement (Progress to the end of 2026): 2520

Second-year target/outcome measurement (Final to the end of 2027): 2550

Data Source:

DBHDS Permanent Supportive Housing Database; DBHDS Enterprise Data Warehouse

Description of Data:

Data are the total number of individuals housed since the inception of the DBHDS Permanent Supportive Housing Initiative.

Data and evaluation coordinator will receive the individual list from the PSH database and do a cross-match with individuals in EDW to identify SMI.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 4

Indicator: Individuals who receive SMI mental health services who are supported by the PSH program and stably housed for at least 12 months

Baseline measurement (Initial data collected prior to and during 2026): 96%

First-year target/outcome measurement (Progress to the end of 2026): 96%

Second-year target/outcome measurement (Final to the end of 2027): 97%

Data Source:

DBHDS Permanent Supportive Housing

Description of Data:

A rolling number of person year over year, whoa re classified as DBHDS SMI in the PSH Database.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 8

Priority Area: Intensity of engagement of adults in adult mental health outpatient services.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the intensity of engagement of adult with SMI in mental health outpatient services.

Strategies to attain the goal:

1. Continue to expand access to a uniform array of adult behavioral health services using the existing System Transformation Excellence and Performance (STEPVA) model and implementation efforts of Certified Community Behavioral Health Clinics (CCBHC).
2. As efforts for technical assistance continue for STEP-VA, Same Day Acces (SDA) will be monitored by continued check-ins, training and technical assistance offered to increase appointment status, post comprehensive needs assessment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of individuals admitted to mental health services during the previous 12 months with serious mental illness (SMI) who received one hour of outpatient services within 30 days of admission (denominator) whor eceived at least two additional hours of outpatient services within 60 days of admission (numerator)

Baseline measurement (Initial data collected prior to and during 2026): 59%

First-year target/outcome measurement (Progress to the end of 2026): 60%

Second-year target/outcome measurement (Final to the end of 2027): 61%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Individuals who received services within 30days of admission into mental health services and an additional two services within 60 days.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 9

Priority Area: Suicide Prevention

Priority Type: SUP, MHS

Population(s): SMI

Goal of the priority area:

Maintenance of suicide prevention infrastructure at the state and community levels.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Total number of firearm retailer partners established

Baseline measurement (Initial data collected prior to and during 2026): 603

First-year target/outcome measurement (Progress to the end of 2026): 610

Second-year target/outcome measurement (Final to the end of 2027): 620

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of wellness activities supporting Suicide Prevention in the state.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Total number of "Lock and Talk Virginia" outreach via lethal means safety deterrents (such as medication lock boxes, gun locks, locking pill caps, locking medical bags).

Baseline measurement (Initial data collected prior to and during 2026): 44469

First-year target/outcome measurement (Progress to the end of 2026): 45000

Second-year target/outcome measurement (Final to the end of 2027): 47000

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of wellness activities supporting Suicide Prevention in the state.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 10

Priority Area: Youth retail access to all tobacco products, including smokeless, cigarillos, e-cigarettes, and other vapor products

Priority Type: SUP

Population(s):

Goal of the priority area:

Decrease the number of minors being sold tobacco and nicotine products.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of all retail outlets in Virginia that have violated sale tobacco and nicotine products to minors (Retail Violation Rate).

Baseline measurement (Initial data collected prior to and during 2026): 12.4%

First-year target/outcome measurement (Progress to the end of 2026): 12%

Second-year target/outcome measurement (Final to the end of 2027): 11.5%

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall impact of the reduction of retail outlets selling tobacco and nicotine products to underage youth in the state.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 11

Priority Area: Increase the public's knowledge about mental illness and decrease the associated stigma

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Decrease the stigma associated with mental illness through increased public knowledge and understanding of mental illness and its effects on individuals, families and communities.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of Mental Health First Aid Trainers from inception of program.

Baseline measurement (Initial data collected prior to and during 2026): 1283

First-year target/outcome measurement (Progress to the end of 2026): 1300

Second-year target/outcome measurement (Final to the end of 2027): 1350

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of trainers available to increase public's knowledge about mental illness and reduce stigma.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: The total number of individuals trained in Mental Health First Aid by certified Trainers in Virginia each year of the program.

Baseline measurement (Initial data collected prior to and during 2026): 6700

First-year target/outcome measurement (Progress to the end of 2026): 6500

Second-year target/outcome measurement (Final to the end of 2027): 6500

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall impact of MH First Aid outreach to increase public's knowledge about mental illness and reduce stigma.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 12

Priority Area: Addressing Adverse Childhood Experience (ACESs) as a community to reduce the impact of childhood trauma leading to problem behaviors, i.e. substance use disorder, suicide, and anxiety.

Priority Type: SUP, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

To better service individuals with Adverse Childhood Experiences so that the likelihood that trauma leads to problem behaviors is significantly reduced.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of Virginia Community Service Boards (CSBs) that are trained to service individuals with ACE

Baseline measurement (Initial data collected prior to and during 2026): 40

First-year target/outcome measurement (Progress to the end of 2026): 40

Second-year target/outcome measurement (Final to the end of 2027): 40

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Measure the state's ability to serve individuals with ACE by number of CSBs trained to serve as catchment areas.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Within the next two fiscal years, at least 3,600 additional individuals will be trained in Adverse Childhood Experiences (ACES) each year.

Baseline measurement (Initial data collected prior to and during 2026): 7927

First-year target/outcome measurement (Progress to the end of 2026): 11,530

Second-year target/outcome measurement (Final to the end of 2027): 11,530

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Measure the state's ability to serve individuals with ACE by number of individuals trained across the state.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 13

Priority Area: Communication mobilization organized to prevent substance use disorders

Priority Type: SUP

Population(s):

Goal of the priority area:

Greater connection between a variety of community coalitions across the state will have an impact on reducing the number of Virginians who become diagnosed with a substance use disorder.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of community coalitions in Virginia that have established a network of CADCA and/or CCOVA

Baseline measurement (Initial data collected prior to and during 2026): 103

First-year target/outcome measurement (Progress to the end of 2026): 104

Second-year target/outcome measurement (Final to the end of 2027): 105

Data Source:

CADCA and CCOVA paid memberships rosters

Description of Data:

Measure of networking and engagement touchpoints between community coalitions and CADCA and/or CCOVA

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 14

Priority Area: Address episodes of institutional confinement in state psychiatric hospitals of individuals with serious mental illness (SMI) served by Virginia's Assertive Community Treatment (ACT) teams

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, BHCS

Goal of the priority area:

To divert adults with serious and persistent mental illness form state hospitalizations through the provision of high-fidelity Assertive Community Treatment.

Strategies to attain the goal:

1. Continue to provide training and consultation to service providers on the provision of high-fidelity ACT.
2. Monitor fidelity of Virginia's ACT program via the use of the Tool of the Measurement of ACT.
3. Continue to require ACT team to report psychiatric hospitalizations of individuals served and track outcomes on a regular basis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Precent reduction in state hospitalization by comparing individuals' number of bed days in the two year prior to ACT admission with the number of bed days the two years following admission to ACT.

Baseline measurement (Initial data collected prior to and during 2026): 44%

First-year target/outcome measurement (Progress to the end of 2026): 45%

Second-year target/outcome measurement (Final to the end of 2027): 45%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Reduction in state hospital bed days utilized by individuals receiving ACT services.

Data issues/caveats that affect outcome measures:

To meaningfully measure the effectiveness of diverting individuals from state hospitals and stabilizing them in the community, we determined that we needed to review at least two years of hospitalization data for each individual after receiving ACT services. The latest complete fiscal year data available at the time of drafting the report is one year prior.

Priority #: 15

Priority Area: Same Day Access Service for Community Behavioral Health

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Offer individuals seeking treatment for behavioral health same day evaluation services and quick follow-up services.

Strategies to attain the goal:

SDA provides comprehensive needs assessment to individuals at the time the assessment is required. Appointments are not necessary. SDA means an individual may walk into or contact a CSB to request mental health or substance use services and receive a comprehensive clinical behavioral health assessment from a licensed or license-eligible clinical the same day. If the individual is determined to need services, the goal of SDA is that they receive an appointment for face to face or other direct services in the program offered by the CSB that best meets their needs within 10 business days, sooner if indicated by clinical circumstances.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of individuals who receive a Same Day Access assessment, and needing follow-up services, will beoffered and keep an appointment within 30 calendar days.

Baseline measurement (Initial data collected prior to and during 2026): 70%

First-year target/outcome measurement (Progress to the end of 2026): 75%

Second-year target/outcome measurement (Final to the end of 2027): 76%

Data Source:

DBHDS Enterprise Data Warehouse

Description of Data:

Percent of individuals receiving SDA assessment who return for a follow-up within 30 days.

Data issues/caveats that affect outcome measures:

Virginia has transitioned to receiving data from providers via HL7 feed beginning July 1, 2025. This will be the first year of data collection in the new system. Virginia will be monitoring data quality and providing technical assistance as providers acclimate to the new system.

Priority #: 16

Priority Area: Increasing Mobile Crisis Response in Virginia

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Decreasing average response time for mobile crisis response

Strategies to attain the goal:

-Improve staffing of mobile crisis teams
-Continue training of teams.
-Increase the number of mobile crisis teams.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of mobile crisis responses statewide with a response time from dispatch to accept/in-transit within one hour.

Baseline measurement (Initial data collected prior to and during 2026): 86%

First-year target/outcome measurement (Progress to the end of 2026): 88%

Second-year target/outcome measurement (Final to the end of 2027): 90%

Data Source:

DBHDS Virginia Crisis Connect (VCC)

Description of Data:

Numerator-number of responses statewide with response time from dispatch to accept/in-transit within one hour.
Denominator-Total number of responses statewide.

Data issues/caveats that affect outcome measures:

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$60,908,095.00		$27,897,142.00	$19,669,624.21	$188,260,168.54	$0.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$9,431,002.00		$0.00	$0.00	$2,759,732.00	$0.00	$0.00	
b. All Other	$51,477,093.00		$27,897,142.00	$19,669,624.21	$185,500,436.54	$0.00	$0.00	
2. Recovery Support Services[c]	$2,860,966.00		$0.00	$18,819,542.82	$3,800,000.00	$0.00	$0.00	
3. Primary Prevention[d]	$19,027,595.00		$0.00	$9,570,477.72	$0.00	$0.00	$0.00	
4. Early Intervention Services for HIV[e]	$0.00		$0.00	$0.00	$2,471,362.00	$0.00	$0.00	
5. Tuberculosis	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$7,584,420.00		$0.00	$2,955,885.00	$9,684,529.76	$0.00	$0.00	
13. Administration[g]	$4,756,898.00		$5,120,226.71	$3,301,798.98	$20,565,405.89	$0.00	$269,485.62	
14. Total	**$156,046,069.00**		**$60,914,510.71**	**$73,986,952.94**	**$413,041,634.73**	**$0.00**	**$269,485.62**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$4,707,544.00	$0.00	$0.00	$8,000,000.00	$0.00	$0.00	$282,500.00
7. State Hospital			$71,406,166.00	$32,163,325.00	$1,041,147,202.00	$0.00	$6,300,544.00	
8. Other Psychiatric Inpatient Care			$5,455,504.00	$0.00	$68,992,258.00	$0.00	$0.00	
9. Other 24-Hour Care (Residential Care)		$0.00	$5,221,612.00	$0.00	$34,841,476.00	$0.00	$0.00	$0.00
10. Ambulatory/Community Non-24 Hour Care		$37,660,348.00	$141,175,306.00	$8,528,508.00	$907,755,016.00	$0.00	$0.00	$0.00
11. Crisis Services (5 percent Set-Aside)[c]		$2,353,772.00	$2,365,516.00	$10,319,238.00	$183,955,148.00	$0.00	$0.00	$2,542,500.00
12. Other Capacity Building/Systems Development								
13. Administration		$2,353,770.00	$24,902,448.00	$118,184.00	$109,234,173.00	$0.00	$1,310,655.00	$0.00
14. Total		**$47,075,434.00**	**$250,526,552.00**	**$51,129,255.00**	**$2,353,925,273.00**	**$0.00**	**$7,611,199.00**	**$2,825,000.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	4904	454
Women with Dependent Children	102253	5628
Individuals with a co-occurring M/SUD	222231	34279
Persons who inject drugs	83343	4870
Persons experiencing homelessness	4432	1642

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

Data and Evaluation Coordinator, An Major reviewed the survey data NSDUH referenced in guidance, however could not locate the population groups identified or were not available in document.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$30,454,048.00
2 . Recovery Support Services[b]	$1,430,483.00
3 . Substance Use Primary Prevention[c]	$9,513,798.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$3,792,210.00
7 . Administration[f]	$2,378,449.00
8. Total	$47,568,988.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	14247090.00
1b. Crisis Services for Adults	1679622.00
1c. CSC/ESMI program for Adults	3359245.00
1d. Other outpatient/ambulatory services for Adults	10383108.00
1e. *Other Direct Services for Adults	0.00
2. Subtotal of Services for Adults	29669065.00
3. Services for Children	
3a. EBPs for Children	65925.00
3b. Crisis Services for Children	674150.00
3c. CSC/ESMI program for Children	1348299.00
3d. Other outpatient/ambulatory services for Children	7338001.00
3e. *Other Direct Services for Children	0.00
4. Subtotal of Services for Children	9426375.00
5. Other Capacity Building/Systems Development[a]	5626224.00
6. Administrative Costs[b]	2353770.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**47075434.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The amount budgeted for children's EBP is based on the results of an EBP survey that is administered to the CSBs to determine how many staff are trained in EBPs and how many people are served utilizing certain EBPs. This number serves as a baseline and is certainly lower than what is spent on EBPs for children. This is a new budget category in the application and through data modernization efforts already underway, this measure should become more accurate as we move forward over the next couple of years.

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$1,718,645
	Selective	$772
	Indicated	$0
	Unspecified	$0
	Total	**$1,719,417**
2. Education	Universal	$2,672,501
	Selective	$7,373
	Indicated	$0
	Unspecified	$0
	Total	**$2,679,874**
3. Alternatives	Universal	$253,736
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$253,736**
4. Problem Identification and Referral	Universal	$11,130
	Selective	$1,110,127
	Indicated	$0
	Unspecified	$0
	Total	**$1,121,257**
	Universal	$2,240,620
	Selective	$737

5. Community-Based Processes	Indicated	$0
	Unspecified	$0
	Total	**$2,241,357**
6. Environmental	Universal	$1,497,736
	Selective	$0
	Indicated	$421
	Unspecified	$0
	Total	**$1,498,157**
7. Section 1926 (Synar)-Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Budget		**$9,513,798**
Total Award [a]		**$47,568,988**
Planned Primary Prevention Percentage		**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$4,493,350
2. Universal Indirect	$3,901,017
3. Selective	$1,119,010
4. Indicated	$421
5. Column Total	**$9,513,798**
6. Total SUPTRS Award[a]	**$47,568,988**
7. Primary Prevention Percentage	**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☑
American Indian/Alaska Native	☐
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☐
Asian	☐
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$398,850.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$398,850.00
2. Infrastructure Support	$1,065,669.00	$14,623.00	$146,442.00
a. Single State Agency (SSA)	$234,858.00	$14,623.00	$146,442.00
b. All other subrecipient contracts	$830,811.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$109,245.00	$264,189.00	$279,509.00
a. Single State Agency (SSA)	$109,245.00	$14,623.00	$117,880.00
b. All other subrecipient contracts	$0.00	$249,566.00	$161,629.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$215,787.00	$14,623.00	$47,191.00
a. Single State Agency (SSA)	$215,787.00	$14,623.00	$47,191.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$85,099.00	$0.00	$635,048.00

a. Single State Agency (SSA)	$85,099.00	$0.00	$135,048.00
b. All other subrecipient contracts	$0.00	$0.00	$500,000.00
7. Training and Education	$214,241.00	$0.00	$301,694.00
a. Single State Agency (SSA)	$74,241.00	$0.00	$101,539.00
b. All other subrecipient contracts	$140,000.00	$0.00	$200,155.00
8. Total	**$1,690,041.00**	**$293,435.00**	**$1,808,734.00**

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems	$26,806.00	$0.00
2. Infrastructure Support	$1,519,788.00	$0.00
3. Partnerships, Community Outreach, and Needs Assessment	$1,420,768.00	$0.00
4. Planning Council Activities	$31,800.00	$0.00
5. Quality Assurance and Improvement	$488,112.00	$0.00
6. Research and Evaluation	$930,104.00	$0.00
7. Training and Education	$1,208,846.00	$122,500.00
8. Total	**$5,626,224.00**	**$122,500.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

a. Please describe how this system differs for youth and adults.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

c. How many IT-COD teams do you have? Please explain.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

d. Do you monitor fidelity for IT-COD? Please explain.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Please see attachment EF #1 Access to Care, Integration, and Care Coordination

8. Please indicate areas of **technical assistance needs** related to this section.

None at this time

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services

Same Day Access (SDA) was the first step of STEP-VA, first introduced in 2017. This allowed Virginians to access their local Community Services Board as the single point of access, despite their insurance coverage status. The intention was that all constituents would be seen that same day for an initial assessment, and be linked with an initial appointment within 10 days. As SDA was implemented across the Commonwealth, it became a valuable resource for shortened wait times and the ability to meet the immediate needs of constituents with varying behavioral health presentations. SDA serves as the entry point into public behavioral health services for individuals with mental health, substance use, and co-occurring disorders, as well as for individuals in the community, discharging from hospitals, or released from incarceration. Over time, barriers such as increased demand for behavioral health services, geographical limitations, and workforce shortages, led to increased difficulty in meeting the community demand for services. As such, DBHDS in collaboration with the CSBs, has gradually adopted and/or improved various tenets of STEP-VA. In FY26, all CSB's will move towards iSERV in an effort to further align and work towards CCBHC application. Using this model, constituents will be triaged for their level of clinical need prior to receiving an appointment, ensuring that those with the most severe needs are seen for their initial assessment urgently.

As part of Right Help Right Now, the state has invested in the Adult Psychiatric Access Line (APAL). APAL is a statewide consultation and care navigation program designed for primary care providers treating adults living with substance use disorders. APAL provides resources to these providers to help them effectively assess, diagnose, and treat patients with SUD, as well as to help them navigate substance use recovery care. This model consists of three components: 1) Provider education on screening, diagnosis, management, and treatment of SUDs; 2) Telephonic case consultations with addiction medicine specialists and/or psychiatrists; and 3) Care navigation assistance to connect with regional behavioral health resources, which can be provided to the provider or to the patient directly. APAL is currently embedded in one region of the state with opportunity for expansion. It is well documented that most individuals feel most comfortable with their PCP's to disclose mental health and substance use struggles, but PCP's are sometimes very uncomfortable with treating such conditions. APAL serves as a pivotal resource in the access of

mental health and substance use resources. In FY 26 and beyond, APAL will expand to additional regions across the state as well as other populations such as geriatric, young adult, and general adult mental health.

Additionally, DBHDS is implementing the Collaborative Care Model in three primary care practice sites via the SAMHSA PIPBHC (Promoting the Integration of Primary and Behavioral Health Care) Grant for the Collaborative Care Model (CoCM), which was awarded in 2024. The Collaborative Care team is led by a primary care provider (PCP) and includes behavioral health care managers, psychiatrists and frequently other mental health professionals all empowered to work at the top of their license. The team implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on patients not meeting their clinical goals. The Collaborative Care Model differs from other attempts to integrate behavioral health services because of the replicated evidence supporting its outcomes, its steady reliance on consistent principles of chronic care delivery, and attention to accountability and quality improvement (QI). This program is currently in the development and early implementation phase, with plans to be offered in the three practice sites in early FY26. The program will leverage APAL services in order to offer psychiatric consultation and education opportunities to the participating primary care providers.

CAA and ARPA funds were used in order to expand, improve or provide access to adult mental health programming such as Coordinated Specialty Care, as well as several CSB's across the state. Some CSC teams across the state are not receiving state general dollars, so ARPA allowed for more CSC teams to be initiated as well as provided funding for operational costs. In 2024, CSB's applied for ARPA dollars in order to improve current STEP-VA operations, which often included expanding access to mental health and substance use programming by bolstering positions and technology and therefore reducing wait times.

Regarding specifically children and family services, efforts from the Office of Child and Family Services (OCFS) to increase to access to care include providing funding to school divisions for School Based Mental Health (SBMH) services which grew from six (6) school divisions in the initial pilot to 23 school divisions in the second round of the pilot. SBMH services are provided in schools which decreases barriers such as transportation, for students in need of mental health supports. OCFS has also increased our provider participation in the Virginia Mental Health Access Program (VMAP), which has seen substantial growth from 500 registered providers in 2020 to 2,500 providers in April of 2025. Through the American Rescue Plan Act (ARPA), OCFS was able to provide funding for two (2) clinical supervisors to provide Adolescent Substance Use Disorder (SUD) clinical supervision virtually which will help to expand our workforce. Once ARPA funding ended on March 24, 2025, we were able to identify other funding sources to continue this program. Additionally, OCFS contracted with the OMNI institute to develop a strategic plan and implementation guides, by region, for adolescent SUD.

In terms of substance use services, Virginia has taken significant strides in addressing substance use disorders (SUDs) through focused initiatives and strategic allocation of Substance Use Prevention, Treatment, and Recovery funds. DBHDS works toward parity and integration of substance use services within our health care system by offering funding and pilot opportunities to our 40 public behavioral health community services boards. DBHDS continues to enhance access to care for the underserved populations. DBHDS supports the development and implementation of mobile units to address transportation and geographic barriers, reaching isolated areas, and individuals in restrictive settings. Such an example is the funding allocated to the Hampton Newport News Community Services Board (H-NNCSB) for the purchase of a mobile unit that offers substance use and co-occurring outreach services to individuals in both Hampton and Newport News catchment areas. This mobile unit offers a variety of services such as behavioral health and medical care screenings, assessments, case management, and crisis services. Other supported behavioral health mobile unit projects are Eastern Shore, New River Valley, Piedmont, and Chesapeake Community Services Board. DBHDS' movement towards parity and integration will include the continuation to uplift mobile units across the Commonwealth, targeting rural areas with identified transportation needs for greater integrated services and to enhance health outcomes for residents who are challenged with substance related disorders, especially for those living in underserved areas.

DBHDS continues to assist with finding solutions for the Opioid and Fentanyl Crisis through various programs. One Pill Can Kill is a campaign that brings awareness to the fentanyl crisis and is a collaboration across many state agencies including DBHDS. The REVIVE! program continues to operate by providing education and supplies to combat opioid overdose. Approximately 235 people have been trained in the desert areas through the REVIVE! program. REVIVE! and the Virginia Department of Health (VDH) work together to provide free training and free naloxone nasal spray (Narcan). VDH will also provide brief training for people who come to the department requesting naloxone. The First Responder Grant is working to ensure that first responders are also trained with REVIVE! knowledge and carry Naloxone to assist with opioid overdose emergencies. Curb The Crisis is also a program to assist in the opioid crisis. It is a program that provides education and resources for treatment for individuals.

The ARPA funding was used to help implement STEP-VA. The STEP-VA initiative is an integrated care model where primary care providers and behavioral health specialists work collaboratively. STEP-VA is also focusing on improving Same Day Access for the CSBs across the state by providing technical assistance and regulations. It was also utilized to increase the engagement and retention of SU services for all patients at 14 of the Commonwealth's CSBs. One CSB was given funding for a SU facility reinvestment.

DBHDS/OSUS has implemented a policy framework to ensure that there is an equitable distribution of funds review to address parity and increase community services boards' ability to

provide a comprehensive and integrated care system throughout the Commonwealth. The amount of Substance Use funding received by each Community Service Board (CSB) is examined and evaluated utilizing a broad spectrum of indicators which are determinants of both need and intended health outcomes. The funding promotes investment telehealth infrastructure to increase access to behavioral health services, especially in rural areas.

DBHDS had developed a solid peer specialist training infrastructure that allows individuals with lived substance use experience to support other individuals who are challenged with addictions. The training of Peer Specialist promotes parity and integration by extending access to care, fostering a more holistic and promoting a patient centered approach; thereby improving outcomes for individuals with substance use disorders. Community-Based Programs fund community-based initiatives that focus on prevention, early intervention, and recovery support. These programs can include support groups, wellness workshops, and public awareness campaigns.

DBHDS is committed to continuous improvement in all aspects of treatment. One of the ways to ensure improvement is to share data with DBHDS and CSBs to ensure all state and federal regulations are met. Our current data system Community Consumer Submission (CCS3) is being upgraded to a new data management system effectively July 2025. Our use of substance use data is pivotal in improving substance use parity and the overall integration of services. Leverage data has and will continue to drive improvements in our understanding of substance use patterns and trends, treatment efficiency and service needs. The utilization of a data-driven approach improves our understanding of our current access bandwidth and quality of care in substance use treatment, ultimately leading to better health outcomes and equitable care for all individuals.

DBHDS utilized data for strategic planning and to promote implementation of evidence-based practices and interventions, such as American Society of Addiction Medicines (ASAM), Narcan Saturation planning, Seeking Safety, and Trauma Inform Care models. DBHDS works in collaboration with academic institutions such as Virginia Commonwealth University to develop interactive data dashboards and conduct research on health disparities to identify distribution of substance use needs and resources across Virginia.

DBHDS participated in the National Governors Association, Improving Maternal and Child Health (MCH)in Rural America team 2024-2025. The MCH Learning Collaborative Virginia team included DBHDS, the Department of Health, and the Department of Medical Assistance (DMAS). Likewise, the Virginia team was placed in the NGA Substance Use and Behavioral Health track. The state received technical assistance on effective models of perinatal substance use disorder programs from SAMSHA, Learning Collaborative Cohort teams (Pennsylvania and Illinois) and the Association of Maternal and Child Health Programs (AMCHP) Virginia selected and identified goals for the state based upon the Governor’s Executive Order 32 which reestablished the

Maternal Health Data Quality Task Force and will compile a final report December 2025. Additionally, Executive Order 11 includes the creation of Maternal and Child Health dashboards and a central resource hub or website to provide family resources and other parent resources. DBHDS Women's Services and Specialty Population Manager represented Virginia at the MCH Learning Collaborative and Healthcare Workforce Policy Academy Closeout Convening (Tempe, Arizonia), in December 2025, and provided updates on perinatal addiction and goals for the state.

DBHDS remains an active member and serves as a maternal addiction subject matter expert on the Virginia Maternal Mortality Review Team, Office of the Medical Examiner's Office, Virginia Department of Health. Twenty percent of maternal mortality in the state of Virginia is attributed to substance use (accidental overdose) and behavioral health issues. DBHDS Women's Services was the team lead for recommendations for the 2024 Maternal Mortality Review report, which includes availability of NARCAN at WIC, libraries, and other public entities that women frequent.

DBHDS, Project LINK sites, and the Virginia Department of Social Services, Child Fatality Prevention, partnered to reduce child fatality as a result of unsafe sleep practices. Project LINK sites provided training on safe sleep and educated parents on safe sleep practices via, "Sleep Baby Safe and Snug" board books during home visits and group therapy. The goal is to continue this initiative after the conclusion of the VDSS grant.

Since its launch in 1992 with five sites, Project LINK has continued to expand steadily. As of 2025, it operates across 14 Community Services Boards (CSBs) in regions 1, 3, 4, and 5 of the Commonwealth. In FY2024, the program was funded through the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Office of Substance Use Services (OSUS), and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Women's Set-Aside.
Project LINK remains a vital and innovative program that supports women and families affected by substance use disorders, co-occurring conditions, and trauma. The program specifically serves pregnant and postpartum women, parenting women with dependent children, and women of childbearing age. As one of the few gender-specific initiatives in Virginia, Project LINK provides access to comprehensive, trauma-informed substance use disorder services.
Project LINK's mission is to remove barriers to treatment, prevention, and recovery for women affected by substance use and their children. This mission is realized through service coordination, stakeholder education, and the expansion of holistic offerings.

2. **Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.**

Virginia has a very close working relationship with Virginia's Department of Medical Assistance Services. Since 2017, Virginia has experienced ongoing positive impacts as a result of Medicaid expansion. Parity across the system is an ongoing goal. In fact, during FY25, Virginia DMAS launched an extensive Behavioral Health Services Redesign project with goals of vastly improving services for co-occurring services for those adults with primary SMI. These services may include quality training and supervision of clinical staff in specific foundational skills and Evidence Based Practices, Evidence Based programming such as the Clubhouse Model, EMDR, CBT, and skills acquisition for employment and stable housing. This project is intended to be budget neutral, by replacing legacy services such as Mental Health Skill Building and In-Home services, to be presented to both Virginia's General Assembly and CMS in 2026.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Please describe how this system differs for youth and adults.

Primary Care and Care Coordination are both crucial steps of STEP-VA toward integrated care. Primary Care ensures that anyone who accesses services at a local Community Services Board who is either SMI or SED will receive primary care screenings, and if they are on an antipsychotic medication, they will receive a comprehensive metabolic screening. These expectations align with CCBHC as well as the AMA. It is well documented that individuals with SMI are diagnosed with chronic conditions such as Diabetes at a much higher incidence than the general public; similarly, individuals with SMI die at much younger ages than the general public. These expectations are required measurements of the CSB's and are documented and monitored on the public-facing dashboard.

Care coordination in STEP-VA is infused throughout all steps. It is expected of all boards that they provide care coordination services to all clients which includes but is not limited to access to primary care due to the above-mentioned data. Care coordination does not stop at referrals but also includes the coordination of treatment services throughout the individual's recovery journey. In FY25, DBHDS and CSB's enhanced their focus on Care Coordination and ensure it is woven throughout all steps. In order to close service gaps, CSB's were able to request additional funding for such endeavors such as hiring care coordinators who will help link individuals with necessary health services at their first point of contact.

For child and family services, DBHDS has worked with the Virginia Chapter of the American Academy of Pediatrics and the Medical Society of Virginia to implement the Virginia Mental Health Access Program (VMAP) which connects pediatric providers with consultation with a child psychiatrist. This is a program that aims to address the shortage of the child mental health workforce, build capacity of

other child health professionals and to identify and treat mental health conditions in children and adolescents. It was first implemented regionally in 2020 through support from the General Assembly and due to its early successes, received additional support in the 2021 General Assembly for statewide implementation. In 2024, the General Assembly allocated further funding for an expansion of VMAP to include the Moms+ Program for maternal mental health as well as the Early Childhood expansion for youth under the age of 6.

b) Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT

Yes, please see response regarding CoCM in prompt # 1. Additionally, two examples of EBPs that utilize integrated treatment for co-occurring disorders that are utilized in Virginia are Coordinated Specialty Care (CSC) and Assertive Community Treatment (ACT).

c) How many IT-COD teams do you have? Please explain

The CoCM program is currently in the development and early implementation phase, with plans to be offered in the three practice sites in early FY26. The Commonwealth of Virginia also supports 65 Assertive Community Treatment (ACT) teams, with each team required to employ a COD specialist skilled at implementing IT-COD principles and practices.

d) Do you monitor fidelity for IT-COD? Please explain

No, however, ACT programs in Virginia are required to participate in fidelity reviews using the Tool for Measurement of Assertive Community Treatment (TMACT) which does evaluate the COD specialist and integration of IT-COD into practice.

e) Do you have a statewide coordinator?

No, not a statewide coordinator for IT-COD in general but DBHDS does have an ACT coordinator

4. **Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:**

   a) Access to behavioral health care facilitated through primary care providers

   b) Efforts to improve behavioral health care provided by primary care providers

   Please see responses regarding APAL and VMAP from prompt #1 regarding resources for primary care providers for adults and children, respectively. Additionally, for the I/DD population, The Office of Provider Network Supports (OPNS) focuses on developing and sustaining a qualified community of providers in Virginia so that people who have developmental disabilities and their families have choice and access to options that meet their needs. Here you will find resources from Provider Development including information on becoming a provider, information about Virginia's Person-Centered Individual Support Plan (ISP), who to contact for technical assistance, and various

training resources.

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

For c) Please see responses to prompts #1, 2 and for d) Please see response for prompt #5

5. **Describe how the state provides care coordination, including details about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs.**

Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

As mentioned in above sections, Virginia's comprehensive system of care, STEP-VA, similar to CCBHC, includes a Care Coordination component which is integral to the success of the system, as well as constituents' ongoing recovery. All Community Services Boards within Virginia's public mental health system are expected to prioritize adults with serious mental illness, and therefore, recruit and train staff as well as implement policies and procedures in order to better serve the complexity of behavioral health care needs. For instance, in calendar year 2024, the STEP-VA Advisory Council (STAC) visited each step of STEP-VA in order to better define and streamline services under each step. An official definition was adopted for care coordination, as well as expectations developed. These expectations will be assessed on an ongoing basis, including through regular site-visits.

STEP-VA care coordination funds are provided primarily through state general funds. An RFA for unallocated fiscal year 2025 funds was launched to provide additional funds to community services boards, by application, with particular interest in expanding their care coordination capacity and delivery. Many boards were provided additional state general funds in order to increase their care coordination staff, focusing on particular entry points into the system, such as Same Day Access.

Individuals in Virginia's system of care may also be receiving care coordination as part of a "bundled" program such as Medicaid-funded Case Management, Assertive Community Treatment and Coordinated Specialty Care. Individuals should be receiving Care Coordination alongside other services if enrolled in these programs. In fact, individuals receiving Medicaid-funded Case Management services are paired with a care coordinator who will ensure that needs are met.

DBHDS currently supports the Virginia Wraparound Implementation Center (VWIC). VWIC is responsible for the training and ongoing coaching support for all High-Fidelity Wraparound (HFW)

workforce members including Intensive Care Coordinators, Youth Support Partners, and Family Support Partners. HFW is an evidence-based approach to working with youth and their families that have multiple system involvement focusing on maintaining the youth in the home/community and supporting the family to develop their system of support and ability to manage the needs of their youth/family.

6. **Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.**

At initial point of contact and request for services, individuals are triaged utilizing a risk assessment which includes both suicidal and homicidal risk questions as well as priority population substance use questions. Responses to these questions provide an initial clinical picture of presentation as well as how quickly an individual should be linked with an initial assessment. The initial assessment, known as a Comprehensive Needs Assessment in the state of Virginia. Includes several assessments and screenings for co-occurring disorders such as the Columbia Suicide Assessment, as well as the ASAM. These screenings and the CNA are appropriate for both youth and adults.

In the Fall of 2021, DBHDS launched the SAMHSA-funded Virginia Youth SBIRT (VA-YSBIRT) Project which is based on the screening, brief intervention, and referral to treatment (SBIRT) protocol. This initiative is not available in all communities. It is designed to expand/enhance the continuum of care for substance use disorder (SUD) services and reduce alcohol and other drug (AOD) consumption and its negative health impact, VA-YSBIRT provides a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Risk stratification is followed by an abbreviated version of Motivational Interviewing – the Brief Negotiated Interview (BNI) and an Active Referral to Treatment (ART) if needed. BNI is a specialized brief intervention with a focus to generate behavior change plans in a brief amount of time. ART involves finding the appropriate and affordable resources and services and ensuring a warm hand-off. DBHDS began the project in the Northern Virginia area, and while that part of the project has wound down, we have now expanded to the Eastern part of Virginia. Through the work with VA-YSBIRT, OCFS recently had a learning session with six (6) interested school divisions across the Commonwealth who expressed interest in having YSBIRT in their schools to expand the reach of the service.

In 2023, the Office of Child and Family Services at DBHDS contracted with the OMNI Institute to complete a multi-component approach to the overarching *Capacity-Building* and *Strategic Planning* project which will identify the gaps along the substance use continuum of care (prevention, harm reduction, early intervention, treatment, and recovery) that are limiting the system's ability to adequately meet the needs of adolescents and their families. The work of OMNI built from the needs assessment to engage in an in-depth strategic planning and implementation process at the state and regional levels. Statewide and regional implementation guides were developed and disseminated to stakeholders in early 2025.

7. **Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD), including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.**

   In Virginia, behavioral health services for individuals with developmental disabilities are primarily accessed through the state's network of Community Services Boards (CSBs). These boards are the first point of contact for accessing behavioral health and developmental services within the Commonwealth. Additionally, the state offers specialized REACH crisis services and waiver services to support individuals with developmental disabilities who experience mental health crises or require community-based support.

   REACH is an acronym that stands for Regional Education Assessment Crisis Services Habilitation. The REACH program is a component of the Virginia Crisis Continuum of Care. It was established to serve individuals diagnosed with a developmental disability (DD) who reside within the Commonwealth of Virginia. REACH services are available within each of the Commonwealth's five regions: Region I (Western), Region II (Northern), Region III (Southwestern), Region 4 (Central), and Region 5 (Eastern).

   The REACH program offers 24/7 mobile crisis response, short term crisis stabilization services, including residential (crisis therapeutic home) and non-residential (services are provided in community locations where the individual lives, works, and participates in services or socializes), and prevention supports to individuals that are experiencing a behavioral health or behavior-related crisis event(s).

   The Virginia Developmental Disabilities Home and Community-Based Services (HCBS) Waivers help eligible people with a developmental disability (DD) to receive services and supports in the community. Waivers fund a variety of supports including those that:

   - provide medical care
   - enable employment

- enable community living
- provide behavioral interventions
- provide home modifications and assistive technology that help people avoid living in a nursing home or other institution.

Virginia applies to the federal Medicaid agency known as the Centers for Medicare and Medicaid Services (CMS) to have waivers. Waivers allow the state to fund certain community-based alternatives to institutional care. The term “waiver” comes from *waiving* the requirement that in order to receive certain services (such as residential supports, nursing supports, employment supports) the individual must live in an institution. Through the waivers, individuals may receive these services while living in the community.

There are three waivers available for individuals with a developmental disability:

- the Building Independence Waiver (BI),
- the Family and Individual Supports Waiver (FIS), and
- the Community Living (CL) Waiver.

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care/OnTrack	9.00
Coordinated Speciality Care/Navigate	2.00
	0.00
	0.00

	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
2,500,003.00	2,500,003.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

At this time, CSC is neither covered under Virginia's Medicaid program nor reimbursed via private insurance. Currently programs are billing for individual components of the model where viable such as peer and psychiatric services, individual/group therapy, and case management.
DBHDS is actively partnering with our state Medicaid Agency, DMAS, in the Behavioral Health Redesign initiative, aimed at bringing online several Evidence-Based Practices, to include CSC. Office of Adult Community Mental Health (OACBH) has provided DMAS with its' own draft CSC service manual and myriad other resources, along with ongoing consultation to inform this process.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

The Commonwealth of Virginia supplies additional support to its' 11 CSC programs through the allocation of $4,000,00.00 in State General Funds. These funds are restricted to support only the CSC services provided by each Community Services Board (CSB).

5. Does the state monitor fidelity of the chosen EBP(s)? ○ Yes ◉ No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ○ Yes ◉ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

• Virginia has identified the use of well-organized Coordinated Specialty Care programs as a means to increase access to essential services and improve outcomes for those with an ESMI/FEP. Programs actively engage individuals, families, and communities where they are and via the means best suited for individuals served. This includes assertive outreach in places such as schools, and the use of social media as a tool to connect with transition-age youth.
• Data collection: OACBH continues to collect data via a WebCAB developed in conjunction with CSC program leaders and SMEs at Westat. Virginia's WebCAB consists of 11 separate surveys that provide both process and outcome measures which programs and the mental health authority can use for quality and system improvement.
• OACBH has identified Duration of Untreated Psychosis (DUP) as a key measure of emphasis, with programs aiming to engage and enroll individuals with two years of FEP.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

• Programs will continue to meet with OACBH subject matter expert quarterly. These meetings serve as a learning collaborative for programs, and a way for the OACBH (with its' extremely limited resources) to provide support, TA, and requisite oversight.
• Programs will continue to use some portion of funds for TTA from outside SMEs.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

• Psychosis (Schizophrenia Spectrum)
• Schizophrenia
• Schizoaffective Disorder
• Bipolar I with Psychotic Features
• Psychosis NOS

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

The incidence of FEP is estimated to be approximately 122,000 individuals per year in the United States, based on data in broadly cited papers by Simon et al.47 and Radigan et al.48
No Virginia-specific data presently available.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

In 2021, Virginia Medicaid and the Virginia Department of Behavioral Health and Developmental Services were directed by our general assembly to put together a five year strategic plan to expand and sustain CSC in Virginia.

Some successes have been in the area of standing up three new programs with a combination of MHBG and ARPA dollars and onboarding teams to the EpiNET system with a Virginia specific battery.

One of the first steps of the five year plan was to conduct a rate study. Unfortunately, authority or funding to proceed with that step did not move forward at that time, but has since been granted and the study is underway at present.

The SAMHSA report was incredibly helpful for us and we think it is going to be helpful moving the study forward. This included the updated cost estimates, additional citations we can present to our GA regarding cost effectiveness, and the range of funding strategies. It was also helpful for our stakeholder and cross agency group to see that it is the norm, not the exception, to have a number of different funding sources.

The range of Medicaid strategies were also very helpful. Specifically, Virginia recently had success implementing three evidence based models of care within Medicaid- Assertive Community Treatment, Multisystemic Therapy, and Functional Family Therapy. We believe that this experience will give us good lessons learned if we receive authority to move forward with CSC in Medicaid. Currently, we would leave multiple options open during the rate study process to determine the best structure for Virginia if we are authorized to move forward, including state plan and waiver approaches. The GA might direct us to take one approach or the other, also.

Because we have not moved forward with some of the first steps of the strategic plan, we have not made progress on a strategy with commercial insurers, although they are at the table as part of our stakeholder group. But, Virginia has mandated that commercial insurers begin to cover mobile crisis response and residential crisis stabilization units beginning January 2024. This legislation was passed about 18 months after these services were implemented within Medicaid and with shared state infrastructure. So, this will also give us a roadmap for a stepwise progression of inclusion in Medicaid followed by commercial coverage under the same structure (which is the approach being taken with crisis services).

12. Please indicate area of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

• DBHDS does not directly provide ESMI/FEP training at this time.
• Several CSC programs have used a portion of their funds to procure trainings for themselves, to include TTA directly from entities such as OnTrack and NAVIGATE.
• OACBH, in consultation with DMAS and Virginia Commonwealth University's School of Social Work are currently partnering to explore avenues to develop and fund a "Center of Excellence", which would serve as a hub for research, training, and fidelity monitoring for CSC programs across the Commonwealth.

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

See attachment EF 3. Person Centered Planning

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

See attachment EF 3. Person Centered Planning

4. Describe the person-centered planning process in your state.

See attachment EF 3. Person Centered Planning

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

See attachment EF 3. Person Centered Planning

6. Please indicate areas of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan
3. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and support to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desire

Does your state have policies related to person centered planning? YES/NO

Yes

If no, describe any action steps planned by the state in developing PCP initiatives in the future.

Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Community Services Boards and Behavioral Health Authorities utilize the Daily Living Activities-20 (DLA-20) Functional Assessment as part of the comprehensive needs assessment to begin services. According to the DLA-20 Functional Assessment Guide to Measuring Outcomes, the DLA-20 is a "functional assessment, proven to reliably estimate clients' functioning in 20 different areas of daily living." Each domain is scored between a one (1) and (7), with anything five and above indicating a strength and four and below indicating a need area.

The assessment process and treatment plan development support person centered care. The administration of the assessment is collaborative between the professional and the client, capturing a 30-day snapshot focusing on the strengths and challenges at that specific time. This shared experience, intentionally looking at current symptoms and their impact on functioning and looking at strengths that could possibly be leveraged to assist in addressing lower sections, often encourages new approaches to treatment. Clients and providers can review all domains based on severity of the problem, providers can recommend a focus on specific activities/domains with lower scores; however, person-centered treatment is a priority and if a client chooses a different activity or area to focus on then this should be incorporated into the treatment planning process. This does not erase the other problem areas or low scores, it simply means they are not the priority for the client and can be revisited when the DLA 20 is reviewed.

Describe the person-centered planning process in your state.

All community-based services within the Commonwealth of Virginia are intended to be person-centered. Virginia operates a Same Day Access service where individuals are able to access mental health and substance use treatment services in a locality close to their residence, during both scheduled and unscheduled times. Virginia is continually working towards making this as accessible as possible to all individuals, to include after hours access or weekends, utilizing telehealth, etc. Individuals present for services and are triaged based on their report of symptomology and needs. Should an individual request a higher level of care in which the local Community Services Board does not have, care collaboration occurs to link the individual to such care. Similarly, if there is a wait for such care, resources are provided based on the individual's needs. Post clinical assessment, the individual will meet with their assigned staff member to develop person-centered treatment goals. Of note, Virginia boasts a large network of MHSUD private treatment providers, should the individual prefer not to access Virginia's public mental health system.

Person-centered care is woven throughout all treatment-related decision-making during the individual's recovery journey. For instance, individuals with a SMI diagnosis who are accessing STEP-VA services also receive primary care services as part of their treatment. This ensures that individuals are also receiving appropriate medical care as needed. Individuals have a personal choice of which primary care provider they will see, as well as the care coordination in which will occur in order to meet their medical basic needs (ie., referrals to other providers, resources, etc.). Another example pertains to if an individual meets a certain clinical criterion for residential care but declines this recommended level of care, clinical staff are able to make other clinical suggestions for other resources which may provide the level of supervision and care which is clinically necessary.

Should an individual's clinical or basic needs change during the course of treatment, subsequent clinical assessment will occur, as well as ongoing modifications to the individual's treatment plan, utilizing person-centered planning.

Person-centered planning is central in the treatment of substance use disorders whereby it emphasizes the importance of individualized care and the active involvement of individuals in their recovery. In the context of substance use treatment in Virginia involves a collaborative approach where individuals are actively

involved in assessing their needs, setting goals, and planning their own recovery journey. This contrasts with traditional, more directive approaches to treatment.
In Virginia, person-centered planning in substance use treatment is identified within the administrative regulations governing behavioral health services. Specifically, code section 12VAC30-50-491, outlines substance use case management services, which include developing a person-centered Individual Service Plan (ISP). This allows the services to be tailored to the person's needs and goals. Additionally, 12VAC30-130-5010 establishes coverage for treatment for substance use disorders, aligning with the American Society of Addiction Medicine (ASAM) Criteria.

Code section 12 VAC30-122-190 defines the requirements for an ISP, including the need for it to be based on the individual's needs, preferences, and desired outcomes, aligning with the principles of person-centered planning. 12VAC35-105-660 specifically addresses ISPS for mental health and substance abuse services, stating that providers must involve the individual in the development, review, and revision of the ISP, ensuring it reflects their needs and preferences. DBHDS utilizes quality review processes/ audit reviews to evaluate the quality of services, including if consumers' needs are being met through person-centered planning.

What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's A Practical Guide to Psychiatric Advance Directives)?"

Person-Centered Planning for Psychiatric Crisis

As health clearly includes mental wellness, over half the states in the US acknowledged this and made laws that allowed people to plan ahead for mental health care. Virginia was the only state that changed its laws to clearly reflect how mental health is one part of the whole person. So, in Virginia an individual can make one Advanced Directive (AD) that covers all of their health care, including mental health care.

In Virginia, there is an overlap between crisis plans and advanced directives, but ADs are more specific and aimed at giving doctors the targeted information they need. Also, ADs are legal documents, but crisis plans are not explicitly legal documents.

Virginia allows ADS to include the following information:

- The medications an individual currently takes
- The medications an individual prefers
- The medications an individual refuses
- Non-medication treatments and strategies that an individual prefers
- Contact information for a psychiatrist, case manager, therapist, etc.
- Information on what helps an individual when they are in crisis
- Information on what makes things worse when an individual is in crisis
- Hospitals and crisis units an individual prefers and does not prefer
- Whether an agent can consent to hospitalization

An individual with prior history or at serious risk for psychiatric crisis can assign an agent to operationalize an advanced directive. That individual can decide what power an agent will have. The law and AD forms assume that an individual wants their agent to have power related to inpatient hospitalization. But one can cross out the power if they do not want their agent to have it.

There are limits on an agent's power over inpatient hospitalization Advance Directives. First, an agent cannot just decide that a person should be inpatient hospitalized for mental health care. Instead, it must be a case where doctors have decided that the person meets the conditions for inpatient hospitalization. Second, there has to be a hospital or unit that is willing to admit the person. Then, it comes time for the doctors to get consent from the agent. (And an agent could refuse consent if the agent does not think it is the best option or what the person would want.) Finally, an agent's consent is good for only 10 days. If the person is doing better before 10 days are done, the person could be found ready to leave the hospital. If the person still needs to be in the hospital, then the hospital will seek continued hospitalization based on the person's consent or a court order.

A person can put mental health details in a separate AD as well. Virginia law makes it possible to put everything in one AD, but it does not require an individual to do so. If they want to make a separate mental health advance directive, they can plan for:

- How will a general medical doctor find out about their mental health medications?
- Will they have different agents for the different ADs?
- Is it OK for their agent to give mental health details if it is important for getting care?

Virginia does not require much to make an AD a legal document. **All a person needs to do is:**

- Sign and date it themselves,
- Have two adults witness them sign it, and
- Have those two adults sign it to say that they witnessed them sign it.

They do not need:

- To use a certain form,
- Have an attorney write it, or
- Get their AD notarized.

There is no need to get a doctor's signature on an AD except in the case in which an individual chooses to give their agent the power to ignore treatments that an individual initially refuses then a doctor's signature is needed for that part.

The doctor's signature is needed because that part gives their agent a lot of power. The law wants to make sure an individual understands that power, so it requires that they talk with a doctor about it. Then a doctor signs to say they understand the power.

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The mission of the Grants Management Office is to standardize, streamline and improve federal and state grant management practices. This office promotes and provides assistance for projects and programs to build, sustain, and deliver the capabilities necessary to prevent, protect against, mitigate, respond to, and recover from all hazards events. The support provided includes all phases of the grant life cycle from application, awarding of the grant agreements, to close-out of the grant agreements and the grant program. Services include:?

Disseminate Funding Opportunity Announcements?

Assist with Grant Application and Budget Development?

Review of Funding Applications?

Award Grant Agreements to Subrecipients?

Provide Guidance and Technical Assistance to Subrecipients?

Monitor Subrecipients?

Assess Project/Program Success

Overview of the Office of Enterprise Management Services

Mission

OEMS introduces and maintains a consistent approach to managing non-IT related?projects, partner?with internal and community -based stakeholders to foster?the relationships?and compliance with the Community Services?Performance Contract and its associated documents.

In addition, our office consults on Community Service Boards' administrative and management issues, interprets policies and procedures, cultivates a mutual understanding and cooperation between CSBs and DBHDS. Our office?works with advocacy organizations and stakeholders to?oversee?the administration and management?of non-IT projects and change initiatives to ensure support of the standards, methodology and technology defined by the organization.

The Office of Enterprise Management Services is primarily comprised of two units, the Office of Community Operations and the Office Management Services (OMS).

The Office of Community Operations (OCO) manages the programmatic interface between DBHDS and SAMHSA at the Federal level. This includes planning, negotiating, collaborating with SAMHSA level project Managers as well as internal programmatic staff related to the use of the federal Block Grants.? Community Operations goals are to work to build bridges between the subject matter experts in the community services division and the administrative staff who work to manage the funding provided through these grants.? Additionally, OCO works on other tasks as needed such as grant writing, strategic planning, project management of multi division DBHDS goals and expectations, and deliverable tracking about the services provided with said funds.?

The Office of Management Services (OMS) is primarily responsible for negotiation and?administration of?the performance contracts?and monitors the accomplishment of contract objectives, performance and outcome measures, and compliance with contract assurances directly and in conjunction with other DBHDS stakeholders.

OMS Program Contract Managers role is to support contract execution of agency contracts with the Community Services Boards (CSBs) in coordination with the Office of Procurement and Administrative Services, with special attention to a more outcome focused performance contract with the CSBs. They work collaboratively with internal stakeholder's program offices, finance, procurement, IT, and others).

Business units are divided into three categories:

Internally, they support business units throughout DBHDS. Business units are broken down by program area. Externally, they support 40 CSBs in five regions throughout the State of Virginia (See attached). Community Services Boards are structured to provide community mental health, developmental disabilities and substance use disorder services which are provided to individuals in need of these services and those who may have co-occurring disorders. Their business units are divided into three primary areas.

Behavioral Health Business Units include Adult Community Behavioral Health, Community Housing, Behavioral Health Wellness, Recovery Services, Substance Abuse Services and Child and Family Services.

The Crisis Portfolio encompasses all areas within the business unit.

The third portfolio area consists of Developmental Services, Forensic Services and Community Integration.

How They Support?

The Program Contract Managers have a portfolio of business units which are assigned at the time of intake. During the intake process, they will review the program staff request to determine if we have all the required materials to begin execution. They work collaboratively with the program staff and the CSBs.

Their office provides in person training, group training, role specific training of our process, and they have regular office hours twice a week. Their website is filed with resource and training material for your convenient.

4. Please indicate areas of technical assistance needs related to this section.

Footnotes:

2024-2025 CSB Performance Contract

https://dbhds.virginia.gov/office-of-management-services/performance-contract-general-terms/

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? ○ Yes ○ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

  Social determinants of health (SDOH) data that can help to better understand behavioral health disparities and adverse childhood experiences

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☐ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☑ Archival indicators (Please list)

• Virginia Department of Behavioral Health and Developmental Services (DBHDS)- Treatment Admissions
• Virginia Department of Behavioral Health and Developmental Services (DBHDS)- Mental Health Services Provided
• Virginia Department of Juvenile Justice- Intake Cases, Probation Cases, and Direct Care Cases
• Virginia Department of Forensic Science- Drug Seizures
• Virginia Office of the Chief Medical Examiner- Accidental and Undetermined Fatal Drug Overdoses
• Virginia Office of the Chief Medical Examiner- Suicides
• Virginia Department of Social Services- Poverty Estimates
• Virginia Department of Social Services- Unemployment Estimates
• Virginia Department of Criminal Justice Services- Uniform Crime Reports: Drug-Related Arrests
• Virginia Department of Health- Virginia Youth Survey: Middle & High School
• U.S. Census Bureau- Population Estimates
- Virginia Adverse Childhood Experiences
Estimates- Virginia Adverse Childhood Experiences

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

See attachment- 2024 Virginia Needs Assessment

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

The Virginia Certification Board (VCB) is a member of IC&RC, the credentialing of prevention, addiction treatment, and recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in 24 countries, 47 states and territories, five Native American regions, and all branches of the U.S. military.
recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in 24 countries, 47 states and territories, five Native American regions, and all branches of the U.S. military.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Virginia has a full-time position dedicated to workforce development. Additionally, OMNI Institute, the state's needs assessment and evaluation contractor, provides training and TA to our state team and local CSBs. Additionally, the state has 502 currently trained Mental Health First Aid trainers, 116 ASIST and/or safeTALK trainers with state general funds dollars. We have also trained 600 Master trainers in Adverse Childhood Experiences.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

A community readiness and coalition readiness assessment is a part of the the provider needs assessment process and completed bi-annually.

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

See attached 2024 Virginia Needs Assessment

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [ ] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) Does the composition of the Advisory Council represent the demographics of the State? ( ) Yes (●) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The EBWG has been active and visible on both the SABG and the PFS SPF and STR/SOR in order to give them a viable role in all prevention work across programs to maintain consistency in approach as we addressed prescription drugs and opioids. Once OMNI Institute increased their capacity, the OBHW was able to utilize their resources to gather and determine the level of effectiveness of programs, practices and strategies. This came at a good time as the EBWG members in the time of COVID and other competing interests became more difficult to engage post-COVID.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Media Campaign
Community Events
Social Media/Website
Resource Guides
Community Presentations/Townhalls
Brochures/Rack Cards

Permanent Drug Dropboxes
Lock and Talk - Community Presentations

b) Education:

Al's Pals: Kids Making Healthy Choices
Too Good for Drugs
24/7 Dads
Second Step
Systematic Training for Effective Parenting (STEP)
Mentor Programs
Healthy Alternatives for Little Ones
Life Skills Training (Botvin)
Understanding Dad
Strengthening Families
Active Parenting
Youth Leadership Programs
Teen Intervene
Ripple Effects Whole Spectrum Intervention

c) Alternatives:

Youth Leadership Programs

d) Problem Identification and Referral:

Parent coaching & referrals (indiv supportive counseling for parents) Project SUCCESS Reconnection Referrals Self Sufficiency Project Student Assistance Program (SAP) Student coaching & referrals

e) Community-Based Processes:

Multi-Agency Collaboration / Coalition
REVIVE Trainings (In person)
ACEs Training
Mental Health First Aid- Adult
REVIVE Training (Virtual)
Naloxone Trainings
Mental Health First Aid- Youth
QPR Gatekeeper Training for Suicide Prevention
Safe TALK
Applied Suicide Intervention Skills Training (ASIST)
SOS Signs of Suicide
Crisis Intervention Team (CIT)
Talk Saves Lives
Technical Assistance to Community Groups

f) Environmental:

Counter Tools
Supply Reduction - Item Distribution
Lock and Talk - Item Distribution
Lock and Talk - Social Marketing
Social Marketing Campaign
Naloxone Distribution for Virtual REVIVE
Drug Deactivation Packets
Lock and Talk - Merchant Education/Gun Shop Project
Permanent Drug Dropboxes
Merchant Education (Alcohol)
Prescription Bag Stickers
Drug Take Backs
Project Sticker Shock
Prescription Drug Lock Boxes
Smart Pill Bottles
Prescriber, Pharmacy, Emergency Department, and Patient Education
Merchant Education (Problem Gambling)
Lock and Talk - Lock Boxes
Proper Disposal with Targeted Groups
Compliance Checks
Lock and Talk - Cable Locks
Naloxone Distribution

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

Annual monitoring visits are done by the Behavioral health Wellness Consultants responsible for monitoring the SUPTRS Prevention set aside. Additionally, all logic models and budgets must be approved before providers can enter data into the data system. Our evaluation team also reviews all data entered into the system to ensure it is appropriate and aligns with the SUPTRSBG requirements.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

See attached 2024 Virginia Substance Use Prevention Block Grant Annual Report

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☐ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

DBHDS
Virginia Department of Behavioral Health and Developmental Services

OMNI INSTITUTE REPORT | 2023-24

Virginia Substance Use Prevention Block Grant Annual Report

SUBMITTED TO:
Virginia Department of Behavioral Health and Developmental Services
Office of Behavioral Health Wellness November 2024

OMNI

For More Information:

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Acknowledgments:

OMNI Institute wants to thank Virginia's Department Behavioral Health and Developmental Services Office of Behavioral Health Wellness and the 40 Community Service Boards across Virginia for their contributions to the creation of this report.

Suggested Citation:

OMNI Institute (2024). Virginia Substance Use Prevention Block Grant Annual Report. Submitted to Department Behavioral Health and Developmental Services Office of Behavioral Health Wellness, Richmond, Virginia.

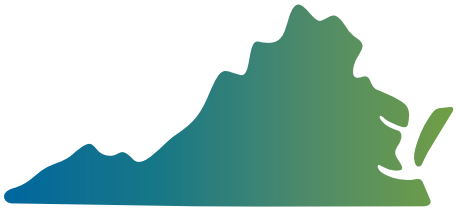
Table of Contents

EXECUTIVE SUMMARY	4
INTRODUCTION	9
Strategic Planning Process	9
Evaluation Planning Process	12
Timeline of Evaluation Activities	12
PREVENTION CAPACITY	13
COMMUNITY MOBILIZATION AND COALITION CAPACITY BUILDING	18
LOCK AND TALK SUICIDE PREVENTION AND AWARENESS	20
MENTAL HEALTH PROMOTION AND SUICIDE PREVENTION TRAININGS	22
ADVERSE CHILDHOOD EXPERIENCES (ACES) TRAININGS	26
COUNTER TOOLS YOUTH RETAIL TOBACCO PREVENTION AND MERCHANT EDUCATION	28
YOUTH CANNABIS PREVENTION	29
PROBLEM GAMBLING PREVENTION	30
PREVENTION OUTCOMES	33
SUSTAINABILITY	35
APPENDIX A: REFERENCES	36
APPENDIX B: PREVENTION LOGIC MODEL	37

DBHDS

Virginia Substance Use Prevention Block Grant | Annual Report 2023-24: Executive Summary

The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant, SUBG or Block Grant for short, is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Virginia's Department of Behavioral Health and Developmental Services (DBHDS) Office of Behavioral Health Wellness (OBHW) distributes grant funds to 40 Community Services Boards (CSBs) across the Commonwealth to plan, implement, and evaluate prevention activities aimed at preventing and/or decreasing substance use.



This report, prepared by OMNI Institute (OMNI), provides an overview of block grant prevention activities during the 2023-24 fiscal year (July 2023 through June 2024). OBHW has contracted with OMNI since 2014 to evaluate Virginia's Block Grant activities and provide training and technical assistance (TA) to build evaluation capacity among Virginia's prevention workforce.

Virginia Prevention Priorities

Since 2014, OMNI and OBHW have partnered to implement the Strategic Prevention Framework within Block Grant activities to provide program structure, build capacity for data-driven prevention, and promote sustainability. In 2017 and 2018, OMNI conducted a statewide needs assessment to identify prevention needs and determine program direction for the 2020-25 funding cycle. From this effort, the following priority areas were identified:

Block Grant Prevention Priority Areas

	Baseline (2019)	Current
Alcohol	**25.4%** of high school youth reported drinking alcohol in the past 30 days.[1] **36.1%** of young adults ages 18-25 reported binge drinking in the past 30 days.[2]	**15.8%** of high school youth reported drinking alcohol in the past 30 days.[3] **31.6%** of young adults ages 18-25 reported binge drinking in the past 30 days.[4]
Tobacco and Nicotine	**14.0%** of VA adults reported smoking cigarettes in the past 30 days.[5] **5.5%** VA high school youth reported smoking cigarettes in the past 30 days, while **19.9%** reported currently using a vaping product.[1]	**10.9%** of VA adults reported smoking cigarettes in the past 30 days.[5] **2.0%** of VA high school youth reported smoking cigarettes in the past 30 days, while **8.1%** reported currently using an electronic vapor product.[3]
Mental Health and Suicide	**7.0%** of VA high school youth reported attempting suicide in the past 12 months.[1] **14.3 out of 100,000** youth ages 15 to 24 died by suicide in VA in 2019.[6] **13.3 out of 100,000 people** died by suicide in VA in 2019.[6]	**7.7%** of VA high school youth reported attempting suicide in the past 12 months.[3] **7.2 out of 100,000** youth ages 15 to 24 died by suicide in VA in 2021.[7] **13.7 out of 100,000** people died by suicide in VA in 2021.[7]

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2022 Needs Assessment Process

Changing legal landscapes in Virginia have brought Problem Gaming and Gambling and Cannabis to the forefront of the prevention landscape. CSBs conducted local needs assessments in 2022 to understand these issues and the readiness of their local communities to address them. This led OBHW to identify these two as emerging areas in need of prevention resources.

Block Grant Prevention Emerging Areas

	Baseline	Current
Cannabis	**55.3%** of young adults who participated in the Virginia 2022 Young Adult Survey have used cannabis in their lifetimes, with **88.8%** of those individuals' using cannabis for the first time under the legal age of 21.[8]	**47.4%** of young adults who participated in the Virginia 2024 YAS have used cannabis in their lifetimes, with **88.7%** of those individuals' using cannabis for the first time under the legal age of 21.[9]
Problem Gaming and Gambling*	**61.5%** of young adults who participated in the Virginia 2022 Young Adult Survey (YAS) had engaged in at least one gaming or gambling activity in the past 30 days.[8]	**35.5%** of young adults who participated in the Virginia 2024 YAS and had gambled at least once in their lives, reported engaging in at least one gaming or gambling activity in the past 30 days.[9]

*Please note that a change in measuring past 30 day gambling behavior occurred between 2022 and 2024, and these values are not directly comparable. All survey respondents in 2022 were asked about past 30-day gambling behaviors, while only those respondents who had gambled at least once in their lifetime were asked about past 30-day behaviors.

Prevention Capacity

Capacity building around assessment, planning, implementation, and evaluation of prevention efforts was provided by OMNI to CSBs through trainings, one-on-one support and resources. **The vast majority of CSBs shared that they have experience collaborating with others (38), experience with relevant prevention strategies and target populations (38) and the capability to use data in their planning (38). This was in stark contrast to the two-thirds (26) reporting that they do not have enough staff capacity and/or financial resources.** This is an increase in the number of CSBs who reported a lack of resources compared to last year (20 CSBs). This finding could highlight the need for streamlining of services and efforts, and/or the increase in allocated resources.

Common barriers reported by CSBs included a community-wide lack of understanding of the current state of use and the risk and protective factors that impact substance use and mental health outcomes. Additional challenges included easy access to alcohol and other substances, lack of transportation in remote communities, and high levels of poverty. Many of these obstacles are deeply rooted in our society and are beyond the direct sphere of influence for preventionists.

PICTURED: The Suicide Prevention Awareness Resource Council (SPARC) with Region Ten CSB at a local community event.

Block Grant Priority Strategies

The 2020-25 strategic planning process involved an exploration of shared risk and protective factors that were impacting the identified priority areas. Targeting shared risk and protective factors allows prevention providers to impact multiple priority areas simultaneously. Five strategies were identified that would serve to address key shared risk and protective factors while strategically building on existing prevention efforts. In 2020, CSBs began implementing these strategies in their communities, for which a majority of Block Grant funds were earmarked. Implementation data from this fiscal year are highlighted below.

Community Mobilization and Coalition Capacity Building

Coalitions demonstrated their effectiveness and commitment to creating healthier communities by educating and engaging their membership and communities. Many coalitions chose to intentionally engage youth, local schools, and youth-serving organizations to implement strategies that were developed by youth, for youth. 33 CSBs reported leading at least one coalition within their community.

71 active coalitions

2,065 coalition members

Lock and Talk Suicide Prevention and Awareness

Lock and Talk implementations focused on messaging and education for community members to practice lethal means safety and discuss mental health. Using a combination of social marketing, merchant education, and item distribution, CSBs worked to prevent both overdoses and suicides in their communities.

Fatal overdoses in Virginia have started trending downward since 2021 – from a rate of 30.5 per 100,000, to 26.1 per 100,000 in 2023.[1] Rates of fatal overdoses are much lower in Virginia than neighboring states. Data from 2022 show a range from 40.3 in Maryland, to 80.9 in West Virginia.[20] While this is due to many factors, it warrants closer monitoring and continued efforts to increase lethal means safety through Lock and Talk implementation.

> *"Local churches have embraced the Lock and Talk message. We have many partners and 'elders' groups' that took up the responsibility of influencing their friends to lock guns and medications."* – Goochland Powhatan CSB

4,330 reached through presentations

5.5M total impressions/reach through social marketing

104 gun retailers visited

31,897 total devices distributed

11,172 lock boxes
11,794 cable locks
5,898 trigger locks
3,033 smart pill bottle/ timer caps

Mental Health Promotion and Suicide Prevention Trainings

Over 12,000 Virginians were trained in how to recognize and support someone experiencing a mental health challenge via Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Trainings (ASIST), safeTALK, and Question. Persuade. Refer. (QPR) curricula. Implementation and reach of MHFA has decreased, while number of trainings and participants across other, shorter curricula have increased, indicating the community may be increasingly seeking opportunities to engage that are less time-intensive.

702 trainings

12,844 people trained*

*Mental Health First Aid, ASIST, safeTalk, and/or QPR

Over three-quarters (77%) of MHFA training participants shared they would act if a person's words or behaviors suggested suicidal intentions on the Suicide Prevention Training Evaluation tool administered by CSBs at the end of each mental health-related training. Among MHFA participants, 80% also reported being able to recognize the signs of someone dealing with a mental health crisis or challenge. Similar results were reported by participants of the other training curricula.

PICTURED: 988 awareness messaging posted in New River Valley CSB's Summer 2024 Update

Adverse Childhood Experiences (ACEs) Trainings

CSBs provided 370 ACE Interface trainings to their communities to increase awareness of the impacts of adverse childhood experiences on health outcomes - including mental health and substance use. CSBs have shared information on ACEs for several years to various community partners, supporting Trauma Informed Care Networks in their communities that are seeking to address the root causes of ACEs.

370 trainings

5,020 people trained

After ACEs trainings, participants are increasingly indicating higher levels of learning and a desire to expand their knowledge about trauma-informed practice.

- 77% agreed or strongly agreed that they want **to seek more information** and guidance regarding trauma-informed practice.
- 80% agreed or strongly agreed that they **want to learn more** about the causes and effects of ACEs.
- 83% indicated they **learned a lot about identifying and addressing ACEs** ansd ACEs' impact on brains and behavior.
- 84% agreed or strongly agreed that they want **to seek more information** and guidance regarding trauma-informed practice.

Counter Tools Youth Retail Tobacco Prevention and Merchant Education

Building on existing relationships with retailers, merchant education efforts are expanding to address additional priority areas, such as alcohol, cannabis and problem gambling. Over one-quarter of CSBs (28%) have re-imagined their merchant education efforts to address these areas. Expanded merchant education offerings realize the efficiency of capitalizing on opportunities to engage with retailers in person. Information is provided on relevant legal requirements of retailers, the risks associated with use, and tips on how to minimize the marketing exposure to underage youth, such as placement of advertisements.

4,157 merchants visited

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Block Grant Emerging Areas

The shifting legal landscape in Virginia has presented additional areas of concern. As a result of a focused needs assessment on cannabis and problem gambling in 2022, OBHW required CSBs to implement strategies to address these topics this fiscal year. With many of the same shared risk and protective factors as other priority areas, prevention strategies were selected by CSBs to impact community awareness and knowledge of the issues. Not all CSBs implemented community-focused strategies, rather dedicating resources to building internal or coalition capacity to address these areas, or bolstering existing strategies that address these areas via a shared risk and protective factor approach. Highlights from implementations are noted below.

Youth Cannabis Prevention

Cannabis focused prevention activities have increased significantly in scope and reach, with the number of CSBs implementing strategies and the reach of media campaigns doubling from the previous fiscal year. While 26 CSBs reported data on cannabis strategy implementations, four CSBs capitalized on a partnership with the Virginia Foundation for Healthy Youth to implement Unfazed, a comprehensive messaging campaign focused on the impacts and risks associated with youth cannabis use.

2.8M
impressions/reach

Logo for Unfazed, a media campaign directed at youth

Problem Gambling Prevention

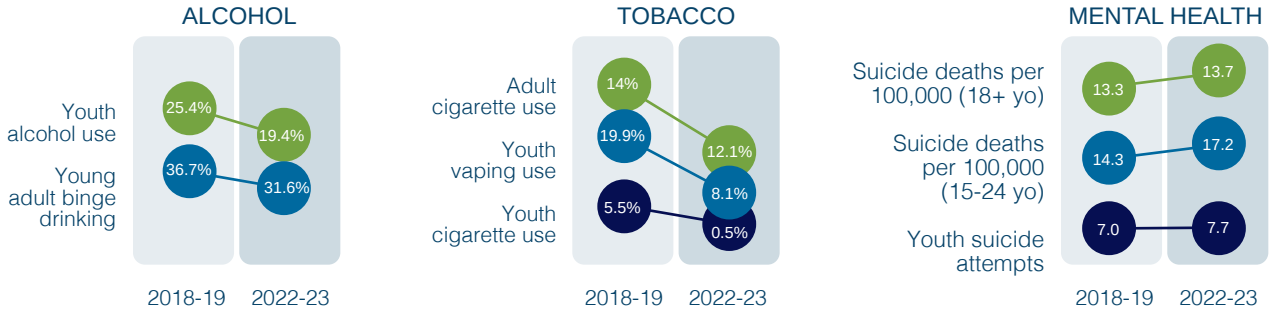
Virginia CSBs are at the forefront of problem gambling prevention work, actively building capacity and focusing on tailored messaging to educate their communities and raise awareness. Applying approaches from other priority areas, CSBs incorporated gambling-specific messaging into existing messaging efforts and capitalized on tobacco retailer education visits to also offer merchant education to retailers selling lottery and scratch tickets and those with skill game machines (sometimes referred to as gray machines).As prevention staff continue to build capacity to tackle problem gambling and identify approaches that work for their community, several CSBs in Region III West held the first Annual Problem Gambling Prevention Conference in Virginia, which brought together partners from multiple sectors to learn, inspire and plan to address problem gambling in the Commonwealth.

10.5M
impressions/reach

Middle Peninsula Northern Neck CSB messaging campaign for March 2024, Problem Gambling Awareness Month

Prevention Outcomes

Outcomes across the OBHW-identified priority areas of alcohol and tobacco are improving. Mental health outcomes, meanwhile, are worsening over time.



Introduction

The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant, or SUBG for short, (formerly the Substance Abuse Prevention and Treatment [SAPT] Block Grant) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Virginia's Department of Behavioral Health and Developmental Services (DBHDS) Office of Behavioral Health Wellness (OBHW) distributes grant funds to 40 Community Services Boards (CSBs) across the Commonwealth to plan, implement, and evaluate prevention activities aimed at preventing and/or decreasing substance use.

This report, prepared by OMNI Institute (OMNI), provides an overview of Block Grant prevention activities during the 2023-24 fiscal year (July 2023 through June 2024). OBHW has contracted with OMNI since 2014 to evaluate Virginia's Block Grant activities and provide training and technical assistance (TA) to build evaluation capacity among Virginia's prevention workforce. OMNI is a nonprofit social science consultancy that provides integrated research and evaluation, capacity building, and data utilization to accelerate positive social change.

Strategic Planning Process

Since 2014, OMNI and OBHW have partnered to implement the Strategic Prevention Framework[10] within Block Grant activities to provide program structure, build capacity for data-driven prevention, and promote sustainability. In 2017 and 2018, OMNI conducted a statewide needs assessment[11] to identify prevention needs and determine program direction. The assessment synthesized a broad array of national, state, and local secondary data sources to better understand the status and needs related to behavioral health in Virginia. The assessment also utilized primary data collection through facilitated discussions with the Statewide Epidemiological Outcomes Workgroup and OBHW staff. In addition, a SWOT (strengths, weaknesses, opportunities, and threats) analysis with local prevention staff to gather information and understand prevention priorities was conducted. From this effort, the following priority areas were identified:

Block Grant Prevention Priority Areas

	Baseline (2019)	Current
Alcohol	**25.4%** of high school youth reported drinking alcohol in the past 30 days.[1] **36.1%** of young adults ages 18-25 reported binge drinking in the past 30 days.[2]	**15.8%** of high school youth reported drinking alcohol in the past 30 days.[3] **31.6%** of young adults ages 18-25 reported binge drinking in the past 30 days.[4]
Tobacco and Nicotine	**14.0%** of VA adults reported smoking cigarettes in the past 30 days.[5] **5.5%** VA high school youth reported smoking cigarettes in the past 30 days, while **19.9%** reported currently using a vaping product.[1]	**10.9%** of VA adults reported smoking cigarettes in the past 30 days.[5] **2.0%** of VA high school youth reported smoking cigarettes in the past 30 days, while **8.1%** reported currently using an electronic vapor product.[3]
Mental Health and Suicide	**7.0%** of VA high school youth reported attempting suicide in the past 12 months.[1] **14.3 out of 100,000** youth ages 15 to 24 died by suicide in VA in 2019.[6] **13.3 out of 100,000** people died by suicide in VA in 2019.[6]	**7.7%** of VA high school youth reported attempting suicide in the past 12 months.[3] **7.2 out of 100,000** youth ages 15 to 24 died by suicide in VA in 2021.[7] **13.7 out of 100,000** people died by suicide in VA in 2021.[7]

Block Grant Prevention Priority Strategies

- Community Mobilization and Coalition Capacity Building
- Lock and Talk Suicide Prevention and Awareness
- Mental Health Promotion and Suicide Prevention Trainings
- Adverse Childhood Experience (ACE) Interface Trainings
- CounterTools Youth Tobacco Prevention and Merchant Education

To impact Virginia's prevention priorities and reach desired outcomes, the OBHW team explored data from the 2018 needs assessment and selected key risk and protective factors underlying the priority areas that could be targeted by implementing new or existing prevention strategies. Based on these discussions, the OBHW team set five priority prevention strategies to target alcohol use, tobacco use, and mental health and suicide prevention across the Commonwealth. For more detailed information on the strategic planning process, please see OMNI's 2019 Strategic Planning Report.[12]

OMNI developed a statewide logic model for the 2020-2025 Block Grant funding period that details the shared relationships between the three priority areas, the risk and protective factors underlying these areas, the priority strategies selected to target those factors, and the desired short-term and long-term impacts of these strategies (See Appendix B). CSBs were required to implement all five priority prevention strategies while reserving some prevention funds to implement strategies focused on local priorities.

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Following developments in the gambling landscape in Virginia, OBHW and OMNI partnered in fiscal year 2021-22 to conduct extensive local needs assessments across all 40 CSBs related to problem gaming and gambling and cannabis. Each CSB was tasked with completing the following: an environmental scan on problem gaming and gambling; and community readiness assessments for problem gaming and gambling as well as for cannabis.

OMNI synthesized and compiled the results of each completed Environmental Scan and Community Readiness Assessment results to provide a clearer picture of problem gaming and gambling, as well as cannabis prevention needs across the Commonwealth. Reports on each component can be found on the 'Reports' page of the VASIS Dashboard website. In response to these findings, this year, OBHW identified Problem Gaming and Gambling and Cannabis as two emerging prevention needs.

Block Grant Prevention Emerging Areas

	Baseline (2019)	Current
Cannabis	**55.3%** of young adults who participated in the Virginia 2022 Young Adult Survey have used cannabis in their lifetimes, with **88.8%** of those individuals' using cannabis for the first time under the legal age of 21.[8]	**47.4%** of young adults who participated in the Virginia 2024 YAS have used cannabis in their lifetimes, with **89.7%** of those individuals' using cannabis for the first time under the legal age of 21.[9]
Problem Gaming and Gambling	**63.6%** of young adults who participated in the Virginia 2022 Young Adult Survey had engaged in at least one gaming or gambling activity in the past 30 days.[8]	**5.5%** of young adults who participated in the Virginia 2024 YAS and had gambled at least once in their lives, reported engaging in at least one gaming or gambling activity in the past 30 days.[9]

In early 2023, CSBs began implementing problem gaming and gambling prevention strategies across Virginia and, this fiscal year, began implementing cannabis prevention strategies. OBHW did not specify the required strategies for either emerging area, allowing CSBs to determine what prevention interventions would best meet their local needs.

Complimenting local problem gaming and gambling and cannabis needs assessments, OMNI, in partnership with OBHW and CSBs, administered the Young Adult Survey (YAS) in 2022 and 2024. The survey was designed to assess behavioral health risk factors, substance use consumption patterns and perceptions, and gaming and gambling perceptions and behaviors for those aged 18-25 across the Commonwealth of Virginia. Over 5,000 participants responded in each administration, enabling a robust snapshot of the current landscape, and a deeper examination of the behavioral and mental health status of historically marginalized communities. Results from the 2022 statewide survey efforts can be found online on the Virginia Social Indicator Summary (VASIS) Dashboard webpage, with 2024 results to be released in early 2025.[9]

A comprehensive statewide needs assessment was conducted in 2023-2024 to further understand impacts made over the last several years on alcohol, tobacco, and mental health and to understand the growing needs for problem gambling and gaming, and cannabis prevention work in Virginia. The statewide needs assessment also reviewed available data on shared risk and protective factors, exploring the landscape related to these factors, both in Virginia and across other states' prevention programs. The 2023-2024 needs assessment results will support renewed strategic planning efforts in 2024-2025 to identify priorities for the 2025-2030 Block Grant funding cycle.

Evaluation Planning Process

To support CSBs in creating individual prevention evaluation plans to monitor progress toward local and state outcomes, OMNI created a comprehensive approach, known to CSBs as the "evaluation roadmap." The roadmap integrates each community's logic model, measurement plan, and data entry plan into one document for ease of use in data entry and reporting. Each roadmap component is linked to the others, allowing CSBs to organize their data to illustrate the prevalence of each priority area, show progress toward outcomes, and track implementation data. Each roadmap component is described below.

LOGIC MODEL

Illustrates the shared relationships between problem areas, strategies, activities, and outcomes. Is a visual representation of CSBs' prevention plans.

MEASUREMENT PLAN

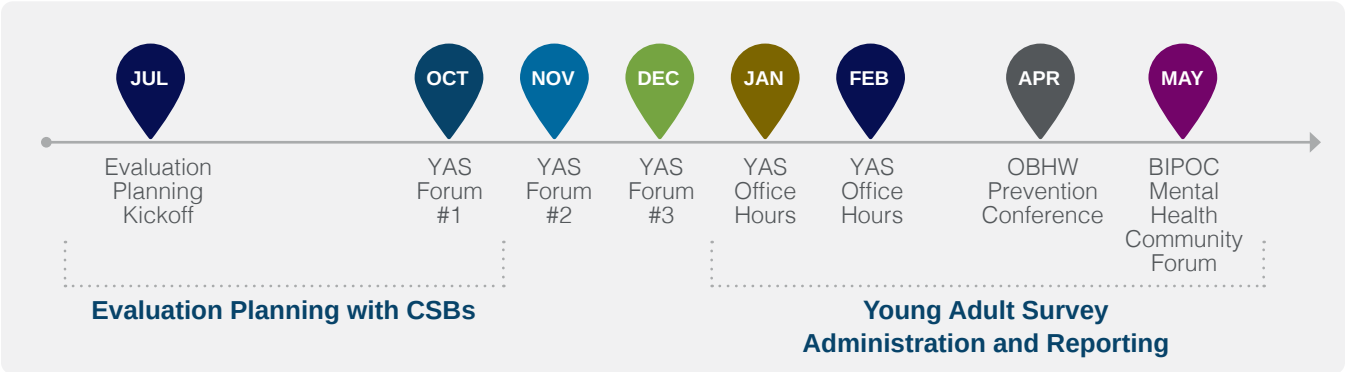
Organizes data sources used to measure progress toward desired outcomes identified in Block Grant logic models.

DATA ENTRY PLAN

Outlines how to enter data into the Performance Based Prevention System (PBPS) to meet grant requirements and inform progress.

Timeline of Evaluation Activities

During the 2023-24 fiscal year, OMNI worked with CSBs to support the implementation of prevention strategies, provide TA around data entry and reporting requirements, and host trainings and Community Forums to provide ongoing discussions around CSB interests and needs. OMNI provided multiple trainings, resources, and hosted drop-in TA sessions on the 2024 Young Adult Survey (YAS) administration. The timeline below provides an overview of critical activities in the 2023-24 fiscal year.



Continuous evaluation efforts throughout 2023-2024 included:

- ACEs Interface Training Evaluation data provided to CSBs quarterly
- Suicide Prevention Training Evaluation data provided to CSBs quarterly
- Data auditing and TA on more than 15,000 implementation activities recorded in PBPS
- 2024 Statewide Needs Assessment data collection, synthesis, and reporting

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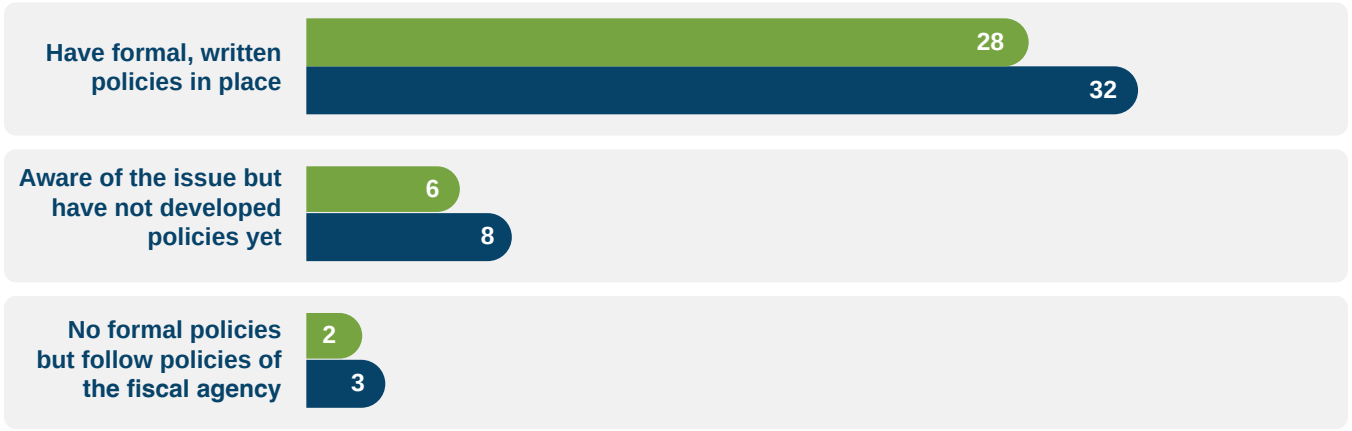
Prevention Capacity

OMNI continues to provide capacity-building services to Virginia CSBs, while also offering support for other essential steps of the Strategic Prevention Framework (SPF), such as assessment, planning, implementation, and evaluation of prevention strategies. These capacity-building efforts remain centered on advancing data literacy and helping the prevention workforce develop key skills and relationships to engage in data-driven prevention more effectively. In Block Grant (BG) Year 1 (FY20-21), OMNI introduced an end-of-year survey to gauge the capacity of the prevention workforce across various steps of the SPF.

Several questions were adapted from the Community Level Instrument, which was developed by the Program Evaluation for Prevention Contract (PEP-C). The survey also aims to assess CSB capacity in applying the SPF principles of cultural competence and sustainability. The survey has been administered annually since its inception, with the latest rounds conducted in FY22-23 and FY23-24. OMNI plans to continue this process throughout the entire five-year grant cycle. Data from the most recent surveys are presented in this section to highlight the current capacity of the BG prevention workforce, with select comparisons made between Year 3 and Year 4 results.

In FY23-24, more CSBs (32) reported having formal, written cultural competence policies in place compared to FY22-23, reflecting a growing commitment to addressing cultural competence and progress in policy implementation.

It is interesting to note that 33 CSBs also reported having cultural competence policies in FY21-22, before FY22-23 saw a decrease to 28. The reasons behind these trends could be multifaceted, including organizational changes or shifting priorities, but the overall increase in formal policies is a positive development.



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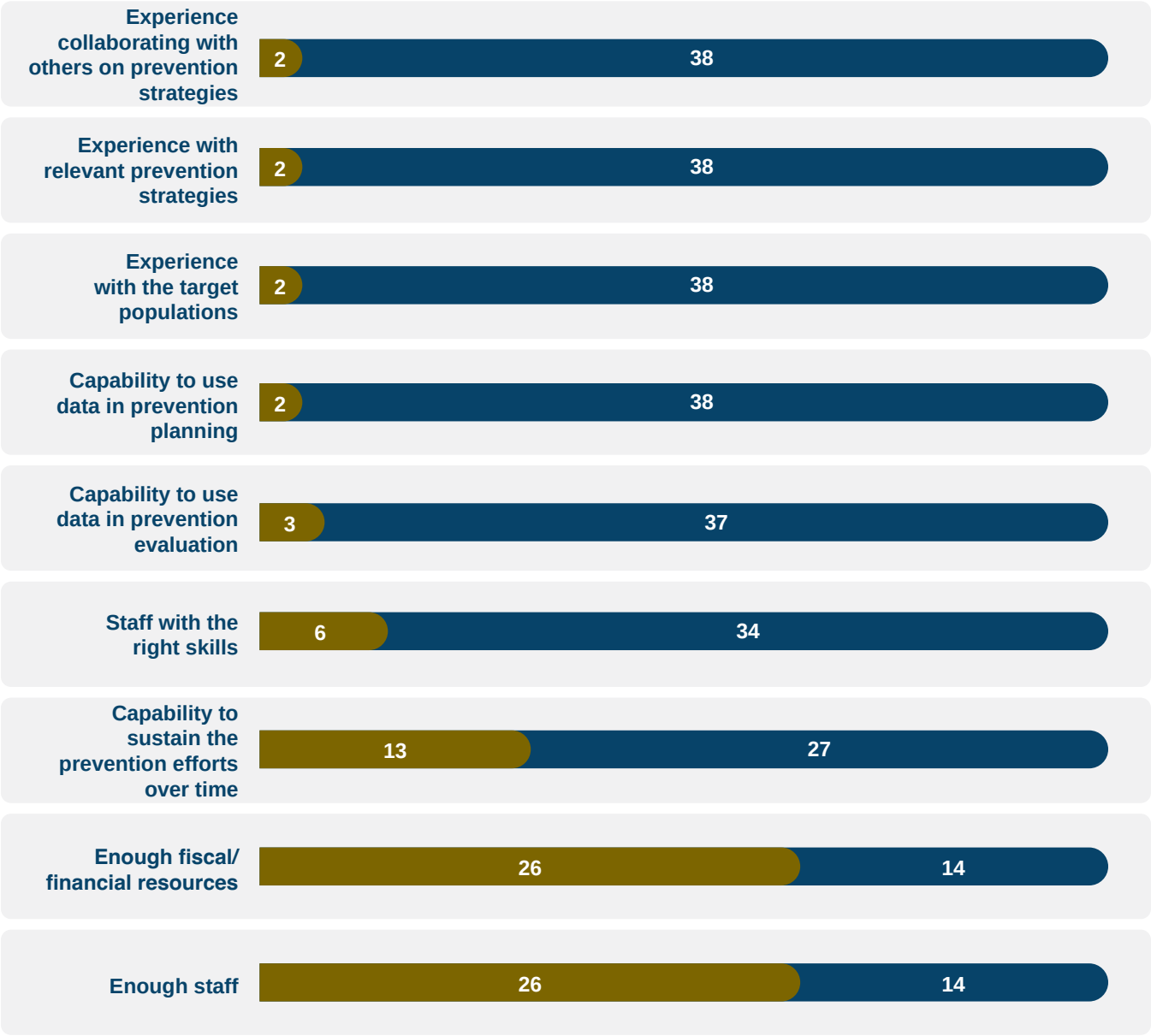
In FY23-24, CSBs continued to agree that they have enough capacity to implement Block Grant prevention strategies, particularly in areas related to collaboration and data usage.

As in previous years, CSBs were asked how much they agreed or disagreed that their organizations have enough capacity in nine key areas to implement their strategies effectively. As shown in the chart below, almost all CSBs agreed that they have the capacity to use data in prevention evaluation (37) and planning (38), experience with relevant prevention strategies (38), and experience collaborating on those strategies (38). These results are consistent with previous years. Despite this, challenges with staffing remain, as more than half of CSBs (26) disagreed that they have enough staff, like FY22-23, although a majority (34) still agreed that their team has the right skills.

This may mean that although CSBs have capable, qualified staff, there may be more prevention efforts than their current staff have the capacity to implement. Concerns about fiscal capacity persisted, with 26 CSBs disagreeing that they had enough financial resources, an increase from the previous year when 20 CSBs disagreed that they had enough financial resources. There was a modest improvement in the capability to sustain prevention efforts over time, but long-term sustainability continues to be an area of focus.

CSBs Agree/Strongly Agree or Disagree/Strongly Disagree they have enough capacity in each area



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In FY23-24, more CSBs (31) implemented strategies specifically targeting subpopulations experiencing health disparities compared to the previous year (24).

This increase reflects a growing commitment to addressing the unique needs of populations through tailored strategies, and an understanding that not all prevention strategies impact everyone the same way. CSBs were asked to identify which of 14 health disparities-related activities they conducted during FY23-24. Key highlights are noted below.

- Collaboration remains paramount to addressing health disparities. Similar to previous years, most CSBs (34) developed partnerships with agencies, organizations, or key collaborators to address health disparities. Additionally, 32 CSBs received training to increase their capacity in this area, while 29 incorporated health disparities in their prevention planning.
- As in previous years, fewer CSBs evaluated outcomes for subpopulations facing substance use health disparities (12), developed plans to sustain progress (12), or assessed changes in the number of individuals served within these populations (11). This may be related to the capacity of staff and resources for further evaluation activities.
- Around two-thirds of CSBs (27) defined specific subpopulations experiencing disparities based on demographics, language, age, socioeconomic status, sexual identity, or literacy, and 24 CSBs identified substance use-related health disparities within these populations. These figures are consistent with last year's findings, demonstrating a continued focus on understanding and addressing disparities.

More than half of CSBs reported defining specific health disparities for subpopulations (24) and actively sought out substance-use related data for subpopulations (26). Doing this enabled CSBs to increase access to services (27), involve subpopulations in Block Grant activities (24), and adapt their strategies to make them apply to subpopulations experiencing health disparities (21).

> *"Loudoun has a large immigrant population and language barriers. Therefore, we have continued incorporating accommodations when needed for events and provided translation for flyers or other services."*
> – Loudoun CSB

> *"The biggest barrier remains funding. For example, reaching a growing immigrant/refugee population is markedly impacted by the lack of funding needed to go far beyond translation services and the ability to hire a community champion to help their populations. Without additional funding to meet current mandates, staff have to step back from the best quality services and just meet minimum requirements."*
> – Blue Ridge Behavioral Healthcare

> *"VCSB's catchment area is shifting and growing in ways previously unseen. Anytime there are social issues impacting the community it affects all systems, resources, and individuals in the community. A general lack of trust in systems nationwide often trickles down to the localities as well. There is not one large barrier to our work in Prevention, rather several barriers that provide some impact on our work."*
> – Valley CSB

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CSBs noted several barriers they encounter that impact their prevention activities in their communities, including the lack of community awareness of the extent or consequences of substance use/misuse shared by 37 CSBs as being a moderate or high barrier.

CSBs were asked to indicate which of 19 demographic, environmental, or cultural factors introduced barriers to their Block Grant prevention activities. They also shared the level of impact (low, moderate, high) that each factor had in the past fiscal year. The common barriers that had moderate or high impact on CSBs remained the same as last year, but a higher number of CSBs reported these barriers as having a moderate or high impact across all factors. This indicates that these challenges have not been addressed, and the impacts of these barriers has grown wider.

Region Ten CSB staff at the SPARC Hope 5k

Number of CSBs Reporting Moderate or High Impact for Common Barriers

36	Cultural norms, attitudes, or practices favoring substance use and easy access to alcohol for underage youth
35	Easy access to alcohol for underage youth
33	Lack of transportation, difficulty reaching some parts of the community
31	Easy access to prescription drugs for nonmedical use
31	High poverty rates/low socioeconomic status
29	Lack of drug-free activities for area youth
27	Lack of supervision for area youth
27	Lack of trust in law enforcement, government, or social services

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Additional barriers most frequently mentioned as having an impact are:

- Increase in community violence, including a high rate of gun violence in urban communities
- Increase in housing/cost of living and lack of affordable housing
- Behavioral healthcare/prevention workforce shortage and staffing changes
- Community resistance at prevention efforts
- Youth reporting being bullied and feeling lonely
- Increase in discrimination within the school system

Throughout the year, CSBs have encountered significant barriers primarily due to staffing shortages and limited resources. Many shared that small teams struggle to meet performance expectations, resulting in overwhelming workloads and high turnover rates. In response, CSBs are increasing salaries and adding positions to improve retention and capacity. Additionally, they are focusing on tailored community engagement strategies to better serve diverse populations and address specific needs. Despite these hurdles, CSBs remain committed to fostering partnerships and adapting their strategies to effectively meet community needs.

> *"Staffing changes were a barrier for us, but we have hired new staff and are optimistic that we will be fully staffed and able to reach our goals. A lesson learned is that even though we were not at full capacity, we were able to persevere and change, continue to educate, train, and provide support to the community at large."*
> – Norfolk CSB

Prevention Priorities

Information and data describing the impact of implementing the identified priority prevention strategies, as well as the emerging areas, are detailed in the following sections. Data used to populate these sections were provided from two main sources –

1) The Performance Based Prevention System (PBPS) database capturing all implementation data (i.e., numbers served, reach, items distributed) and targeted risk and protective factors.

2) An annual end-of-year survey focused on successes, challenges and impact stories collected directly from CSBs.

Valley CSB at the Out of the Darkness Walk where they raised $1,100

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Community Mobilization and Coalition Capacity Building

Coalitions demonstrated their effectiveness and commitment to creating healthier communities by educating and engaging their memberships and communities on key prevention topics and available resources.

33 CSBs reported leading at least one coalition. CSBs partnered with and involved community leaders, local partner organizations, and various community members to build capacity and mobilize community engagement. This fiscal year, coalitions focused on intentional outreach in their community and strengthening the involvement of their coalition membership. Data from the end-of-year survey shows that 93% of CSBs reported having active coalitions supporting prevention initiatives, and 68% of CSB coalitions report being successful in positively impacting issues relevant to their communities. This demonstrates that connections with community partners are vital to attaining the desired outcome of a healthier Virginia.

Adequate funding and support have allowed coalitions to expand their outreach efforts, diversify programming, and produce valuable community resources. These successes were not achieved in isolation but through the deliberate involvement of local communities. CSBs engaged community members in efforts to build community capacity around specific issues, assess community needs, engage in strategic planning, and secure funding.

To reduce gun violence in their community, Hampton-Newport News Community Services Board mobilized their coalition, the "Community Builders Network (CBN)," which was awarded grant funding for the third consecutive year through the City of Newport News Gun Violence Intervention Program (GVIP). CBN involves community organizations in the effort to reduce gun violence through solutions ranging from an educational curriculum focused on life skills and trauma-informed practices, mental health services, and case management. Mount Rogers CSB and Appalachian Substance Abuse Coalition (ASAC) collaborated with local law enforcement's annual "National Night Out" events in Carroll, Grayson, Smyth Counties, and Galax City—a free event to promote crime prevention and harm reduction.

33
CSBs lead coalitions

71
active coalitions

2,065
coalition members

> *"In year three, CBN will implement the Rise Above Trauma-Informed, Social-Emotional Learning and Substance Use Prevention Curriculum, which focuses on teaching life skills for social-emotional learning, to help youth overcome and thrive. With this grant award the coalition hopes to impact gun violence as well as other risk factors for substance misuse and increase protective factors for the youth."*
> –Hampton-Newport News CSB

> *"The coalition's coordinator invites subject matter experts from the community to present on specific topics such as new trends in vaping, legalization of marijuana, and problem gambling to inform the coalition about the issues they are addressing. This approach has led to the development of many new partnerships, and attendance has improved by 100%. Additionally, the coalition has created and distributed a resource guide that allows citizens to access immediate assistance for their needs with a simple phone call."*
> – Highlands CSB

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Coalitions were committed to incorporating and raising up youth voices to help inform prevention efforts.

Out of the 71 active coalitions, the highest sector representation comes from youth groups, schools, and youth-serving organizations. Youth membership was a common focus in the past year, as coalitions continued to recruit youth and incorporate youth voices in their work. Youth have supported CSBs in identifying and diversifying the strategies they are implementing, with greater importance being placed on developing and implementing strategies by youth, for youth.

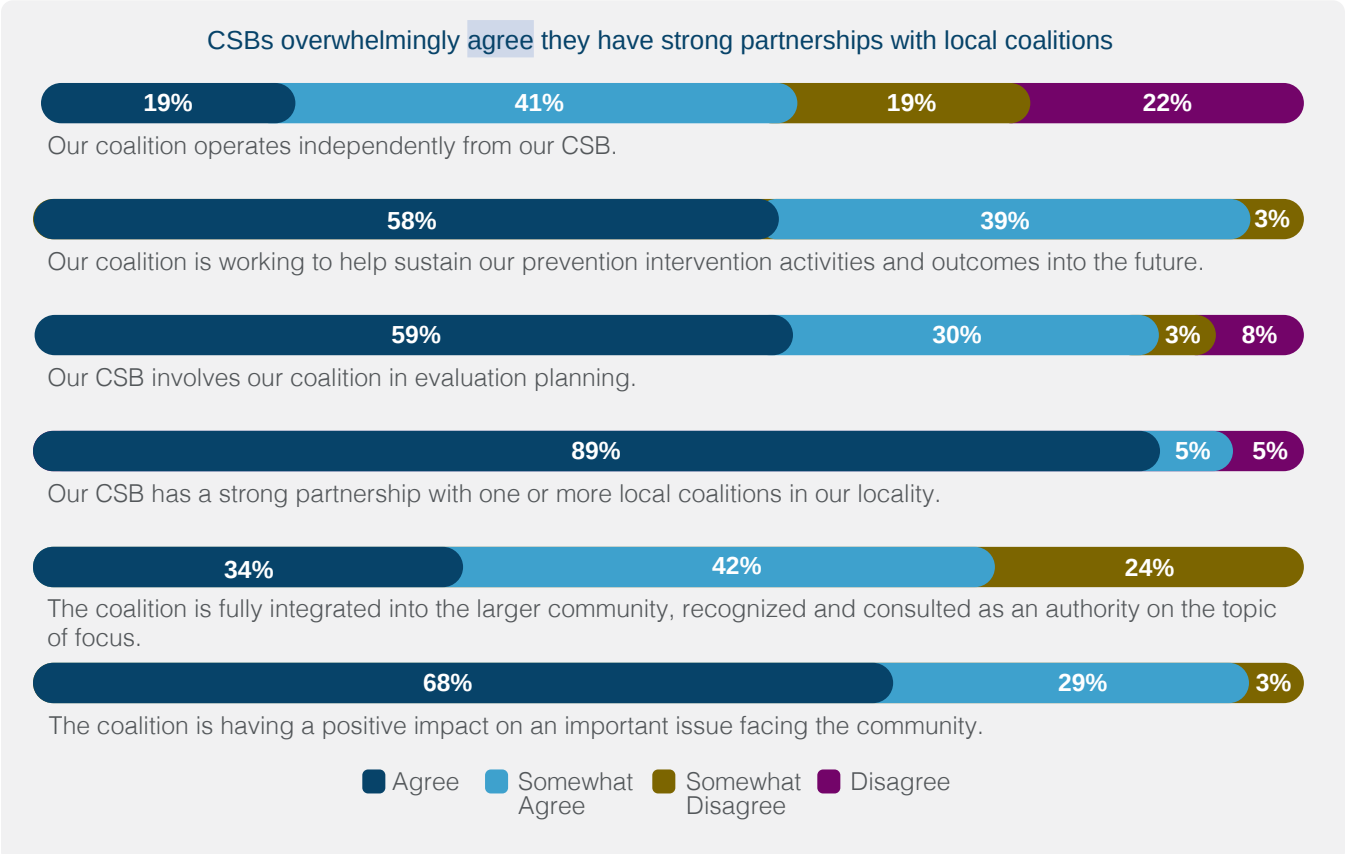
Risk & Protective Factors

- Early Onset of Use
- High Rates of Depression/Sadness
- Low Perception of Risk of Use

The Salem Prevention Planning Team (SPPT), a coalition partnered with Blue Ridge Behavioral Healthcare, worked closely with a local high school to create an anti-vaping campaign. Students from Salem High School developed the concept, production, and distribution of an anti-vaping media campaign for youth. It was highlighted in the end-of-year survey that “Youth led the campaign; it was so successful that it was expanded beyond Salem to our entire catchment area.”

CSBs maintained strong partnerships with local coalitions and continue to develop and expand the role of coalitions in informing and supporting work at the CSB level.

Data from the end-of-year survey shows that CSBs continue to hold strong partnerships with one or more local coalitions and view their coalitions as positively impacting their communities on important issues. They continue to involve their coalitions in evaluation planning, working with them to ensure long-term sustainability of prevention activities. Fewer CSBs agreed that coalitions operate independently from their CSB as compared to the previous year, which may be a result of CSBs increasing staff positions for coalition coordinators.



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Lock and Talk Suicide Prevention and Awareness

Lock and Talk programs continue to encourage community members to practice lethal means safety and discuss mental health via information dissemination, merchant education, and item distribution.

38 CSBs reported data related to their implementation of Lock and Talk. Information dissemination remains a pillar of Lock and Talk programs, reaching 5.5 million impressions this year. CSBs distribute Lock and Talk messaging through a variety of means, including billboards, PSAs, flyers, brochures, and social media.

Lock and Talk presentations create conversations that resonate with community members.

CSBs reached 4,330 community members via community presentations this year as awareness of Lock and Talk initiatives continues to grow. Many communities, including schools, are looking for ways to engage in conversations about suicide prevention and gun safety and recognizing the strength in developing partnerships with CSBs. A local middle school asked Henrico Area Mental Health and Developmental Services to provide a Lock and Talk presentation for their PTA meeting, reaching a crucial group in their community.

Eastern Shore CSB (ESCSB) highlighted their ongoing presence at community events, often attended by residents with firearms and prescription medications in their homes. Partnering with ESCSB's Recovery Services, they offered the Lock and Talk program to high-risk individuals and families. Additionally, they worked alongside local Fire and Rescue teams to promote Lock and Talk initiatives and organized 'Pop-Up' drug take-back events.

38
CSBs implemented Lock and Talk

5.5M
impressions/ reach through social marketing

4,330
reached through presentations

104
gun retailers visited

31,897
total devices distributed

11,172 lock boxes
11,794 cable locks
5,898 trigger locks
3,033 smart pill bottle/ timer caps

Risk & Protective Factors

- High Rates of Depression/Sadness
- Low Awareness and/or Knowledge
- Access to Lethal Means

Rockbridge Area CSB Lock and Talk billboard

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Across Virginia, signs of a broader impact from Lock and Talk and complimentary efforts have begun to emerge.

When examining overdose deaths since 2019, the latest year of data available when the initial 2020-25 strategic plan was developed, rates are showing a steady decrease after a peak in 2021. Overdose fatalities from all drugs in 2023 was 26.1 per 100,000[13], a considerable decrease from 2021. Similarly, overdose deaths attributed to prescription medication have decreased from 4.3 in 2021[7], to 2.4 in 2023.[13] Many factors contribute to overdose deaths, such as changes in the availability of drugs, access to behavioral health supports, and cultural and social shifts. Yet, it is likely that Lock and Talk and other complementary prevention efforts have contributed to these encouraging trends.

> *"Local churches have embraced the Lock and Talk message. We have many partners and 'elders' groups' that took up the responsibility of influencing their friends to lock guns and medications. Other influential partners include Health Departments, libraries, Sheriff's Offices, NAACP, schools, recovery community partners, Rural Overdose and Outreach, golf courses, and realtors. People love the idea that limiting access is quick and effective."*
>
> – Goochland-Powhatan CSB

	2019	2020	2021	2022	2023
Overdose fatalities from all drugs, rate per 100,000	18.1	25.8	30.5	29.0	26.1
Overdose fatalities from prescription drugs, rate per 100,000	3.6	4.2	4.3	3.3	2.4

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Mental Health Promotion and Suicide Prevention Trainings

Suicide prevention trainings reached over 12,000 Virginians, providing education on how to recognize and support someone experiencing a mental health challenge.

CSBs were required to offer Mental Health First Aid (MHFA) trainings in their communities, along with one of three suicide prevention trainings this fiscal year: Applied Suicide Intervention Skills Training (ASIST), safeTALK, or Question. Persuade. Refer. (QPR). 38 CSBs reported implementation data related to these specific mental health curricula. More details on the content of these trainings are outlined below.

38 CSBs provided trainings

702 trainings

12,844 people trained*

*Mental Health First Aid, ASIST, safeTalk, and/or QPR

ASIST	2-day trainings focused on helping caregivers recognize and intervene to prevent the risk of suicide. The learning process is based on adult learning principles and involves highly participatory workgroups.
safeTALK	Four-hour trainings teaching the TALK steps—Tell, Ask, Listen, Keep Safe—to engage those with thoughts of suicide and help to connect them with life-affirming resources.
QPR	1–2-hour introductory trainings for general audiences enhance a general awareness of suicide through public education while teaching community members the warning signs of suicidal thinking and behavior. QPR also covers three basic intervention skills that can help avert the tragedy of suicide.
MHFA	8-hour trainings provide essential skills to offer initial assistance and support to someone who may be developing a mental health or substance use issue or facing a crisis.

Overall, the number of MHFA, ASIST, safeTalk and QPR trainings decreased slightly from 740 last fiscal year to 702 this fiscal year – the number of individuals trained, however, increased from 11,459 to 12,844 participants indicating that community members continue to engage with CSB suicide prevention training offerings. The decline in the number of training sessions offered could be due to many reasons. Many CSBs reported challenges due to a decrease in staff capacity to coordinate training efforts, which, when considering outreach, prep, and follow-up, can be resource-intensive. Staff turnover has also contributed to these challenges, with some CSBs onboarding new staff who require training and certification to facilitate these trainings.

> *"The feedback from community members indicated their gratefulness for free trainings such as MHFA, ASIST, QPR, and safeTalk. Having conversations about mental health creates partnerships in the city where individuals can access resources."*
> – Virginia Beach CSB

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Mental Health First Aid continues to be the most-delivered training, offering unique curricula tailored toward supporting youth and adults, alongside various, population-specific add-on modules.

Throughout all CSBs, MHFA for youth, adults, and teens trained a total of 6,348 community members, which is fewer than in the previous year. MHFA is the most time-intensive curricula, at 8 hours of training time, and, while MHFA trainings have decreased compared to previous fiscal years, implementations of QPR, safeTALK, and ASIST have increased, all of which are less time-intensive. This indicates that community members may be facing greater time constraints that make the lengthy MHFA training course inaccessible. Increasing offerings of trainings requiring a shorter time commitment by participants may be appealing to some community partners, including schools, and may allow CSBs to better meet community needs.

Training Type	# of Trainings	# Individuals Trained
Mental Health First Aid (MHFA)- Adult	▼ 271	▼ 3,985
Mental Health First Aid (MHFA)- Youth	▼ 160	▼ 2,363
Question. Persuade. Refer. (QPR)	132	▲ 2,467
safeTALK	▲ 105	▲ 1,754
Applied Suicide Intervention Skills Training (ASIST)	▲ 34	▲ 494

▲ 10% or greater increase from previous fiscal year

▼ 10% or greater decrease from previous fiscal year

Some CSBs also opted to implement additional suicide or mental health focused trainings and presentations in order to meet the growing community demand for resources and information. This fiscal year, seven CSBs implemented Signs of Suicide (SOS), Talk Saves Lives, and/or More Than Sad in an effort to provide additional educational opportunities for community members using established curricula or content.

Training Type	# of Trainings	# Individuals Trained
Signs of Suicide (SOS)	▼ 27	▼ 7,963
Talk Saves Lives	▲ 17	▲ 392
More Than Sad	▲ 2	▲ 21

▲ 10% or greater increase from previous fiscal year

▼ 10% or greater decrease from previous fiscal year

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

The Virginia Suicide Prevention Training Evaluation tool gathers feedback from participants to better track the impact of training on potential behavior changes in the future.

The tool was created by OMNI in collaboration with two CSBs and OBHW between February and June 2023. The tool was created to address challenges associated with tracking data for various curricula across the Commonwealth, enhancing the ability to comprehensively evaluate impacts. Living Works, the parent organization for ASIST and safeTALK, partnered with OBHW and OMNI to develop data-sharing protocols to streamline the collection of curriculum-specific training feedback.

Data on the number of trainings delivered as well as the number of participants in each training are documented in the Performance Based Prevention System (PBPS) as implementation activities to satisfy the Block Grant performance measure for suicide prevention training. Conversely, the Virginia Suicide Prevention Training Evaluation tool is voluntary, and not all training participants submit responses. Therefore, results only represent a portion of Virginians who attended mental health trainings.

The Virginia Suicide Prevention Training Evaluation tool collected responses from 2,411 participants across 239 trainings in its inaugural year.

The majority of responses were provided by MHFA participants, followed by safeTALK, ASIST, QPR and Lock and Talk. MHFA participants reported the highest levels of knowledge, intent to intervene, and compassion towards those experiencing a mental health challenge.

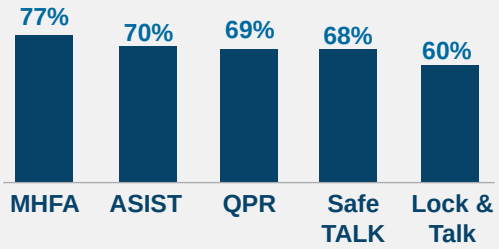
Results suggest that 84% of MHFA participants 'strongly agreed' that they recognize the signs that someone may be dealing with a mental health challenge or crisis. A majority (77%) of MHFA participants 'strongly agreed' that if a person's words and/or behaviors suggest the possibility of suicide, they will take action, indicating a high level of knowledge and skill in understanding how to approach mental health crises. 83% of MHFA participants 'strongly agreed' that they would listen without expressing judgment to anyone they suspect is experiencing a mental health challenge or crisis.

Community partnerships have helped suicide prevention trainings reach community members from historically marginalized communities.

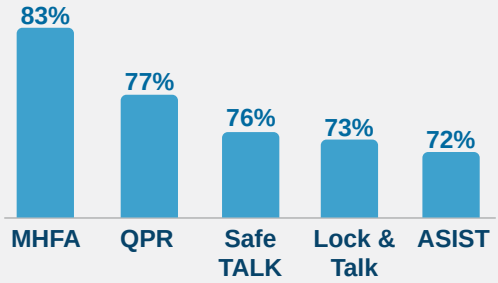
Partnerships with schools, colleges, local organizations, and community events played a crucial role in engaging a diverse audience and raising awareness of available resources in historically marginalized communities. Over the past year, one of Fairfax-Falls Church's key achievements was engaging underserved communities to combat stigma surrounding mental health. They facilitated both open enrollment and customized QPR trainings, which led to increased participation and attendance. To meet the needs of Spanish-speaking community members, QPR training was consistently offered in Spanish and allowed them to engage new pockets of the community they had not previously reached.

I recognize the signs that someone may be dealing with a mental health challenge or crisis.

If a person's words and/or behaviors suggest the possibility of suicide, I will take action to help them.



I will listen without expressing judgment to anyone I suspect is experiencing a mental health challenge or crisis.



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38 CSBs reported reaching millions of people through broad mental health promotion and suicide awareness activities via media campaigns, community events, and presentations.

Activities ranging from Facebook or website posts and other social media, broadcast media, and resource guide distribution, to community walks and events ensured that messaging about mental health and wellness reached communities across Virginia. Presentations were held at places of worship, senior centers, colleges, and more. In their efforts, some CSBs turned to more wellness-focused messages this year, focusing conversations on stress management, resiliency, and developing healthy coping skills as means of increasing protective factors.

Activate Your Wellness social marketing campaigns developed by OBHW were implemented by 12 CSBs, reaching more than 500,000 people.

The Activate Your Wellness messaging campaign focuses on engaging Virginians across eight core dimensions of wellness, including mental and behavioral health, physical health, and financial health. Messaging was communicated via social media, print ads in newspapers, and at community events, such as health fairs.

38
CSBs raised awareness

12.0M
impressions/reach

Risk & Protective Factors

- High Rates of Depression/Sadness
- High Rates of Suicidal Thoughts
- Low Awareness and/or Knowledge

> *"Over the past year, one of our accomplishments was to go into underserved communities and discuss the importance of reducing stigma often attached to suicide prevention."*
> – Fairfax-Falls Church CSB

Activate Your Wellness messaging implemented throughout the community by Chesterfield CSB

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Adverse Childhood Experiences (ACEs) Trainings

37 CSBs reported providing 370 ACE Interface trainings to their communities to increase awareness about the impacts of adverse childhood experiences on health outcomes.

Experiencing a higher number of ACEs has been associated with several adverse health outcomes, including increased likelihood of substance use, mental health concerns, and chronic disease such as cancer, diabetes, and heart disease.[14] The ACE Interface curriculum is designed to educate community members from all backgrounds about the range of impacts resulting from traumatic childhood events while promoting strategies that support individual and community health and well-being.

The number of trainings delivered across Virginia increased slightly compared to last fiscal year while the overall number of attendees decreased. Community awareness around ACEs in the larger population continues to grow, resulting in a smaller pool of trainees seeking introductory ACEs training. Despite high saturation, CSBs continue to identify and reach new allies with their ACEs-focused efforts, including those less often engaged in these conversations such as school bus drivers and school nutrition staff.

Alleghany-Highlands Community Services was successful in developing a partnership in their community that will require ACEs trainings for all Mobile Crisis Responders in their area. Since the beginning of the current 5-year SUPTRS Block Grant cycle, over 37,400 Virginians have participated in a CSB-delivered ACE Interface training.

37
CSBs held ACEs trainings

370
trainings/ presentations

5,020
people trained

Risk & Protective Factors

- High Rates of Depression/Sadness
- Low Perception of Risk of Use
- Early Onset of Use

> *"ACEs trainings continue to be the training that our community members and partners did not know how much they needed… ACEs continues to be the backbone of preventative influence in making positive personal and societal change and we feel it is the core of our prevention work."*
> – Western Tidewater CSB

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CSBs and communities are working together to combat ACEs by developing trauma-informed care networks and building individual and community-level resiliency.

As more and more community members build awareness of the impact of ACEs, attention has turned towards identifying and implementing strategies that support community members – particularly youth – in building resiliency. Region Ten's Trauma Informed Care Network (TICN) partnered with a local art project, Bridge Progressive Arts Initiative, as well as local school groups including Men of Color, Honor and Ambition/Women of Color, Honor and Ambition (MOCHA/WOCHA), Black Girls Gather, and a therapeutic mentoring group, on a mural project. "After learning about ACEs and resilience," staff shared, "the youth were given the opportunity to apply what they learned to their own lives to determine what resilience means to them and incorporate those ideas into a creative mural project guided by a professional artist and resident in counseling."

The ACEs Post-Training Evaluation Survey highlights learning outcomes.

Available in both English and Spanish, the ACEs Post-Training Evaluation Survey, offered through the Qualtrics platform to measure training outcomes, was successfully completed by 1,624 participants across 148 trainings. While ensuring that participants complete the evaluation continues to remain a challenge across CSBs, engagement has increased with 32% of ACEs training participants competing the survey this fiscal year compared to 28% last year. Through the survey, participants shared their insights on ACEs, how they impact daily interactions, and how they will use their learnings in their work and daily interactions. The data below includes trainings funded entirely or in part by Block Grant.

84% agreed or strongly agreed that they **want to seek more information** and guidance regarding trauma-informed practice.

83% indicated they *learned* **a lot about identifying and addressing ACEs and ACEs'** impact on brains and behavior.

80% agreed or strongly agreed that they **want to learn more** about the causes and effects of ACEs.

77% indicated they *learned* **a lot about why their community needs to get organized** and mobilized to identify and address ACEs.

ACEs training participants are increasingly demonstrating their intended learning outcomes.

Outcomes across all domains improved at least three percentage points this fiscal year when compared to last year. Training participants' desire to seek more information and guidance regarding trauma-informed practices saw the highest increases, with 84% of participants indicating a desire for further learning this year compared to 78% last year.

> *"As a result of this training, I will be more mindful about connecting current behaviors in clients and community to possible ACEs."*
> – ACEs training participant

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Counter Tools Youth Retail Tobacco Prevention and Merchant Education

Building on existing relationships with retailers, merchant education efforts are expanding to address additional priority areas.

36 CSBs reported hundreds of hours spent by prevention staff, coalition members and community members visiting tobacco and nicotine retailers in their communities this fiscal year. This includes gas stations and convenience stores, but also grocery stores, vape shops and bars. With so many retail locations across the Commonwealth, CSBs have a two-year period in which to visit every tobacco and nicotine retailer in their catchment area.

The 2023-24 fiscal year was the second year in the most recent two-year cycle. Due to the length of time allowed to complete retailer visits, three CSBs had previously completed their visits in the prior fiscal year. This year alone, CSBs conducted merchant education visits at 63% of the available retailers in Virginia. Given the time-intensive nature of completing retailer visits, particularly across large catchment areas, CSBs have also exercised creativity in boosting staff capacity. Colonial CSB has been partnering with a local Office of Community Engagement to hire an intern to assist visits while others have mobilized their youth coalition and leadership team members.

36
CSBs conducted retailer visits

4,157
merchants visited

Risk & Protective Factors

- Ease of Access
- Early Onset of Use

> *"Many of the stores were thankful for the materials provided... Getting to meet local business owners while doing the project was fascinating and helpful when they were willing to tell us about their thoughts on prevention, risk, and resiliency."*
>
> – Goochland-Powhatan CSB

Recognizing that many of these locations also sell alcohol, cannabis, and offer gambling opportunities, over one-quarter of CSBs (28%) have re-imagined their merchant education efforts to address these areas as well.

Expanded merchant education offerings realize the efficiency of capitalizing on existing opportunities to engage with retailers in person. Information is provided on relevant legal requirements of retailers, the risks associated with use, and tips on how to minimize the marketing exposure to underage youth, such as placement of advertisements.

Partnering with Counter Tools provides CSBs with detailed information on the retailers in their communities, allowing CSBs to prioritize their resources effectively and track their visits. While the system has historically been used to track tobacco related merchant education visits, it was expanded this fiscal year to also allow CSBs to track merchant education visits related to alcohol and gambling in Virginia.

CSBs are implementing a broad range of strategies to address underage use.

Some CSBs, like Rappahannock Area, have noticed an increase in tobacco and vape retailers in their area, as well as CBD and cannabis shops - not all of whom have welcomed merchant education visits. As such, CSBs are ensuring that their efforts are also serving to educate youth directly. Tobacco education strategies implemented this fiscal year included partnerships with high schools to provide educational materials and presentations to students and their caregivers and working with law enforcement to complete extra compliance checks.

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Youth Cannabis Prevention

DBHDS

Cannabis-focused prevention activities have increased significantly in scope and reach.

CSBs have demonstrated increased capacity for engaging in cannabis-focused prevention efforts, with 26 CSBs reporting on strategies in this area this fiscal year compared to 11 in the previous fiscal year. 16 cannabis prevention media campaigns were implemented this fiscal year to disseminate messaging about the risks of cannabis use utilizing social media, radio, or TV Public Service Announcements (PSAs), and other forms of media campaigns to reach twice as many Virginians as in the previous year (1.4M).

Four CSBs implemented Unfazed – a media campaign focused on educating youth about the impacts and risks of using cannabis. Developed by the Virginia Foundation for Healthy Youth, and implemented in partnership with OBHW and CSBs, **Unfazed messaging distributed by CSBs reached 8,602 Virginians** in 2023-24.

This fiscal year, Chesapeake Integrated Behavioral Healthcare implemented Johnny's Ambassadors, a presentation program designed to raise awareness among youth and adults about cannabis and its effects. The presentations aimed to equip adults and parents with tools to discuss youth cannabis use and educate the youth in their lives about the impacts on adolescent well-being and development. The trainings reached 2,270 youth and 46 adults.

CSBs continue to navigate the complexities of Virginia's cannabis laws along with the community's perceptions of cannabis use.

Although adults in Virginia can legally possess cannabis by storing it at home and carrying up to one ounce in public, retail sales of recreational cannabis are not yet a reality. As a result, adults can only legally obtain cannabis through medical dispensaries or by growing up to four plants at home.[15]

CSBs have reported significant challenges with cannabis prevention due to increased access following legalization and widespread confusion regarding the legal status of recreational use and sales. Efforts to inform parents and youth about the risks of cannabis have been met with resistance from the community, including negative reactions on social media. With the legalization of cannabis and home cultivation in Virginia, youth access has become a growing concern. With no dedicated funding to address cannabis prevention, CSBs have needed to be resourceful in utilizing multiple funding streams and relying on shared risk and protective factors. Despite these obstacles, CSBs continue working to provide prevention and mental health resources, though the lack of legal regulation, community trust, and cultural acceptance remain major hurdles.

26
CSBs implemented cannabis prevention

2.8M
people reached through media campaigns

Messaging shared via social media by Middle Peninsula-Newport News CSB

> *"Virginia Beach partners with Virginia Beach Public Schools to offer the Substance Abuse Intervention Program (SAIP), a ten-day instructional program designed for students who are first-time violators of the School Board policies regarding drug and alcohol use and abuse. Marijuana possession and/or use continues to be the number one cause of students entering the program."*
>
> – Virginia Beach Department of Human Services

Risk & Protective Factors

- Early Onset of Use
- Perceived Risk/Harm
- Increase Knowledge/Awareness
- Perceptions of Parental Approval/ Disapproval

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Problem Gambling Prevention

Virginia CSBs are at the forefront of problem gambling prevention work, actively building capacity and focusing on tailored messaging to educate their communities and raise awareness.

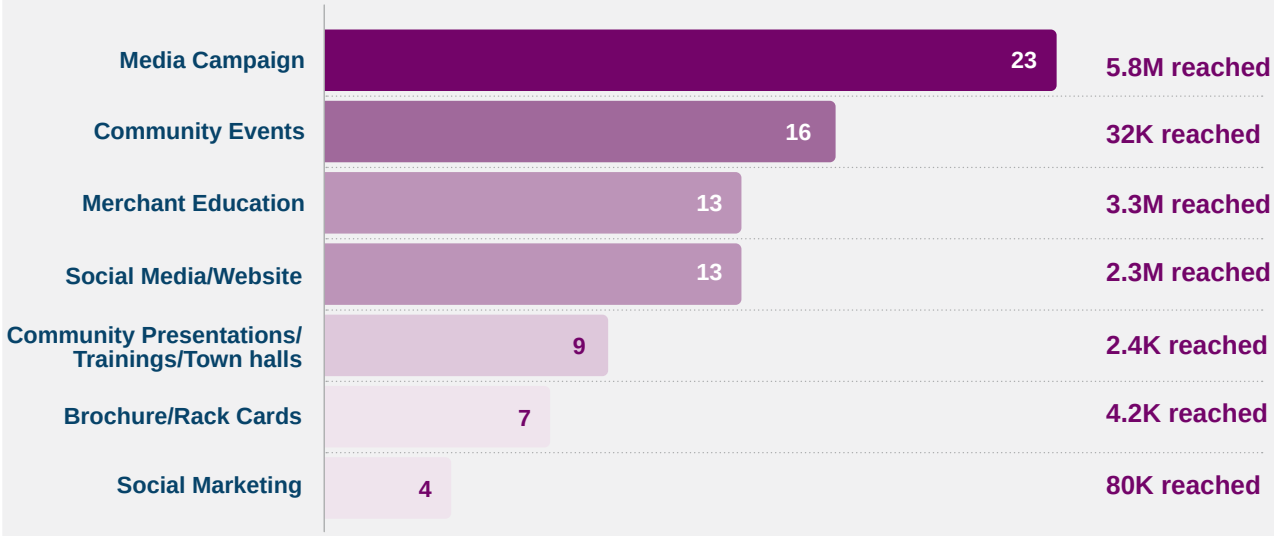
31
CSBs implemented problem gambling strategies

10.5M
people reached

In the 2023-24 fiscal year, 31 CSBs continued to track and report their prevention strategies and programs using funds from the Problem Gambling Treatment and Support Fund established in 2020. This fund, utilizing gambling operator tax dollars, provides ongoing funding to support Virginia's gambling prevention, treatment, and recovery efforts. An additional eight CSBs received funding to support problem gambling prevention efforts to grow their knowledge, capacity and planning activities. Those receiving funding submitted Problem Gambling Quarterly Reports allowing for comprehensive tracking of CSB efforts across the Commonwealth.

While some CSBs are currently investing resources primarily in building internal and coalition capacity to address problem gambling, others have moved towards implementing strategies within their communities. Strategies implemented this fiscal year that included a direct focus on problem gambling included information dissemination, merchant education, and community presentations. CSBs relied on a combination of media formats to reach their communities, including printed materials like brochures, rack cards, and resource guides; larger marketing opportunities with billboards, bus ads, and PSAs; and in-person messaging with community presentations, tabling at community events, town halls, and schools. Many also worked to build capacity via strengthening and building partnerships, educating coalition members, and attending national conferences.

Count of CSBs implementing specific problem gambling strategies and their reach



Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Problem gambling funding has allowed CSBs to incorporate problem gambling prevention into existing efforts as well as build new programs.

As gathered in the Problem Gambling Quarterly Report, CSBs reported multiple successful efforts to increase awareness in their communities:

- Blue Ridge Behavioral Healthcare developed www.PreventProblemGambling.org, to raise problem gambling awareness, including on the signs of problem gambling and connect people to the problem gambling national hotline and resources.
- Fairfax-Falls Church CSB and Loudoun CSB created media campaigns directing the audience to the Virginia Problem Gambling website www.vcpg.net during a traditionally heavy sports betting season around the Super Bowl and NCAA tournament in January through March 2024. This effort resulted in over 4.2 million ad impressions and over 8,000 ad clicks.
- Henrico CSB also implemented a similar media campaign tailored to sports betting with a "March Madness Problem Gambling Awareness PSA on TV and streaming media… Through targeting sports fans across 18 zip codes, there were 50,604 impressions of the ad with 12,705 households being reached. Our TV campaign total resulted in 174,016 impressions reaching over 72,000 people in our catchment."

> *"We also worked to increase awareness and understanding of problem gambling with service providers by hosting a virtual workshop in March entitled Hidden Addiction: Recognizing and Treating Problem Gambling as a Co-Occurring Disorder. The workshop was followed up with information on becoming a Virginia PG Treatment provider through VPGH."*
> – Horizon CSB

Taking an environmental approach to addressing problem gambling in their communities, 13 CSBs conducted 1,326 visits to provide merchant education to local gambling retailers, educating them on laws related to gaming and gambling product sales and retailers' responsibilities for upholding those laws. This included placement of gaming and gambling machines and advertisements that may be appealing to youth. One goal of merchant education is to limit the sales, and hence the participation, of gambling for underage youth, such as their purchasing lottery scratch off tickets.

CSBs have been proactive in building internal and community-level capacity to engage in problem gaming and gambling prevention efforts by building partnerships, expanding the number of implemented strategies, educating community members, and increasing messaging efforts.

Using key data provided by the Young Adult Survey, the NCPG/NGAGE survey, qualitative data via focus groups and in-person interactions, and conversations during monthly Problem Gambling meetings hosted by OBHW ensures that efforts are data-driven and meet the needs of diverse communities. This comprehensive data collection approach instills confidence in the effectiveness of prevention strategies.

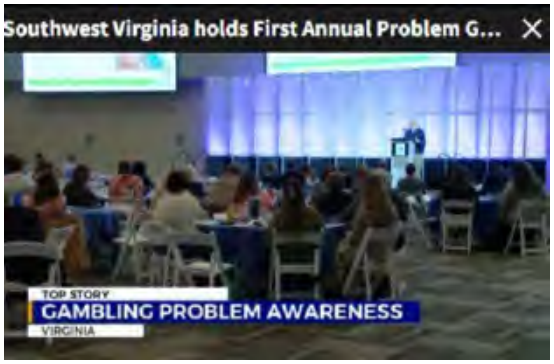
Anne Rogers, the Responsible Gambling Coordinator from DBHDS, speaking at the National Conference on Gambling Addiction and Responsible Gambling

In the last Problem Gambling Quarterly Report, out of the 39 CSBs, 51% reported that they had worked to build new partnerships with others to prevent problem gambling. CSBs have joined forces and created collaborative efforts to engage their shared communities and ease the burden of working in isolation, potentially duplicating efforts. Piedmont CSB, Southside CSB, and Danville-Pittsylvania CSB meet monthly for the Southern Virginia Problem Gambling Collaborative as a capacity-building initiative, "We will begin to invite community members and other stakeholders to quarterly meetings in July (2024). We have created a Facebook page to help educate the public on problem gambling and how to get needed help and resources." Additionally, CSBs are invited to participate in the monthly Problem Gambling Prevention meetings coordinated by Anne Rogers from DBHDS. These are spaces for capacity building, resource sharing, and news on partnership developments and collaborations.

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

This year, many CSBs attended the NCPG Conference on Gambling Addiction and Responsible Gaming, which catalyzed the first Annual Problem Gambling Prevention Conference in Virgnia.

Hosted by the Region III West Wellness Council, a collaboration of five CSBs, this conference was a testament to the collective effort and commitment of CSBs in tackling problem gambling. Held in March 2024, the inaugural conference attracted more than 100 community members. The theme of the conference was 'Help, Hope, and Healing.' The all-day event included various speakers, and the conference allowed attendees and some CSB staff to learn from experts in the field. The collaborative nature of the conference underscores the inclusivity and shared responsibility in addressing problem gambling, making participants feel part of the collective effort.



WJHL-TV News Channel 11 covered the first Problem Gambling Prevention Conference in the Southwest Virginia Region

CSBs utilized media campaigns, presentations, and trainings to educate communities on problem gaming and gambling.

CSBs shared information about problem gambling and gambling in their communities through various means, including brochures, resource guides, TV and radio ads, billboards, presentations, and community events. CSBs shared instances of connection with community members at events, learning more about the personal and family impacts problem gambling challenges. These moments have allowed CSBs to have meaningful conversations, share resources, and raise awareness.

> *"The Hampton-Newport News CSB Prevention Youth Summit provided for the first time education and awareness for youth to address Problem Gaming and Gambling. The youth had an opportunity to address what are the risk they see with Problem Gaming and Gambling as well as identifying resources they felt the community could provide to increase proactive factors surrounding problem gaming and gambling."*
>
> – Hampton-Newport News CSB

Direct education with youth has grown since the previous year with presentations and curricula like Kids Don't Gamble Wanna Bet and Youth Making Choices.

Risk & Protective Factors

- Early Onset of Use
- Low Awareness and/or Readiness
- Low Perception of Risk

With the increasing popularity and availability of sports betting, CSBs are tailoring their outreach and messaging to combat the influence of betting in the lives of children in grades 3-12. Loudoun CSB reported their staff provided "…PGP [Kids Don't Gamble Wanna Bet] evidence-based programming to 142 youth grades 3-12 in Prevention after school programming for high-risk youth. Pre and post-tests were conducted to measure learning. The elementary level increased or maintained knowledge by 94%. The middle and high school level increased or maintained knowledge by 100%." Taking a more holistic approach to problem gambling prevention, Prince William CSB strategically partnered with a financial education organization to conduct workshops to help educate their community about the links between financial literacy and problem gambling, demonstrating the strength of partnerships in addressing community issues.

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Prevention Outcomes

CSBs across the Commonwealth of Virginia continue to target focus areas related to alcohol, tobacco, and mental health/suicide as outlined in the 2020-2025 Statewide Logic Model. In targeting these areas, CSBs have continued to be dedicated to the implementation and execution of strategies to increase overall protective factors related to substance use and mental health.

Over the course of each year, CSBs reflect on the progress towards intermediate and long-term outcomes. This reflection not only provides prevention staff the opportunity to carefully observe how their communities have responded to various prevention efforts, but it also encourages staff to anticipate needs or changes as a result. The following are the desired long-term outcomes at the state level, accompanied by the most recent data from 2021-23 and a comparison with data from 2018-19 pertaining to these outcomes.

Alcohol

Desired Outcomes	Current Indicators	Change from Baseline
↓ Decrease in youth alcohol use	**15.8%** of VA high school youth reported drinking alcohol in the past 30 days (VYS, 2023)[3]	↓ Decrease from **25.4%** in 2019[1]
↓ Decrease in young adult binge drinking	**31.6%** of VA young adults (ages 18-25) reported binge drinking in the past month (NSDUH, 2021-22)[16]	↓ Decrease from **36.7%** in 2018-19[2]

Tobacco/Nicotine

Desired Outcomes	Current Indicators	Change from Baseline
↓ Decrease in youth tobacco/nicotine use	**2.0%** of VA high school youth reported smoking cigarettes in the past 30 days (VYS, 2023)[3]	↓ Decrease from **5.5%** in 2019[1]
	8.1% of VA high school youth reported using a vaping product in the last 30 days (VYS, 2023)[3]	↓ Decrease from **19.9%** in 2019[1]
↓ Decrease in adult tobacco/nicotine use	**12.1%** of VA adults (ages 18+) reported cigarette use in the past month (NSDUH, 2021-22)[16]	↓ Decrease from **14.0%** in 2018-19[2]

Mental Health/Suicide		
Desired Outcomes	Current Indicators	Change from Baseline
↓ Decrease in youth suicide attempts	**7.7%** of VA high school youth have attempted suicide in the past year (VYS, 2023)[3]	↑ Increase from **7.0%** in 2019[1]
↓ Decrease in youth death by suicide	**17.2 per 100,000** youth and young adults (ages 15-24) died by suicide in VA[17]	↑ Increase from a rate of **14.3 per 100,000** in 2019[18]
↓ Decrease in adult death by suicide	**13.7 per 100,000** adults (ages 18+) died by suicide in VA[17]	↑ Increase from a rate of **13.3 per 100,000** in 2019[18]

All state-level alcohol and tobacco-related outcomes for this fiscal year have demonstrated positive changes with decreases in use behaviors.

Among the mental health/suicide-related outcomes, all three outcomes have shown increases in prevalence, meaning more Virginians are experiencing mental health challenges than in 2019.

Several factors may have led to the increased rates of suicide among youth, young adults, and adults. An increase in societal and cultural shifts, paired with political uncertainty and the continued recovery from the COVID-19 pandemic may all contribute to the current state of mental health challenges in Virginia, and across the nation. These continued trends are indicative of a need for more targeted strategy implementations and resources surrounding mental health and suicide, as well as an investment in strengthening protective factors to support communities.

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Sustainability

Continuing their collaborative efforts, 35 CSBs worked on developing a partnership structure that will continue to function into the future.

In the 2023-24 fiscal year, 40 CSBs reported their commitment to ensuring the sustainability of prevention activities and outcomes within their communities.[19] CSBs reported implementing a similar number of sustainability-building activities this year, with 141 activities compared to 146 in the previous year. The number of activities focused on sustainability is trending downward over the last several years. These continued decreases may indicate that CSBs have successfully completed or advanced efforts in several key areas, thereby requiring fewer activities to maintain progress. As sustainability initiatives mature, the focus often shifts from establishing new activities to refining and sustaining existing efforts, which can naturally result in a decrease in the total number of activities while still maintaining or enhancing impact.

35 CSBs worked to develop a partnership structure that will continue to function into the future.

31 CSBs worked to ensure prevention strategy activities are incorporated into the missions/ goals and activities of other organizations.

23 CSBs worked to gain formal adoption of prevention strategy activities into other organizations practices.

22 CSBs worked to ensure that prevention staff positions are folded into other organizations.

19 CSBs redirected, restructured, or utilized other funding sources or in-kind resources.

8 CSBs worked to implement local-level laws, policies, or regulations to guarantee the continuation of prevention strategy activities or outcomes.

Three CSBs reported that they undertook additional approaches to enhance their sustainability efforts. One CSB advocated for a full-time Prevention Specialist, while another pursued sustainable funding opportunities within their CSB. A third CSB submitted an application for the Drug-Free Communities Grant for expanded funding.

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Appendix B: Prevention Logic Model

	PROBLEM	TARGETED RISK FACTORS	STRATEGIES	IMPACT
ALCOHOL	1 in 4 VA high school youth report drinking alcohol in the past 30 days (VYS, 2017) 1 in 3 VA young adults report binge drinking in the last month (NSDUH, 2018)	**LOW PERCEPTION OFRISK OF USE** **EARLY ONSET OF USE**	**COALITION DEVELOPMENT** Bringing together community leaders and stakeholders for collective action **ACES TRAININGS** Understanding the impacts of adverse childhood experiences	**DECREASE IN YOUTH ALCOHOL USE** **DECREASE IN YOUNG ADULT BINGE DRINKING**
TOBACCO/NICOTINE	1 in 6 VA adults report smoking cigarettes (BRFSS, 2017) 1 in 15 VA high school youth report smoking cigarettes currently, while 1 in 9 report currently using a vaping product (VYS, 2017)	**LOW PERCEPTION OF RISK OF USE** **EARLY ONSET OF USE**	**COALITION DEVELOPMENT** Bringing together community leaders and stakeholders for collective action **COUNTER TOOLS** Developing responsible retailer practices **ACES TRAININGS** Understanding the impacts of adverse childhood experiences	**DECREASE IN YOUTH TOBACCO/ NICOTINE USE** **DECREASE IN ADULT TOBACCO/ NICOTINE USE**
MENTAL HEALTH/SUICIDE	1 in 14 VA high school youth have attempted suicide in the past year (VYS, 2017) 9.9 out of 100,000 youth ages 15-19 died by suicide in VA in 2019 (America's Health Rankings, 2019) 13.8 out of 100,000 adults died by suicide in VA in 2019 (America's Health Rankings, 2019)	**HIGH RATES OF DEPRESSION/ SADNESS** **HIGH RATES OF SUICIDAL THOUGHTS**	**SUICIDE PREVENTION TRAININGS** Recognizing and addressing signs of suicide **COALITION DEVELOPMENT** Bringing together community leaders and stakeholders for collective action **ACES TRAININGS** Understanding the impacts of adverse childhood experiences **LOCK AND TALK** Suicide prevention through lethal means restriction	**DECREASE IN YOUTH SUICIDE ATTEMPTS** **DECREASE IN YOUTH DEATHS BY SUICIDE** **DECREASE IN ADULT DEATHS BY SUICIDE**

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The State of Behavioral Health and Wellness in Virginia

2024 Prevention Needs Assessment Findings

The State of Behavioral Health and Wellness in Virginia

2024 Prevention Needs Assessment Findings

Submitted to:

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August 2024

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Acknowledgments:

The OMNI Institute wants to thank OBHW staff and CSB Prevention staff for their contributions to the creation of this report.

Suggested Citation:

The OMNI Institute (2024). The State of Behavioral Health and Wellness in Virginia: 2024 Statewide Needs Assessment Findings. Submitted to the Department of Behavioral Health and Developmental Services Office of Behavioral Health Wellness, Richmond, VA.

Table of Contents

Executive Summary 4
Introduction 14
Literature Review 17
- Background 17
- Shared Risk and Protective Factor Overview 19
- Framework and Models 23
- State Profiles 29

Qualitative Data Collection 42
- Community Alignment with State Priorities 42
- Prevention Approach 44
- Risk & Protective Factors Driving Behavioral Health Outcomes 44
- Priority Populations 47
- Community Partnerships & Coalitions 47
- CSB Capacity Challenges 49
- Capacity Building Needs 52

Data Snapshots 54
- Focus Area: Alcohol 54
- Focus Area: Tobacco and Vapor Products 61
- Focus Area: Opioids 65
- Focus Area: Fentanyl 68
- Focus Area: Cannabis 70
- Focus Area: Heroin 73
- Focus Area: Cocaine 76
- Focus Area: Methamphetamine 78
- Focus Area: Hallucinogen 80
- Focus Area: Over the Counter (OTC) Medications 81
- Focus Area: Problem Gaming and Gambling 82
- Focus Area: Suicide and Mental Health 85

Risk and Protective Factors: Adverse Childhood Experiences (ACEs) 93
Risk and Protective Factors: Active Parenting and Parental Involvement 97
Risk and Protective Factors: Healthy Coping Skills, Emotional Regulation and Resiliency 98
Risk and Protective Factors: Prosocial and Extracurricular Involvement 99
Risk and Protective Factors: Self-Esteem 100
Risk and Protective Factors: Social Isolation and Social Supports 101
Mentors 103
Conclusion 104
Reference List 106
Appendix A: Risk & Protective Factor Research Overview 116

Executive Summary

The Office of Behavioral Health Wellness (OBHW), located within the Virginia Department of Behavioral Health and Developmental Services (DBHDS), contracted with OMNI Institute in July 2023 to complete a statewide needs assessment focused on various prevention and behavioral health-related topics, setting the foundation for the launch of a strategic planning process focused on identifying priorities for the prevention and behavioral health landscape in Virginia for 2025-2030.

Priority areas for the previous 2020-25 Substance Use Block Grant (SUBG) cycle were alcohol, tobacco, and suicide prevention with six accompanying strategies.

The 2020-25 Virginia Substance Use Block Grant Logic Model

	Problem	Targeted Risk Factors	Strategies	Impact
Alcohol	1 in 4 VA high school youth report drinking alcohol in the past 30 days (VYS, 2017)	Low perception of risk use Early onset of use	**Coalition Development** Bringing together community leaders and stakeholders for collective action **ACES Trainings** Understanding the impacts of adverse childhood experiences	Decrease in youth alcohol use Decrease in young adult binge drinking
Tobacco/Nicotine	1 in 6 VA adults report smoking cigarettes (BRFSS, 2017) 1 in 15 VA high school youth report smoking cigarettes currently, while 1 in 9 report currently using a vaping product. (VYS, 2017).	Low perception of risk use Early onset of use	**Coalition Development** Bringing together community leaders and stakeholders for collective action **Counter Tools** Developing responsible retailer practices **ACES Trainings** Undestanding the impacts of adverse childhood experiences	Decrease in youth tobacco/nicotine use Decrease in young adult tobacco/ nicotine use
Mental Health/Suicide	1 in 14 VA high school youth have attempted suicide in the past year (VYS, 2017) 9.9 out of 100,000 youth ages 15-19 died by suicide in VA in 2019 (America's Health Rankings, 2019) 13.8 out of 100,000 adults died by suicide in VA in 2019. (America's Health Rankings, 2019)	High rates of depression/ sadness High rates of suicidal thoughts	**Mental Health First Aid and Suicide Prevention Trainings** Recognizing and addressing signs of suicide **Coalition Development** Bringing together community leaders and stakeholders for collective action **ACES Trainings** Undestanding the impacts of adverse childhood experiences **Lock and Talk** Suicide prevention through lethal means safety	Decrease in youth suicide attempts Decrease in youth death by suicide Decrease in adult deaths by suicide

2024 Needs Assessment Process

Throughout the 2020-25 cycle, the prevention workforce experienced challenges resulting primarily from the need to address an ever-growing list of substances and issue areas. The additions of emerging statewide priorities, including over-the-counter medication misuse, cannabis, and problem gaming and gambling, placed significant strain on local prevention capacity, as the workforce was repeatedly called on to build content-area expertise around these new topic areas and add additional strategies to their current prevention programs, all the while continuing to address existing priorities. Reflecting these challenges, the 2023-24 needs assessment encompassed a broader goal for setting prevention and behavioral health program priorities for 2025-2030: to examine leading prevention frameworks and approaches of other states to identify opportunities for a more streamlined statewide prevention approach in Virginia.

The needs assessment is comprised of three core components:

LITERATURE REVIEW

A review of the current literature, highlighting leading prevention frameworks and models that consider the interconnectedness of behavioral health outcomes, examining how five different states designed their prevention systems to incorporate a focus on shared risk and protective factors, and exploring specific prevention strategies that could be implemented in Virginia to support the creation of thriving, resilient communities.

FOCUS GROUP FINDINGS

An overview of findings from primary data collection efforts (focus groups), which were conducted to gather perspectives from both the direct prevention workforce within Virginia's Community Services Boards and staff from OBHW, who oversee efforts at a state level.

DATA SNAPSHOTS

A summary of the most recently available secondary data on substance use, mental health, and problem gambling across Virginia.

The report further summarizes recommendations and potential next steps for OBHW to consider as it moves into strategic planning in the fall of 2024.

Literature Review

Risk and Protective Factors

Risk and protective factors are integral to understanding how individual and collective experiences determine behavioral health outcomes. Risk factors refer to a variety of biological, psychological, family, community, and/or cultural characteristics associated with a higher likelihood of negative outcomes. Protective factors, conversely, are those characteristics – on those same levels – that lower the likelihood of negative behavioral health outcomes in an individual's life.

Rather than addressing individual substances or issue areas in isolation, a shared risk and protective factor approach prioritizes the underlying factors contributing to both substance use and mental health challenges. This method allows for a more comprehensive assessment of risk, prioritization of key populations, and expansion of initiatives that strengthen protective factors.

Virginia's current strategic plan already integrates several priority strategies aligned with this approach, including ACEs Interface trainings, Mental Health First Aid, and Lock and Talk. Expanding these efforts with additional initiatives prioritizing shared risk and protective factors would create a more cohesive and streamlined strategy, reducing information overload for CSBs and reinforcing a whole-person approach to behavioral health. A stronger emphasis on protective factors can also help CSBs navigate the stigma that may hinder community participation in substance use prevention programs while enabling them to invest more resources in community-facing initiatives.

By shifting prevention efforts further upstream, this approach strengthens protective factors and reduces risk factors, decreasing the likelihood that individuals turn to substance use in response to adversity. To further enhance prevention and behavioral health efforts in Virginia from 2025 to 2030, OBHW may consider incorporating or expanding the following additional strategies:

Active Parenting and Parental Involvement

Evidence-based parenting programs have been implemented by numerous CSBs throughout the last five-year SUBG cycle but are not a component of the current statewide priorities. Expanding the availability of resources to support the implementation of parent education and family management programs may help build stronger, healthier, and more resilient families in Virginia and expand pathways through which resources can be directly provided to community members.

Healthy Coping Skills, Emotional Regulation and Resiliency

Virginia's current SUBG model includes suicide prevention strategies that provide information to participants on how to identify and support individuals in distress but does not include strategies that support individuals in building these skills to support their own well-being. These strategies have become an increasing focus of CSBs engaging in trauma-informed work in their communities, with CSBs distributing resource kits and hosting workshops focused on building skills to cope with stress and trauma.

Prosocial and Extracurricular Involvement

Despite the lack of inclusion of these types of strategies in current state priorities, many CSBs have utilized available funding to create programs that allow for meaningful connections among youth. Youth education and alternative strategies such as Sources of Strength and summer camps have been implemented by many CSBs over the last five years and offer an opportunity to engage in institutional learning and possible expansion.

Self-Esteem

While initiativesthat have a goal of supporting individuals in building self-esteem are not currently found within the state's strategic plan, some CSBs are utilizing a portion of their SUBG funds to implement such efforts. Programs such as youth leadership and mentor programs serve to develop self-esteem among youth participants, while some programs focused on supporting parents can help build self-esteem among parents.

Social Isolation and Social Supports

Explicitly centering the risks of social isolation and the power of connection and social support in improving behavioral health outcomes would establish rationale for expansion of the LUV campaign and for increasing the resources available to CSBs to implement strategies focused on building connection and social support in their communities.

Mentors

Youth-adult leadership and mentorship programs are strong pillars of many CSB prevention efforts and create opportunities for increasing youth engagement in coalition efforts.

The following table provides an overview of key shared risk and protective factors where established research is available that illustrates the relationship between these factors and multiple substance use and behavioral health outcomes. The lack of a relationship does not indicate that a risk or protective factor is not relevant for a given issue area, rather that research is either limited in strength or in clarity (i.e. recent research does not demonstrate consistent and clear impact).

	●	●	●	●	●	●	●	●	●
ACEs	✓	✓	✓	✓	✓	✓	✓	✓	✓
Active Parenting and Parental Involvement	✓	✓	✓	✓	✓				✓
Ease of Access		✓	✓	✓	✓		✓		
Healthy Coping Skills, Emotional Regulation, and Resilience	✓	✓	✓	✓	✓	✓		✓	
High Self-Esteem		✓			✓	✓		✓	
Parental Approval, Disapproval, and Use		✓	✓	✓			✓	✓	✓
Peer Approval, Disapproval, and Use		✓	✓	✓			✓		✓
Perceptions of Risk		✓	✓	✓		✓		✓	
Prosocial and Extra-Curricular Involvement	✓	✓			✓	✓			
Social Isolation	✓	✓	✓		✓	✓			
Social Supports	✓	✓	✓		✓	✓	✓	✓	
Trusted Adults, Peers, and Mentors	✓	✓	✓		✓			✓	✓

- ● General impact on substance use outcomes
- ● Alcohol
- ● Cannabis
- ● Gambling
- ● Mental Health & Suicide
- ● Opioids
- ● Stimulants
- ● Tobacco
- ● Vaping

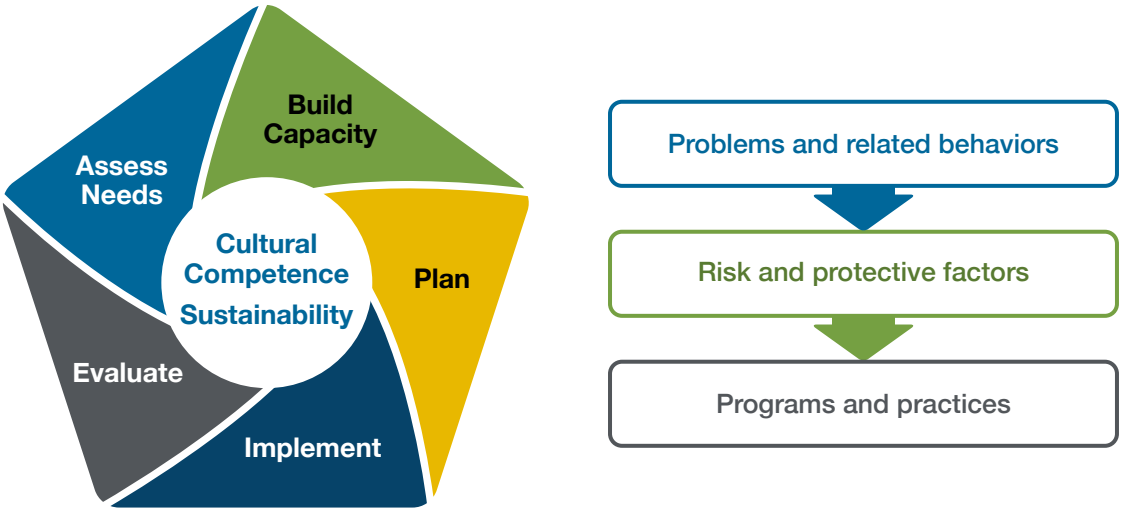
Detailed descriptions of each risk and protective factor and how each has been targeted in Virginia's prevention program to date can be found in the main report. An overview of relevant research can be found in Appendix A.

Frameworks and Models

A variety of frameworks and models exist that offer unique perspectives on how to think about the drivers of health outcomes and how best to approach the design of meaningful interventions. Currently, Virginia relies on two models to guide their prevention approach, including:

The Strategic Prevention Framework (SPF)

SPF's primary utility is in its conceptualization of a continuous cycle of activities that allow for the development of appropriate, effective, and well-planned interventions, while highlighting the need to engage in a continuous cycle of assessment, capacity building, planning, implementation, and evaluation.



CADCA's Seven Strategies for Community Change

CADCA highlights 7 strategies coalitions can adopt to create meaningful community-level change, with each method representing a key element for building and maintaining a healthy community. The model separates strategies into individual and environmental efforts, acknowledging the impact of individual- and environment-level factors in determining behavioral health outcomes, while highlighting the importance of information dissemination programs, skill-building programs, and programs that increase support networks as key strategies for creating individual-level change.

CADCA'S Seven Strategies for Community Changes

1	Providing information	INDIVIDUAL
2	Enhancing Skills	
3	Providing Support	
4	Enhancing Access/Reducing Barriers	ENVIRONMENTAL
5	Changing Consequences	
6	Physical Design	
7	Modifying/Changing Policies	

Additional Models and Frameworks

It is recommended that OBHW integrate additional prevention frameworks that center risk and protective factors to create greater alignment with the findings of this needs assessment and emerging trends in the field. Breaking down substance- and problem-specific siloes and prioritizing efforts that more broadly, but no less meaningfully, address behavioral health and wellness can create a stronger, more well-rounded approach to prevention. Several additional models that consider the interconnectedness of behavioral health outcomes while focusing on key risk and protective factors include:

The Socio-Ecological Model (SEM)

SEM illustrates the different ways people's circumstances, relationships, and environments affect their behaviors by organizing risk and protective factors into different levels, from the micro, individual level, up to the macro, society level. By breaking down risk and protective factors into their socio-ecological sections, agencies can better understand the role they play in shaping outcomes and how to create a broad yet targeted prevention program that address drivers of behavioral health outcomes from a variety of angles that are mutually reinforcing. The SEM is being operationalized as an organizational framework in multiple states that are taking a shared risk and protective factor approach to prevention and can support the selection of mutually re-enforcing priority areas and strategies at multiple levels of intervention.

Resiliency Theory

Geared toward youth, Resiliency Theory provides a conceptual framework for considering a strengths-based approach to understanding child and adolescent development and informing intervention design by focusing on identifying the strengths and assets of youth that can keep them away from problem behavior and external factors and resources that provide youth with opportunities to learn and practice skills, such as parental support, adult mentors, and youth programs. While less salient across state-prevention programs than the SEM, Resliency Theory offers a framework for prioritizing protective factors and centers several key shared risk and protective factors.

State Profiles

As a part of the literature review, state profiles were developed to better understand how and which states were already utilizing a risk and protective factor approach in their prevention systems. States were selected based on existing familiarity with their prevention frameworks, information shared by state prevention leaders at the National Prevention Network conference in 2023, and availability of strategic plans or similar information on state agency websites. The selection process also considered relevant indicator data related to prevalence rates, selecting states that are similarly positioned to Virginia. This creates an opportunity for improved monitoring and allows for a better understanding of the impact of a shared risk and protective factor approach, including how long it takes to see an impact from these types of interventions. Selected states include Arizona, Colorado, Ohio, Oregon, and Utah.

	Measure		Arizona	Colorado	Ohio	Oregon	Utah	Virginia
Alcohol	Use in the Past Month	2021-2022	**50.3%** [46.2, 54.3]	**59.4%** [56.2, 62.6]	**53.1%** [50.8, 55.4]	**58.2%** [54.5, 61.8]	**32.6%** [29.8, 35.6]	**54.9%** **[52.5, 57.3]**
		2018-2019	**53.2%** [50.0, 56.3]	**64.9%** [61.9, 67.8]	**55.5%** [53.5, 57.4]	**61.7%** [58.7, 64.5]	**32.5%** [29.7, 35.3]	**55.3%** [52.8, 57.7]
		2017-2018	**54.3%** [51.1, 57.4]	**66.6%** [63.6, 69.4]	**55.1%** [53.1, 57.1]	**61.5%** [58.6, 64.4]	**31.1%** [28.5, 33.9}	**55.1%** [52.6, 57.7]
	Binge Drinking in the Past Month	2021-2022	**24.1%** [21.1, 27.5]	**26.6%** [23.7, 29.6]	**26.4%** [24.5, 28.4]	**24.0%** [21.3, 27.0]	**15.3%** [13.3, 17.6]	**23.2%** [21.3, 25.2]
		2018-2019	**23.1%** [20.8, 25.6]	**31.2%** [28.6, 34.0]	**26.7%** [25.1, 28.4]	**26.0%** [23.6, 28.6]	**17.9%** [16.0, 20.1]	**24.6%** [22.6, 26.6]
		2017-2018	**24.9%** [22.4, 27.6]	**32.5%** [29.7, 35.4]	**26.9%** [25.3, 28.5]	**26.5%** [24.1, 29.1]	**16.6%** [14.7, 18.7]	**24.6%** [22.7, 26.6]
Tobacco	Tobacco Product Use in the Past Month	2021-2022	**20.1%** [17.5, 23.1]	**19.8%** [17.5, 22.3]	**27.7%** [25.7, 29.8]	**19.6%** [17.1, 22.3]	**14.1%** [12.2, 16.2]	**19.5%** [17.7, 21.5]
		2018-2019	**20.5%** [18.2, 23.0]	**22.3%** [20.1, 24.6]	**29.1%** [27.4, 30.9]	**22.2%** [19.9, 24.6]	**15.8%** [13.9, 18.0]	**23.3%** [21.5, 25.2]
		2017-2018	**22.8%** [20.4, 25.4]	**23.1%** [20.9, 25.4]	**28.8%** [27.1, 30.5]	**22.5%** [20.4, 24.8]	**16.6%** [14.6, 18.7]	**21.7%** [20.0, 23.5]
	Cigarette Use in the Past Month	2021-2022	**16.1%** [13.8, 18.8]	**14.3%** [12.2, 16.5]	**23.1%** [21.2, 25.1]	**15.5%** [13.3, 17.9]	**10.1%** [9.0, 12.4]	**14.9%** [13.4, 16.6]
		2018-2019	**17.1%** [15.0, 19.3]	**17.6%** [14.7, 19.8]	**22.9%** [21.4, 24.5]	**17.1%** [15.2, 19.2]	**12.8%** [11.1, 14.7]	**17.9%** [16.2, 19.6]
		2017-2018	**18.6%** [16.4, 20.9]	**18.5%** [16.4, 20.6]	**23.2%** [21.7, 24.8]	**17.7%** [15.8, 19.9]	**13.7%** [11.9, 15.7]	**16.8%** [15.2, 18.5]
Cannabis	Use in the Past Month	2021-2022	**20.0%** [17.0, 23.2]	**20.5%** [18.1, 23.2]	**15.6%** [14.1, 17.3]	**23.0%** [20.2, 26.1]	**10.3%** [8.6, 12.1]	**13.9%** [12.1, 15.5]
		2018-2019	**11.5%** [9.7, 13.6]	**18.2%** [16.0, 20.5]	**10.6%** [9.6, 11.7]	**19.4%** [17.2, 21.8]	**6.7%** [5.5, 8.1]	**8.1%** [7.0, 9.4]
		2017-2018	**11.4%** [9.6, 13.6]	**18.1%** [15.9, 20.6]	**8.6%** [7.7, 9.6]	**19.7%** [17.4, 22.1]	**6.3%** [5.2, 7.6]	**7.4%** [6.4, 8.6]

	Measure		Arizona	Colorado	Ohio	Oregon	Utah	Virginia
Opioids	Heroin Use in the Past Year	2021-2022	**0.3%** [0.1, 0.6]	**0.3%** [0.1, 0.6]	**0.4%** [0.2, 0.7]	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.7]
		2018-2019	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.7]	**0.5%** [0.3, 1.0]	**0.3%** [0.2, 0.6]	**0.3%** [0.2, 0.6]
		2017-2018	**0.3%** [0.1, 0.5]	**0.4%** [0.2, 0.7]	**0.5%** [0.3, 0.8]	**0.4%** [0.2, 0.8]	**0.3%** [0.2, 0.6]	**0.4%** [0.2, 0.7]
	Pain Reliever Misuse in the Past Year	2021-2022	**3.5%** [2.6, 4.6]	**3.3%** [2.5, 4.3]	**3.5%** [2.8, 4.3]	**4.0%** [3.1, 5.2]	**3.6%** [2.8, 4.6]	**2.8%** [2.2, 3.5]
		2018-2019	**3.9%** [3.2, 4.9]	**4.1%** [3.3, 5.1]	**4.1%** [3.5, 4.8]	**4.7%** [3.8, 5.9]	**3.9%** [3.2, 4.7]	**3.5%** [2.9, 4.2]
		2017-2018	**4.2%** [3.4, 5.1]	**4.8%** [3.9, 5.8]	**4.3%** [3.7, 5.0]	**4.6%** [3.8, 5.7]	**3.9%** [3.3, 4.7]	**3.6%** [3.0, 4.3]
Mental Health	Major Depressive Episode in the Past Year	2021-2022	**9.1%** [7.7, 10.6]	**10.2%** [8.8, 11.8]	**9.5%** [8.5, 10.6]	**11.1%** [9.5, 12.9]	**11.0%** [9.6, 12.5]	**7.9%** [7.1, 8.9]
		2018-2019	**7.8%** [6.7, 9.2]	**8.5%** [7.3, 9.8]	**8.8%** [8.0, 9.8]	**9.5%** [8.1, 11.1]	**9.8%** [8.6, 11.2]	**7.0%** [6.1, 8.0]
		2017-2018	**7.2%** [6.0, 8.6]	**8.6%** [7.3, 10.0]	**8.0%** [7.1, 9.0]	**8.9%** [7.6, 10.4]	**10.0%** [8.7, 11.4]	**6.3%** [5.3, 7.4]
	Serious Thoughts of Suicide in the Past Year	2021-2022	**5.2%** [4.3, 6.1]	**5.9%** [5.0, 7.0]	**5.2%** [4.6, 5.9]	**5.6%** [4.8, 6.6]	**7.1%** [6.2, 8.2]	**4.8%** [4.1, 5.5]
		2018-2019	**5.0%** [4.1, 6.1]	**5.5%** [4.6, 6.7]	**6.1%** [5.4, 6.9]	**5.7%** [4.7, 6.8]	**6.2%** [5.2, 7.4]	**4.2%** [3.5, 5.0]
		2017-2018	**4.4%** [3.6, 5.5]	**5.5%** [4.5, 6.7]	**5.2%** [4.5, 5.9]	**5.4%** [4.4, 6.5]	**6.5%** [5.4, 7.7]	**4.1%** [3.5, 5.0]

Trends for alcohol, tobacco, and opioids are moving in the desired direction – meaning lower use rates across all states – with a few exceptions for alcohol and opioids. Use rates for cannabis have increased among all states, including Virginia, since 2017. Mental health outcomes were more mixed. All states have seen an increase in the percent of the population reporting a major depressive episode. However, some states have made positive strides in reducing the level of suicidal ideation, albeit not Virginia. Given that several states began their shared risk and protective factor initiatives in 2020 or 2022, some of these trends were already developing before new structuring was in place.

Full state profiles, including information about each state's primary models and frameworks, priority strategies identified by states, and SAMHSA funding allocations, can be found in the main report.

Qualitative Data Collection

Thirty-two CSB prevention staff across twenty-one organizations participated in focus groups covering topics such as programming, funding, staffing, partnerships, and overall prevention models, as well as successes and challenges encountered in their ongoing prevention work. In addition, a focus group was held with staff within OBHW to gather perspectives of those coordinating efforts and supporting CSBs at the state level.

Findings from these efforts highlight a growing consensus among participating CSB and OBHW staff that a shift toward addressing shared risk and protective factors is necessary to create a more sustainable, holistic approach to prevention. Current strategies, which often silo prevention efforts by specific substances or issue areas, can limit capacity, contribute to burnout, and detract from a more integrated, community-driven response.

1 Shifting Toward a Shared Risk and Protective Factor Approach

CSB staff emphasized the importance of moving beyond issue-specific prevention efforts to a broader framework that addresses the underlying factors influencing both substance use and mental health concerns. This shift is driven by:

- ✓ The recognition that current prevention priorities are often reactive in nature, primarily focusing on high severity/lethality issues. This leads to inconsistent investment in long-term, comprehensive strategies.
- ✓ The need for a prevention model that aligns with established research demonstrating the interconnectedness of mental health and substance use.
- ✓ The opportunity to reallocate resources toward upstream prevention efforts that support broader community resilience and well-being.

2 Challenges in CSB Capacity and Workforce Development

CSBs reported facing significant capacity constraints that hinder their ability to effectively implement prevention strategies. Key challenges include:

- ✓ The burden of meeting training facilitation quotas, even when participation is low, diverting time and resources from other prevention activities.
- ✓ Expanding job responsibilities beyond traditional prevention work, such as media campaign coordination and graphic design, which dilute staff capacity.
- ✓ A need for more staff, more competitive pay, and consistent training and onboarding to strengthen workforce retention and effectiveness.

3 Enhancing Prevention Efforts Through Capacity Building and Policy Engagement

To support the transition to a shared risk and protective factor approach, CSB staff identified several capacity-building needs:

- ✓ Opportunities for prevention staff to engage in advocacy and policy efforts, ensuring that prevention priorities are directly reflected in legislative decisions.
- ✓ Improved coordination across state agencies to streamline efforts, share information, and reduce duplicative work.

By adopting a more holistic prevention approach that centers shared risk and protective factors, CSBs can re-focus prevention efforts more upstream, strengthening protective factors and reducing risk factors so that substance use is not where individuals turn when facing adversity.

Data Snapshots

Virginia has seen declines in substance use rates across most issues and substance categories, particularly among youth, with reductions in alcohol use, tobacco and vapor product use, opioid misuse, and other illicit substance use (e.g., heroin, cocaine, methamphetamines, hallucinogens).

While these declines are encouraging, some concerning trends persist, including rising rates of binge drinking among young adults, disparities in substance use among marginalized groups, increases in gambling participation, and continued mental health challenges.

To effectively implement a shared risk and protective factor approach, it is essential to expand data collection efforts related to these factors. Currently, most available data focus on mental health symptoms such as depression, anxiety, and poor health, along with substance use prevalence rates, rather than the underlying factors impacting these outcomes. Data on youth coping skills, emotional regulation, resilience, and self-esteem across different age groups is especially limited. To support evaluation efforts, this shift in approach should be accompanied by a commitment to gathering data on these factors.

For a full breakdown of substance use trends and data snapshots by category, see the main report.

Summary

Based on the findings of this needs assessment, it is recommended that OBHW integrate a shared risk and protective factor approach to Virginia's prevention framework for 2025-2030 to better align with emerging trends. This shift would create a more cohesive strategy, reducing information overload for CSBs and supporting a whole-person approach to behavioral health. Rather than focusing on individual substances or issue areas, this approach prioritizes the underlying factors contributing to both substance use and mental health challenges, assessing risk factors, prioritizing key populations, and expanding protective factor focused initiatives.

A greater focus on protective factors would allow CSBs to more easily navigate the stigma that may prevent community engagement in substance use-focused programs and also allow them to invest more of their capacity in community-facing work. Substance-specific messaging can still be incorporated into these approaches, but by making them a part of – rather than the primary focus of – efforts, prevention programs can become more approachable to a larger audience, including communities that have been marginalized and who may be navigating additional stigma or barriers related to substance use and mental health.

By adopting a shared risk and protective factor approach, Virginia can create a more effective, evidence-based prevention strategy that strengthens protective factors, reduces risk factors, and ensures long-term behavioral health improvements across communities.

Introduction

The Office of Behavioral Health Wellness (OBHW) within the Virginia Department of Behavioral Health and Developmental Services (DBHDS) contracted with OMNI Institute in July 2023 to complete a statewide needs assessment focused on various prevention and behavioral health-related topics. The previous statewide prevention-focused needs assessment was conducted in 2018, followed by a strategic planning process in 2019 that led to the identification of three statewide priority areas and subsequent priority strategies that all 40 Community Service Boards (CSBs) were required to implement in the 2020-2025 Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS-BG or SUBG) cycle. The priority areas for the 2020-25 SUBG cycle identified through this process were alcohol, tobacco, and suicide prevention with six accompanying strategies.

The 2020-25 Virginia Substance Use Block Grant Logic Model

	Problem	Targeted Risk Factors	Strategies	Impact
Alcohol	1 in 4 VA high school youth report drinking alcohol in the past 30 days (VYS, 2017)	Low perception of risk use Early onset of use	**Coalition Development** Bringing together community leaders and stakeholders for collective action **ACES Trainings** Understanding the impacts of adverse childhood experiences	Decrease in youth alcohol use Decrease in young adult binge drinking
Tobacco/Nicotine	1 in 6 VA adults report smoking cigarettes (BRFSS, 2017) 1 in 15 VA high school youth report smoking cigarettes currently, while 1 in 9 report currently using a vaping product. (VYS, 2017).	Low perception of risk use Early onset of use	**Coalition Development** Bringing together community leaders and stakeholders for collective action **Counter Tools** Developing responsible retailer practices **ACES Trainings** Undestanding the impacts of adverse childhood experiences	Decrease in youth tobacco/nicotine use Decrease in young adult tobacco/ nicotine use
Mental Health/Suicide	1 in 14 VA high school youth have attempted suicide in the past year (VYS, 2017) 9.9 out of 100,000 youth ages 15-19 died by suicide in VA in 2019 (America's Health Rankings, 2019) 13.8 out of 100,000 adults died by suicide in VA in 2019. (America's Health Rankings, 2019)	High rates of depression/ sadness High rates of suicidal thoughts	**Mental Health First Aid and Suicide Prevention Trainings** Recognizing and addressing signs of suicide **Coalition Development** Bringing together community leaders and stakeholders for collective action **ACES Trainings** Undestanding the impacts of adverse childhood experiences **Lock and Talk** Suicide prevention through lethal means safety	Decrease in youth suicide attempts Decrease in youth death by suicide Decrease in adult deaths by suicide

Throughout the 2020-25 SUBG cycle, the prevention workforce experienced challenges resulting primarily from the need to address an ever-growing list of substances and issue areas. The 2020-25 SUBG cycle saw the additions of emerging statewide priorities, including over-the-counter medication misuse, cannabis, and problem gaming and gambling, placing significant strain on local prevention capacity, as the workforce was continuously called on to build new capacity and learning around these new topic areas and add new strategies to their current prevention programs, all the while continuing to address existing priorities. As such, the 2023-24 needs assessment encompasses a broader goal: to examine leading prevention frameworks and the prevention approaches of other states to identify clear opportunities for an improved statewide prevention approach in Virginia.

Research consistently demonstrates the interconnectedness of behavioral health outcomes – including links between substance use, mental health concerns, and problem gaming and gambling. This interconnectedness has been especially evident in recent years as efforts to increase awareness around the impact of adverse childhood experiences (ACEs) have expanded across the state. As ACE Interface trainings and trauma-informed care initiatives have proliferated over the past several years, prevention staff, coalitions, and communities in Virginia are more educated on the impact of childhood trauma, which is clearly and consistently linked with increased substance use, poorer mental health outcomes, and higher rates of suicide throughout the lifespan. Further, the prevention workforce has built capacity and become more fluent in the language of trauma, root causes, the social determinants of health, and resiliency. Building on these collective learnings, the needs assessment process to prepare for the 2025-30 SUBG cycle placed special attention on shared risk and protective factors, including ACEs, as a potential unifying theme for more cohesively and efficiently addressing multifaceted prevention work.

As such, OMNI completed the following components of work to get a broad, clear view of not only the current state of behavioral health and prevention in Virginia, but also to explore the literature, relevant frameworks, and the approaches of other states to guide Virginia's prevention work in the future. The needs assessment entailed the following components of work:

LITERATURE REVIEW

- Prevention Frameworks and Approaches
- State Profiles and Data Reviews
- Strategy Implementation Best Practices

PRIMARY QUALITATIVE DATA COLLECTION

- Focus groups with prevention staff at Community Service Boards throughout Virginia
- A focus group with staff at the Virginia Office of Behavioral Health Wellness

SECONDARY DATA ANALYSIS

- Summary of the current state of specific substances and behavioral health topics, including risk and protective factor data
- Summary of key data gaps needed to successfully measure outcomes in a risk and protective factor driven prevention model

This 2023-24 Needs Assessment Report will be used as a foundation for the launch of a strategic planning process focused on identifying priorities for the prevention and behavioral health landscape in Virginia for 2025-2030.

The report is structured to follow the needs assessment components outlined above. First, we will walk through our review of the prevention literature, highlighting leading prevention frameworks and models that consider the interconnectedness of behavioral health outcomes. Next, we detail our examination of how five different states designed their prevention systems to incorporate a focus on shared risk and protective factors. Then, we explore some specific prevention strategies that could be implemented in Virginia to support the creation of thriving, resilient communities.

We then turn to the findings of our primary data collection efforts (focus groups), which were conducted to gather perspectives from both the direct prevention workforce at Virginia's Community Services Boards and staff from Virginia's Office of Behavioral Health Wellness, who oversee efforts at a state level. Focus groups offer perspectives on the current state of prevention in Virginia and opportunities for the future.

Finally, we present data snapshots that highlight the most recently available data on substance use, mental health, and problem gambling across Virginia. Examining the data will help to illuminate the current state of substance use and behavioral health in Virginia, as well as provide an update to the data from the 2018 prevention needs assessment. We will be able to assess whether current priorities are supported by this updated data, and we can further consider whether specific subpopulations should be the target of prevention efforts in the next SUBG cycle. Overall, the snapshots will provide a better understanding from which to frame future goals and the vision for the next five-year strategic plan. The report will end with recommendations and potential next steps for OBHW to consider as it moves into strategic planning in the fall of 2024.

Literature Review

Background

Research linking substance use, mental health, and problem gambling has been widely established and indicates the presence of shared predictors increasing the likelihood of individuals experiencing poor behavioral health outcomes. During the 2020-2025 SUBG cycle, prevention providers began implementing strategies to increase awareness of adverse childhood experiences (ACEs), which include a range of traumatic events throughout childhood/adolescence that have been linked with a higher likelihood of substance use and poor mental health outcomes throughout the lifespan. Through their ACEs efforts, Virginia providers have demonstrated that focused efforts on root causes of negative behavioral health outcomes can be a meaningful approach to addressing a wide range of issue areas simultaneously. This approach to center shared drivers of behavioral health outcomes – rather than focusing on individual outcomes and singular drivers thereof – has been increasingly adopted by key prevention agencies.

In September 2022, the National Institute of Health's (NIH) National Institute on Drug Abuse (NIDA) published its strategic plan identifying priorities in the field of prevention work between now and 2026.[1] NIDA recognizes that the commitment needed to execute and carry out this work effectively comes from carefully observing and understanding the following principles and factors:

1. Identifying and developing evidence-based approaches to reduce the stigmatization of substance use disorders (SUD).
2. Understanding the nuances in SUD that occur based on biological sex/sexual orientation/gender identity.
3. Developing evidence-based approaches to reduce health disparities and promote health equity.
4. Understanding that SUDs often occur in conjunction with other mental illnesses and health conditions.
5. Developing initiatives that center those with lived experiences.

NIDA's strategic plan focuses on broader approaches to impact those at the highest risk and who experience the greatest impacts from substance use. To tackle the complex and interwoven nature of substance use, mental health, and physical health outcomes, the plan highlights the need for efforts universal enough to effect change in more than one area. This focus on identifying antecedents of substance use often centers on shared risk and protective factors.

In September 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) followed in NIDA's footsteps with the release of their 2023-26 Strategic Plan, which includes a key focus on the need to address shared risk and protective factors to address behavioral health outcomes.[2] SAMHSA's plan identifies four primary goals:

- ✓ Preventing substance use and overdose
- ✓ Enhancing access to suicide prevention and mental health services
- ✓ Promoting resilience and emotional health for children, youth, and families
- ✓ Integrating behavioral and physical health care
- ✓ Strengthening the behavioral health workforce

Throughout SAMHSA's strategic plan, a focus on the drivers of behavioral health outcomes is evident, including a "strategic focus on increasing protective factors across the lifespan in order to mitigate risks to individual- and population-level well-being and resilience." Taking a broader approach to primary prevention and focusing on an earlier point of intervention, SAMHSA notes, has the capacity to decrease the need for treatment and recovery services. This includes "strengthening social determinants of health, supporting healthy social and emotional development, reducing and addressing childhood and other trauma, supporting parents and strengthening families, expanding evidence-based programs in schools, and improving the safety and livability of community environments." In addition, SAMHSA notes the importance of expanding mental health literacy through delivery of outreach activities, trainings, and provision of technical assistance to increase community understanding of mental health, including symptoms and how to support individuals experiencing mental distress, as well as increasing programming targeted towards children, youth, families, and young adults.

This review will highlight how a focus on risk and protective factors can better shape our understanding of and approach to the areas of substance use, problem gaming and gambling, and suicide prevention, effectively breaking down the silos found within a substance-specific approach to prevention to create a more cohesive model. An approach to prevention that recognizes the efficiencies of shared risk and protective factor approach has the potential to create a cohesive and clear prevention narrative, streamline programs, and maximize efficiencies and use of prevention funds, while simultaneously reducing the strain on the prevention workforce. We will explore current and emerging prevention frameworks that incorporate a shared risk and protective factor lens, elaborate on key risk and protective factors that underlie a multitude of behavioral health issues, and identify evidence-based and evidence-informed strategies that can be leveraged to create impact across a variety of prevention areas. Findings will culminate in an exploration of various state prevention models that center a shared risk and protective factor approach. This exploration also serves to identify potential leaders and allies in this area of prevention and understand how these states are incorporating this lens into their state prevention approaches. State profiles include the specific prevention frameworks underlying each state's approach, key strategies/initiatives being implemented and provide a comparison of funding allocations and key indicators between each state and Virginia.

Shared Risk and Protective Factor Overview

Risk and protective factors are integral to understanding how individual and collective experiences determine behavioral health outcomes. Risk factors refer to a variety of biological, psychological, family, community, and/or cultural characteristics associated with a higher likelihood of negative outcomes. Protective factors, conversely, are those characteristics– on those same levels – that *lower* the likelihood of negative behavioral health outcomes in an individual's life. Protective factors may also be referenced as positive countering events. Some of these factors are fixed, meaning they don't change over time, and some of them are considered variable, such as adverse childhood experiences (ACEs).[3] Risk and protective factors have a cumulative effect on individual development and integrating these as the primary focus of prevention programs, rather than specific substances or problem areas, allows programs to simultaneously and efficiently impact multiple prevention areas and substances.

The following table provides an overview of key risk and protective factors and identifies where established research is available illustrating the relationship between these factors and substance use and behavioral health outcomes. An overview of relevant research can be found in Appendix A.

	●	●	●	●	●	●	●	●	●
ACEs	✓	✓	✓	✓	✓	✓	✓	✓	✓
Active Parenting and Parental Involvement	✓	✓	✓	✓	✓				✓
Ease of Access		✓	✓	✓	✓		✓		
Healthy Coping Skills, Emotional Regulation, and Resilience	✓	✓	✓	✓	✓	✓		✓	
High Self-Esteem		✓			✓	✓		✓	
Parental Approval, Disapproval, and Use		✓	✓	✓			✓	✓	✓
Peer Approval, Disapproval, and Use		✓	✓	✓			✓		✓
Perceptions of Risk		✓	✓	✓		✓		✓	
Prosocial and Extra-Curricular Involvement	✓	✓			✓	✓			
Social Isolation	✓	✓	✓		✓	✓			
Social Supports	✓	✓	✓		✓	✓	✓	✓	
Trusted Adults, Peers, and Mentors	✓	✓	✓		✓			✓	✓

● General impact on substance use outcomes
● Alcohol
● Cannabis
● Gambling
● Mental Health & Suicide
● Opioids
● Stimulants
● Tobacco
● Vaping

ACEs

A large body of evidence establishes the relationship between increased exposure to adverse childhood experiences (ACEs) and higher likelihood of engaging in substance use.[4] Specific research demonstrates the impact of ACEs on alcohol[5,6,7,] cannabis[8], opioid[9,10], stimulant[11], tobacco[8,12,13,] and vape use.[8,12] ACEs were similarly linked with increased gambling[14] and poor mental health outcomes.[15,16] ACEs exposure was the most widely shared risk factor identified, with links to every behavioral health area or substance examined. ACEs have been a focus of Virginia's prevention program since 2016, with all Virginia CSBs expected to conduct ACEs trainings as part of their annual performance contracts for SUBG. 8 CSBs also receive additional "Self-Healing Communities" funds, which build upon existing ACE-related efforts to develop trauma-informed care networks in their communities. Virginia's prevention workforce is well positioned to continue to build upon these efforts as part of a shared risk and protective factor approach.

Active Parenting and Parental Involvement

Active parenting and parental involvement, including youth and adolescent perceptions of high parental engagement was tied to overall reductions in youth substance use [17,18], with clear indications for reduction of alcohol[19], cannabis[19], and vape use[20], as well as decreased mental distress and suicidal ideation.[21] Evidence-based parenting programs, such as Active Parenting, Nurturing Parenting Programs, and Strengthening Families, have been implemented by numerous CSBs throughout the last five-year SUBG cycle but are not a component of the current statewide priorities. Expanding the availability of resources to support the implementation of parent education and family management programs may help build stronger, healthier, and more resilient families in Virginia and expand pathways through which resources can be directly provided to community members.

Ease of Access

Ease of access – from retailers, at home, or from social sources – was established as a risk factor with specific evidence linking accessibility of alcohol[5,22], cannabis[23,24], stimulants[115], and gambling opportunities with increased likelihood of use[25]. Increased access to lethal means, including medications and firearms, was associated with an increase in suicide rates.[26,27] Easy access to tobacco, as well as lethal means access, are currently being addressed in the state prevention model via the merchant education strategies of CounterTools and Lock & Talk. As efforts to address cannabis and problem gambling have increased, CSBs have also begun implementing merchant education with cannabis retailers and gambling operators. Targeted risk and protective factors within the current state model are broader in their conceptualization, focusing on early onset of use and poor mental health rather than directly naming the drivers thereof, including ease of access. Increased specificity in the risk and protective factors being targeted can help prevention providers create a clearer connection between interventions and outcomes.

Healthy Coping Skills, Emotional Regulation, and Resiliency

Building healthy coping skills, the ability to self-regulate emotions, and other resiliency factors were correlated with lower likelihood of substance use,[28,29,30,31,32] with specific linkages to decreased alcohol[33,34], cannabis[33], opioid[35], and nicotine use.[33] Healthy coping skills, emotional regulation, and resiliency were also linked to lower mental distress, suicidal ideation[36] and disordered gambling.[117,118.] Virginia's current SUBG model includes suicide prevention strategies, such as Mental Health First Aid, that provide information to participants on how to identify and support individuals in distress, but does not include strategies that support individuals in building these skills to support their own well-being. These strategies have become an increasing focus of CSBs engaging in trauma-informed work in their communities, with CSBs distributing resource kits and hosting workshops focused on building skills to cope with stress and trauma. Virginia's Activate Your Wellness Media campaign also serves to build these skills across eight dimensions of wellness, providing a key opportunity for expansion.

Parental Approval, Lack of Disapproval, and Use

Research establishing the risks of parental approval, lack of parental disapproval, and/or parental use were interwoven, but established that parental approval, lack of disapproval, and/or parental use increased the likelihood of alcohol[37,38], cannabis[23,38,39,40], stimulants[115], tobacco[38,41], and vape use[41], as well as increased likelihood of youth participation in gambling activities[119]. Despite a lack of focus on parental approval, lack of disapproval, and use in the current state prevention model, many CSBs implement family management, parenting programs, and media campaigns that include a focus on this area, such as the "We Don't Support Underage Use" media campaign. Incorporating a focus on these factors in the state prevention model would allow CSBs to build out these programs and increase parental engagement in conversations about youth substance use.

Peer Approval, Disapproval, and Use

Similar to parental attitudes, evidence related to peer approval and use were similarly interwoven and were shown to increase the likelihood of alcohol[37,42], cannabis[23,38,40,43], stimulants[115], and vape use[44], as well as gambling.[25] Peer disapproval was found to decrease the likelihood of alcohol, cannabis, and vape use among youth.[114]

While peer perceptions are not currently targeted in the state prevention model, many CSBs implement youth alternative and education programs such as after-school programs, youth clubs, mentor programs, and leadership programs. These programs support youth in engaging in substance-free environments with their peers, encourage youth to be leaders in their communities, and encourage youth to engage in healthy decision-making. Some CSBs engage in social norms messaging campaigns, which can serve to directly address misconceptions about peer use that may encourage substance use behaviors, though these can be challenging to implement and evaluate due to the need for specific data that is not commonly collected. However, measures related to peer alcohol use norms were incorporated into the new iteration of the Virginia Young Adult Survey, first implemented statewide in 2022, which provides a key opportunity to address alcohol use norms among young adults 18 to 25 moving forward.

Perceptions of Risk

Low perceptions of the risk of harm associated with substance use is currently a targeted risk factor in Virginia's strategic plan related to the priority areas of Alcohol and Tobacco use. A review of evidence found low perceptions of risk to be associated with increased alcohol[45], cannabis[45,46], opioid[47], and tobacco[45,48] use as well as increased gambling participation.[25] Information dissemination efforts such as media messaging and community presentations, including messaging aimed at increasing risk perceptions around substance use, are commonly implemented by CSBs.

Prosocial and Extracurricular Involvement

Participation in prosocial or extracurricular activities, such as after-school programs, clubs, youth leadership programs, and recreational activities, was found to have an overall association with lower youth substance use[17,49], with specific evidence linked to reduced youth alcohol[5] and opioid use[50], as well as lower risk of suicide and mental distress.[51] Despite the lack of inclusion of these types of strategies in current state priorities, many CSBs have utilized available funding to create programs that allow for meaningful connections among youth. Youth education and alternative strategies such as Sources of Strength and summer camps have been implemented by many CSBs over the last five years and offer an opportunity to engage in institutional learning and possible expansion.

PROOF

Self-Esteem

Higher levels of self-esteem were correlated with decreased alcohol[52], opioid[53], and tobacco use[54], as well as decreased mental distress[122,123] and suicidal ideation.[55,56] While initiatives that have a goal of supporting individuals in building self-esteem are not currently found within the state's strategic plan, some CSBs are utilizing the 20% of their SUBG funds earmarked for community-driven strategies to implement such efforts. Programs such as youth leadership and mentor programs serve to develop self-esteem among youth participants, while some programs focused on supporting parents can help build self-esteem among parents. Activate Your Wellness campaign efforts may also indirectly serve to build self-esteem among those engaging with its messaging – including resources and messaging specifically targeted at helping them develop a stronger and more positive sense.

Social Isolation and Social Support

Social isolation was generally identified as a risk factor for increased substance use and poor mental health outcomes,[57,58] with research establishing a direct relationship between isolation and increased alcohol[5,57,59] cannabis[43,59] and opioid use[60,61], as well as an increased risk of mental distress and suicidality.[62,63] Increased social support was identified as the most widely shared protective factor examined. Increases in social support were correlated with a reduced risk of overall substance use[64], with specific evidence indicating decreases in alcohol[65,66], cannabis[66], opioid61[61,67], stimulant[66], and tobacco[57,66] use, as well as a decrease in mental distress and suicidal ideation.[63]

Virginia does not currently include social isolation as a targeted risk factor, though a narrative around social isolation is integrated in the state's ACEs work and is the central pillar of the statewide Lift Up Virginia (LUV) campaign. At the community level, many CSBs are implementing strategies focused on these areas as part of their community-driven strategies, for which 20% of their SUBG funds are earmarked – most notably alternative events and youth development programs (e.g. after-school programs, youth leadership programs, etc.). Explicitly centering the risks of social isolation and the power of connection and social support in improving behavioral health outcomes would establish rationale for expansion of the LUV campaign and for increasing the resources available to CSBs to implement strategies focused on building connection and social support in their communities.

Trusted Adults, Peers, and Mentors

Healthy relationships with a trusted adult, peer, or mentor were associated with overall decreased substance use.[68,69] Specific evidence illustrates the effectiveness of healthy peer and adult mentor presence in decreasing the likelihood of alcohol[38], cannabis[38], tobacco[38], and vape use.[70] The presence of trusted adults, peers, and mentors is also associated with improved mental health outcomes.[120,121]Youth-adult leadership and mentorship programs are strong pillars of many CSB prevention efforts and create opportunities for increasing youth engagement in coalition efforts.

Strategies that promote protective factors may allow CSBs to more easily navigate stigma. Some individuals may be unlikely to attend a substance use prevention event because they don't feel it applies to them or are uncomfortable attending due to social stigma around substance use. These individuals may be more willing to attend a wellness-focused event that indirectly incorporates substance use prevention messaging.

Frameworks and Models

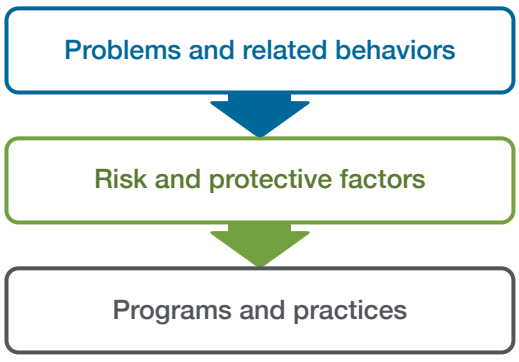
A variety of frameworks and models exist that offer unique perspectives on how to think about the drivers of health outcomes and how best to approach the design of meaningful interventions. This section will discuss several theories and models that may help to guide prevention planning and that prioritize risk and protective factors in their approach rather than focusing on specific substances or behaviors.

Models Currently Used in Virginia

The Strategic Prevention Framework[71]

SAMHSA's Strategic Prevention Framework (SPF) has long been central to Virginia's prevention approach. The framework's primary utility is in its conceptualization of a continuous cycle of activities that allow for the development of appropriate, effective, and well-planned out interventions. The SPF highlights the need to engage in a continuous cycle of assessment, capacity building, planning, implementation, and evaluation.

While the SPF includes a focus on risk and protective factors, it centers on problems and related behaviors as the initial step to assessment. Once the problems or behaviors are identified, it prompts its users to identify risk and protective factors before identifying programs and practices. The centering of problem areas within this process can make it challenging to fully map out shared risk and protective factors and to understand linkages between various behavioral health outcomes when the steps are approached on a problem-by-problem basis. By re-envisioning the risk and protective factor identification process within this model to be centered on identifying factors associated with one or more identified problems, the SPF model can be well suited to the development of a shared risk and protective factor focused approach to prevention.



CADCA's Seven Strategies for Community Change[72]

CADCA equips coalitions with the tools, knowledge, and support they need to create positive change in their communities. CADCA highlights Seven Strategies for Community Change coalitions can adopt to create meaningful community-level change, with each method representing a key element for building and maintaining a healthy community. The model separates strategies into individual and environmental efforts, acknowledging the impact of individual- and environment-level factors in determining behavioral health outcomes. CADCA identifies the importance of information dissemination programs, skill-building programs, and programs that increase support networks as key strategies for creating individual-level change. Improving systems through enhanced access to services and care, alongside policy modifications and changes, are identified as key strategies for creating environmental change. Along with coalitions across Virginia, CADCA's framework has been adopted by member coalitions across much of the U.S. including in Connecticut[73], Missouri[74], New Jersey[75], New York[76], Ohio[77], and Wisconsin.[78]

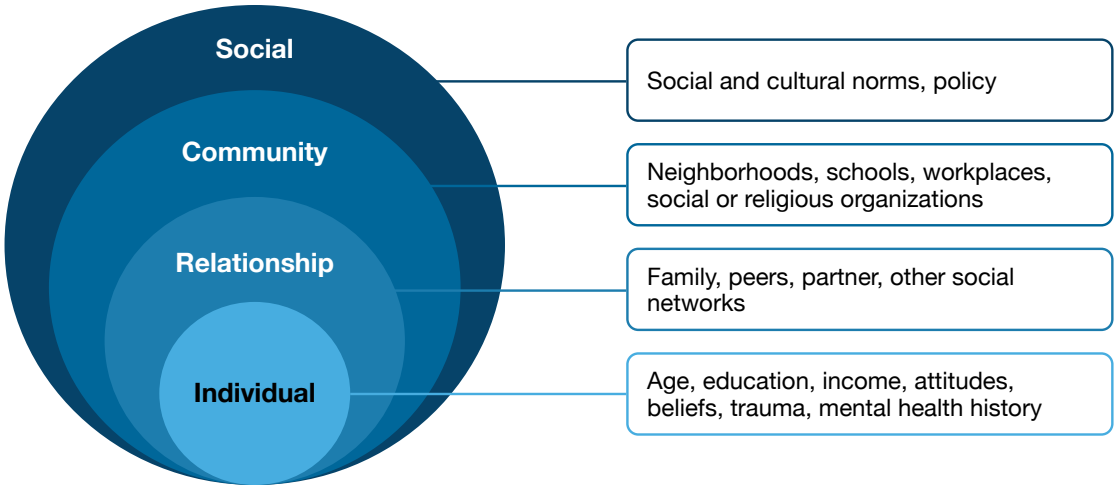
CADCA'S Seven Strategies for Community Changes

1	Providing information	INDIVIDUAL
2	Enhancing Skills	
3	Providing Support	
4	Enhancing Access/Reducing Barriers	ENVIRONMENTAL
5	Changing Consequences	
6	Physical Design	
7	Modifying/Changing Policies	

Additional Models and Frameworks for Consideration

The Socio-Ecological Model[79]

The Socio-Ecological Model (SEM) helps us understand the different ways people's circumstances, relationships, and environments affect their behaviors. The SEM organizes risk and protective factors into different levels, from the micro, individual level, up to the macro, society level. While the levels of the SEM can change slightly from source to source, they follow the basic format of individual, interpersonal relationships, community, and society. By breaking down risk and protective factors into their socio-ecological sections, agencies can better understand the role they play in shaping outcomes and how to create a broad yet targeted prevention program that address drivers of behavioral health outcomes from a variety of angles that are mutually reinforcing. Use of the SEM in developing prevention programs is supported by national and global agencies including the CDC[79], Prevention Technology Transfer Center Network[80], and UNICEF[81]. The SEM is currently used in the conceptualization of prevention programs in several states, including Arizona[82], Colorado[83], Minnesota[84], and Ohio.[85]



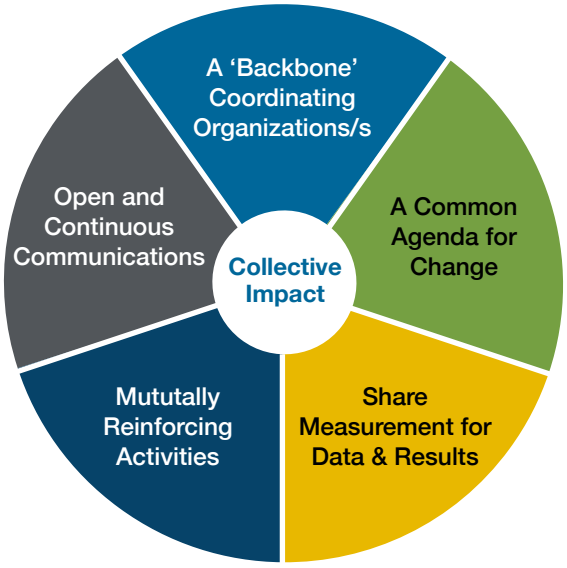
Use of the Socio-Ecological Model would support Virginia in ensuring a well-rounded set of risk and protective factors to prioritize, thus ensuring a coordinated and cohesive approach to prevention that acknowledges the multiple levels of influence that drive behavioral health outcomes.

The Collective Impact (CI) Approach[86]

The Collective Impact (CI) approach suggests that complex issues, such as substance use, cannot be solved by one sector alone, emphasizing cross-sector collaboration as the key pathway to driving change. The CI approach promotes the idea of a single "backbone" organization that leads the efforts and facilitates work from supporting organizations as vested partners.

In the CI approach, vested partners work together to identify a common agenda for change. Through implementation of mutually reinforcing activities, continuous communication, and the identification of shared measurement tools, these organizations can strategically target different aspects of the issue being addressed and maximize impact by capitalizing on each entity's strengths.[87] Use of the Collective Impact approach to creating cross-sector solutions has been supported by the U.S. Drug Enforcement Agency's Campus Drug Prevention Program.[88] It is integrated in the conceptualization of prevention frameworks in several states, including Arizona[89], Colorado, Ohio[90], and Oregon[91], as well as in the city of Chicago.[92]

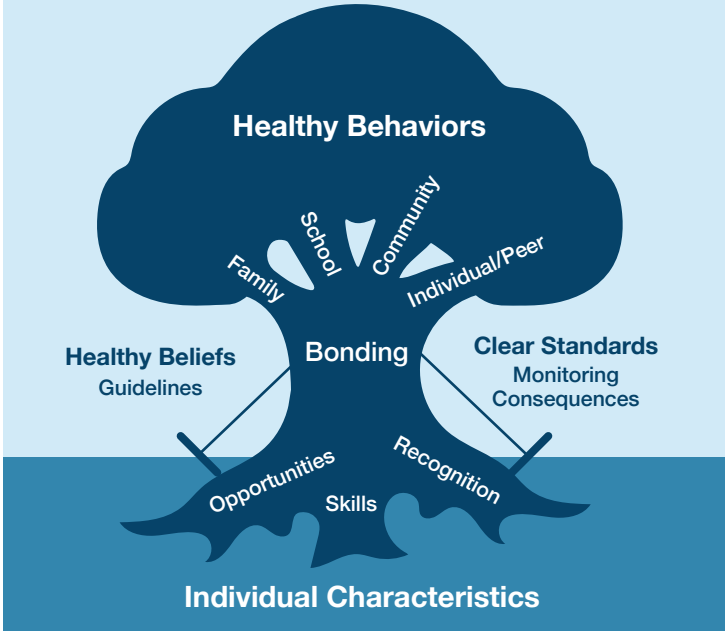
Use of the Collective Impact approach would allow Virginia's prevention programs to create stronger partnerships with key agencies and organizations across the Commonwealth by establishing common goals, identifying mutually reinforcing activities, establishing shared measurement systems, and creating platforms for continuous communication.



Social Development Strategy[93]

The Social Development Strategy (SDS) is a youth-focused model that concentrates on protective factors that help youth build the skills needed to face the risks and challenges that can lead to problem behaviors such as substance use. A recent study describes SDS as "a model for organizing prevention into a practical strategy that promotes positive youth development while reducing risk."[94] Like the socio-ecological model, the SDS looks at the many interconnected factors that impact youth, including communities, families, schools, and peers, and rests on theories that hypothesize that 1) prosocial bonding promotes prosocial behavior, 2) behavior is learned in groups through rewards and punishment, and 3) the paths for prosocial and anti-social behaviors and dispositions are separate but parallel. The SDS focuses on developing opportunities for learning, skill building, recognition, bonding, and the establishment of clear standards for youth behavior. The Social Developmental Strategy has been recognized by the Prevention Technology Transfer Center Network[95] and is a foundational component of the Center for Communities that Care.[96] The SDS is currently being utilized by Ohio's Department of Mental Health and Addiction Services in their statewide substance use and suicide prevention framework[85] as well as by agencies and coalitions in Utah.[97,98] Communities that Care, which is based upon the SDS, is incorporated in the state prevention approaches in both Colorado[83] and Utah.[99]

Use of the Social Development Strategy would create opportunities for Virginia to develop a stronger narrative and approach to youth- and families-focused prevention work. Integration of population-specific frameworks and models promotes an understanding that the needs and experiences of individual groups are unique and cannot be met by a one-size-fits all solution. Given similarities between the models, the SDS could easily be used in conjunction with the Socio-Ecological Model.

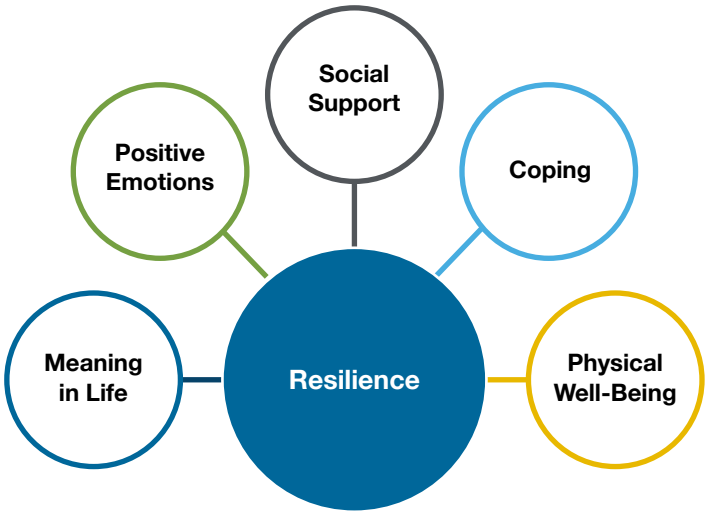


Resiliency Theory[100]

Resiliency Theory, another theory geared toward youth, focuses on identifying the strengths and assets of youth that can keep them away from problem behavior. Resiliency is a protective factor that youth can develop and build on throughout their lives. Resiliency Theory provides a conceptual framework for considering a strengths-based approach to understanding child and adolescent development and informing intervention design.

Resiliency Theory focuses attention on protective contextual, social, and individual variables that interfere or disrupt developmental trajectories from risk to problem behaviors, mental distress, and poor health outcomes. Resiliency theory is modeled on the theory of assets and resources as key promotive factors, which "operate in opposition to risk factors and help youth overcome negative effects of risk exposure." Positive factors that reside within individuals such as self-efficacy and self-esteem are defined as assets. Factors external to individuals are considered resources and include parental support, adult mentors, and youth programs that provide youth with opportunities to learn and practice skills. Ohio's Department of Mental Health and Addiction Services currently utilizes this approach in the conceptualization of their statewide substance use and suicide prevention framework.[85]

Use of Resiliency Theory could create opportunities to emphasize protective factors and youth-targeted prevention efforts that take a strengths-based approach. Incorporating population-specific models and frameworks ensures efforts reflect the understanding that many drivers of behavioral health outcomes are unique to certain demographic groups.



Developmental Assets Framework[101]

The Developmental Assets Framework "identifies 40 research-based, positive experiences and qualities that influence young people's development, helping them become caring, responsible, and productive adults." The assets are divided into external assets (focused on relationships) and internal assets (focused on social-emotional strengths in youth). Building external assets would mean focusing on increasing social supports, empowering youth, establishing clear rules and consequences for youth behaviors, encouraging youth to make healthy choices, and creating opportunities for youth to engage in prosocial and after school programs to ensure they have opportunities that promote constructive use of time. Building internal assets would mean focusing on encouraging youth to believe in themselves, engage in opportunities for learning, build strong personal value systems that promote healthy life choices, learn strong social skills and healthy coping skills, and develop high self-esteem and a positive sense of self. A robust body of research supporting the impact that these assets have on youth well-being has been established.[102]

Use of the Socio-Ecological Model would allow Virginia's prevention leadership to ensure they are selecting a well-rounded set of risk and protective factors to prioritize, thus ensuring a coordinated and cohesive approach to prevention that acknowledges the multiple levels of influence that drive behavioral health outcomes.

The Icelandic Prevention Model

The Icelandic Prevention Model emphasizes creating environments that promote healthy lifestyles through "the collaboration of numerous parties, e.g. parents, teachers, community centers, sports clubs, and more.[103] The Icelandic Model uses a "toolkit approach" to health promotion, which assumes that communities vary greatly in strengths, opportunities, and resources.[104] The focus of the Icelandic Model is to strengthen protective factors and mitigate risk factors at the local community level within each of the domains of parents and family, the peer group, the school environment, and leisure time outside of school. The toolkit provides five guiding principles, including 1) applying a primary prevention approach, 2) engaging communities and schools, 3) engaging vested partners to engage in data-driven decision making, 4) integrating research, policy, practice, and the community in its implementation, and 5) ensuring the scope of solutions is aligned with the nature of the problem. The toolkit further outlines ten core steps for development, continuous monitoring, and improvement of efforts. Studies show that this theory-based approach has reduced substance use in Iceland over the past 20 years.[104] The model has expanded worldwide into over 30 countries, with resources and guidance now coordinated under the organization "Planet Youth." The Icelandic Prevention Model was recently adopted by the Public Health Agency of Canada[105] and the Washington State Tribal Prevention System.[106]

The Icelandic Prevention Model provides useful, actionable resources and guidance that can help inform Virginia's prevention approach. The model is well-suited to meeting the needs of diverse communities in acknowledging that approaches must be tailored to meet the capacity and resources of individual communities. Fully implementing the model with fidelity would require investment across agencies for it to be successful.

State Profiles

As a part of our literature review, we developed state profiles to better understand how and which states were already utilizing a risk and protective factor approach in their prevention systems. States were selected based on existing familiarity with other state approaches, information shared by state prevention leaders at the National Prevention Network conference in 2023, and availability of strategic plans or similar information on state agency websites. These profiles map out individual state approaches, risk and protective factors, funding allocations, and key strategies being prioritized at the state level.

These profiles are designed to help Virginia understand how other states are 'telling the story' of their prevention work and how they are centering risk and protective factors in their approach to addressing substance use and mental health in their communities. They may also provide opportunities for information sharing and relationship building across states with similar approaches.

Identifying a cohort of similarly positioned states in terms of prevalence rates can also create opportunities for improved monitoring and allow for a better understanding of the impact of a shared risk and protective factor approach, including how long it takes to see an impact from these types of interventions. To monitor such trends in the data, we selected relevant indicator data to compare across the identified states. In general, trends for alcohol, tobacco, and opioids are moving in the desired direction – meaning lower use rates across all states – with a few exceptions for alcohol and opioids. Use rates for cannabis have increased among all states, including Virginia, since 2017. Mental health outcomes were more mixed. All states have seen an increase in the percent of the population reporting a major depressive episode. However, some states have made positive strides in reducing the level of suicidal ideation, albeit not Virginia. Given that several states began their shared risk and protective factor initiatives in 2020 or 2022, some of these trends were already in progress before new structuring was in place.

Data below are from SAMHSA's National Survey on Drug Use and Health (NSDUH), displaying data for all adults, age 18 and older. Due to methodological differences while collecting data in 2020 during the COVID-19 pandemic, data for 2019-2020 were not released by SAMHSA.

Note: *Green indicates states where Virginia's outcomes or rates are more favorable, while gray indicates states where outcomes are more favorable than those in Virginia. Yellow indicates similar outcomes. Differences between Virginia and other states are only noted in the most recent year of data available to denote the most current comparisons available.*

	Measure		Arizona	Colorado	Ohio	Oregon	Utah	Virginia
Alcohol	Use in the Past Month	2021-2022	**50.3%** [46.2, 54.3]	**59.4%** [56.2, 62.6]	**53.1%** [50.8, 55.4]	**58.2%** [54.5, 61.8]	**32.6%** [29.8, 35.6]	**54.9%** **[52.5, 57.3]**
		2018-2019	**53.2%** [50.0, 56.3]	**64.9%** [61.9, 67.8]	**55.5%** [53.5, 57.4]	**61.7%** [58.7, 64.5]	**32.5%** [29.7, 35.3]	**55.3%** [52.8, 57.7]
		2017-2018	**54.3%** [51.1, 57.4]	**66.6%** [63.6, 69.4]	**55.1%** [53.1, 57.1]	**61.5%** [58.6, 64.4]	**31.1%** [28.5, 33.9}	**55.1%** [52.6, 57.7]
	Binge Drinking in the Past Month	2021-2022	**24.1%** [21.1, 27.5]	**26.6%** [23.7, 29.6]	**26.4%** [24.5, 28.4]	**24.0%** [21.3, 27.0]	**15.3%** [13.3, 17.6]	**23.2%** [21.3, 25.2]
		2018-2019	**23.1%** [20.8, 25.6]	**31.2%** [28.6, 34.0]	**26.7%** [25.1, 28.4]	**26.0%** [23.6, 28.6]	**17.9%** [16.0, 20.1]	**24.6%** [22.6, 26.6]
		2017-2018	**24.9%** [22.4, 27.6]	**32.5%** [29.7, 35.4]	**26.9%** [25.3, 28.5]	**26.5%** [24.1, 29.1]	**16.6%** [14.7, 18.7]	**24.6%** [22.7, 26.6]

	Measure		Arizona	Colorado	Ohio	Oregon	Utah	Virginia
Tobacco	Tobacco Product Use in the Past Month	2021-2022	**20.1%** [17.5, 23.1]	**19.8%** [17.5, 22.3]	**27.7%** [25.7, 29.8]	**19.6%** [17.1, 22.3]	**14.1%** [12.2, 16.2]	**19.5%** [17.7, 21.5]
		2018-2019	**20.5%** [18.2, 23.0]	**22.3%** [20.1, 24.6]	**29.1%** [27.4, 30.9]	**22.2%** [19.9, 24.6]	**15.8%** [13.9, 18.0]	**23.3%** [21.5, 25.2]
		2017-2018	**22.8%** [20.4, 25.4]	**23.1%** [20.9, 25.4]	**28.8%** [27.1, 30.5]	**22.5%** [20.4, 24.8]	**16.6%** [14.6, 18.7]	**21.7%** [20.0, 23.5]
	Cigarette Use in the Past Month	2021-2022	**16.1%** [13.8, 18.8]	**14.3%** [12.2, 16.5]	**23.1%** [21.2, 25.1]	**15.5%** [13.3, 17.9]	**10.1%** [9.0, 12.4]	**14.9%** [13.4, 16.6]
		2018-2019	**17.1%** [15.0, 19.3]	**17.6%** [14.7, 19.8]	**22.9%** [21.4, 24.5]	**17.1%** [15.2, 19.2]	**12.8%** [11.1, 14.7]	**17.9%** [16.2, 19.6]
		2017-2018	**18.6%** [16.4, 20.9]	**18.5%** [16.4, 20.6]	**23.2%** [21.7, 24.8]	**17.7%** [15.8, 19.9]	**13.7%** [11.9, 15.7]	**16.8%** [15.2, 18.5]
Cannabis	Use in the Past Month	2021-2022	**20.0%** [17.0, 23.2]	**20.5%** [18.1, 23.2]	**15.6%** [14.1, 17.3]	**23.0%** [20.2, 26.1]	**10.3%** [8.6, 12.1]	**13.9%** [12.1, 15.5]
		2018-2019	**11.5%** [9.7, 13.6]	**18.2%** [16.0, 20.5]	**10.6%** [9.6, 11.7]	**19.4%** [17.2, 21.8]	**6.7%** [5.5, 8.1]	**8.1%** [7.0, 9.4]
		2017-2018	**11.4%** [9.6, 13.6]	**18.1%** [15.9, 20.6]	**8.6%** [7.7, 9.6]	**19.7%** [17.4, 22.1]	**6.3%** [5.2, 7.6]	**7.4%** [6.4, 8.6]
Opioids	Heroin Use in the Past Year	2021-2022	**0.3%** [0.1, 0.6]	**0.3%** [0.1, 0.6]	**0.4%** [0.2, 0.7]	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.7]
		2018-2019	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.8]	**0.4%** [0.2, 0.7]	**0.5%** [0.3, 1.0]	**0.3%** [0.2, 0.6]	**0.3%** [0.2, 0.6]
		2017-2018	**0.3%** [0.1, 0.5]	**0.4%** [0.2, 0.7]	**0.5%** [0.3, 0.8]	**0.4%** [0.2, 0.8]	**0.3%** [0.2, 0.6]	**0.4%** [0.2, 0.7]
	Pain Reliever Misuse in the Past Year	2021-2022	**3.5%** [2.6, 4.6]	**3.3%** [2.5, 4.3]	**3.5%** [2.8, 4.3]	**4.0%** [3.1, 5.2]	**3.6%** [2.8, 4.6]	**2.8%** [2.2, 3.5]
		2018-2019	**3.9%** [3.2, 4.9]	**4.1%** [3.3, 5.1]	**4.1%** [3.5, 4.8]	**4.7%** [3.8, 5.9]	**3.9%** [3.2, 4.7]	**3.5%** [2.9, 4.2]
		2017-2018	**4.2%** [3.4, 5.1]	**4.8%** [3.9, 5.8]	**4.3%** [3.7, 5.0]	**4.6%** [3.8, 5.7]	**3.9%** [3.3, 4.7]	**3.6%** [3.0, 4.3]

	Measure		Arizona	Colorado	Ohio	Oregon	Utah	Virginia
Mental Health	Major Depressive Episode in the Past Year	2021-2022	**9.1%** [7.7, 10.6]	**10.2%** [8.8, 11.8]	**9.5%** [8.5, 10.6]	**11.1%** [9.5, 12.9]	**11.0%** [9.6, 12.5]	**7.9%** [7.1, 8.9]
		2018-2019	**7.8%** [6.7, 9.2]	**8.5%** [7.3, 9.8]	**8.8%** [8.0, 9.8]	**9.5%** [8.1, 11.1]	**9.8%** [8.6, 11.2]	**7.0%** [6.1, 8.0]
		2017-2018	**7.2%** [6.0, 8.6]	**8.6%** [7.3, 10.0]	**8.0%** [7.1, 9.0]	**8.9%** [7.6, 10.4]	**10.0%** [8.7, 11.4]	**6.3%** [5.3, 7.4]
	Serious Thoughts of Suicide in the Past Year	2021-2022	**5.2%** [4.3, 6.1]	**5.9%** [5.0, 7.0]	**5.2%** [4.6, 5.9]	**5.6%** [4.8, 6.6]	**7.1%** [6.2, 8.2]	**4.8%** [4.1, 5.5]
		2018-2019	**5.0%** [4.1, 6.1]	**5.5%** [4.6, 6.7]	**6.1%** [5.4, 6.9]	**5.7%** [4.7, 6.8]	**6.2%** [5.2, 7.4]	**4.2%** [3.5, 5.0]
		2017-2018	**4.4%** [3.6, 5.5]	**5.5%** [4.5, 6.7]	**5.2%** [4.5, 5.9]	**5.4%** [4.4, 6.5]	**6.5%** [5.4, 7.7]	**4.1%** [3.5, 5.0]

To understand how a risk and protective factor approach is applied at a community level, state profiles also highlight priority strategies identified by states. Throughout the state profiles, strategies are organized using the Center for Substance Abuse and Prevention's (CSAP)'s six prevention strategy classifications (commonly referred to as CSAP strategies):[107]

INFORMATION DISSEMINATION

Information dissemination strategies provide awareness and knowledge of the nature and extent of alcohol, tobacco, and drug use, misuse, and addiction, and their effects on individuals, families, and communities. They also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

EDUCATION

Education strategies involve two-way communication and are distinguished from information dissemination strategies by the fact that interaction between the educator/facilitator and the participants is the basis of their activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systemic judgment abilities.

ALTERNATIVE ACTIVITIES

Alternative activities strategies encourage the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs and would, therefore, minimize or remove the need to use these substances.

PROBLEM IDENTIFICATION AND REFERRAL

Problem identification and referral strategies aim to identify those individuals who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs and to assess if their behavior can be reversed through education. It should be noted, however, that these strategies do not include any activity designed to determine if a person is in need of treatment.

COMMUNITY-BASED PROCESS

Community-based process strategies aim to enhance the ability of the community to more effectively provide prevention services for substance use disorders and suicide. Activities in these strategies include organizing, planning, and enhancing the efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking.

ENVIRONMENTAL

Environmental strategies establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco, and other drugs in the general population. These strategies are divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to service and action-oriented initiatives.

Arizona

Prevention Framework

In December 2020, Arizona Health Care Cost Containment System (AHCCCS) published its Strategic Plan in which its vision, values, and purpose are described as person-centered, community-based, demonstrating cultural competence, and are compassionate and equity-focused in nature.[108] Arizona uses the Socio-Ecological Model to understand the risk and protective factors they wish to address. This prevention model is focused on addressing community-level and youth-specific factors.

Community-focused risk and protective factors:

- Social isolation
- Family connection
- Mental health
- Healthy relationships

Youth-specific risk and protective factors:

- Academic engagement
- Conflict resolution
- Self-esteem
- Communication
- Peer pressure

SAMHSA Funding Allocations[109]

Non-Discretionary Funding	Arizona Population[110]: 7.2 million	Virginia Population: 8.6 million
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)	$23,915,312	$23,786,958
Community Mental Health Services Block Grant (MHBG)	$23,109,821	$24,405,709
Projects for Assistance in Transition from Homelessness (PATH)	$0	$0
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	$695,410	$755,026
Total	**$47,720,643**	**$48,947,693**

Discretionary Funding

	Arizona	Virginia
Mental Health	$499,523	$125,000
Substance Use Prevention	$0	$0
Substance Use Treatment	$0	$0
Total	**$499,523**	**$125,000**

Overall Funding

	Arizona	Virginia
Mental Health	$24,304,754	$25,285,735
Substance Use	$23,915,412	$23,786,958
Total Funds	**$48,220,166**	**$48,072,693**

Strategies and Implementation

Arizona distributes SUBG funds to select grantees through regular RFPs. The next funding application is anticipated to be available in 2026. Part of Arizona's SUBG funding is allocated to their "Trauma-Informed Substance Abuse Prevention Program (TISAPP)", which aims to prevent substance use by supporting and expanding the use of trauma-informed care principles. TISAPP grantees represent a mix of community organizations, nonprofits, behavioral health service providers, school districts, and county government offices.

Key Strategies by CSAP Classification

Environmental
- Policies restricting sales and marketing of vapor products to youth

Prevention Education
- Family programs on trauma-informed care
- School-based prevention education programs

Information Dissemination
- Utilizing social media to reach parents and youth
- Media campaigns on risk factors and consequences
- Media campaigns to increase awareness of telehealth

Alternatives
- Culturally relevant well-being-focused community activities
- Family recreational programs

Identification of Programs and Referral to Services
- Programs to increase knowledge of referral options and processes

Community-Based Process
- Coalition development
- Trauma-informed community networks

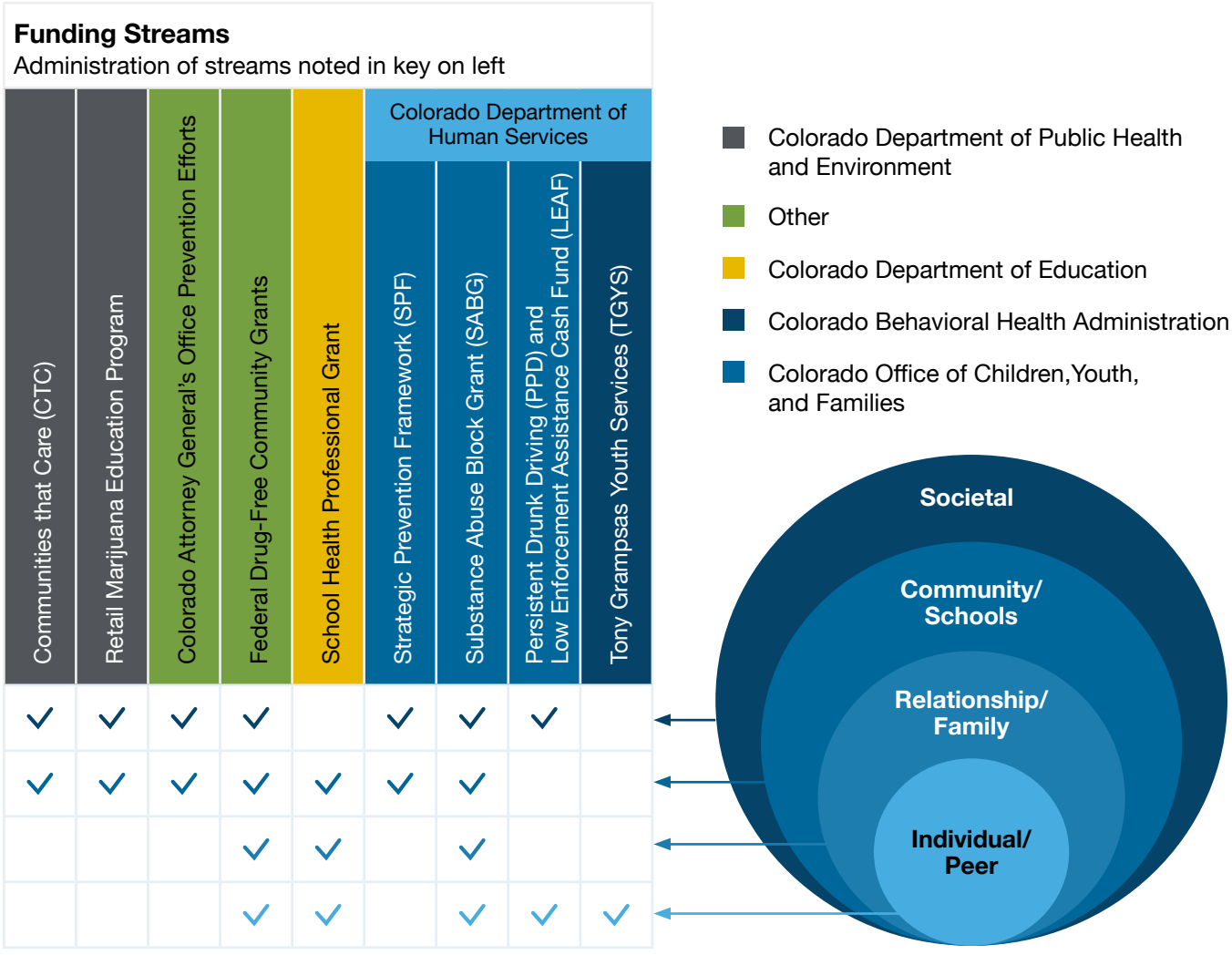
Colorado

Prevention Framework

The Colorado Health Institute published its Statewide Strategic Plan in 2019, funded by the Colorado Behavioral Health Administration (BHA). The strategic plan takes a shared risk and protective approach to preventing substance use.[111] Colorado uses the Socio-Ecological Model (SEM) to structure its programs and is focused on upstream factors — conditions that affect health outside of individual characteristics and the health care system. These are also known as social determinants of health. SUBG funds are leveraged to address all areas of the SEM, with an emphasis on the following protective factors in focus:

- Building youth resilience
- Strengthening families, communities, and schools
- Changing environments, policies, and social norms

Colorado's strategic plan aims to strengthen the prevention system in place in Colorado by coordinating funders and the efforts they support. It outlines distinct, coordinated roles for prevention funders to play to best support and strengthen the system and actively identifies where various state agencies and funding streams are focused within the SEM (illustrated below).



In addition to utilization of the SEM, Colorado actively utilizes the Communities that Care model to build community capacity and engagement.

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

SAMHSA Funding Allocations[109]

Non-Discretionary Funding	Colorado Population: 5.8 million	Virginia Population: 8.6 million
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)	$19,113,973	$23,786,958
Community Mental Health Services Block Grant (MHBG)	$18,627,388	$24,405,709
Projects for Assistance in Transition from Homelessness (PATH)	$0	$0
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	$492,538	$755,026
Total	**$37,232,899**	**$48,947,693**

Discretionary Funding	Colorado	Virginia
Mental Health	$499,523	$125,000
Substance Use Prevention	$0	$0
Substance Use Treatment	$0	$0
Total	**$499,523**	**$125,000**

Overall Funding	Colorado	Virginia
Mental Health	$24,304,754	$25,285,735
Substance Use	$23,915,412	$23,786,958
Total Funds	**$48,220,166**	**$48,072,693**

Strategies and Implementation

Colorado's SUBG funds are awarded to select grantees through regular RFPs, which include a mix of government entities (e.g. counties, cities, schools, school districts, universities, health and human services departments, etc.), tribal entities, nonprofits, community-based organizations, coalitions, and faith-based organizations. Grantee programs are organized under three categories:

- Under-Resourced High-Needs Programs
- Priority Population Programs
- Evidence-Based Programs and Policies

Key Strategies by CSAP Classification

Environmental
- Regulatory policies and laws restricting underage sales and limiting retailer density

Prevention Education
- LifeSkills Trainings
- Strengthening Families
- Mentorship programs

Information Dissemination
- Information dissemination for youth and families

Alternatives
- Youth prosocial programs

Identification of Programs and Referral to Services
- School-based mentoring programs for at-risk youth

Community-Based Process
- Suicide prevention trainings

Ohio

Prevention Framework

The goal of Ohio's Prevention Strategic Plan for 2021 – 2024 is to increase the knowledge, skills, and abilities of community coalition leaders to implement systemic changes that can mitigate a broad variety of risk factors and develop protective factors capable of impacting mental, emotional, and behavioral disorders including substance use, suicide, and problem gambling. Ohio's prevention work is guided by several frameworks and theories that center risk and protective factors:

- Social Developmental Strategy
- Resiliency Theory
- MEB Health Promotion and Prevention
- Socio-Ecological Model
- The Collective Impact (CI) Approach
- Prevention Institute's Tool for Health and Resilience in Vulnerable Environments (THRIVE), complemented by the Adverse Community Experiences and Resilience Framework (ACE|R)
- The Youth Empowerment Conceptual Framework (YECF)

Funding Allocations[109]

Non-Discretionary Funding	Ohio Population: 11.8 million	Virginia Population: 8.6 million
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)	$33,045,089	$23,786,958
Community Mental Health Services Block Grant (MHBG)	$30,285,423	$24,405,709
Projects for Assistance in Transition from Homelessness (PATH)	$0	$0
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	$1,111,335	$755,026
Total	**$64,441,847**	**$48,947,693**

Discretionary Funding	Ohio	Virginia
Mental Health	$2,400,000	$125,000
Substance Use Prevention	$50,000	$0
Substance Use Treatment	$360,987	$0
Total	**$2,810,987**	**$125,000**

Overall Funding	Ohio	Virginia
Mental Health	$33,796,758	$25,285,735
Substance Use	$33,456,076	$23,786,958
Total Funds	**$67,252,834**	**$48,072,693**

Strategies and Implementation

Ohio manages 50 County Behavioral Health Boards, across which its 88 counties are distributed. In addition, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) issues RFPs and contracts with vendors and agencies for providing services. OhioMHAS funds 32 programs/services.

Key Strategies by CSAP Classification

Environmental
- Unknown

Prevention Education
- Ohio Children of Incarcerated Parents Initiative
- Youth-adult mentorship programs

Information Dissemination
- Media campaigns
- Community presentations

Alternatives
- Before and after school programs
- Youth leadership programs

Identification of Programs and Referral to Services
- Problem ID and referral programs in K-12 and postsecondary schools

Community-Based Process
- Mental Health First Aid
- Crisis Intervention Training
- Coalition development
- Technical assistance programs for community groups and workplaces

Oregon

Prevention Framework

In Ohio, primary prevention and population-based substance use prevention initiatives are coordinated through the Oregon Health Authority-Public Health Division (OHA-PHD). OHA-PHD endorses the Oregon Alcohol and Drug Policy Commission's (OADPC) 2020-2025 Strategic Plan. While the plan does not note a specific framework in use, it was developed with an understanding of "substance misuse as a complex issue requiring comprehensive solutions coordinated across multiple sectors." The plan sought to identify "primary contributors to ATOD-related problems before jumping to strategies and activities." Strategies were identified that have the strongest documented effect on outcomes for priority populations and substances.[112] The OADPC's Strategic Plan outlines the following key prevention priorities:

- Increasing access to family- and school-based intervention programs
- Decreasing the availability and excessive marketing of harmful products
- Reducing retail and social access to psychoactive substances for those who are underage
- Increasing perceptions of harm
- Decreasing over-serving of alcohol in restaurants and bars and general sales of alcohol to individuals who are impaired
- Increasing the use of health-promoting laws and policies
- Strengthening the use of effective early intervention and harm reduction strategies, including Kindergarten to postsecondary student assistance programs and EAP
- Increasing access to alternative pain and stress management therapies
- Strengthening and expanding the prevention workforce

SAMHSA Funding Allocations[109]

Non-Discretionary Funding	Oregon Population: 4.2 million	Virginia Population: 8.6 million
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)	$13,094,334	$23,786,958
Community Mental Health Services Block Grant (MHBG)	$15,232,494	$24,405,709
Projects for Assistance in Transition from Homelessness (PATH)	$0	$0
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	$473,700	$755,026
Total	**$28,800,528**	**$48,947,693**

Discretionary Funding	Oregon	Virginia
Mental Health	$800,000	$125,000
Substance Use Prevention	$0	$0
Substance Use Treatment	$0	$0
Total:	**$800,000**	**$125,000**

Overall Funding	Oregon	Virginia
Mental Health	$16,506,194	$25,285,735
Substance Use	$13,094,334	$23,786,958
Total Funds	**$29,600,528**	**$48,072,693**

Strategies and Implementation

One of Oregon's objectives is to increase the ability of all system members to use evidence-based practices, policies, programs, and services. Part of this work is targeting one or more substance use risk and protective factors. Services in Oregon are delivered through Tribal programs, community mental health programs, local public health departments, individual health care provider agreements, coordinated care organizations (CCOs), and other partners.

Key Strategies by CSAP Classification

Environmental

- Alcohol, Tobacco, and Cannabis retailer compliance checks
- Retailer merchant education
- Regulatory policies and laws restricting underage sales and limiting retailer density
- Increased tobacco sales tax, coupon limits, and minimum prices and dedication of tax revenue for prevention and control programs
- Supporting implementation of vape- and smoke-free campus policies

Prevention Education

- School- and community-based family support programs

Information Dissemination

- Implementation of media and public health education campaigns to educate parents, caregivers, and family members about substance use risks on youth, older adults, and vulnerable populations
- Alcohol-free community and other events

Alternatives

- Prosocial programs for youth

Identification of Programs and Referral to Services

- Problem ID and referral programs in K-12 and postsecondary schools

Community-Based Process

- Safe Serve Trainings

Utah

Prevention Framework

The Office of Substance Use and Mental Health (OSUMH), under the Utah Department of Health and Human Services, consults and coordinates with federal, state, and local partners regarding programs and services. The office also contracts for substance use and mental health programs funded with state and federal funds. A state-level Utah Substance Abuse Advisory Council also works on coordinating prevention programs. The Utah Department of Health is using a shared risk and protective factor approach to improve collaboration across sectors, both at the state and local levels. Through partnerships with the local health departments, communities have been trained on primary prevention principles and social determinants, including identifying and addressing root causes that affect communities. Utah actively engages the Communities that Care model to build community capacity. Risk and protective factors targeted by Utah include:

- Anti-social behavior
- Access and utilization of health care
- Commitment to school
- Coping skills
- Emotional regulation
- Enhanced physical environments that improve safe and healthy living
- Family conflict
- Family management
- Individual, family, and community connectedness
- Parental knowledge of parenting skills
- Risk perceptions
- Prosocial engagement
- Self-esteem
- Social skills
- Socioeconomic conditions
- Social norms that promote safety and health
- Underage alcohol use

In 2020, Utah reported significant evidence that prevention investments have resulted in a steady decrease in youth use rates in nearly all substance use categories in the state.[113]

Funding Allocations[109]

Non-Discretionary Funding	Utah Population: 3.8 million	Virginia Population: 8.6 million
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)	$12,755,925	$23,786,958
Community Mental Health Services Block Grant (MHBG)	$10,959,193	$24,405,709
Projects for Assistance in Transition from Homelessness (PATH)	$0	$0
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	$473,700	$755,026
Total	**$24,188,818**	**$48,947,693**

Discretionary Funding	Utah	Virginia
Mental Health	$218,324	$125,000
Substance Use Prevention	$0	$0
Substance Use Treatment	$0	$0
Total:	**$218,324**	**$125,000**

Overall Funding	Utah	Virginia
Mental Health	$11,651,217	$25,285,735
Substance Use	$12,755,925	$23,786,958
Total Funds	**$24,407,142**	**$48,072,693**

Strategies and Implementation

Providers in Utah implement a wide range of strategies. A full inventory of prevention strategies implemented in Utah, last updated in 2020, is available here.

Key Strategies by CSAP Classification

Environmental
- Retailer merchant education
- Regulatory policies and laws restricting underage sales and limiting retailer density
- Lethal means safety

Education
- Life Skills Training
- Parents Empowered
- Safe Dates
- Grandfamilies

Information Dissemination
- Media campaigns (Know Your Script and Gray Matters)

Alternatives
- After school programs

Identification of Programs and Referral to Services
- Anger management programming

Community-Based Process
- Suicide prevention programs
- Coalition development

Qualitative Data Collection

Gathering perspectives of prevention staff is important to ensuring that assessment efforts are not only data-driven, but also community-connected. Prevention staff provide a vital voice for those they serve within their catchment areas and provide insights into capacity issues, challenges with implementation, community needs and readiness, and agency support needs. OMNI and OBHW plan to incorporate prevention staff perspectives throughout the upcoming strategic planning process to ensure that outcomes are tailored to the needs and strengths of the prevention workforce and their communities.

To ensure that the voices of local prevention staff were incorporated into this needs assessment, the OMNI team led a series of focus groups with CSB staff. These focus groups surfaced prevention needs at the community and workforce levels, identified misalignment between state and local needs, explored potential priorities not reflected in the broader research conducted, and identified challenges or limitations experienced in implementing the current state strategic plan. Thirty-two CSB prevention staff across twenty-one organizations participated in one of five virtual focus groups, with nine CSB staff also attending a follow-up in-person focus group. Focus group questions included topics such as programming, funding, staffing, partnerships, and overall prevention models. CSB staff were also asked to share successes and challenges encountered in their ongoing prevention work and to reflect on how they can leverage their successes to continue to positively impact their communities moving forward. In addition to focus groups with CSB staff, a focus group was held with staff within OBHW to gather perspectives of those coordinating efforts and supporting CSBs at the state-level.

Community Alignment with State Priorities

CSB staff participants shared their perspectives on the current statewide prevention framework and its alignment with the experiences and priorities at the CSB and community levels.

In the current statewide strategic plan, priority strategies are generally focused on impacting a specific substance or issue area. CSB staff surfaced that this creates capacity issues, as staff time is spread across a vast number of strategies to ensure each issue is being addressed. The wide range of prevention work and priorities, it was noted, also contributed to information overload among community members as they struggle to understand what the key issues are that they should be focusing on.

Staff also shared frustrations with state-level requirements dictating the level of resources allocated towards specific strategies or issues that keeps them from being able to meet the needs of the populations they are serving. Because the needs vary across communities, the lack of flexibility around what to prioritize felt like a point of disconnect.

> *Honestly, a lot of times it feels more like a firefighting method. Like what's the highest priority today? Let's tackle that.*
>
> CSB PREVENTION STAFF

Allowing for some flexibility in the use of funds or increasing the amount of funds that can be utilized for implementation of community-driven strategies can help CSBs to better meet the unique needs and demands of their communities. Consider an a la carte menu offering of priority areas/strategies, rather than a fixed course menu.

Mental health and suicide were identified as the most important problem areas at both the state and community levels. However, CSB staff shared dissatisfaction with the amount of funding received to do work in this area, noting that the funding amount has not changed in some time despite increasing need and demand for mental health and suicide related programming from communities. The demand for these types of programs has exceeded their capacity to provide them.

Reassessing the amount of funding going towards mental health and suicide prevention initiatives, including regional suicide prevention initiative funding to ensure CSBs, can better meet the demands from their communities and partners.

CSB staff noted that their community members prioritize prevention areas based on the severity/lethality of the issue and can feel reactive in nature. Staff specifically referenced ongoing opioid work as appearing higher priority to community members when compared to state priorities, due to a greater risk of lethality associated with opioids. These sentiments were shared by OBHW staff, who also recognized the reactive nature of prevention efforts and agreed that this approach to prevention is not sustainable long-term and contributes to burn-out. CSBs shared a desire to see the prevention field shift to take on a more holistic view of prevention and an increased focus on primary prevention efforts that addresses the overarching factors that drive behavioral outcomes.

Key Takeaways

- ✓ CSB staff participants agreed that all priority areas are important, but feel more focus should be given to suicide prevention, including providing adequate funding.
- ✓ Current demarcation of prevention work by individual substance or issue area negatively impacts CSB capacity and contributes to burnout.
- ✓ The ways in which priority areas are determined, especially by communities, is seen as reactive and focusing primarily on high severity/lethality issues and leading to disinvestment or disengagement in other prevention areas.
- ✓ CSB staff participants see the value in a more holistic and less substance- or outcome-driven approach to prevention.

Prevention Approach

CSB staff participants were also asked about their familiarity with prominent prevention models that may support a more cohesive prevention approach in Virginia. CSBs were familiar with SAMHSA's Strategic Prevention Framework (SPF) and most used it in their work, some noting that, given capacity strains, it is all they typically have time to utilize. While more tenured staff members (those who have been in the field for over a decade) were familiar with community and protective factor driven prevention work, namely stemming from their familiarity working within the Communities That Care model, most CSB staff were not aware of other prevention frameworks or models that could be used to guide their efforts. The prevention approach, tenured staff reflect, seems to be coming full circle and returning to similar models as what they worked in early in their careers.

> *I'm only even vaguely familiar with other prevention models because I have a degree in public health, so I know there are other models out there. SPF is all we have time for.*
>
> CSB PREVENTION STAFF

Seasoned prevention staff offer a unique perspective on the strengths and weaknesses within current and past prevention models. Creating opportunities for these staff members to provide input during planning efforts can also serve to increase buy-in from staff who may feel that the wheel is being re-invented.

Key Takeaways

- ✓ CSB staff participants are mostly familiar with Strategic Prevention Framework but feel it may not be sustainable or enough.
- ✓ Seasoned prevention staff see a shift to a risk and protective factor driven model as coming full circle and returning to approaches they saw early in their careers.

Risk & Protective Factors Driving Behavioral Health Outcomes

CSB staff participants were asked about their communities' strengths and what protective factors they saw as being especially impactful in promoting behavioral health and wellbeing, as well as what risk factors were driving negative behavioral health outcomes in communities.

CSB staff highlighted family dynamics as a major contributing factor impacting youth substance use. Staff shared that when families in their communities engage in substance use, it creates a ripple effect and leads youth to feel that their parents are accepting of use and that there is low risk associated with use. Further, they shared that family use facilitates easy access to substances in homes. Several CSB staff participants noted that parental and family involvement in parenting education and family management programs has historically predicted greater long-term engagement in their CSB's programming. As families and youth graduated out of said programs, they saw families placing greater value on efforts promoting behavioral health and wellbeing and continued to stay involved with CSB staff and activities.

Participation in parenting and family management programs can increase long-term community engagement with CSB programming. Increased investment in these programs has the potential to build community readiness and investment in prevention.

Social isolation and overall lack of social support were identified by CSB staff as prime drivers impacting behavioral health outcomes - especially among youth. CSB staff participants noted that many youth lack trusted adults and mentors. Having trusted adults, peers, and mentors available and engaged with youth in the community, along with opportunities for prosocial and extra-curricular programming, were seen as an important protective factor. These programs provide access to supportive resources and are needed to combat ever increasing rates of social isolation among youth.

Prosocial and extra-curricular programming can serve to address multiple risk and protective factors simultaneously by addressing social isolation and lack of social supports while building connection with trusted adults and mentors and supporting the development of healthy coping skills and self-esteem.

Social stigma continues to undermine prevention efforts and engagement. CSB staff working in rural or low-income areas shared that mental health and substance use are still topics that are not talked about openly in their communities. This is further compounded by cultural norms in some communities that discourage open discussion of these topics. CSB staff participants called for increased partnerships with trusted sources in their communities to share prevention messaging and increase engagement in programming. CSB prevention programs, they shared, do not always have the capacity or shared lived experiences needed to connect with marginalized communities. These partnerships can support them in building these connections.

Increased investment in partnership and coalition development that prioritizes those working with communities who have been marginalized and those with lived experience can help CSBs build stronger connections with individuals most in need for the services they are providing.

> *Primary prevention is not valued in our communities. There's such a disconnect… I can't do a gambling coalition because no one thinks it's a problem.*
>
> CSB PREVENTION STAFF

Retailer compliance with regulations restricting underage sales was also seen as a challenge as CSBs work to reduce access to substances, especially for those who are underage. CSB staff participants shared frustrations with lack of enforcement of regulations. During CounterTools and other merchant education visits, they are often left waiting for law enforcement or other entities to address concerns with retailers since they are not able to enforce regulations themselves. They shared that who is responsible for enforcement is not always clear to begin with, making it difficult for CSBs to know who to engage when issues arise. Retail access to gambling and cannabis products was commonly observed among CSBs, with skill games and synthetic cannabis products (including Delta 8), readily available and poorly regulated.

Improved state-level coordination and clear identification of regulatory bodies, as well as clear procedures for reporting issues, can help reinforce prevention efforts to address easy access and reduce underage sales of alcohol, cannabis, tobacco, and gambling products.

Unsurprisingly, CSB staff participants identified several social determinants of health that are affecting behavioral health outcomes. The rising cost of living in their communities is creating significant financial strains and community members are too focused on making ends meet to be able to participate in events or programs. Even when folks are looking to participate, many find it hard to attend due to lack of transportation or childcare. Partnerships that allow CSBs to host events at schools or in other community centers that are more accessible to community members help bridge that gap, though competition for time and resources can make these partnerships challenging.

Key Takeaways & Protective Factors

- ✓ Active Parenting and Parental Involvement
- ✓ Parental Approval, Disapproval, and Use
- ✓ Trusted Adults, Peers, and Mentors
- ✓ Social Supports
- ✓ Easy Access
- ✓ Stigma
- ✓ Social Supports
- ✓ Lack of Transportation
- ✓ Lack of Income
- ✓ Lack of Childcare

> *People …[will] take a brochure home...but they don't have two hours to come sit in a parenting program. They don't have two hours to come sit at any kind of program. They all have kids where we live, childcare is low, transportation is horrible… especially for us and any other smaller rural community."*
>
> CSB PREVENTION STAFF

Priority Populations

To identify areas of focus and advance health equity across Virginia, CSB prevention staff provided insights on their connections to vulnerable populations and what communities they see as currently being underserved. CSB staff pride themselves on being community centered and noted that their connection to the community is the primary facilitator for engaging in meaningful prevention work. Many prevention staff have been doing this work for years and have come to know their community members and their needs well, especially those serving smaller or more rural catchment areas.

Youth and families were identified as priority populations across all participating prevention program staff. There is both need for and interest in engaging more in school- and family-based settings, though some participants shared challenges with establishing partnerships with educational institutions due to parental resistance and competing priorities for classroom time. Being able to identify and address mental, behavioral, or substance use concerns at a younger age and supporting healthy, supportive family dynamics, they noted, has a lot of impact in improving behavioral health outcomes across the lifespan. Being able to connect directly with youth allows CSBs to provide them with the resources they need to forge healthy paths to adulthood. CSBs also shared successes building increased connection with young adult populations as a result of Young Adult Survey collection efforts in recent years, and the need to better serve this population.

Prioritizing programs that focus on early childhood through young adulthood can have lasting impact on long-term behavioral health outcomes by creating healthy paths to adulthood and addressing risk and protective factors during key developmental stages.

Older adults, LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning individuals) and BIPOC (Black, Indigenous, and People of Color) individuals, and faith-based and refugee communities were also identified as target populations, with prevention efforts focusing on reducing social stigma, promoting healthy coping skills, and building resiliency and connection. Though some CSB staff noted interest in being more involved with these populations, they also recognized that community partners often have stronger, more trusted relationships with those populations that can both facilitate stronger interventions and help fill any gaps that their own CSB cannot address.

Key Priority Populations

- ✓ Families
- ✓ Youth and Children
- ✓ Young Adults
- ✓ Older Adults
- ✓ LGBTQ+
- ✓ BIPOC
- ✓ Faith-based communities
- ✓ Refugee communities

Community Partnerships & Coalitions

Throughout conversations with CSB prevention staff participants, community partnerships and coalitions were highlighted as critical facilitators in their ability to carry out prevention work. Partners often serve populations or focus areas that are beyond the CSB's expertise in a way that reinforces CSB efforts, fills in gaps, or provides wraparound services, altogether paving the way for a more holistic wellness approach. CSBs and communities recognize the importance of having invested partners involved but find it difficult to engage with other organizations and coalitions due to constrained staff and community member time and funding at the CSB and community organization level. CSB staff participants indicated that both their staff and community members are feeling overburdened. Combined with the lack of dedicated resources, this can quickly cause partnerships to crumble.

Coalitions play a vital role in providing a direct connection between CSBs, partner organizations, and community members, and contribute to building community capacity and engagement in prevention efforts. Although coalitions are successful and valued, CSB staff participants noted that there must be a dedicated staff person to coordinate efforts to ensure their success. Several CSB staff shared that their CSBs utilized ARPA funding to hire a coalition coordinator over the past couple of years. Coalition coordinators focus on building coalition engagement and increasing partnerships. Without these coordinators, they shared, maintaining their coalition's function – let alone building coalition capacity – are challenging. ARPA funds are set to expire at the end of 2024 - CSBs who have leveraged these funds to hire for coalition-focused roles fear that terminating these positions due to lack of funding will cause them to lose the momentum that these roles have allowed them to build across their coalitions.

Increased funding to support CSBs in hiring coalition coordinators boosts coalition engagement and functioning. High functioning coalitions can help mitigate capacity constraints at the CSB level by increasing the availability of resources to support their efforts.

Schools and community-based organizations, including youth and community resource centers, also serve as crucial partners supporting community prevention efforts. Some CSBs shared success in creating strong partnerships with retailers who are not only following regulations but are actively supporting prevention work and identifying the important role they serve in helping reduce youth access substances. Overall, CSB staff see the need to continue to foster relationships with partner agencies at both the community and state level, but often lack the time they need to be able to foster these relationships. CSB staff participants feel like their communities are being oversaturated with information from CSBs and their partners, who, it was noted, are often doing similar work. CSBs shared a desire for less duplication of efforts across agencies, including between DBHDS and other state-level agencies such as VDH or DOE. CSB staff shared feeling like they are often in competition with other state agencies, such as the Virginia Department of Health (VDH), finding that efforts are duplicated and inconsistently implemented. This creates confusion among community members about where programs are coming from or who to turn to for resources. They believe that having the support of OBHW to make and encourage these connections will help improve overall communications, community outcomes, and improved utilization of resources. OBHW staff shared similar views, identifying a lack of collaboration in the Commonwealth as a whole –across state- and community-level agencies, as well as between CSBs. This gap, they noted, creates a disconnected and disorganized prevention approach.

Developing stronger state-level partnerships and collaboration can increase the availability of resources dedicated to prevention work across Virginia and allow for prevention efforts across agencies to be better coordinated and mutually reinforcing.

Key Takeaways

- ✓ Dedicated coalition coordinators can greatly improve coalition engagement and effectiveness.
- ✓ There is duplication of efforts happening across state- and community-level agencies that contributes to an uncoordinated prevention approach.

CSB Capacity Challenges

CSB staff were asked to elaborate on the capacity-related challenges they have encountered due to the current prevention model on the workforce and surface additional supports that may be needed. As prevention work has continued to expand throughout the years into additional problem areas, efforts have become less targeted and efficient, they shared. Prevention staff are expected to be experts across all prevention areas, which can be overwhelming – especially for new staff. Some described the current prevention model as having a cradle-to-grave approach, focused on reaching as many people as possible and at all points of the lifespan. This approach, they noted, does not allow them the time they need to develop meaningful connections with community members that have a lasting impact. CSB staff participants mentioned that the statewide push to focus on environmental strategies and implement media campaigns pulls them away from being able to engage directly with their communities face-to-face. As a result, some CSB staff participants have pivoted to explore and rely more on other funding sources outside of OBHW that allow them to focus on community-level connection and approach prevention efforts more holistically.

> *I don't like that we address them as separate issues. I don't think they are separate issues. I would rather change our culture to where we have intentional, focused, and connected conversations and that people felt belonging.*
>
> CSB PREVENTION STAFF

> *I think it's hard for us to do everything we're doing… I mean for one person to worry about Mental Health First Aid, ACEs, QPR, REVIVE!, YAS survey, Lock and Talk - it's a lot of stuff that we do. And it's sometimes hard with the funding that we have to balance all of that… I have a lot of my county-funded staff running around trying to meet the performance measures for the state versus actually doing the programs in the community that we have for youth, the afterschool and the things that we know are very impactful. You know, it's a weird balance for us trying to do everything we're trying that we have to do, plus doing the meaningful programs and having programs for youth and all the things that we want to do that we know works."*
>
> CSB PREVENTION STAFF

The wide range and scope of strategies CSBs are implementing also creates a burden around data entry. CSBs are often expected to enter multiple entries in PBPS for the same event – a result of implementing multiple strategies simultaneously and limitations within the data system that prevent them from being able to track these types of efforts.

Data system improvements to allow CSBs to enter fewer activities for events where they are implementing more than one strategy can help reduce data entry burden.

> *We can say that [separating substances] made data entry more complicated because a lot of the same substances have similar strategies. You know, if we're doing a community event, we're not going to just talk about tobacco, we're not going to just talk about alcohol or opioids, we're going to talk about everything because you have a captive audience, you have people there that want to talk, we're going to talk about everything.*
>
> CSB PREVENTION STAFF

Keeping up to date on data entry while managing ongoing community efforts is especially difficult for CSBs navigating turnover among staff. Staff turnover continues to impact much of the CSB prevention workforce capacity. Lack of staffing requires many staff members to frequently work evenings and weekends in order to be present at community events, limiting their time and ability to relax and prepare for their work. Across the board, CSB staff shared frustrations about the ever-expanding scope of their roles, with many having to take on the role of being media and graphic design expert for campaigns, along with other things that they are not formally trained in. Many staff shared stories of themselves and their colleagues working second jobs to make ends meet. Staff at several CSBs have transitioned to other higher-paying and more specialized positions within their CSBs or at other agencies, such as VDH, sometimes taking on near identical roles elsewhere for much greater salaries. Low pay, along with lack of incentives for increased education or certifications, has led to a shift in how the prevention field is perceived by the work force. Rather than being seen as a career track, one seasoned CSB staff noted, prevention roles are now seen as simply a job. Prevention programs struggle to recover when departing staff are specialized in a certain topic or trained as a facilitator for a curriculum. When new staff come in, participants shared, they are often overwhelmed and isolated, especially those working in smaller CSB prevention programs. CSB and OBHW staff alike identified the need for increased training and mentorship opportunities for CSB prevention staff to create a stronger, more connected prevention workforce.

Providing training opportunities and creating formal mentorship opportunities for new and existing staff may help CSB prevention staff can help prevention staff feel more supported by DBHDS and create a stronger, more connected prevention workforce.

Increased investment in the prevention workforce through salary improvement and incentives, or recognition of individuals attaining higher prevention-relevant education and/or certifications, can strengthen the prevention career track and decrease staff turnover.

While CSB staff participants recognize the importance of providing training opportunities to community members, they felt that some curricula are not well-suited to meeting the needs of community members. The eight hours required to complete Mental Health First Aid, for instance, is not always feasible for attendees and leads to low turnout. Further contributing to a lack of turnout is a feeling that training content for some curricula are not up to date or available at the level of depth needed. The saturation of ACEs training content is high at this point and was provided as a specific example by CSB staff participants. Community members and CSB staff alike, they shared, are looking for resources and trainings that allow them to build on the existing trainings and take that next step in building their prevention skillset.

New or expanded training curricula are needed to better meet the needs of community members. Consider skills-based trainings that equip participants with the resources they need to manage their mental health, including those that promote care seeking behaviors or allow them to build healthy coping skills, regulate their emotions and/or cope with stress.

Meanwhile, the capacity that these trainings require from CSBs is high. Logistics such as participant recruitment and material preparation require a significant investment of time – that investment is frustrating for CSBs when few community members show up on the day of the training. This does not always feel worth it or like a good use of resources for CSBs but is necessary for them to meet requirements about the number of trainings they facilitate. Shifting to focus on collaborative efforts across multiple CSBs, allowing them to pool resources to conduct these trainings, has helped address this issue, some participants shared.

Key Takeaways

- ✓ Some community level trainings do not meet the needs of community members due to length or content level/depth, leading to low turnout.
- ✓ Trainings require a lot of CSB capacity investment and the need to meet minimum requirements for the number of trainings being facilitated – regardless of low turnout – pulls resources away from other efforts.
- ✓ There is high saturation of some trainings. CSBs and communities are looking for options that let them continue to build their skills.
- ✓ CSBs feel that the currently prioritized strategies take them away from directly engaging with their communities.
- ✓ Separating problem areas creates an overburden of data entry for CSBs when implementing strategies addressing multiple priority areas
- ✓ CSB prevention staff scope of work continues to expand into topics that are not prevention related, such as graphic design.
- ✓ CSB prevention staff are not compensated enough for their work and expertise they bring.
- ✓ High turnover is reducing the capacity of the prevention workforce.

Capacity Building Needs

CSB staff participants see shifts around media campaign management, policy improvements, and increased resources for staffing and training as essential to building the capacity of the prevention workforce. With many CSBs sharing the difficulties of managing media campaign work, which they saw as time intensive and outside of their expertise and training, a need for a shift in how media campaigns are managed and coordinated was identified. Some CSB staff participants that work within local governments have a dedicated person that works on this outside of the prevention team who manages media campaign efforts. However, many smaller CSBs do not have this option, and their staff are the ones that manage the logistics and implementation of media campaigns. CSB staff participants mentioned that they believe campaigns that are part of the required priority areas should all be consistent and tracked together, requiring implementation and coordination at a region or state level. For general statewide campaigns, such as Activate Your Wellness, CSB staff participants noted that the state should track all these implementations and run the campaign entirely. This would then be done by one dedicated person with expertise in media campaigns, shifting what can sometimes be complex work away from CSBs. They felt that when CSBs are implementing similar campaigns simultaneously, lack of cohesiveness in design and approach creates a sense of competition and can lead to poor data quality because of overlap in campaign reach/impressions. Shifting implementation and tracking of campaigns, while still providing adaptable materials to CSBs, would allow them to reinforce messaging while feeling less pressure and responsibility over the larger campaign.

Rethinking how media campaigns are managed and implemented at the state and CSB levels could allow CSBs to invest greater time and resources into community-centered prevention efforts.

CSBs also expressed a desire for increased communication and a larger voice around policy work that impacts their prevention efforts, especially related to new problem areas such as cannabis and problem gambling. CSB staff participants see firsthand that some regulations, such as retailer compliance, are not being enforced and would like to share this information and be part of creating state-level change to address these issues. CSB staff participants also shared an interest in increased communication and education about the policies that are being brought to legislation and their impacts. The rapidly changing policy landscape around problem gambling and cannabis work has been especially challenging. It can be difficult for CSBs to track these changes and know how to move forward with messaging to their community, as they want to ensure information they provide is accurate.

Improved communications about policy developments would allow CSBs to provide timely, accurate information to their communities about the issues they need to know about.

Engaging CSBs in policy work could help advance prevention-related policy efforts. CSBs offer a unique voice and perspective about the needs of communities across Virginia.

A need for increased resources supporting the prevention workforce was also identified. Some CSBs have one or two staff for their entire catchment area and are still expected to do the same amount of outreach and effort as other CSBs that are fully staffed. While catchment areas may be smaller in terms of population, they often serve larger geographic areas that take more time to provide services to, due to travel. Even those with full staffing find it difficult to keep up with all the work as it continues to grow. In addition to increased staffing, they believe that having increased pay can help them retain staff, so that staff do not feel the need to work additional jobs to make ends meet and generally promote a healthier work-life balance. Some staff participants mentioned frustrations about the lack of incentivization and value placed on increased education and qualifications. As staff pursue said opportunities, they shared, they often end up leaving prevention teams to pursue increased salaries. Professionalization of the prevention career track to offers salary and title changes as staff develop increased qualifications would allow for greater retention.

Another way to increase capacity and retain staff that was identified by participants was improved onboarding and training that foster investment and connection among prevention staff from day one. Both CSB staff participants and OBHW staff suggested the benefits of mentorship programs or learning cohorts for new staff in encouraging collaboration and connection between CSBs. This would also allow CSBs to know more about the work that other CSBs are doing and share best practices. It was noted that the onboarding and training should focus on risk and protective factors to equip staff with the fundamental understanding they need to approach prevention work across priority areas.

While partnerships are crucial to supporting prevention efforts, CSB staff identified challenges in evaluating multi-system efforts. Having shared metrics and a system that allows them to track outcomes across programs, they shared, would be helpful in creating a collective prevention movement and a clear narrative about why prevention matters and how partners are together working to serve their communities. CSBs notes that community partners conduct Mental Health First Aid and similar trainings also implemented by CSB prevention staff and knowing how each program is going - and being able to identify individual strengths across programs - would facilitate better collaboration.

Identifying opportunities for streamlined data collection and data sharing across agencies doing prevention related work in Virginia can allow for improved evaluation of overall efforts, identify areas for collaboration, and create a stronger prevention narrative.

Key Takeaways

- ✓ CSBs are not trained to coordinate media campaigns, which take considerable resources to implement. These efforts take away from their ability to be present with their community members.
- ✓ CSBs would like to be more involved at the advocacy and policy level, whether it is learning about legislation or actively advocating for prevention-related topics that directly impact their work
- ✓ CSB staff participants identified the following workforce development needs:
  - Increased staffing and pay to better retain staff
  - Consistent training and onboarding to prevention work across Virginia
  - Incentives and recognition for prevention staff who are building skills and increasing their prevention-related qualifications.
- ✓ Shared information and coordination are necessary to prevent duplicative efforts across state agencies and improve evaluation of overall efforts.

Focus Area: Alcohol

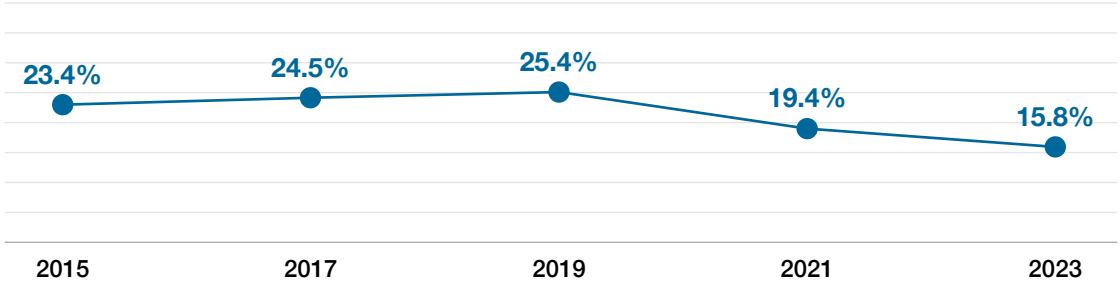
In Virginia, alcohol continues to be the most frequently used substance across all ages. Over half (54.2%) of Virginia adults have consumed at least one drink of alcohol in the past month (n=4,936, [52.8, 55.7]).(BRFSS, 2022) This has remained relatively consistent for the past 30 years, with data showing past 30-day use rates for alcohol fluctuating from a high of 56.0% (n=3,132, [54.1, 57.8]) in 2011 to a low of 51.3% (n=4,775, [50.0, 52.7]) in 2019. (BRFSS, 1995 – 2022)

Use Across the Lifespan

YOUTH

Rates of past 30-day alcohol use among high school youth have decreased to 15.8% (n=1,905, [12.9, 19.3]) in 2023 after rising for several years.(VYS, 2023) Lifetime alcohol use data is not collected at the high school level.

Percent of High School Youth Who Reported Consuming Alcohol in the Past 30 Days



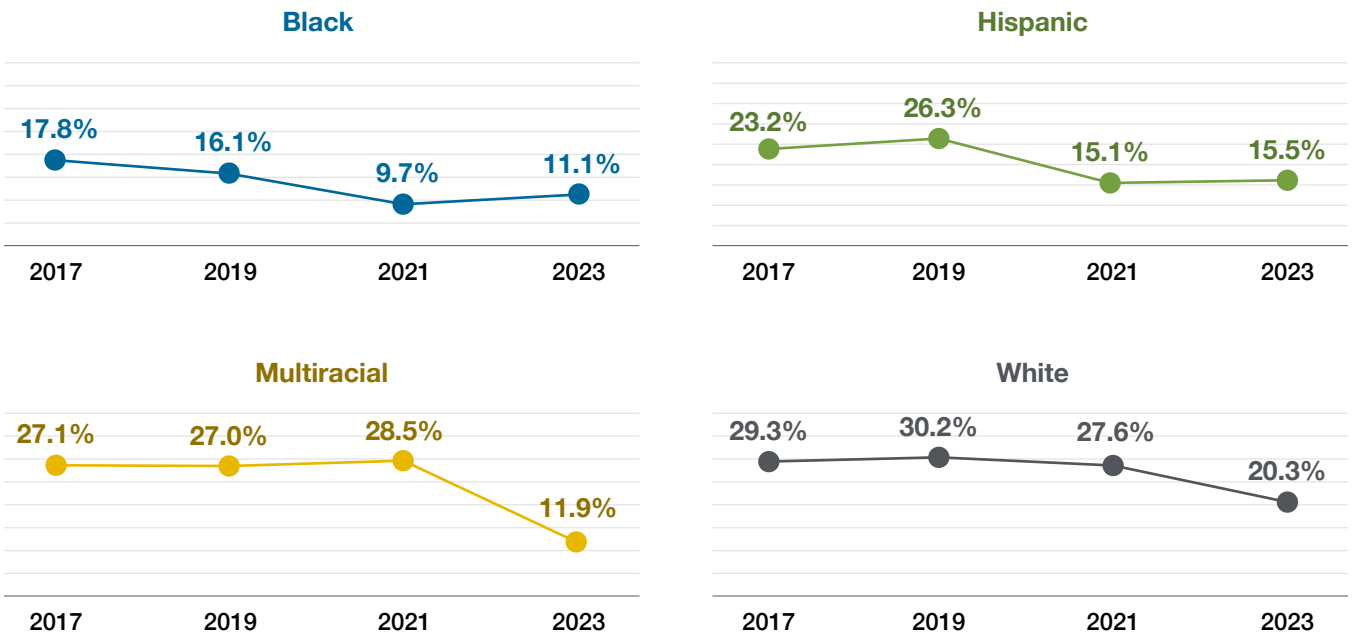
Despite decreasing rates of alcohol use among youth overall, discrepancies exist among specific groups of youth. High school youth identifying as gay, lesbian or bisexual reported a past 30-day alcohol use rate of 25.5% (n=257, [18.4, 34.1]), much higher than their heterosexual/straight peers (14.4%) (n=1,380, [11.7, 17.6]).(VYS, 2023) Female students consistently report higher past 30-day alcohol use than males. 18.1% (n=969, [14.3, 22.7]) of female high school students reported drinking alcohol at least once in the past 30 days compared to 13.7% (n=932, [11.0, 16.9]) of male students. This is the reverse of trends seen among adults, where use rates are higher for males.

30-day alcohol use rates among White high school aged youth (20.3%, n=640, [16.5, 24.8]) were the highest when considering race and ethnicity, despite having fallen from 27.6% (n=985, [23.2, 32.4]) in 2021. Hispanic/Latine/x (15.5%, n=512, [9.8, 23.6]) youth had the second highest rate of past 30-day alcohol use, after a slight increase from 15.1% (n=711, [10.6, 21.1]) in 2021.(VYS, 2023)

Rates have fallen faster for youth identifying as Black, Hispanic or Multiracial than the overall youth population. Rates of past 30-day alcohol use among black youth were 17.8% (n=573, [14.0, 22.3]) and 16.1% (n=720, [12.0, 21.3]) in 2017 and 2019, respectively, before falling to 11.1% (n=392, [8.7, 14.0]) in 2023. Youth identifying as Hispanic reported a past 30-day use rate of 15.5% (n=512, [9.8, 23.6]) in 2023 – a decrease from 26.3% in 2019 (n=835, [21.9, 31.2]).(VYS, 2023)

High school youth identifying as Multiracial saw a sharp decrease in alcohol use between 2021 and 2023. The rate of multiracial high school youth reporting past 30-day alcohol use fell from 28.5% in 2021 (n=214, [17.7, 42.5]) to 11.9% in 2023 (n=193, [6.9, 19.8]).(VYS, 2023) This is the lowest past 30-day alcohol use rate reported by Multiracial youth in the Virginia Youth Survey to date.

Percent of High School Youth Who Reported Consuming Alcohol in the Past 30 Days, by Race/Ethnicity



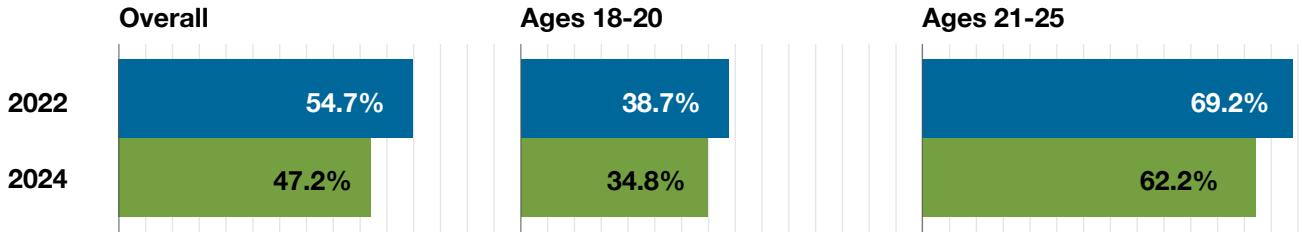
YOUNG ADULTS

In 2024, 74.2% (n=4,376, [73.1, 75.3]) of young adults aged 18-25 reported having consumed alcohol at least once in their lives.(YAS, 2024) This was a decrease from 78.3% (n=4,114, [77.2, 79.4]) in 2022. Young adults who are Black, Indigenous, and People of Color (BIPOC) reported lower levels of lifetime alcohol use (69.0%, n=1,814, [67.3, 70.8]) than their White/Non-Hispanic peers (79.0%, n=2,391, [77.6, 80.5]).(YAS, 2024)

Percent of Young Adults Ages 18-25 Who Reported Having Ever Consumed Alcohol

Rates of past 30-day alcohol use among young adults aged 18-25 have decreased from 54.7% (n=5,234, [53.4, 56.1]) in 2022 to 47.2% (n=5,870, [45.9, 48.5]) in 2024.[YAS, 2024] Young adults legally allowed to consume alcohol reported higher rates of past 30-day use than those under age 21 – 62.2% (n=2,663, [60.4, 64.1]) vs. 34.8% (n=3,207, [33.1, 36.4]) in 2024. Looking across the lifespan, those ages 21-25 reported the highest past 30-day use rate. When considering lifetime use, 63.7% (n=4,350, [62.3, 65.2]) of young adults who reported having ever consumed alcohol reported drinking at least once in the past 30 days.

Percent of Young Adults Who Reported Consuming Alcohol in the Past 30 Days, by Age Group and Sexual Orientation



BIPOC respondents reported past 30-day alcohol use at a much lower rate (40.4%, n=1,060, [38.6, 42.2]) than their non-BIPOC peers (53.3%, n=1,609, [51.5, 55.1]).[YAS, 2024]

Differences were present when looking at the sexual orientation of young adults, although the disparities were not as pronounced as for youth. 47.5% of young adult respondents identifying as heterosexual/straight had used alcohol within the past 30 days (n=1,854, [45.9, 49.1]), compared to 50.3% of LGBQ+ young adult respondents (n=681, [47.7, 53.0]).[YAS, 2024]

ADULTS

55.0% [52.3, 57.6] of adults age 26 or older in Virginia reported alcohol within the past 30 days.[NSDUH, 2022] This is slightly higher than the median national rate of 52.5% [51.7, 53.2].[NSDUH, 2022]

Past 30-day alcohol use was higher among males than among females. 57.7% (n=2,350, [55.5, 59.9]) of males 18 or older reporting using alcohol compared to 50.9% (n=2,586, [48.9, 52.9]) of females. Data for trans and gender-diverse adults were not available.[BRFSS, 2022]

Differences between racial groups are also present for past 30-day alcohol use, though variance in sample sizes creates difficulty in understanding the true range in outcomes across race and ethnicity.

In Virginia, past 30-day use was reported by:

57.1% of White adults (n=3,851, [55.5, 58.7])

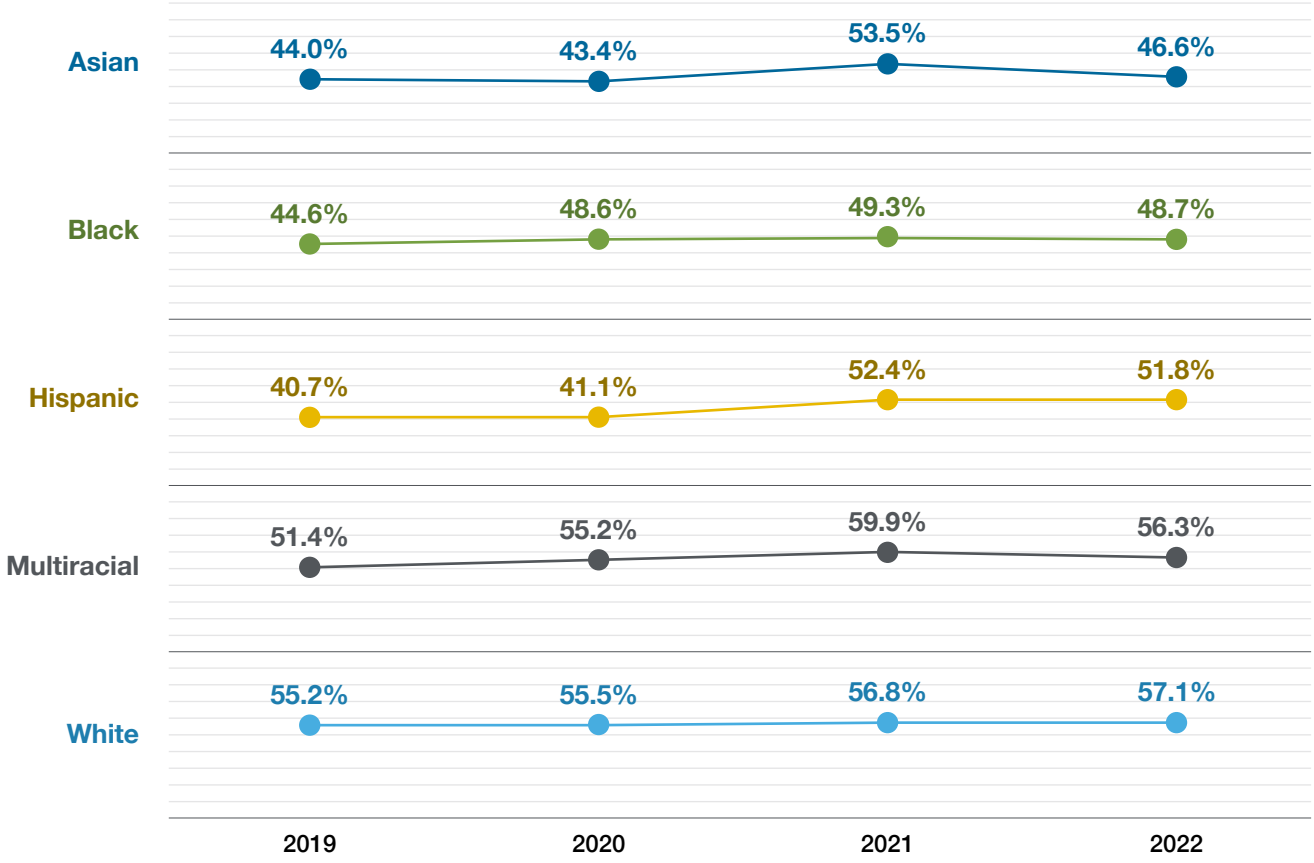
56.3% of multiracial, non-Hispanic adults (n=91, [47.0, 65.5])

51.8% of Hispanic adults (n=243, [46.0, 57.7])

48.7% of Black, non-Hispanic adults (n=607, [45.0, 52.3])

46.6% of Asian, non-Hispanic adults (n=106, [38.7, 54.6]).[BRFSS, 2022]

Percent of Adults Ages 18+ Who Reported Consuming Alcohol in the Past 30 Days, by Race/Ethnicity

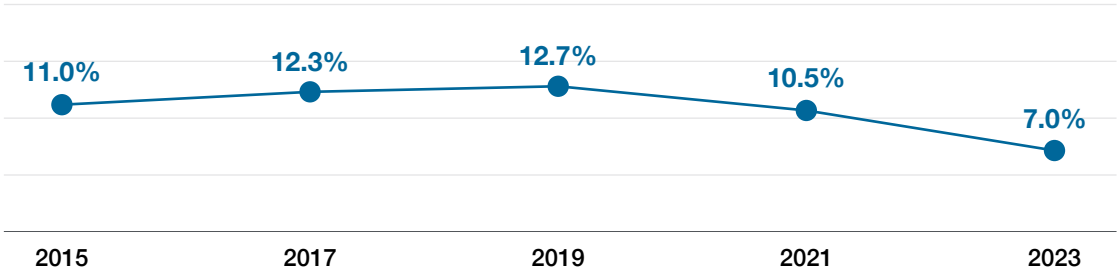


Binge Drinking Across the Lifespan

YOUTH

Overall, binge drinking behaviors in youth appear to be trending downward, in the desired direction. 7.0% (n=1,925, [5.2, 9.2]) of youth reported engaging in binge drinking behaviors within the past 30 days in 2023, a decrease from 10.5% (n=3,012, [7.8, 14.0]) in 2021.[(YVS, 2023)]

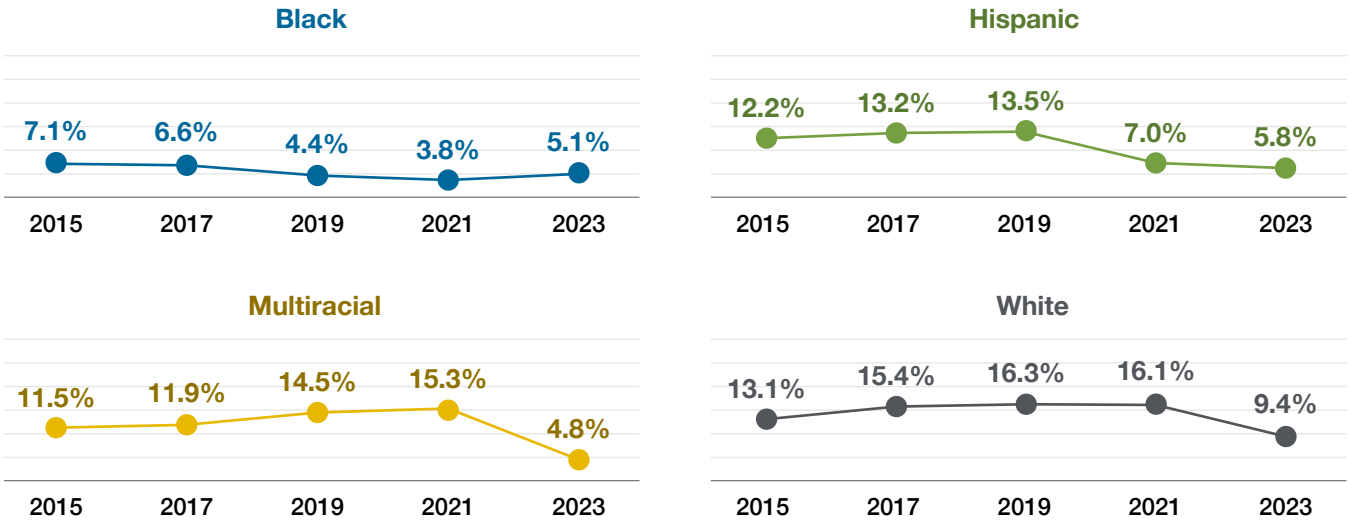
Percent of High School Youth Who Reported Binge Drinking in the Past 30 Days



Following past 30-day use rate trends, disparities among past 30-day binge drinking rates are also present when looking at race and ethnicity. White high school youth continue to have the highest reported a past 30-day binge drinking rates compared to their peers (9.4%, n=645, [6.9, 12.7]).[(YVS, 2023)] This was a drastic decrease from 2021, when White youth reported a past 30-day binge drinking rate of 16.1% (n=990, [13.2, 19.5]). However, it remains higher than their Black (5.1%, n=394, [3.6, 7.3]) or Hispanic peers (5.8%, n=520, [2.6, 12.2]).[(YVS, 2023)]

Mirroring the decrease in past 30-day alcohol use, youth identifying as Multiracial saw the largest decrease from 2021 to 2023 – going from 15.3% (n=216, [9.4, 24.0]) to 4.8% (n=197, [2.2, 10.5]).(VYS, 2023) The only increase in past 30-day binge drinking behaviors was seen in students identifying as Black, increasing from 3.8% (n=883, [2.3, 6.1]) in 2021 to 5.1% in 2023.(VYS, 2023)

Percent of High School Youth Who Reported Binge Drinking in the Past 30 Days, By Race/Ethnicity



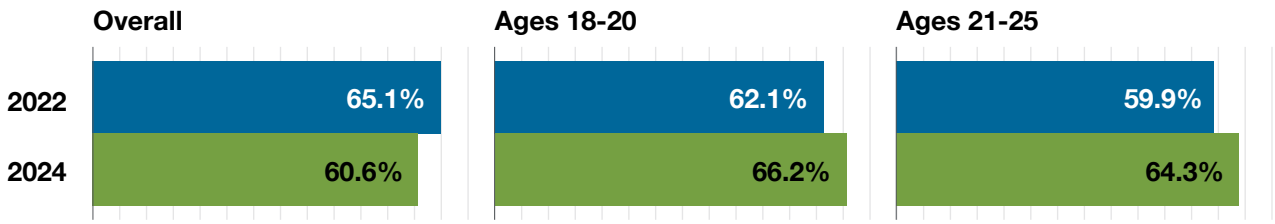
High school youth identifying as Gay, Lesbian or Bisexual reported a past 30-day binge drinking rate of 9.0% in 2023 (n=259, [5.7, 13.8]), which is a decrease from 2021 (15.5%, n=497, [10.0, 23.3]). However, this remains higher than their Heterosexual/straight peers (6.4% (n=1,394, [4.7, 8.8]).(VYS, 2023) Data on youth sexual identity was not collected prior to 2021. Following overall past 30-day use rate trends, female students reported higher binge drinking rates (7.8%, n=978, [5.9, 10.3]) in the past 30 days than male students (6.2, n=943, [4.2, 9.1]).

Percent of High School Youth Who Reported Binge Drinking in the Past 30 Days, by Sexual Orientation, Sex

YOUNG ADULTS

While any past 30-day alcohol use is decreasing among young adults, binge drinking is increasing. The rate of past 30-day binge drinking among young adults ages 18-25 who have had alcohol in the past 30-days has seen a large increase from 60.6% (n=2,865) in 2022 to 65.1% (n=2,754, [63.3, 66.8]) in 2024.(YAS, 2024)

Percent of Young Adults Who Reported Binge Drinking in the Past 30 Days, by Age

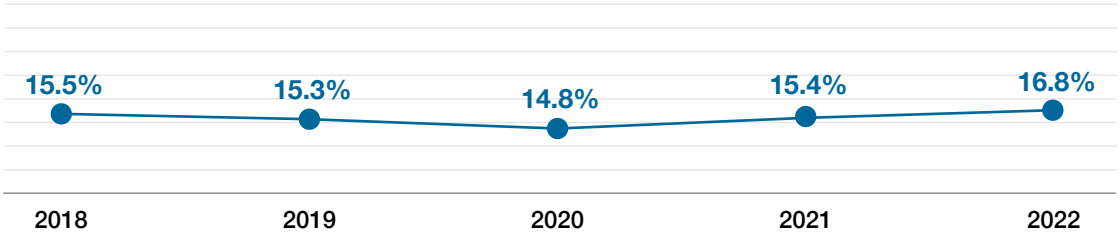


While LGBQ+ young adults reported higher overall past 30-day alcohol use than their straight/heterosexual peers, they were less likely to report having binge drank during that time. 66.6% (n=1,851, [64.4, 68.7]) of straight/heterosexual young adults who drank alcohol in the past 30 days reported binge drinking at least once compared to 60.4% (n=679, [56.7, 64.1]) of their LGBQ+ peers.(YAS, 2024)

ADULTS

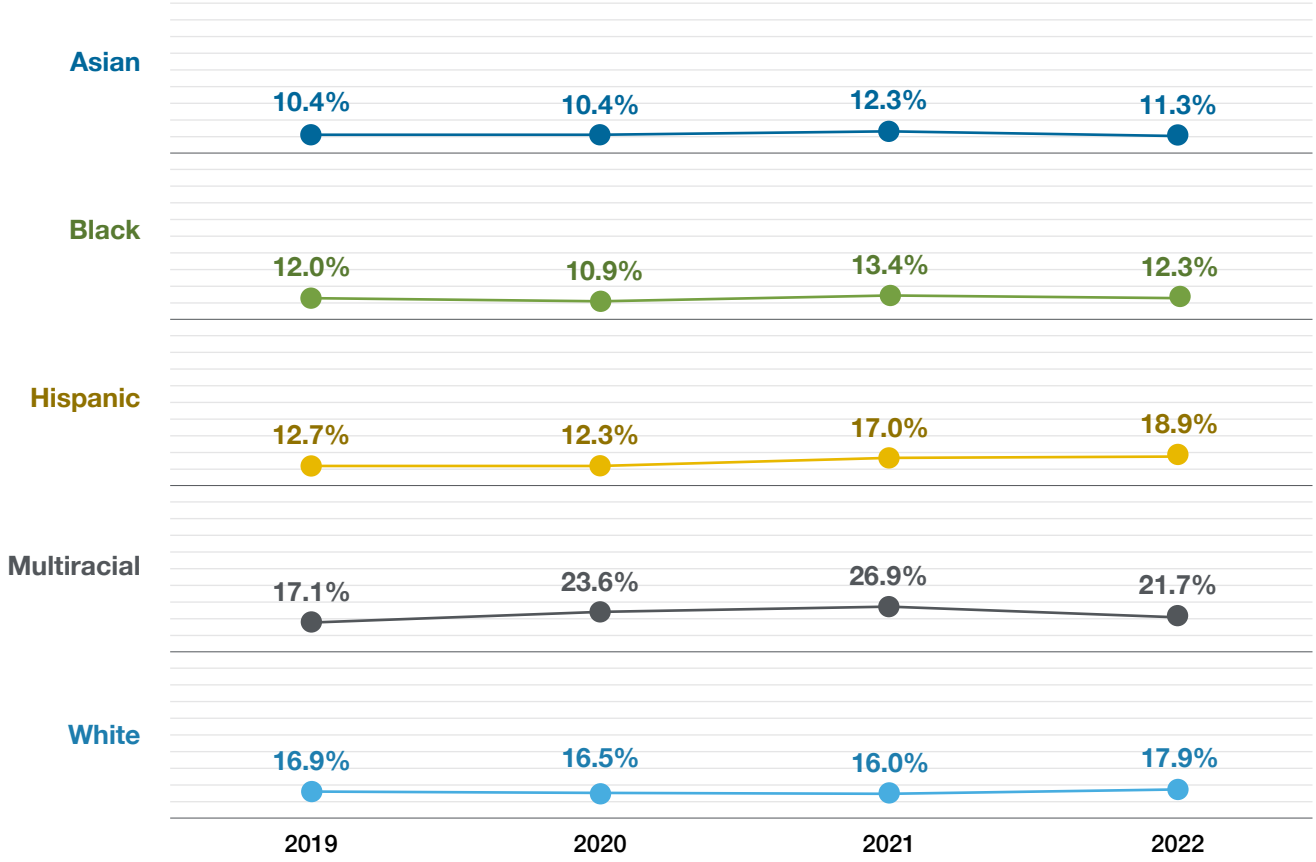
Similar to trends among young adults, binge drinking among adults in Virginia is also on the rise in recent years.(BRFSS, 2022) 16.8% (n=1,219, [15.6, 17.9]) of adults have had at least four alcoholic drinks on one occasion in the past 30 days.(BRFSS, 2022)

Percent of Adults Ages 18+ Who Reported Binge Drinking in the Past 30 Days



When looking at differences in binge drinking behaviors across racial groups, multiracial adults consistently engaged in binge drinking behaviors at higher rates than other racial groups. Hispanic adults reported a substantial increase in binge drinking behaviors between 2020 (12.3%, n=64, [8.8, 15.8]) and 2022 (18.9%, n=87, [14.6, 23.2]).(BRFSS, 2022)

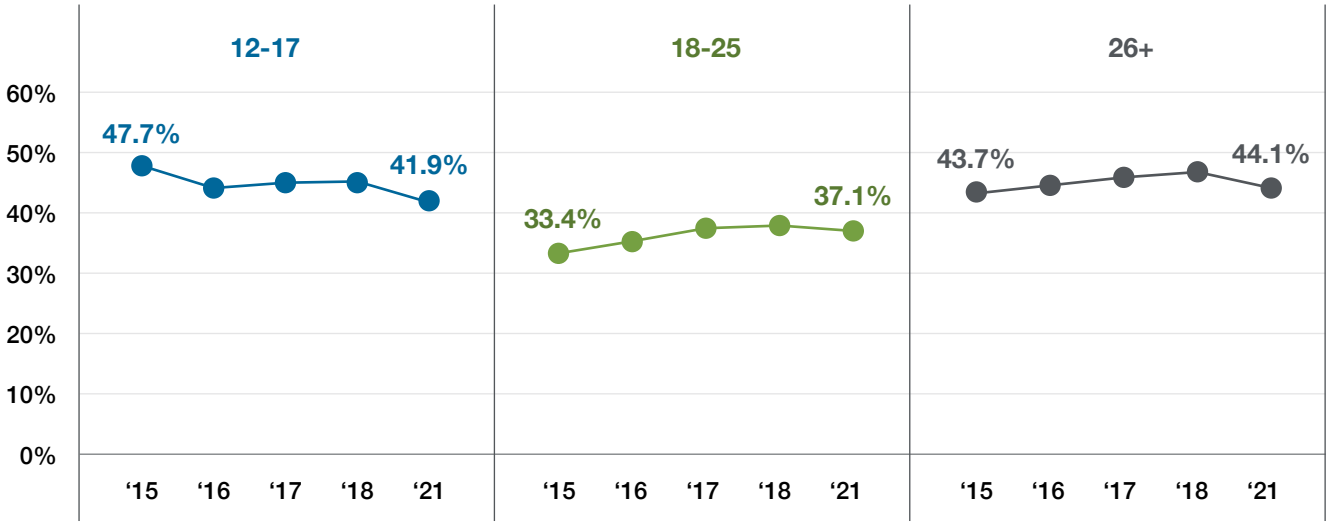
Percent of Adults Ages 18+ Who Reported Binge Drinking in the Past 30 Days, by Race/Ethnicity



Perceptions of Risk

Across the lifespan, perceptions of risk associated with binge drinking once or twice a week continue to increase.[(NSDUH, 2021)] Young adults ages 18-25 consistently perceive the lowest risk associated with binge drinking when compared with other age groups.

Percent of Respondents Who Perceive Great Risk with Binge Drinking Once or Twice a Week, By Age Group

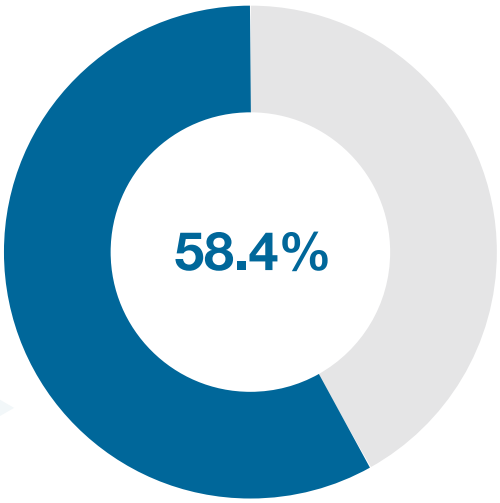


Among young adults in 2024, one-third (33.5%, n=5,906, [32.3, 34.7]) believe there is 'great risk' when binge drinking.[(YAS, 2024)] The perceptions of risk held by young adults can impact their behaviors, not only increasing the likelihood of engaging in heavy or excessive alcohol use but also increasing the likelihood of drinking and driving. Perceived risk of driving after having one alcohol beverage was low, while rates of driving after having one or more drink was high. 35.7% (n=5,911, [34.5, 36.9]) of young adults believe there is a 'great risk' associated with drinking one alcoholic beverage – 25.5% (n=2,750, [23.9, 27.1]) of young adults who reported past 30-day alcohol use drove after drinking one drink of alcohol at least once during that time period.[(YAS, 2024)] Although 78.0% (n=5,897, [77.0, 79.1]) of young adults believe there is a 'great risk' associated with driving after drinking four or more alcoholic beverages, 11.0% (n=2,749, [9.8, 12.1]) of young adults who reported past 30-day alcohol use drove after binge drinking at least once in the past month.[(YAS, 2024)]

Ease of Access

The majority (58.4%, n=3,168, [55.2, 61.5]) of young adult respondents ages 18-20 years old find it 'very easy' or 'sort of easy to access alcohol, despite being underage. Only 1 in 5 underage young adults (21.5%, n=3,168, [19.4, 23.6]) reported that it was 'sort of hard' or 'very hard' to access alcohol, while 1 in 4 (19.1%, n=3,168, [18.7, 21.5]) were 'unsure' how accessible alcohol is.[(YAS, 2024)]

Percent of young adults ages 18-20 who reported that it is "very easy" or "sort of easy" to get alcohol, despite being underage (2024)



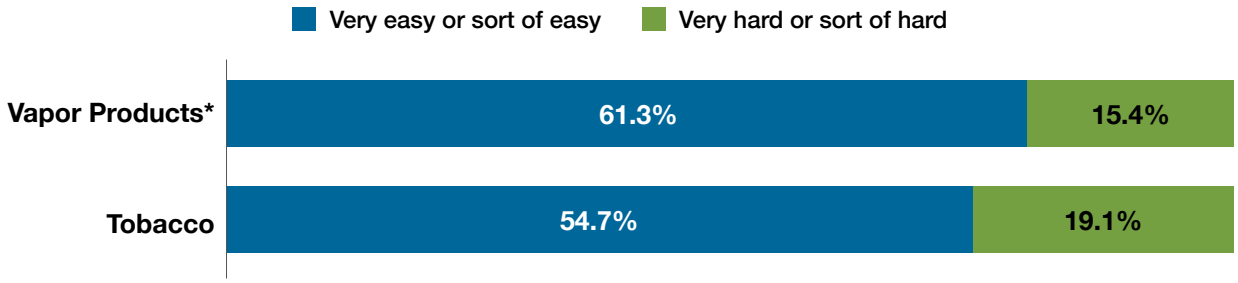
Focus Area: Tobacco and Vapor Products

In 2019, the national legal age of purchasing tobacco products, including nicotine, vapor, or alternative tobacco products, increased from 18 to 21.[(DBHDS)] This was done to decrease retail access to tobacco products for youth and placed the age of purchase in line with that of alcohol and cannabis.

Access to Tobacco and Vapor Products

In 2024, most young adult respondents ages 18-25 reported that it was either very easy or sort of easy for people under the age of 21 to access tobacco and vapor products.[(YAS, 2024)] Results were similar when broken up by respondents ages 18-20 and 21-25. 5.7% (n=130, [2.4, 12.9]) of high school youth in 2023 who used an electronic vapor product in the past 30 days reported that they got their electronic vapor products by buying them in a store. This is an increase from 3.4% (n=388, [1.8, 6.3]) in 2021, indicating that, indicating potential shortcomings in the effort to restrict sales to minors.[(VYS, 2023)]

Young Adults' Perceived Ease of Accessing Tobacco or Vapor Products While Underage, 2024

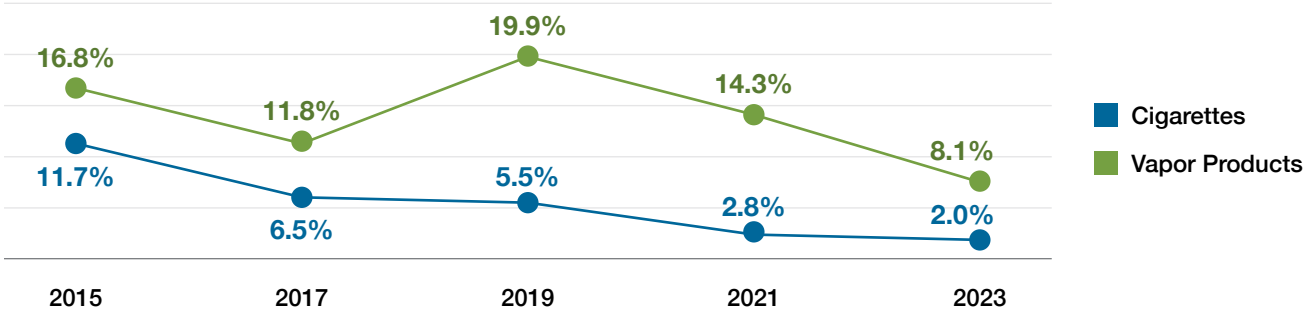


Use Across the Lifespan

YOUTH

Since 2015, high school youth are reporting less cigarette use with the past 30-days. Since peaking in 2019, use of electronic vapor products in the past 30 days, which has consistently been higher than cigarette use, continues to decline.[(VYS, 2023)] The question on electronic vapor product usage was altered slightly between 2021 and 2023, with additional questions on vapor products asked in 2023 that were not asked previously.

Percent of High School Youth Who Reported Using Cigarettes or Vapor Products in the Past 30 Days



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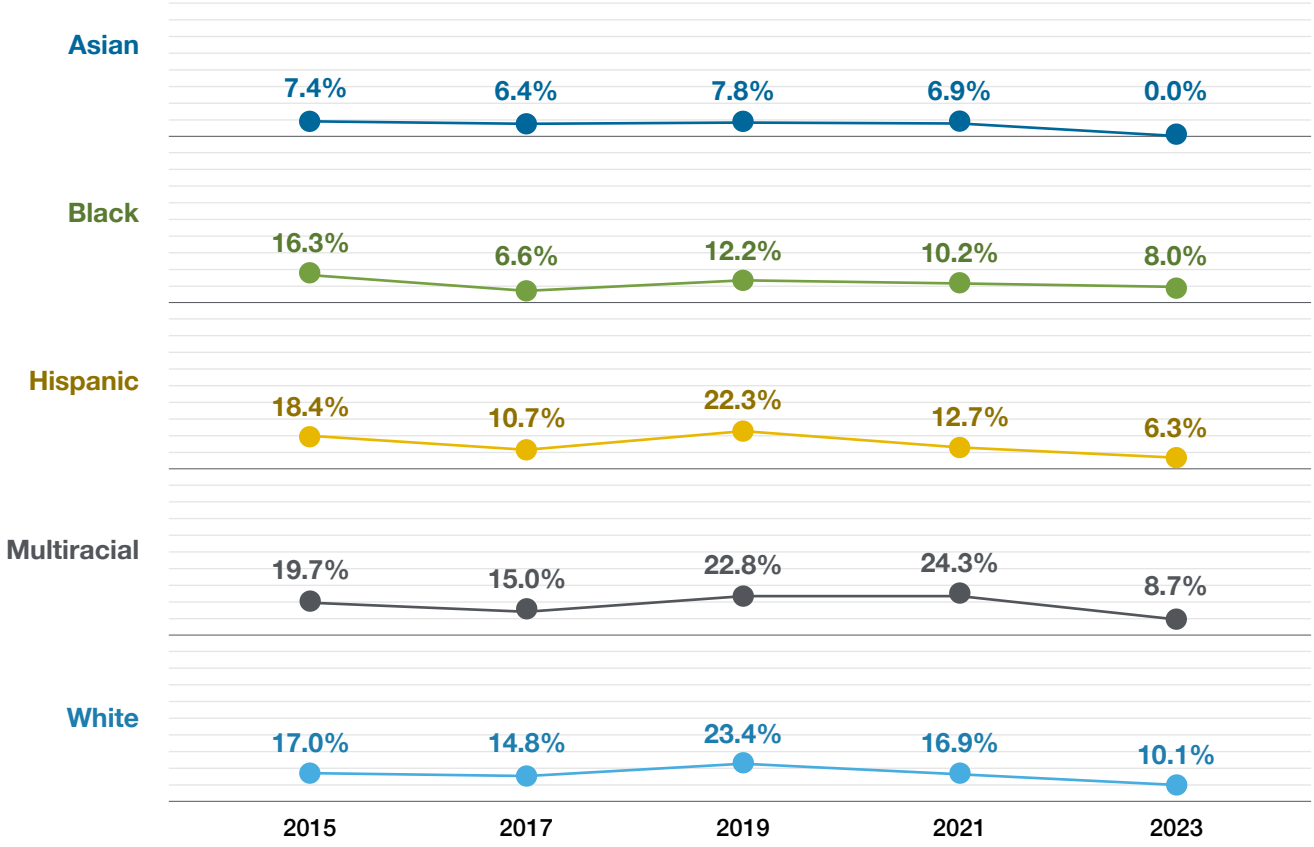
When looking deeper into youth use of electronic vaport products, some differences across racial and ethnic groups emerge, though usage rates across vary widely for many groups across the years. Youth identifying as being multiracial reported higher rates compared to their peers.[VYS, 2023]

Percent of High School Youth Reporting Past 30 Day Vapor Product Use, By Race/Ethnicity



Electronic vapor product use rates vary based on sexual identity.[VYS, 2023] 2023 survey data found that rates of past-30 day electronic vapor use rate among youth identifying as Gay, Lesbian or Bisexual (17.2%, n=243, [10.9, 26.0]) was more than twice the rate of their Heterosexual/Straight peers (6.4%, n=1,339, [4.5, 9.0]).[VYS, 2023]

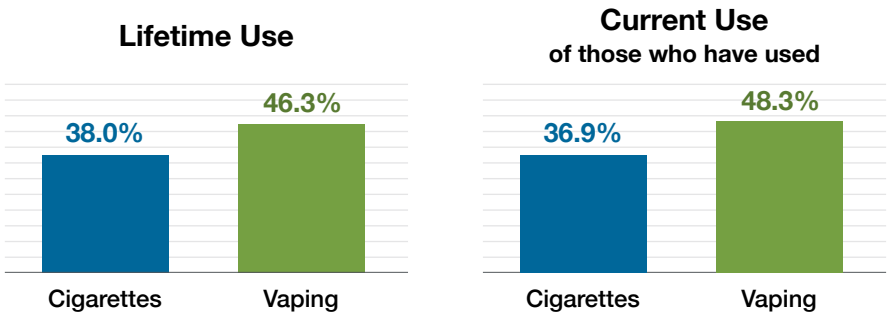
Percent of High School Youth Reporting Past 30 Day Vapor Product Use, By Sexual Orientation

17.2%	10.4%	6.4%
Gay, Lesbian, or Bisexualy	Other/Questioning	Heterosexual/Straight

YOUNG ADULTS

The percent of young adults ages 18-25 years old who reported having ever used tobacco or vapor products decreased between 2022 and 2024, falling from 43.7% to 38.0% for tobacco, and 51.4% to 46.3% for vaping. [YAS, 2024] Mirroring youth, folks are more likely to have used electronic vaping products in their lifetime compared to cigarettes.

Across all young adult respondents, 13.9% (n=5,870, [13.0, 14.8]) reported having used tobacco products in the past 30-days - down from 16.7% (n=5,230, [15.7, 17.7]) in 2022.(YAS, 2024) Similarly, rates of past 30-day vape use decreased from 15.9% (n=5,180, [24.7, 27.1]) in 2022 to 22.2% (n=5,816, [21.1, 23.2]) in 2024. Among those who reported ever having used tobacco products, 36.9% (n=2,215, [34.9, 38.9]) reported having used them in the past 30 days. Those who reported having ever vaped were much more likely to report past-30 day use than lifetime tobacco users. 48.3% (n=2,668, [46.4, 50.2]) of young adults who reported having ever vaped reported having vaped at least once in the past 30 days.



Young adults identifying as LGBQ+ reported higher lifetime use rates of vapor products in both 2022 (59.0%, n=1,386, [56.4, 61.6]) and 2024 (52.7%, n=1,348, [50.0, 55.3]) compared to their Straight/heterosexual peers (2022: 49.1%, n=3,322, [47.4, 50.8]; 2024: 45.8%, n=3,893, [44.3, 47.4]).(YAS, 2024)

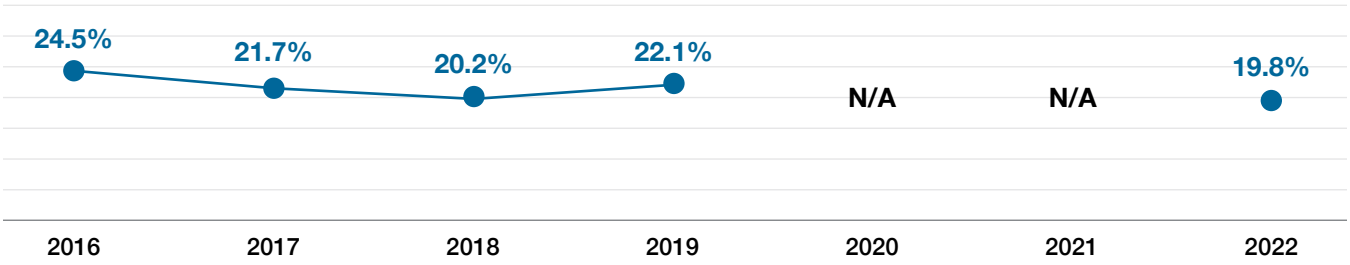
Between 2022 and 2024, the rate for vapor product use declined more rapidly among BIPOC respondents than among non-BIPOC young adults.(YAS, 2024) This may suggest that focused prevention efforts on this population may be having the desired outcomes.

		BIPOC	Non-BIPOC
Lifetime Use	2022	49.3%	52.8%
	2024	43.2%	49.5%
Past 30-Day Use (among lifetime users)	2022	52.6%	49.2%
	2024	46.6%	49.0%

ADULTS

Current cigarette use for adults ages 27 and older has been trending downward for several years, falling from 17.7% [15.8, 19.4] in 2016-17 to 15.6% [13.9, 17.4] in 2021.(NDUH, 2022) Meanwhile, the use of e-cigarettes has risen from 4.7% (n=318, [4.2, 5.7) in 2017 to 7.7% (n=449, [6.8, 8.5]) in 2022.(BRFSS, 2017-2022) Use of e-cigarettes is more common among young adults, while use of cigarettes is more common among older adults.

Percent of Adults Ages 26+ Who Reported Using Any Type of Tobacco Product in the Past 30 Days(NSDUH)



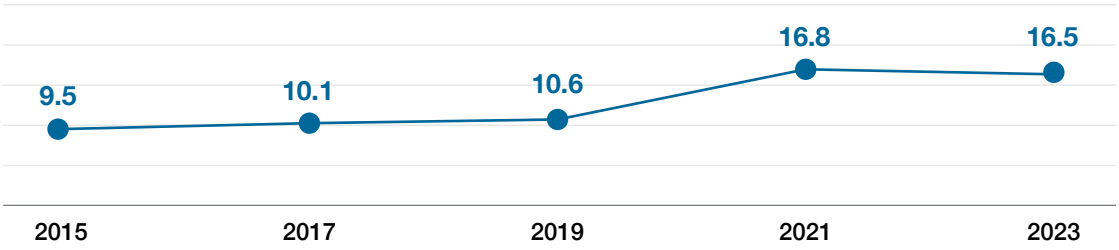
Perceptions of risk

Data on individual perceptions of risk of harm for tobacco and/or vapor product usage is not collected for youth, and adult data focuses on daily heavy cigarette usage. However, information shared from young adults ages 18-25 may help shed some light on the awareness of harms related to tobacco use of any kind.

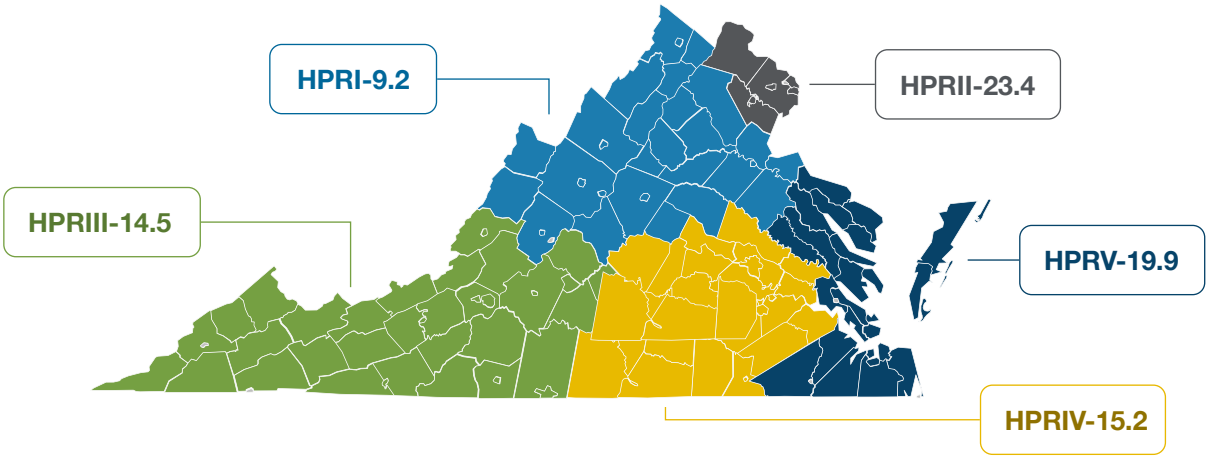
Approximately 1 in 4 (24.6%, n=5,888, [22.9, 26.3]) young adults believe that using vape products poses no risk or slight risk to individuals. Similarly, 24.9% (n=5,898, [23.2, 26.6]) of young adults who believe tobacco use has no risk or slight risk associate with usage.[(YAS, 2024)]

SYNAR

SYNAR rates show the percentage of violations for selling tobacco products to minors. Compliance rates for retailers must be less than 20 - meaning that less than 20% of all sales are made to underage youth.[(SAMHSA, 2024)] From 2018 to 2022, the statewide SYNAR rate has increased from 10.6 to 16.5.[(SYNAR, 2022)]



In 2022, the VA Health Planning Region (HPR) II had the highest rate of SYNAR violations at 23.4 and HPR I had the lowest SYNAR violation rate at 9.2.[(SYNAR, 2022)]



Focus Area: Opioids

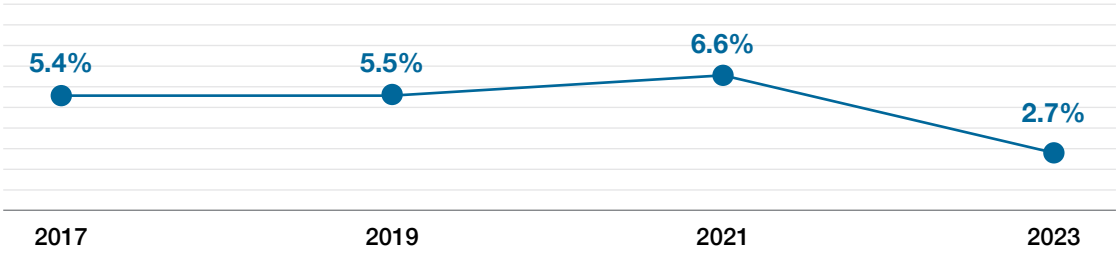
Opioids are a class of drugs that includes prescription pain relievers, heroin, and synthetic opioids, such as fentanyl. Nationally, over 75% of drug overdose deaths involved an opioid.(CDC, 2022) In Virginia 79% of drug overdose deaths involved opioids, such as fentanyl, fentanyl analogs, and tramadol.(VDH, 2022) Compared to all drugs, opioids account for about half of all emergency department visits.(VDH, 2022)

Use Across the Lifespan

YOUTH

High school youth reporting past 30-day misuse of prescription medications decreased significantly from 6.6% in 2021 (n=3,020, [5.0-8.5]) to 2.7% in 2023 (n=1,914, [1.7, 4.1]).(VYS, 2023) The question asked of students was revised slightly, adding in specific examples of prescription medications, which may have impacted the results.

Percent of High School Youth Who Reported Misusing Prescription Medications in the Past 30 Days

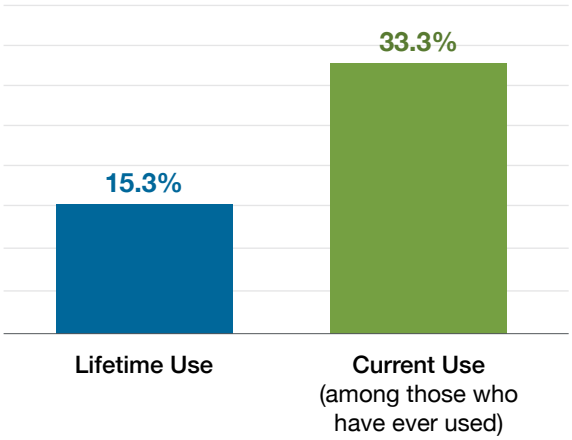


Prescription drug misuse rates show differences among racial/ethnic populations, with consistently higher misuse rates reported for Black, Hispanic/Latine/x, and multiracial youth.(VYS, 2023)

	2017	2019	2021	2023
Black	6.6%	6.9%	8.9%	1.6%
Hispanic/Latino	7.3%	6.8%	6.5%	3.4%
White	4.7%	4.8%	4.7%	3.1%
Multiracial	6.1%	6.5%	10.3%	1.5%

YOUNG ADULTS

15.3% (n=5,894, [14.3, 16.2]) of 18 to 25-year-olds reported misusing prescription medications in their lifetime, with 33.0% (n=892, [29.0, 36.0]) of those respondents reporting use in the past 30 days.(YAS, 2024) Despite a decrease in lifetime prescription drug misuse from 2022, where 20.7% (n=5,245, [19.6, 21.9]) of young adults had ever misused prescription medications, past 30 day use among lifetime users increased. In 2022, 31% (n=1,075, [28.2, 33.7]) of those who reported having ever misused prescription drugs had misused them in the past 30 days.(YAS, 2022) Across all young adult respondents, 5.0% (n=5,877, [4.4, 5.6]) reported past 30-day prescription medication misuse.(YAS, 2024)

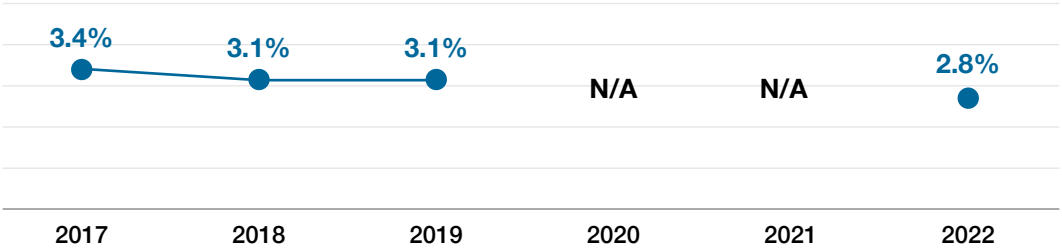


Young adults who identified as LGBQ+ reported higher lifetime rates of prescription medication misuse than straight/heterosexual respondents. Among those who identified as LGBQ+, 19.2% (n=1,353, [17, 21.2]) reported having misused prescription medication in their lifetime compared to 14.1% (n=3,914, [13, 15.2]) of their straight/heterosexual peers.(YAS, 2024)

ADULTS

2021-22 estimates report 2.8% [2.2, 3.6] of adults ages 26 or older had misused pain relievers in the past year, which is lower than the national median of 3.2% [3.0, 3.5].(NSDUH, 2022) Rates of pain reliever misuse has been steadily declining in both Virginia and the US, down from 3.7% [3.0, 4.5] in Virginia and 4.0% [3.8, 4.2] nationally in 2015-16.(NSDUH, 2015-2022)

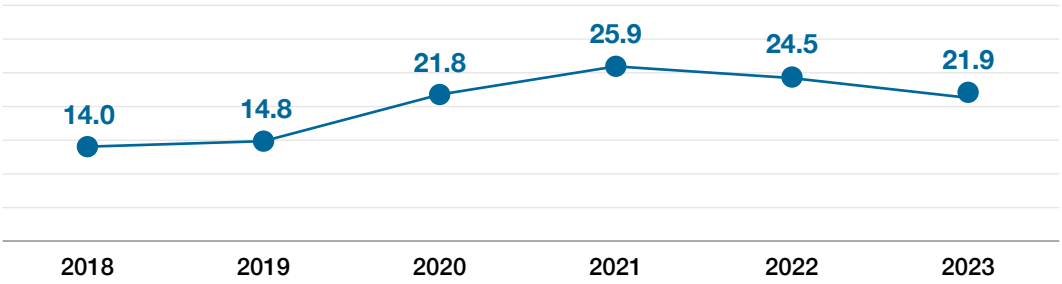
Percent of Adults Ages 26+ Who Reported Misusing Pain Relievers in the Past 12 Months



Overdose and Mortality Rate

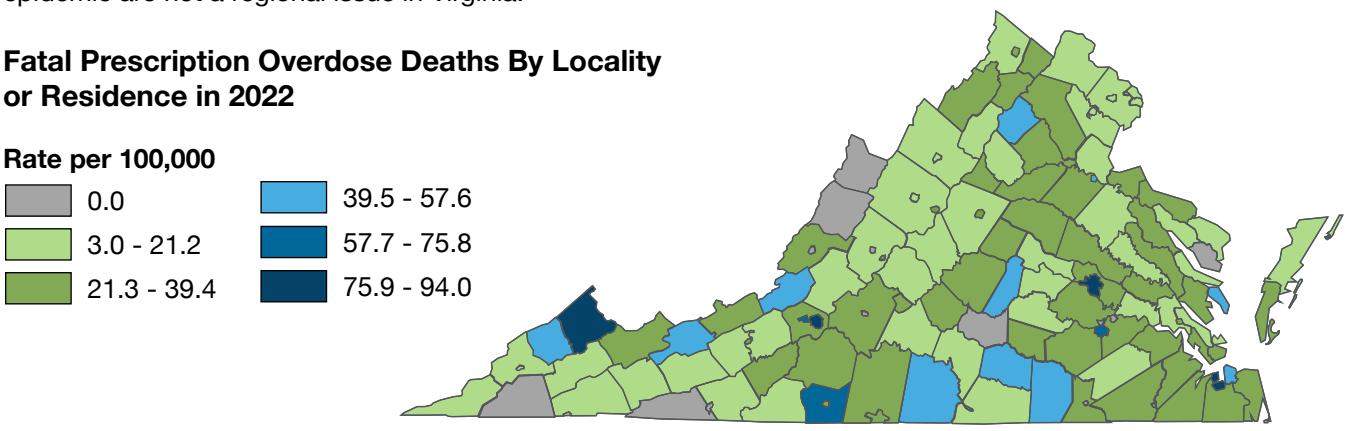
After a steady upward trajectory, Virginia's fatal opioid overdose rate per 100,000 people peaked in 2021 and has since been in a decline. Still, rates remain higher than those prior to 2021.(VDH, 2023)

Opioid Overdose Rate Per 100,000 People



While the northern part of the state has the most fatalities caused by opioids by count, various hotspots can be identified throughout the state when considering population density, indicating that the impacts of the opioid epidemic are not a regional issue in Virginia.(OCME, 2022)

Fatal Prescription Overdose Deaths By Locality or Residence in 2022

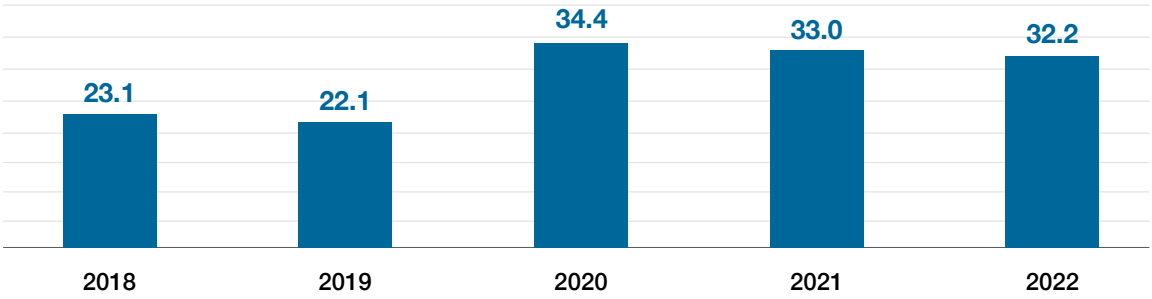


While white individuals comprise the majority (60.4%) of opioid overdose deaths, black men are disproportionately dying by overdose. Among black men, there were 64.3 deaths per 100,000 people – much higher than the rate of white men (34.8 per 100,000). Individuals ages 35-44 saw the highest all-opioid overdose death rates among both females and males, with 73.8 deaths per 100,000 males and 27.2 deaths per 100,000 females.[(OCME, 2022)] Disparities in overdose death rates across sex and race may indicate the need to focus on these particular sub-populations.

Emergency Department Visits – All Opioid Types

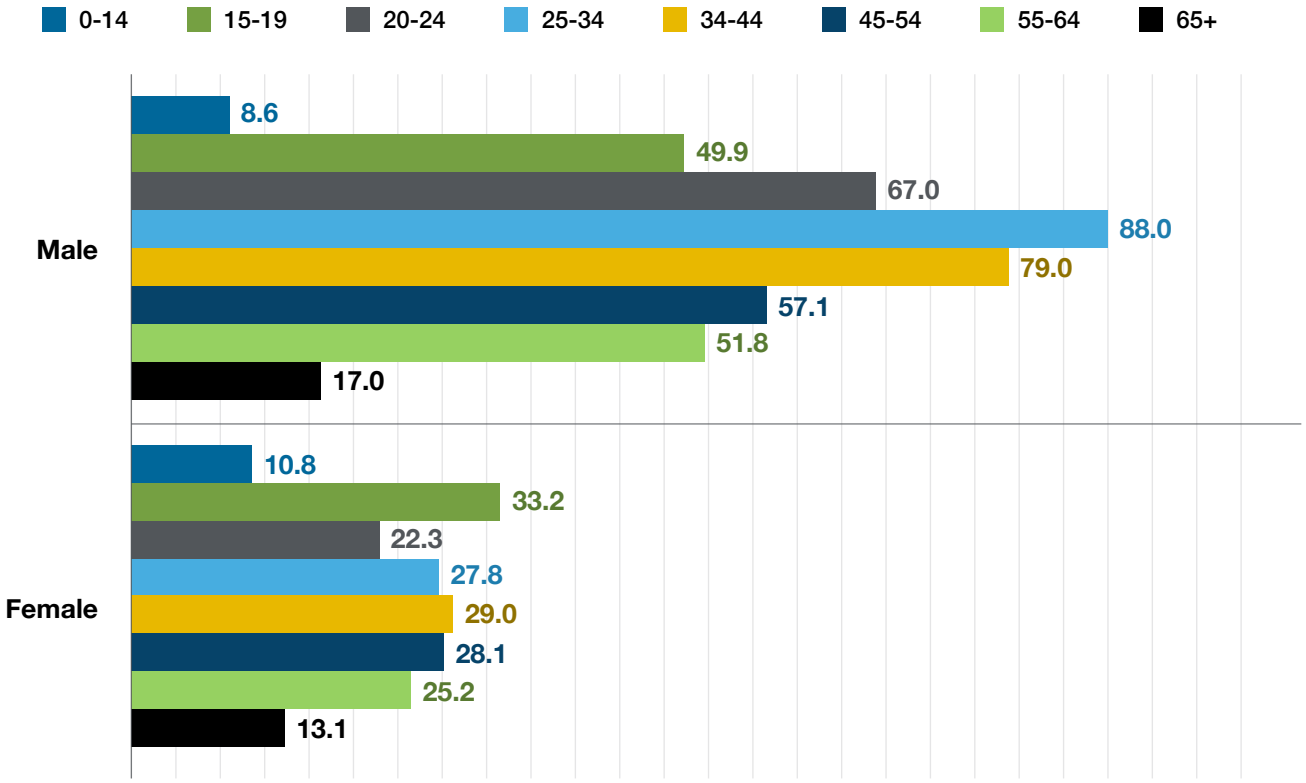
Virginia saw a significant spike in the number of Opioid-related Emergency Department visits from 2018 to 2020. Since 2020, the rate of opioid overdose-related ED visits in Virginia has decreased by a rate of 2.2 per 10,000 people, though it remains significantly higher than pre-2020 rates.[(VDH, 2018-2022)]

Opioid Overdose Related Emergency Department Visits Per 10,000 Visits



25 to 34-year-olds have consistently had the highest rates of opioid-related emergency department visits. [(VDH, 2018-2022)] This suggests that prevention activities may benefit from focusing on youth and young adults

Opioid Overdose Related Emergency Department Visits Rate Per 10,000 Visits in 2022, By Sex & Age Group



Focus Area: Fentanyl

Fentanyl is a synthetic opioid that has become increasingly common over the past several years. Pharmaceutical fentanyl is approved by the Food and Drug Administration for pain relief, but it can have lethal consequences if misused. In addition to legally manufactured fentanyl, there is also illegally manufactured fentanyl which is available in different forms including liquid and powder.(CDC, 2024) Since 2018, fentanyl has caused the most deaths compared to all other opioids.(OCME, 2021)

Use Across the Lifespan

YOUTH

High school youth were asked directly about fentanyl for the first time in 2023. Less than one-percent (0.9%, n=1,915, [0.4,1.7]) reported having ever used fentanyl at least once during their lives.(VYS, 2023) Youth also reported past 30-day use of fentanyl at 0.4% (n=1,909, [0.1, 1.1]).(VYS, 2023)

The Virginia Youth Survey also asked about where respondents were accessing fentanyl. Responses were too low to be reported when asked if youth accessed their fentanyl from a friend or non-family member.

Percent of High School Youth Who Reported Misusing Fentanyl

0.9%
Youth Lifetime Use

0.4%
Youth Current Use

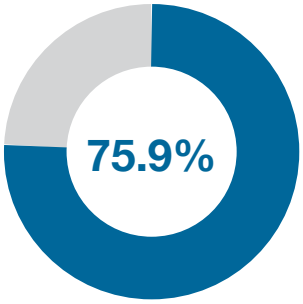
YOUNG ADULTS

Young adults aged 18-25 were asked directly about fentanyl for the first time in the 2024 Young Adult Survey. 83.0% (n=4,798, [80.5, 85.6]) of young adult respondents were very aware or somewhat aware of fentanyl.(YAS, 2024) More young adults were aware of the risks associated with fentanyl use (91.3%, n=4,358, [88.6, 93.9]). Over a third of young adults (34.2%, n=1,637, [32.9, 35.6]) reported that they were not familiar at all with how and why fentanyl is legally prescribed.(YAS, 2024)

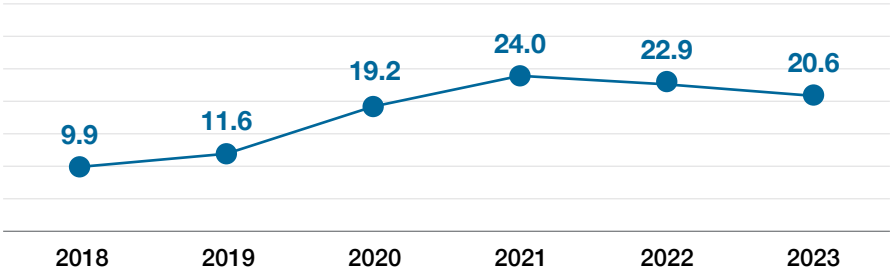
Overdoses and Mortality

2020 was a tipping point in Virginia when the number of Fentanyl deaths doubled compared to previous years. In 2021, fentanyl was involved in 75.9% of all drug overdose deaths in Virginia.(OCME, 2022) The fatal fentanyl overdose rate per 100K people in Virginia has increased from 9.9 in 2018 to a high of 24.0 in 2021 before decreasing to a rate of 20.6 in 2023.(VDH, 2023)

Percent of Overdose Deaths Involving Fentanyl in 2021

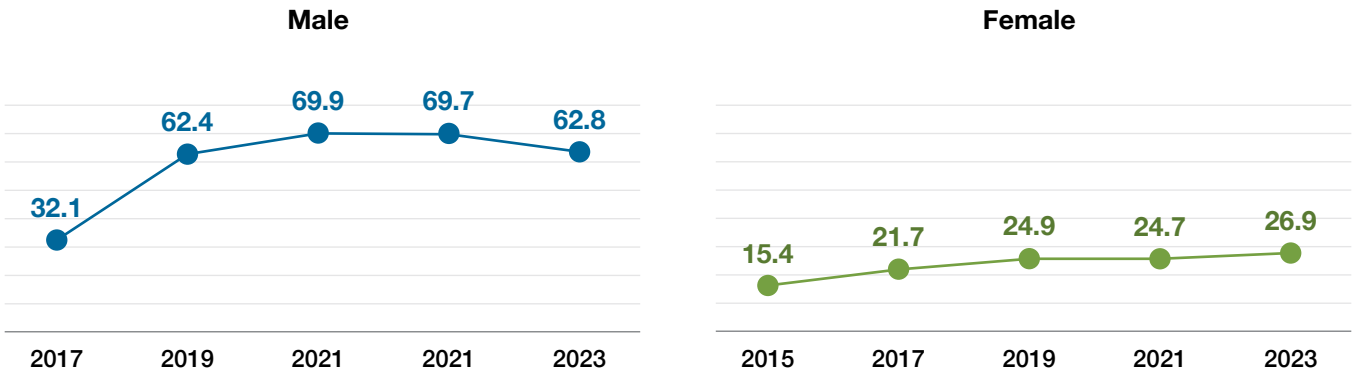


Fentanyl & Other Synthetic Opioid Overdose Deaths Per 100,000 People



Often, illicitly produced fentanyl is mixed in with heroin or sold disguised as heroin, leading to unknowing consumption of fentanyl. In 2023, fentanyl and/or heroin overdose rates were highest among 35-44 years olds at 62.8 deaths per 100,000 men and 26.9 deaths per 100,000 women in this age group.[(VDH, 2023)]

Fatal Fentanyl and Other Synthetic Opioid Overdose Rate Per 100,000 People 35-44 Years Old, By Sex



Focus Area: Cannabis

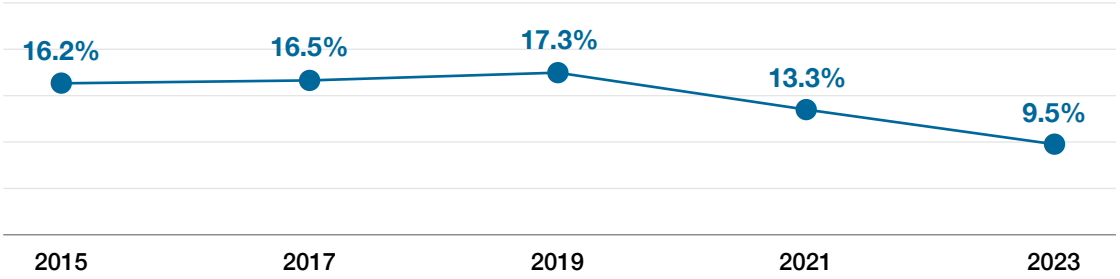
Recreational cannabis use became legal in Virginia in July 1, 2021 for anyone 21 years and older. The retail sale of recreational cannabis is not yet permitted, though individuals over the age of 21 can legally posses up to one ounce of cannabis. Cannabis can also be used for medicinal purpose. Qualified individuals – those with a valid prescription from a medical provider – may purchase cannabis products from a number of medical cannabis dispensaries throughout Virginia.(CFAH, 2023)

Use Across the Lifespan

YOUTH

Despite legalization, the rate of past 30-day use among high school youth in Virginia has declined since 2019. Approximately 1 in 10 (9.5%, n=1,906, [6.9, 12.9]) high school youth reported using cannabis at least once in the past 30 days. Current cannabis use data shows differences among racial and ethnic groups, though past 30-day use rates have decreased across all groups.(VYS, 2023) White youth reported a past 30-day use rate of 10.8% (n=641, [7.2, 15.9]) in 2023, a higher rate compared to Black youth (10.1%, n=383, [6.8, 14.9]) and Hispanic/Latino youth (8.3%, (n=519, [4.6, 14.4]).(VYS, 2023) Youth identifying as Multiracial had the highest rate of past 30-day cannabis use at 11.0% (n=197, [7.2, 16.4]).(VYS, 2023)

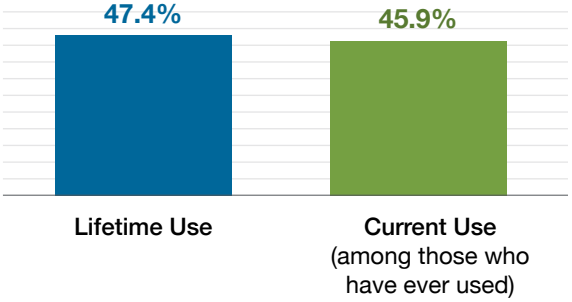
Percent of High School Youth Who Reported Using Cannabis in the Past 30 Days



In 2023, high school youth were asked about using cannabis with electronic vapor products. 6.1% (n=1,862, [4.4, 8.5]) reported vaping cannabis at least once in the past 30-days.(VYS, 2023) Vaping cannabis was more common for females (7.8%, n=937, [5.5, 10.8]) than for males (4.7%, n=921, [3.0, 7.1]).(VYS, 2023)

YOUNG ADULTS

Nearly half (47.4%, n=5,887, [46.1, 48.7]) of 18–25-year-olds in Virginia have used cannabis in their lifetime.(YAS, 2024) Of those who have used cannabis at least once, 45.9% (n=2,768, [44.1, 47.8]) have used cannabis in the past 30 days. 21.7% (n=5,866, [20.6, 22.7]) of all young adult respondents had used cannabis within the past 30 days. Looking across the lifespan, young adults reported the highest rate of cannabis use in the past 30 days.



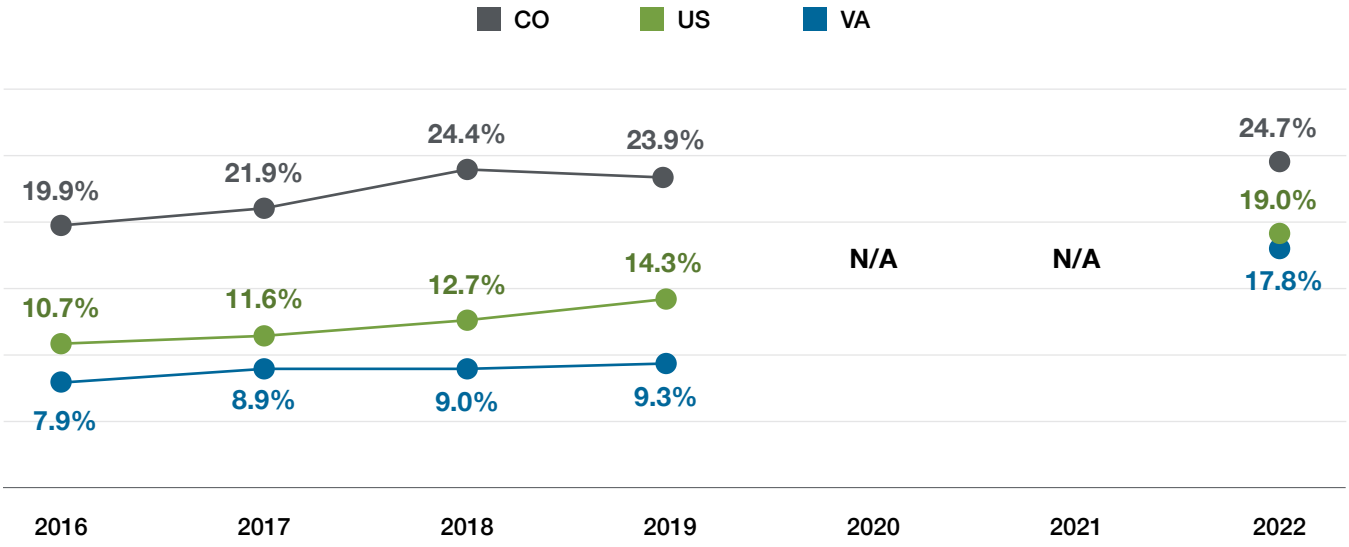
Young adult respondents identifying as Transgender or Gender Diverse (TGD) reported much higher lifetime cannabis use compared to their peers.(YAS, 2024) Among lifetime users, TGD young adults also reported higher use rates within the past 30 days than their non-TGD peers. The same disparity was present for young adults identifying as LGBQ+, who reported higher lifetime and past 30-day use than their straight/heterosexual peers.

	Lifetime Use	Past 30 Day Use (among lifetime users)
Trans or gender diverse (TGD)	**58.5% (n=260, [52.5, 64.4])**	**59.9% (n=152, [52.1, 67.7])**
Cisgender/Not Trans or gender diverse	47.2% n=5,287, [45.8, 48.5])	44.7% (n=2,478, [42.7, 46.6])
LGBQ+	**61.8% (n=1,354, [59.2, 64.4])**	**53.4% (n=833, [50.0, 56.8])**
Straight/Heterosexual	44.2% (n=3,909, [42.7, 45.8])	41.4% (n=1,719, [39.0, 43.7])

ADULTS

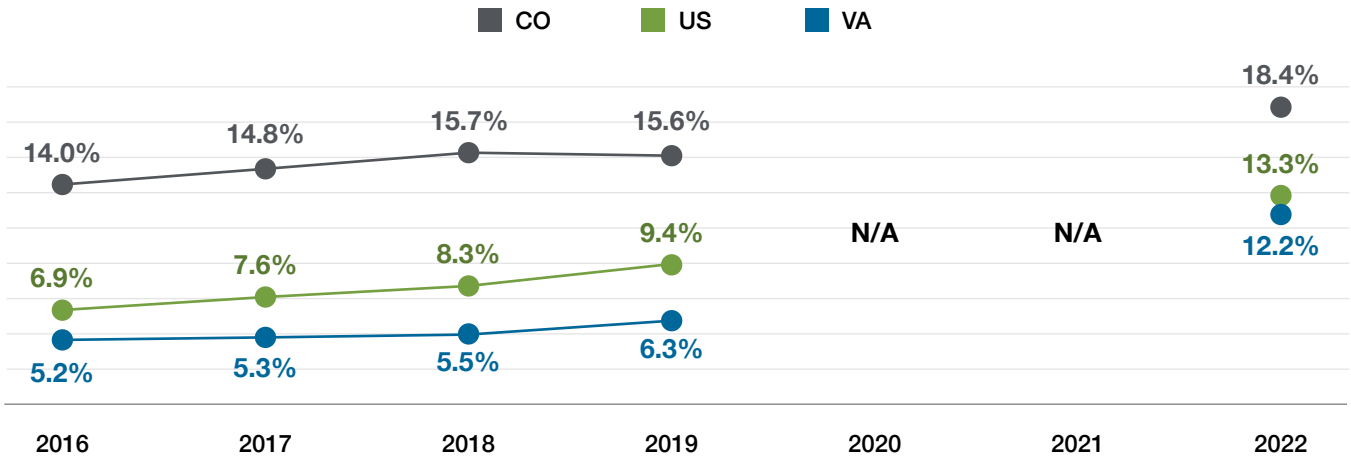
The past year use rate of cannabis for anyone 26 and older in Virginia is lower compared to the national rate and Colorado, which legalized recreational cannabis in 2014.(NSDUH, 2022) However, there was a noticeable increase in past year use rates in Virginia after cannabis was legalized – almost doubling the use rate from 9.3% [7.9, 10.9] in 2019 to 17.8% [18.8, 19.9] in 2022.

Percent of Adults Ages 26+ Who Reported Using Cannabis in the Past 12 Months



Similarly, the past-month use rate of cannabis for anyone 26 and older is lower in Virginia when compared to the national rate and Colorado.(NSDUH, 2021)

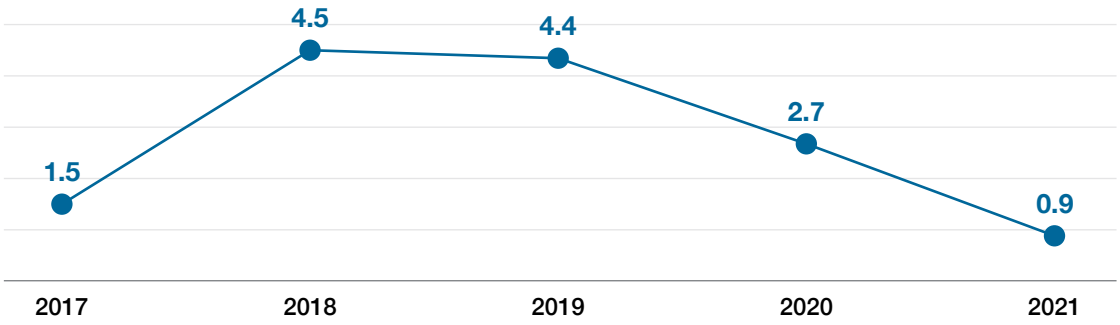
Percent of Adults Ages 26+ Who Reported Using Cannabis in the Past 30 Days



Arrests and Drug Seizures

As expected given legalization in 2021, statewide cannabis arrests rates have fallen dramatically, from 4.5 arrest per 100,000 people in 2019 to 0.9 arrest per 100,000 people in 2021.[(VASIS, 2021)]

Cannabis Seizures Per 100,000 People



Although the overall arrest rate for cannabis is dropping, there is still an overrepresentation of Black, African or African American in arrests compared to the total population proportions. Black Virginians comprised 20% of the population in 2021 yet made up 49.4% of cannabis-related arrests the same year.[(VASIS, 2021)]

The difference between males and females is also misaligned with the overall population distribution. 80.7% of all cannabis-related arrests in 2021 were of males, even though they make up 49.5% of the Commonwealth's population. Meanwhile females represent 19.3% of cannabis arrests and comprise over half of the population (50.5%).[(VASIS, 2021)]

Focus Area: Heroin

Heroin is a highly addictive opioid made from opium poppy plants that can be injected, smoked, or snorted.(CDC, 2024) It is often used in conjunction with other substances, like prescription medications or cocaine.

Use Across the Lifespan

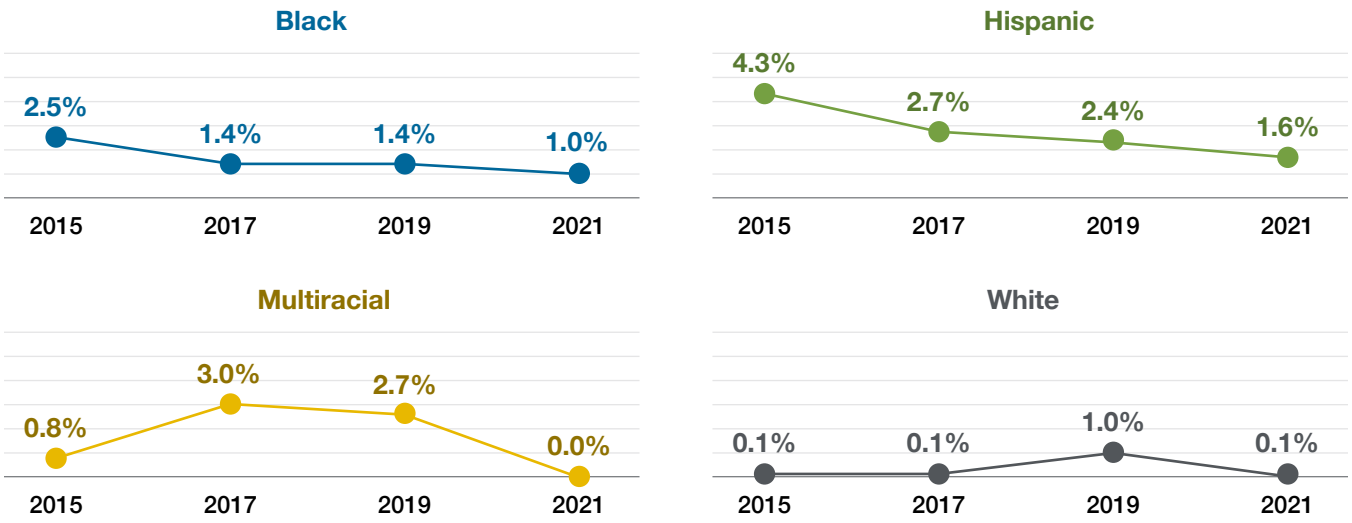
YOUTH

Heroin use in the past 30 days among high school youth has been decreasing over the last ten years, which may be due, in part, to the rise of fentanyl use.(VYS, 2021) Please note, this data point was not collected in the 2023 Virginia Youth Survey administration.

Percent of High School Youth Who Reported Using Heroin in the Past 30 Days

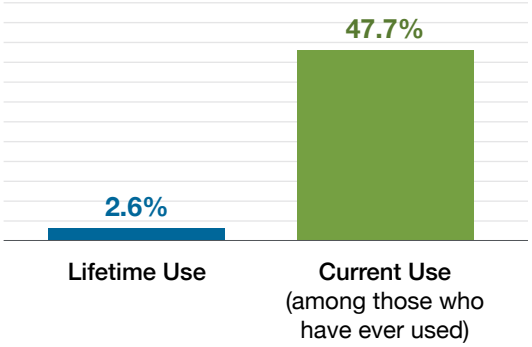
Students identifying as Hispanic/Latino report consistently higher rates of past 30-day use than the overall youth population. Rates were twice as high in 2021 for Hispanic/Latino youth (1.6%, n=716, [0.3, 3.3]) than the overall rate (0.7%, n=3,014, [0.4, 1.1]).(VYS, 2021)

Percent of High School Youth Who Reported Using Heroin in the Past 30 Days, by Race/Ethnicity



YOUNG ADULTS

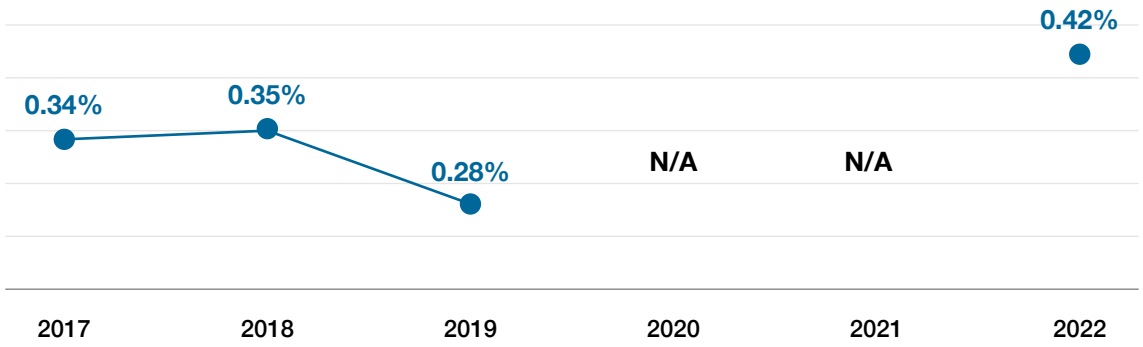
2.6% (n=5,876, [2.23, 3.1]) of young adults reported lifetime heroin use in 2024.(YAS, 2024) Almost half (47.7%, n=153, [39.8, 55.6] of these lifetime users reported having used it in the past 30 days, indicating high likelihood of continued use upon onset.(YAS, 2024) Across all young adult respondents, 1.2% (n=5,874, [1.0, 1.5]) had used heroin in the past 30 days. Some differences were evident between transgender and gender diverse (TGD) young adults and those who are cisgender/not TGD. 6.2% (n=260, [3.2, 9.1]) of TGD young adults reported lifetime heroin use compared to 2.5% (n=5,276, [2.1, 2.9]) of their non-TGD peers.



ADULTS

Past year heroin use among adults 26 or older in Virginia was 0.42% [0.22, 0.80] in 2022, mirroring the 2022 use rates for the United States (0.45%, [0.38, 0.54]).(NSDUH, 2022) Rates have increased since 2019, though exact trends are difficult to identify given lack of available data in the years between.

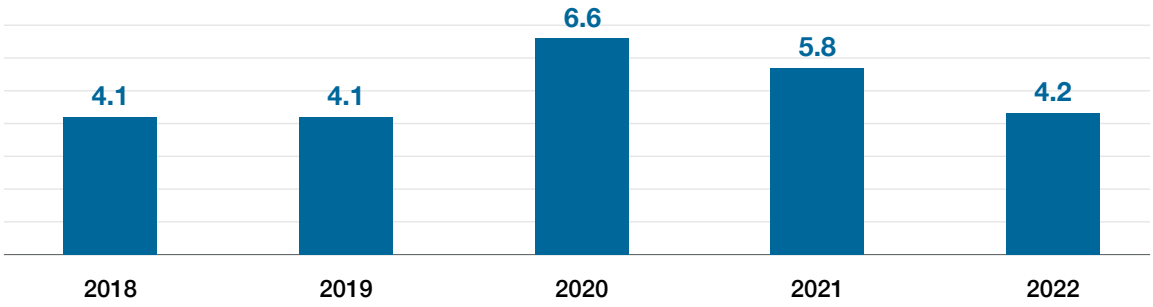
Percent of Adults Ages 26+ Who Reported Using Heroin in the Past 12 Months



Emergency Department Visits - Heroin

In 2022, Heroin ED visits have returned to a similar pre-pandemic rate of 4.2 per 10,000 emergency department visits. The peak of ED visits was 6.6 per 10K ED visits in 2020.(VDH, 2022) Trends in 2022 consistently identify much higher heroin-related ED visit rate among males compared to females. The largest age group represented are Virginians ages 25-34, with heroin-related emergency room visits occuring at a rate of 15.1 per 100,000 males and 4.0 per 100,000 females within this age group.

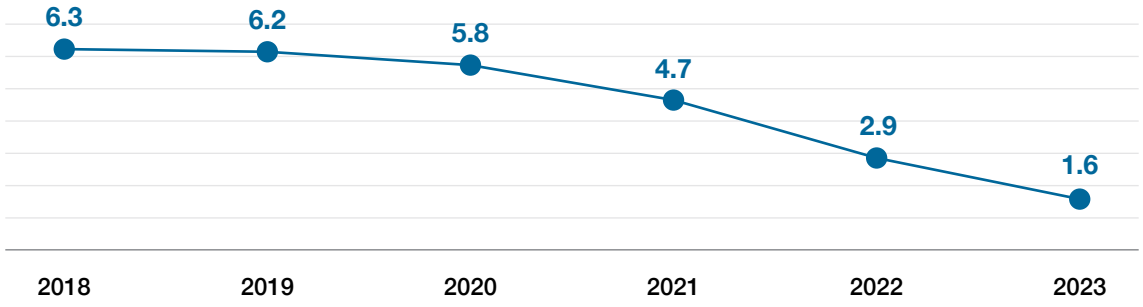
Heroin Overdose Related Emergency Department Visits Per 10,000 Visits



Overdose Rates

Since the peak of heroin overdoses in 2018 (6.3 deaths per 100,000 people), rates have continued to decrease, with the most recent rate at 1.6 deaths per 100,000 people in 2023.(VDH, 2023)

Heroin Overdose Death Rate Per 100,000 People

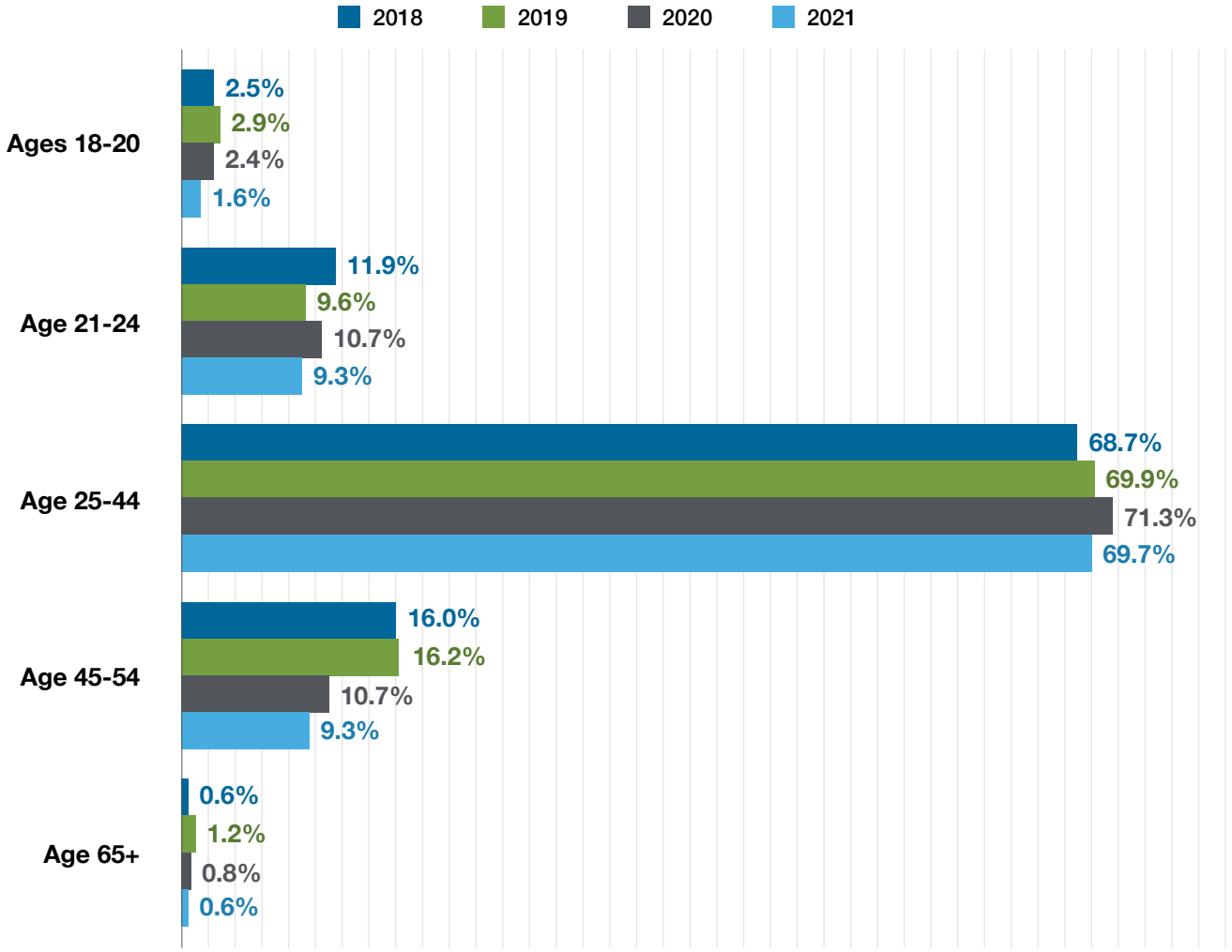


Arrests and Drug Seizures

Statewide heroin arrests rates from 2018 to 2021 have remained steady between 1.0 and 1.2 arrests per 100,000 people.[(VASIS, 2021)]

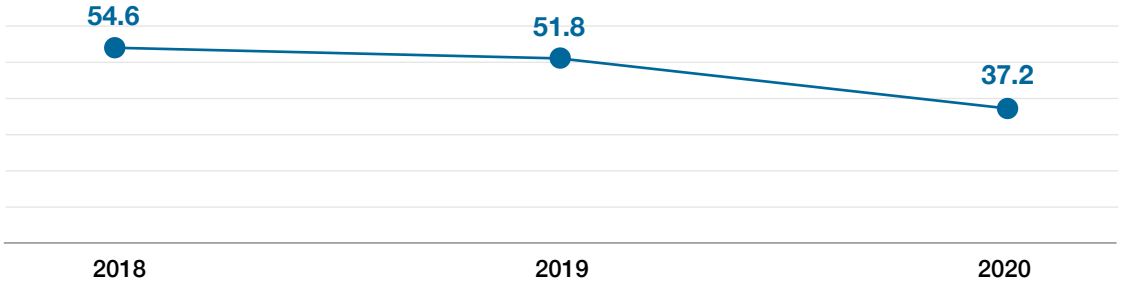
Adults ages 25-44 represent the vast majority of individuals arrested for heroin–related charges, constituting more than 68% of arrests each year since 2018. Adults ages 45-64 are the second most represented age group.

Percent of heroin-related arrests by age group



Statewide heroin seizures have decreased from 2018 to 2020 (54.6 to 37.2 seizures per 100,000).[(VASIS, 2021)] Heroin represented 8% of all drugs seized and tested in 2020, which is a decrease from a high of 16% in 2015.

Heroin Seizures Per 100,000 People



Focus Area: Cocaine

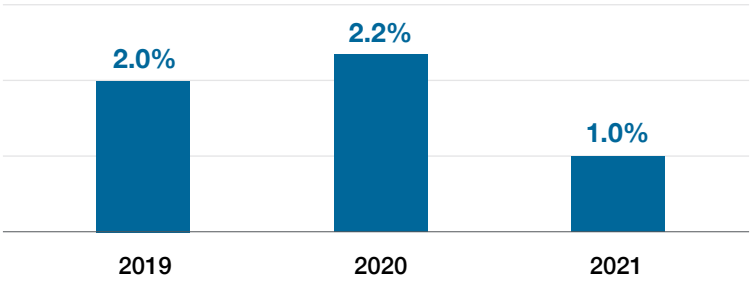
Cocaine is a stimulant that can be snorted, smoked, or injected.[(CDC, 2024)] The use of cocaine has varied over the decades.

Use Across the Lifespan

YOUTH

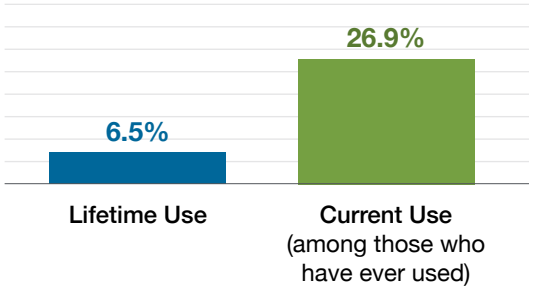
Cocaine use in the past 30 days among high school youth has decreased since 2019.[(VYS, 2021)] There are slight differences across racial groups, with youth identifying as Hispanic/Latino reporting a past 30-day use rate of 1.6% (n=718, [0.7, 3.7]), higher than rates among White youth (0.9%, n=999, [0.4, 1.9]) or Black youth (1.0%, n=879, [0.3, 3.0]).[(VYS, 2021)] Please note, this data point was not collected in the 2023 Virginia Youth Survey administration.

Percent of High School Youth Who Reported Using Cocaine in the Past 30 Days



YOUNG ADULTS

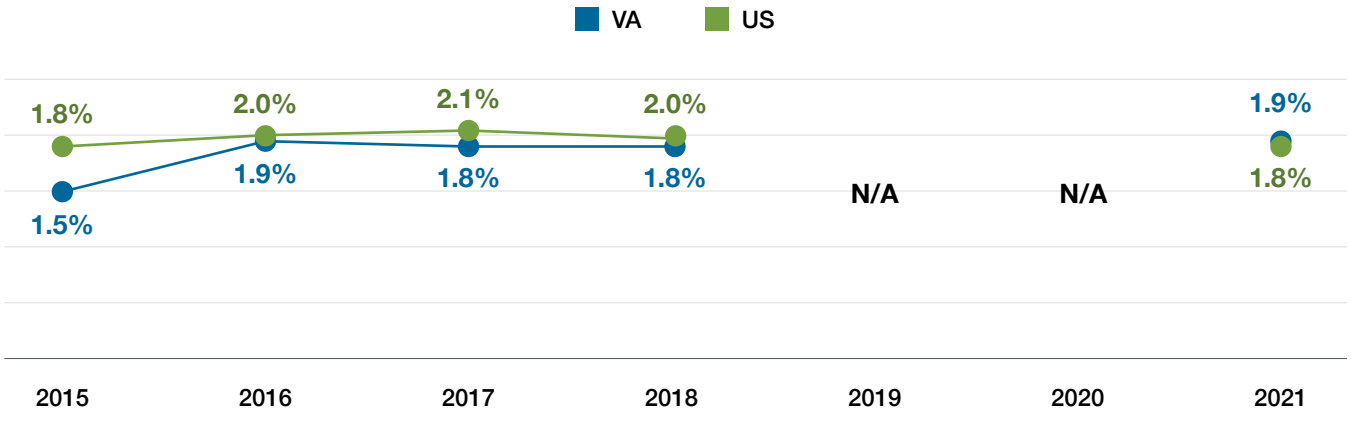
Rates of lifetime use of cocaine among young adults have decreased from 11.0% (n=5,244, [10.2, 11.9]) in 2022, to 6.5% (n=5,884, [5.8, 7.1]) in 2024.[(YAS, 2024)] Past 30-day use of those who had ever used cocaine has also decreased from 32.9% (n=572, [29.0, 36.7]) to 26.9% (n=375, [22.4, 31.4]). Across all young adult respondents, 1.7% (n=5,879, [1.4, 2.0]) had used cocaine in the past 30 days.



ADULTS

The rate of past year cocaine use has remained relatively steady and below the national rate except for in 2021.[(NSDUH, 2021)] Recent trends are difficult to identify given lack of available data.

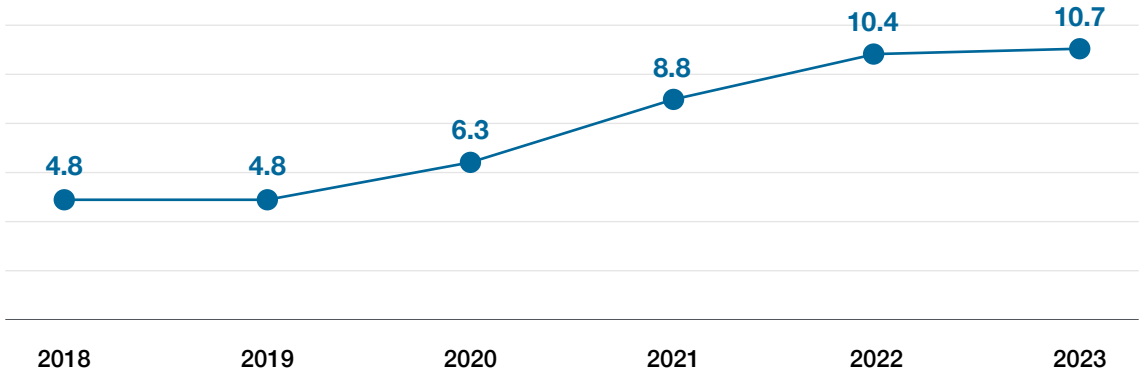
Percent of Adults Ages 18+ Who Reported Using Cocaine in the Past 12 Months



Overdoses and Mortality Rate

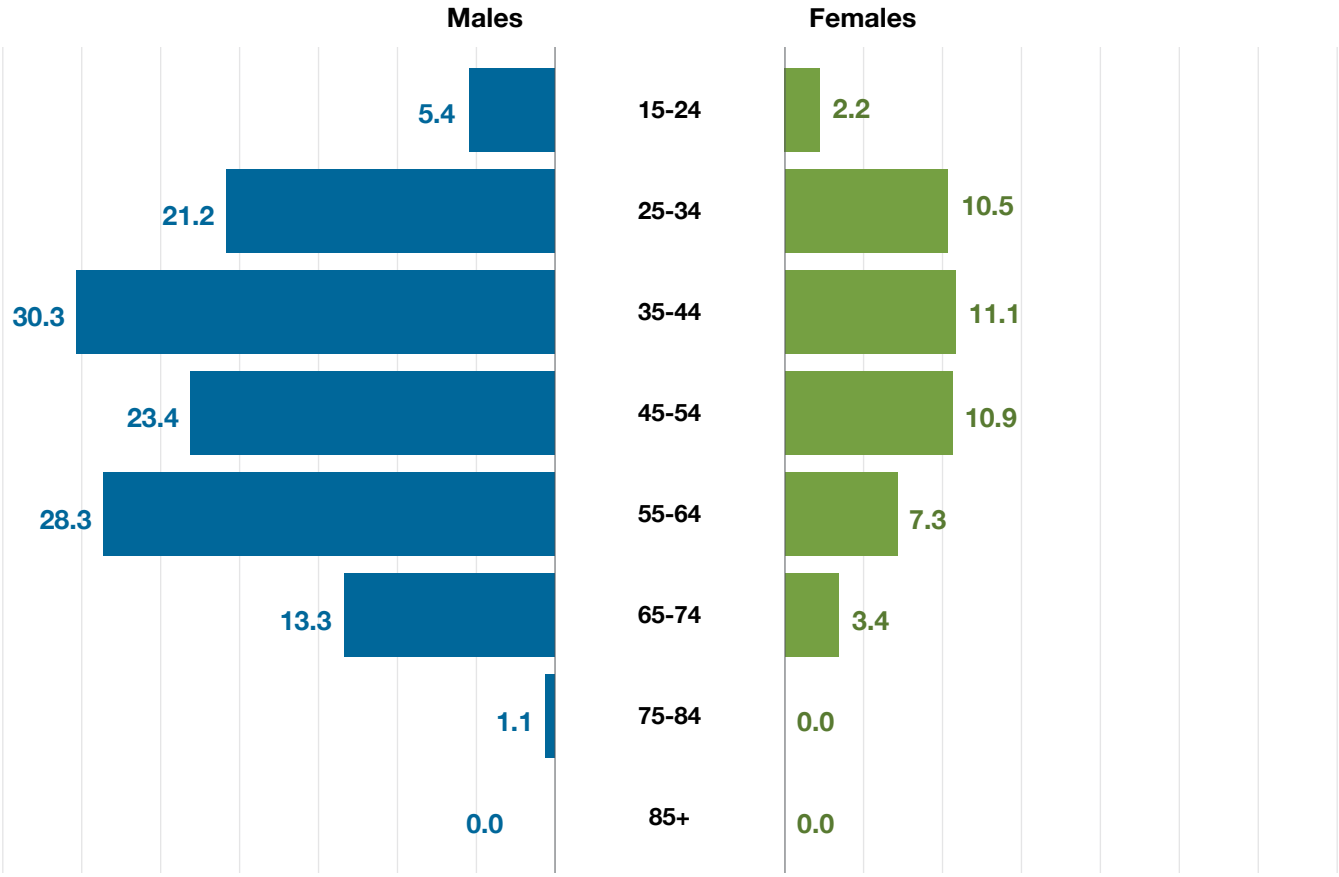
In 2023, there were 10.7 cocaine related overdoses per 100,000 people in Virginia. This rate has increased slightly from the previous year.[OCME, 2021] The rate of cocaine overdoses may be misleading, as cocaine is often mixed with fentanyl, a strong opioid that has significantly impacted overdose rates. In 2023, the combination of cocaine and fentanyl was present in 34.2% of all fatal overdoses.[VDH, 2023]

Cocaine Related Overdose Deaths Per 100,000 People



There are differences among sex and age groups.[VDH, 2023] Males tend to have higher rates of fatal overdoses due to cocaine than females, and overdoses tend to be highest among ages 35-44 and 55-64.

Cocaine Related Overdose Deaths Per 100,000 People, By Sex & Age Group



Focus Area: Methamphetamine

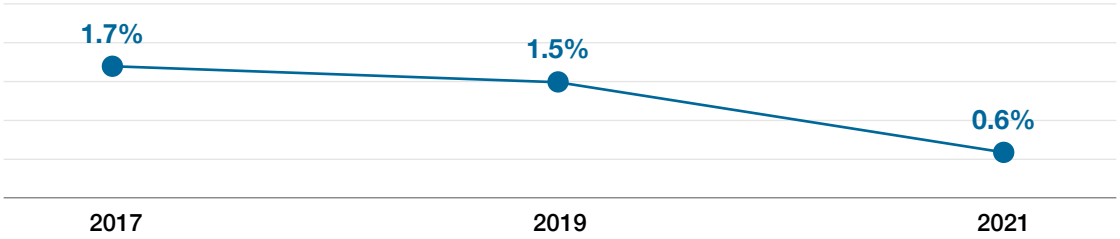
Methamphetamine, also known as meth, is a type of human-made stimulant drug that can be highly addictive. (CDC, 2024) It has been documented that individuals are at higher risk if they are low-income, live in rural areas, are male or White.(CDC, 2020)

Use Across the Lifespan

YOUTH

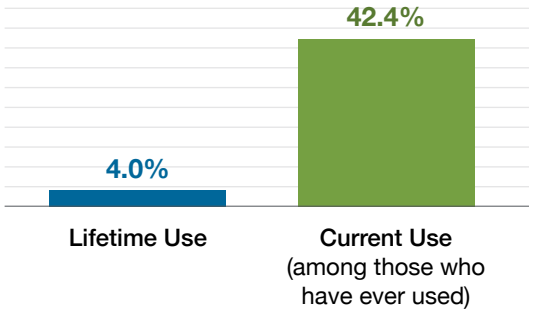
Past 30-day methamphetamine use among high school students has been decreasing in recent years, dropping to 0.6% (n=3,020, [0.4, 0.9]) in 2021.(VYS, 2021) Variance exists when examining sex and race, though small sample sizes create challenges in ascertaining the true difference. Please note, this data point was not collected in the 2023 Virginia Youth Survey administration.

Percent of High School Youth Who Reported Using Methamphetamine in the Past 30 Days



YOUNG ADULTS

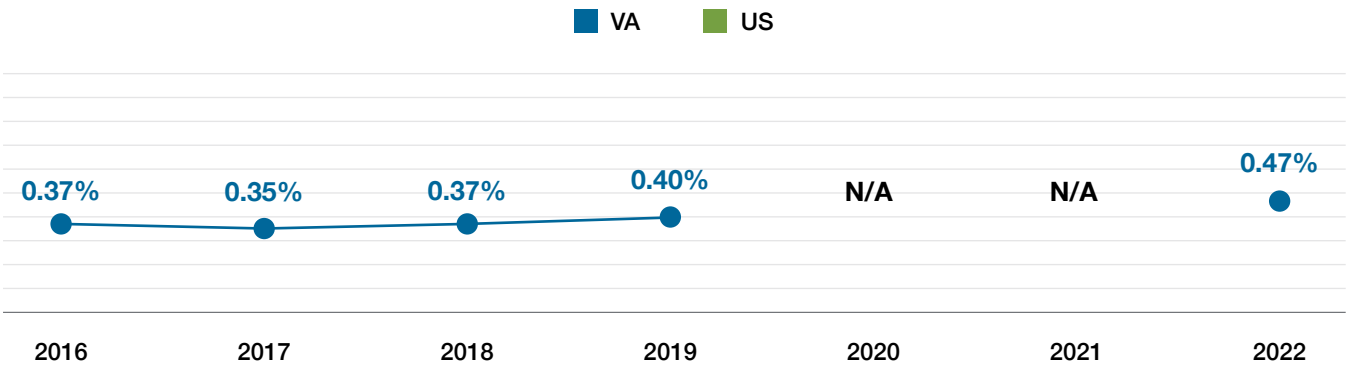
In 2024, 4.0% (n=5,889, [3.5, 4.5]) of young adult respondents aged 18-25 reported having used methamphetamine at least once in their lifetime.(YAS, 2024) 42.4% (n=231, [36.1, 48.8]) of lifetime users reported past 30-day use, indicating high likelihood of continued use upon onset. These use rates have declined since 2022, when lifetime use was at 6.5% (n=5,239, [5.9, 7.2]) and past 30-day use was 52.8% (n=335, [47.5, 58.2]).(YAS, 2022) Across all young adult respondents, 1.7% (n=5,885, [1.4, 2.0]) reported using methamphetamine at least once in the past 30 days.(YAS, 2024)



ADULTS

Past-year methamphetamine use in 2021-22 among adults aged 26 or older was 0.47% [0.25, 0.88], which is much lower than the national rate of 1.12% [0.98, 1.28].(NSDUH, 2022) Rates among Virginia adults do seem to be increasing over time, with rates steadily climbing since reaching a low of 0.35% [0.18, 0.66] in 2016-17.(NSDUH, 2016-17)

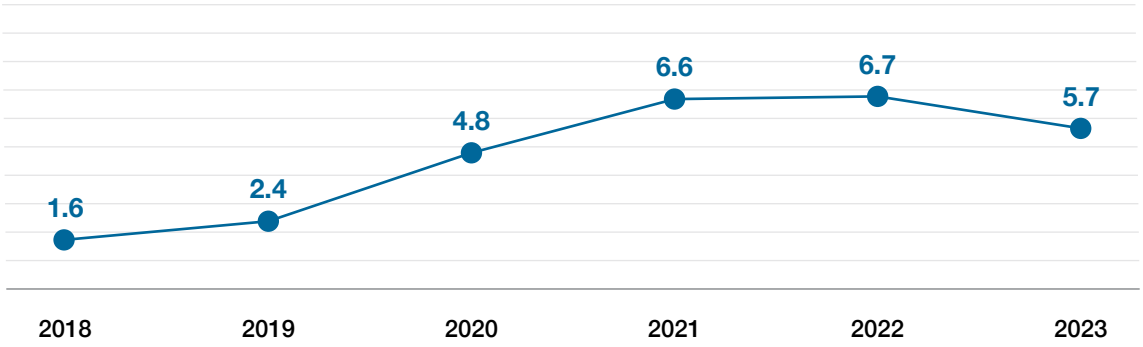
Percent of Adults Ages 26+ Who Reported Using Methamphetamine in the Past 12 Months



Overdoses and Mortality Rate

Virginia monitors the overdose rates attributed to methamphetamine in combination with other psychostimulant drugs, like ecstasy. Cocaine is monitored separately. Fatal overdoses for psychostimulants had been increasing in recent years, up to 6.7 per 100,000 people in 2022, but declined in 2023 to 5.7 per 100,000 people.[(VDH, 2023)]

Psychostimulant Related Overdose Deaths Per 100,000 People

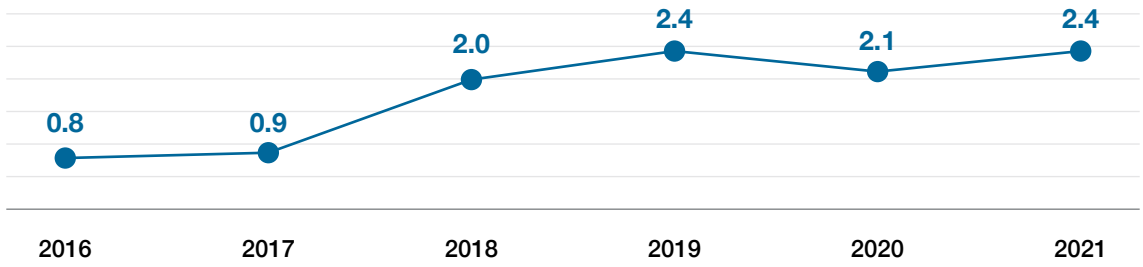


Overdoses involving psychostimulants show higher rates for males than females.[(VDH, 2023)] For 35-44 year olds in Virginia, males have a psychostimulant fatal overdose rate of 17.1 per 100,000 people, compared to 9.4 per 100,000 people for females.[(VDH, 2023)]

Arrests and Drug Seizures

The Department of Criminal Justice Services reports the number of arrests related to amphetamine and methamphetamine together. The statewide rate of arrests for amphetamine/methamphetamine charges has increase sharply over the last decade.[(VASIS, 2021)]

Amphetamine/Methamphetamine Related Arrests Per 100,000 People



Aligning with known risk factors, individuals identifying as White comprised 90.8% of all amphetamine/methamphetamine arrests in 2021, even though only 68.8% of Virginia's general population identify as White. [(VASIS, 2021)]

Focus Area: Hallucinogen

Hallucinogens and psychedelics are mood altering drugs that can also change a person's perception of their surroundings and experiences.[(NIDA, 2024)] Common hallucinogens include mushrooms, ecstasy/MDMA, LSD, PCP, and ketamine.

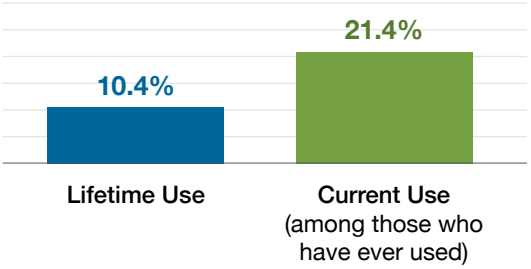
Use Across the Lifespan

YOUTH

Data on hallucinogen use among youth is not collected/reported at the state level.

YOUNG ADULTS

Overall, young adult respondents between the ages of 18-25 reported a lifetime use rate of 10.4% (n=5,888, [9.6, 11.2]) for hallucinogens.[(YAS, 2024)] Of those who had used hallucinogens previously, 21.4% (n=607, [18.2, 24.7]) reported using them at least once over the past 30 days. Across all young adult respondents, 2.2% (n=5,883, [1.8, 2.6]) reported having used hallucinogens in the past 30 days.

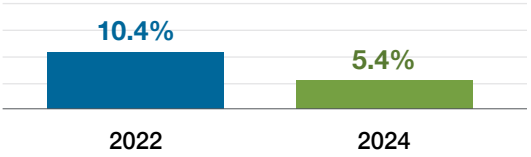


When examining lifetime use data, Transgender and Gender Diverse (TGD) young adults reported using hallucinogens at almost twice the rate of non-TGD young adults – 18.8% (n=261, [14,0, 23.5]) compared to 9.8% (n=5,286, [9, 10.6]).[(YAS, 2024)] The same was also true for LGBQ+ young adults (16.7%, n=1,356, [14.8, 18.7]) compared to straight/heterosexual young adults (8.2%, n=3,907, [7.4, 9.1]). Approximately one in five (21.4%, n=607, [18.2, 24.7]) young adults who reported ever using hallucinogens reported having used them at least once int the past 30 days. Across all young adults, 2.2% (n=5,883, [1.8, 2.6]) reported past 30-day hallucinogen use.

Ecstasy

Data are collected on a specific hallucinogen – ecstasy, also known as MDMA. Lifetime ecstasy use for young adults has fallen from 2022 to 2024, from 10.4% (n=5,232, [9.6, 11.2] to 5.4% (n=5,880, [4.9, 6.0]).[(YAS, 2024)] 29.4% (n=316, [24.4, 34.5]) of young adults who had used ecstasy before had used within the past 30-days. Across all young adults, 1.6% (n=8,876, [1.3, 1.9] reported past 30-day ecstasy use.

Lifetime Ecstasy Use Among Young Adults Ages 18-25



ADULTS

2021-22 estimates found 1.8% [1.3, 2.5] adults ages 26 or older in Virginia reported past year hallucinogen use - below the national rate 2.3% [2.1, 2.5].[(NSDUH, 2022)] Data on hallucinogen use was not available prior to 2022.

Focus Area: Over The Counter (OTC) Medications

OTC medication misuse is defined as the use of non-prescription medication in a way that is not intended. OTC misuse is common among youth as OTC medications, such as cough or anti-diarrheal medicines, are easily accessible.[(AAC, 2024)] There is no data available for adults age 26 or older on OTC medication misuse.

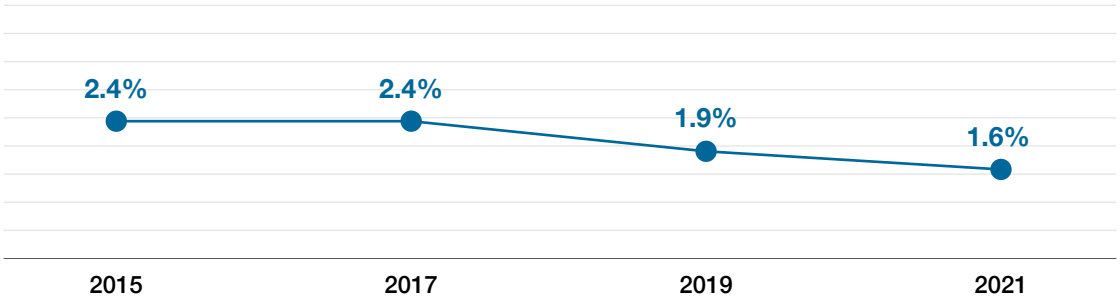
Use Across the Lifespan

YOUTH

OTC medication misuse is commonly associated with younger youth – as such, Virginia has asked middle school students about OTC misuse and has not asked high school youth about OTC misuse since 2015. Please note, this data point was not collected in the 2023 Virginia Youth Survey administration.

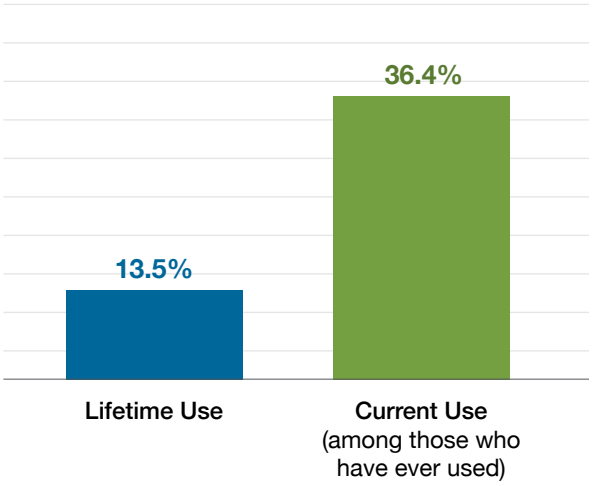
Lifetime use rates of OTC medication misuse have been decreasing in recent years among middle school students.[(VYS, 2021)] Past 30-day OTC misuse for high school students in 2015 was 4.8% (n=5,063, [4.8, 6.0]) - exactly twice as high as the middle school student lifetime misuse rate – indicating that the perception of OTC use being more common among younger youth may be erroneous.[(VYS, 2021)]

Percent of Middle School Youth Who Reported Having Ever Misused OTC Medications



YOUNG ADULT

In 2024, 13.5% (n=5,892, [12.6, 14.3]) of 18 to 25-year-olds had misused OTC medications in their lifetime, with over a third (36.4%, n=786, [33.0, 39.8]) of those individuals reporting having misused OTC medications in the past 30 days.[(YAS, 2024)] LGBQ+ young adult respondents reported a higher lifetime OTC misuse rate (15.8%, n=1,352, [13.9, 17.8]) compared to their Straight/ Heterosexual peers (12.6%, n=3,914, [11.6, 13.7]). Straight/heterosexual young adults who reported lifetime OTC misuse were, however, more likely to report past 30-day misuse (38.9%, n=489, [34.5, 43.2]) than their LGBQ+ peers (28.2%, n=213, [22.1, 34.2]). Across all young adult respondents, 4.9% (n=5,884, [4.3, 5.4]) reported misusing OTC medications in the past 30 days.



Focus Area: Problem Gaming and Gambling

Access to gambling in Virginia, and around the nation, has expanded drastically over the last decade. In Virginia, legalized gambling in the form of bingo, lottery, and horse race betting had remained unchanged since the 1980s. 2020 ushered in a new era with legalized online betting, sports betting and the approval for 5 brick-and-mortar casinos to be built around the commonwealth.

Problem gamlbing refers to behaviors that have negative outcomes or consequences on an individual's life, including their daily life, finances, relationships, and/or career.(NCPG, 2024) Problem gaming is defined similarly, but is focused on engagement in video and online gaming practices that have negative impacts.(WHO, 2024) Given the fast rise in access for both gambling and gaming, Virginia has begun to examine data and issues related to problem gaming and gambling – outlined below.

National Trends

Overall gambling has decreased from 2018 to 2021 across the US.(NGAGE, 2021)

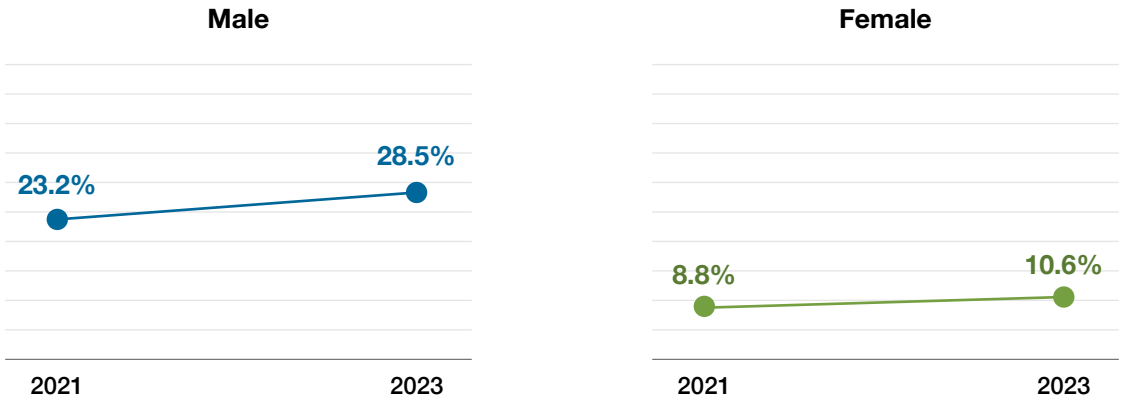
Overall lottery game engagement has also decreased from 2018 to 2021. (NGAGE, 2021)

Use Across the Lifespan

YOUTH

19.8% (n=1,871, [17.7, 22.2]) of high school youth reported engaging in gambling behaviors within the past 12 months, increasing from 16.0% (n=2,930, [14.3, 17.8]) in 2021.(VYS, 2023) This includes a range of gambling behaviors, including betting on sports, a card game, the lottery, online gambling, or betting on the outcomes of a video game. Those who are male were much more likely to report gambling in the past year. Over 1 in 4 (28.5%, (n=914, [25.0, 32.3]) male students reporting gambling in the past year compared to about 1 in 10 (10.6%, n=953, [8.3, 13.6]) female students.(VYS, 2023)

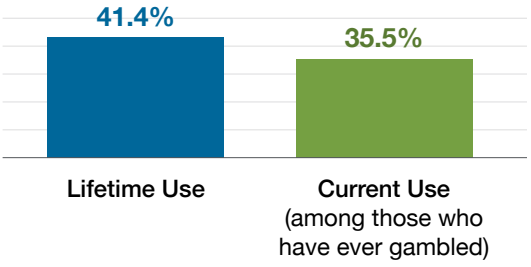
Percent of High School Youth Who Reported Gambling in the Past Year, By Sex



Some differences among racial and ethnic groups was reported. Students identifying as Hispanic/Latino had the highest level of reported gambling, at 23.6% (n=508, [20.7, 26.9]), followed by students identifying as White (20.2%, n=629, [17.1, 23.8]) and those identifying as Black (18.1%, n=380, [14.4, 22.4]).(VYS, 2023) Past 30-day gambling was lowest among youth identifying as Multiracial (17.4%, n=193, [12.2, 24.1]) or Asian (14.4%, n=138, [9.2, 21.8]).(VYS, 2023)

YOUNG ADULTS

Among young adults ages 18-25, 41.1% (n=5,885, [39.9, 42.4]) have engaged in gambling behavior in their lifetime.(YAS, 2024) Of those who have gambled, over one-third (35.5%, n=2,406, [33.6, 37.4]) have done so in the past 30 days. Across all young adult respondents, 14.6% (n=5,868, [13.7, 15.5]) reported having gambled at least once in the past 30 days.



In alignment with overall trends, men reported much higher rates of gambling than individuals who are women or non-binary or questioning their gender. Nearly 1 in 2 (48.3%, n=2,049, [46.1, 50.4]) men reported having gambled at least once.(YAS, 2024) Of lifetime gamblers, 47.6% (n=987, [44.5, 50.7]) reported past 30-day gambling.

	Lifetime Gambling	Past 30-Day Gambling (among lifetime gamblers)
Men	**48.3% (n=2,049, [46.1, 50.4])**	**47.6% (n=987, [44.5, 50.7])**
Women	37.8% (n=3,380, [36.2, 39.4])	26.2% (n=1,270, [23.8, 28.6])
Non-Binary or Questioning Folx	47.8% (n=253, [41.7, 54])	29.8% (n=121, [21.6, 37.9])

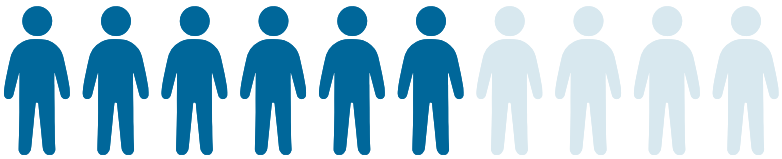
Gambling behaviors by young adult respondents show some differences across both sexual orientation and race. While lifetime use rates are similar, young adults identifying as straight/heterosexual reported a higher rate of past 30-days gambling (37.6%, n=1,634, [35.2, 39.9]) than those identifying as LGBQ+ (29.3%, n=584, [25.6, 33]).(YAS, 2024)

	Lifetime Gambling	Past 30-Day Gambling (among lifetime gamblers)
Straight/Heterosexual	42.0% (n=3,908, [40.4, 43.5])	**37.6% (n=1,634, [35.2, 39.9])**
LGBQ+	**43.4% (n=1,354, [40.7, 46.0])**	29.3% (n=584, [25.6, 33.0])

Meanwhile, BIPOC individuals reported a higher rate of past 30-day gambling (39.1%, n=907, [36.0, 42.3]) compared to their White, non-Hispanic peers (33.0%, n=1,433, [30.6, 35.4]), despite lower lifetime use rates, indicating BIPOC young adults may be more prone to continued gambling upon onset.(YAS, 2024)

	Lifetime Gambling	Past 30-Day Gambling (among lifetime gamblers)
BIPOC	34.7% (n=2,625, [32.9, 36.6])	**39.1% (n=907, [36.0, 42.3])**
White, Non-Hispanic	**47.6% (n=3,019, [45.9, 49.4])**	33.0% (n=1,433, [30.6, 35.4])

Sports betting is a key driver in young adult gambling behaviors. 60.7% (n=825, [52.8, 68.7]) young adults who reported gambling in the past 30 days participated in some form of sports betting. Approximately 1 in 10 (9.6%, n=825, [7.6, 11.6]) young adults who gambled in the past 30 days bet on sports daily or almost daily.(YAS, 2024) Sports betting was particularly high among men – among men who gambled in the past 30 days, 3 in 4 (75.9%, n=465, [64.5, 87.4]) bet on sports at least once. In comparison, less than half (39.2%, n=319, [28.7, 49.7]) of women who had gambled in the past month had bet on sports.



60.7%
of young adults who reported gambling in the past 30 days participated in some form of sports betting

ADULTS

The National Council on Problem Gambling reported state-level gambling behavior data in 2018. At that time, 79.0% of adults in Virginia reported gambling in some form within the past year. Playing the lottery (70.0%) and buying a raffle ticket (45.0%) were the most common forms of gambling.(NGAGE, 2018)

Almost 1 in 4 adults (24.0%) reported betting on sports within the last year, and 1 in 5 (21.0%) engaged in playing fantasy sports.(NGAGE, 2018) This is despite the fact that sports betting had not yet been legalized in Virginia at that time.

Focus Area: Suicide and Mental Health

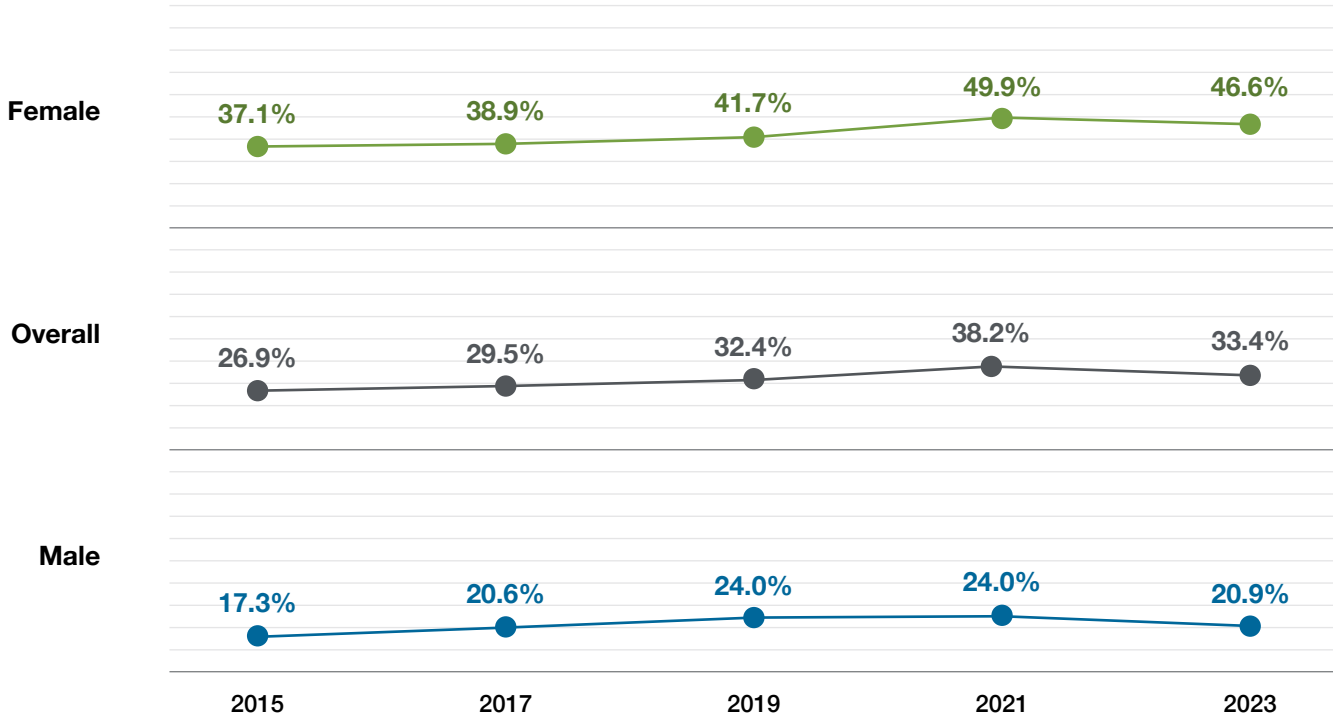
Mental health and substance use disorders can become life-threatening if they go untreated. Prevention work can help catch symptoms from the beginning and/or provide resources and skills to communities before they become lethal. As noted throughout the report, there is strong overlap between the shared risk and protective factors for using substances and the shared risk and protective factors for mental health and suicide. Impacting poor mental health and preventing suicide are also likely to reduce substance use.

Depressive Symptoms and Episodes

YOUTH

Rates of high school youth reporting feeling sad or hopeless decreased between 2021 and 2023. In 2023, 33.4% (n=1,952, [29.0, 38.1]) of high school youth reported feeling sad or hopeless for over two weeks within the past year to the point that they stopped doing some usual activities.(VYS, 2023) Rates are highest among female students. Almost half (46.6%, n=993, [39.8, 53.5]) of female high school youth in Virginia reported feeling sad or hopeless for over two weeks within the last year compared to 20.9% (n=955, [17.5, 24.7]) of male students.(VYS, 2023)

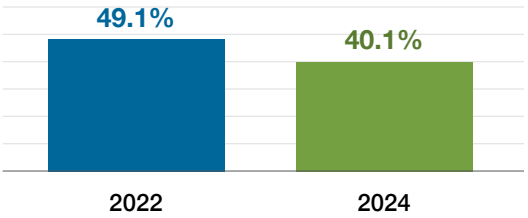
Percent of High School Youth Reporting Feel Sad or Hopeless For Over Two Weeks in the Past 12 Months



YOUNG ADULTS

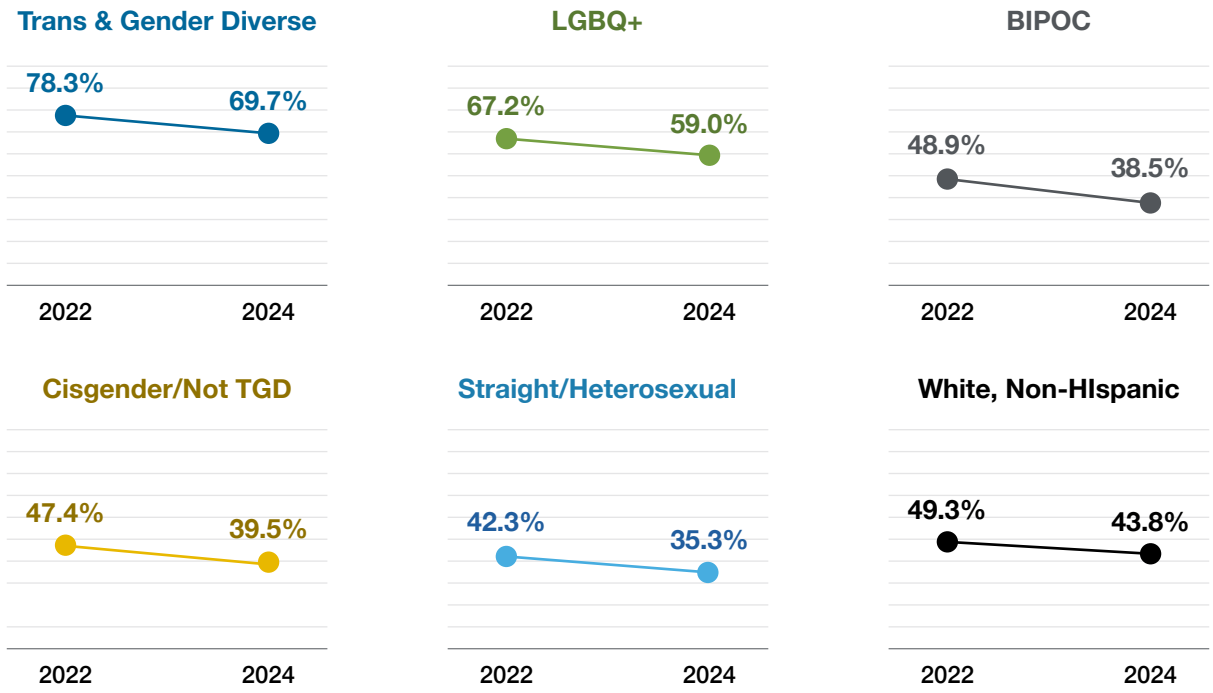
Data collected from the respondents of the 2024 Young Adult Survey revealed that those aged 18-25 are not experiencing the same increase trend as youth. Rates of feeling sadness or hopeless for more than two weeks have decreased from 2022 (49.1%, n=5,023, [47.7, 50.4]) to 2024 (40.1%, n=5,723 [39.7, 42.3]).(YAS, 2024)

Young adult rates of depressive symptoms



Some populations reported much higher rates of depressive symptoms, including transgender and gender diverse (TGD) young adults and those identifying as LGBQ+, when compared to their peers. TGD individuals reported rates thirty percentage points higher than their non-TGD peers, while rates among LGBQ+ individuals were over twenty percentage points higher than their straight/heterosexual peers. Trends may reflect a need for additional supports for these higher risk populations.

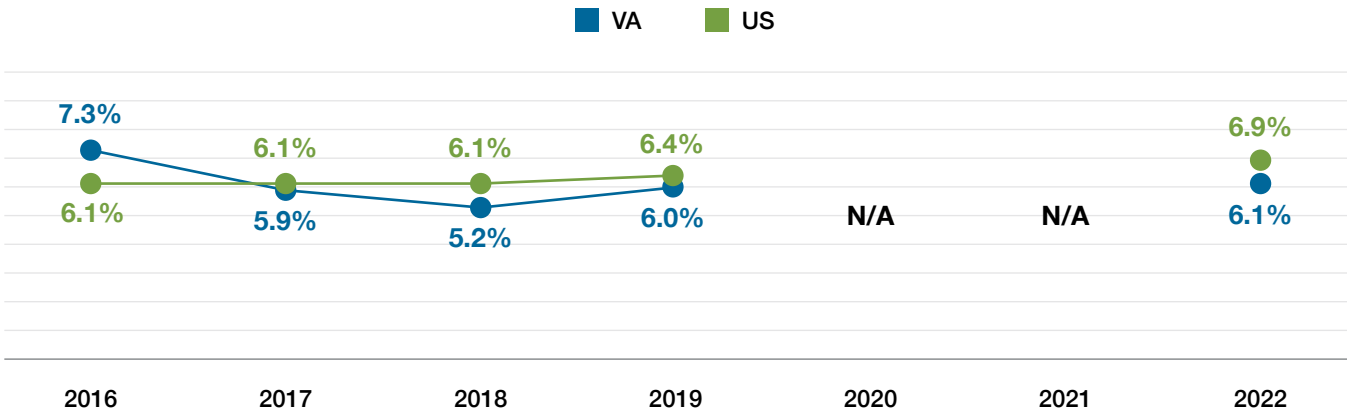
Percent of Young Adults Reporting Feel Sad or Hopeless For Over Two Weeks in the Past 12 Months, By Gender Identity, Sexual Orientation, and Race/Ethnicity



ADULTS

Data on adults experiencing sadness or hopelessness for more than two weeks is currently not collected in a way that aligns with measures collected for other age groups. SAMHSA's National Surveys on Drug Use and Health (NSDHU) does report on adult rates of experiencing a major depressive episode within the past year. Recent data has demonstrated consistent increases over the years nationally.(NSDUH, 2021) Trends in Virginia indicate show a decline a significant decline in the rate of adults ages 26+ reporting at least one major depressive episode in the past year from 2016 to 2018, after which rates began to rise again.

Percent of Adults Ages 26+ Reporting At Least One Major Depressive Episode in the Past Year

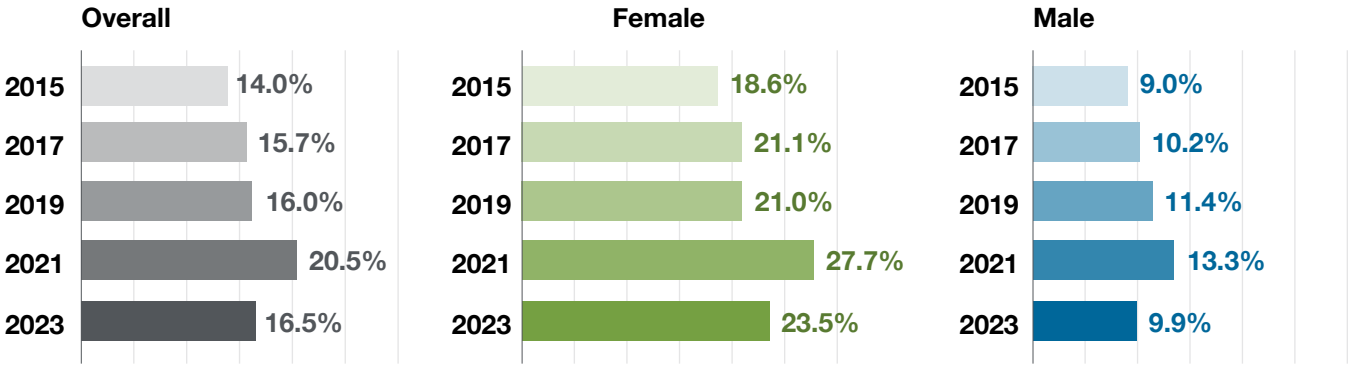


Suicidal Ideation

YOUTH

16.5% (n=1,947, [13.1, 20.6]) of high school aged youth report having seriously considered suicide within the past year– meaning nearly 1 in 6 high school youth have experienced suicidal ideation in the past twelve months.[(VYS, 2023)] This was a decrease from 2021, where 20.5% (n=3,044, [18.1, 23.1]) of youth had experienced suicidal ideation in the past year.[(VYS, 2021)] Aligning with data on experiencing depressive symptoms, females reported a higher rate of past-year suicidal ideation than males.[(VYS, 2023)]

Percent of High School Youth Who Report Having Seriously Considered Suicide in the Past 12 Months, Overall and By Sex

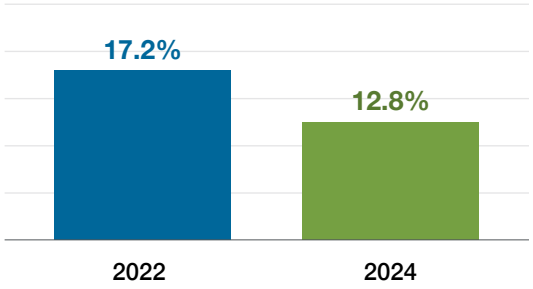


YOUNG ADULTS

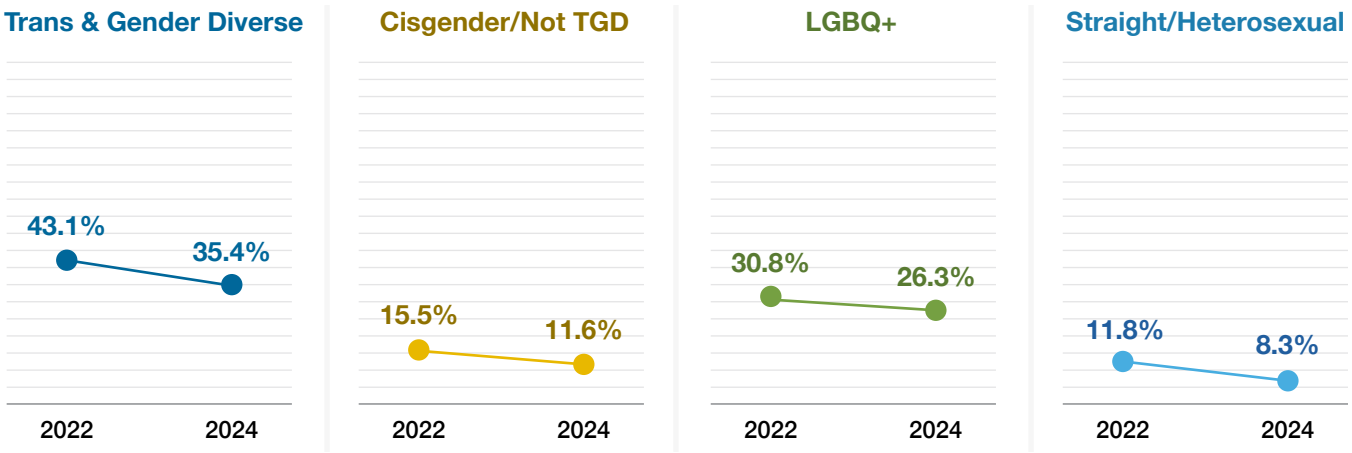
In alignment with young adult trends in experiencing feelings of sadness or hopelessness, young adult respondents also reported a decrease in suicidal ideation within the past year, from 17.2% (n=5,014, [16.1, 18.2]) in 2022 to 12.8% (n=5,669, [12.0, 13.7]) in 2024.[(YAS, 2024)]

Strong disparities were found when comparing the experiences of young adults across gender identity and sexual orientation. Trans and gender diverse and LGBQ+ young adults reported much higher rates of suicidal ideation when compared to their peers.

Decrease in young adult suicidal ideation



Percent of Young Adults Who Reported Experiencing Suicidal Ideation in the Past 12 Months, by Gender Identity and Sexual Orientation

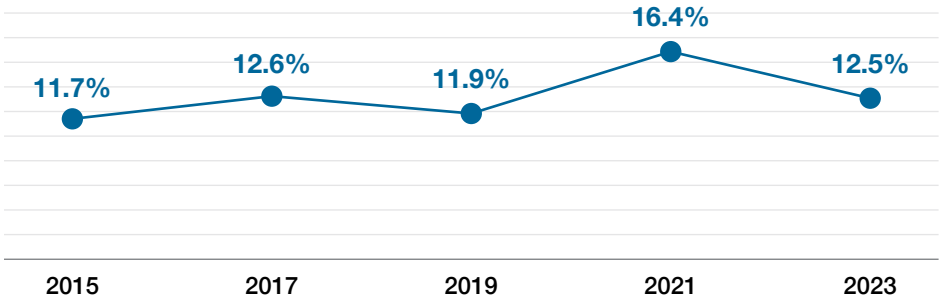


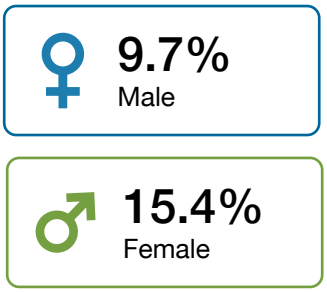
Suicide Attempts

YOUTH

High school youth who reported having made a plan for how they would attempt suicide in the past year has decreased from 16.4% (n=3,027, [14.6, 18.5]) in 2021 to 12.5% (n=1,932, [10.2, 15.2]) in 2023.[(VYS, 2021)] [(VYS, 2023)] As is the case with other mental health related data, females reported much higher rates of making a suicide plan than males 15.4% (n=979, [12.4, 18.9]) of females reported having made a suicide plan in the past 12 months compared to 9.7% (n=949, [7.3, 12.7]) of males.[(VYS, 2023)] Important to note is the large drop in rates for females between 2021 and 2023 - 22.9% (n=1,496, [19.9, 26.3]) in 2022 compared to 15.4% in 2024.[(VYS, 2021)] [(VYS, 2023)]

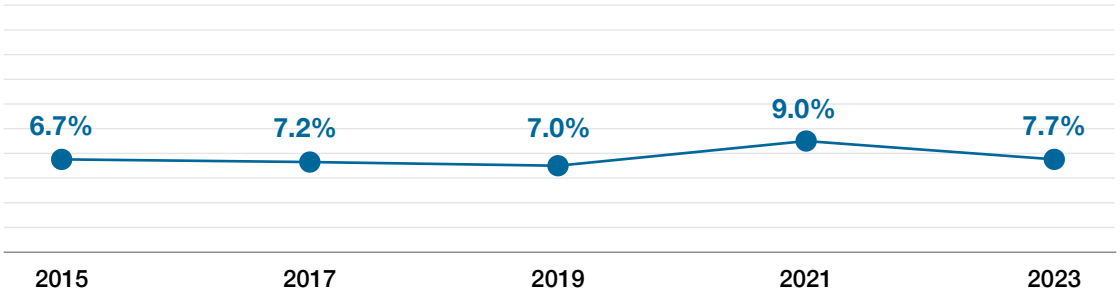
Percent of High School Youth Who Reported Making a Suicide Plan in the Past 12 Months, Overall and By Sex



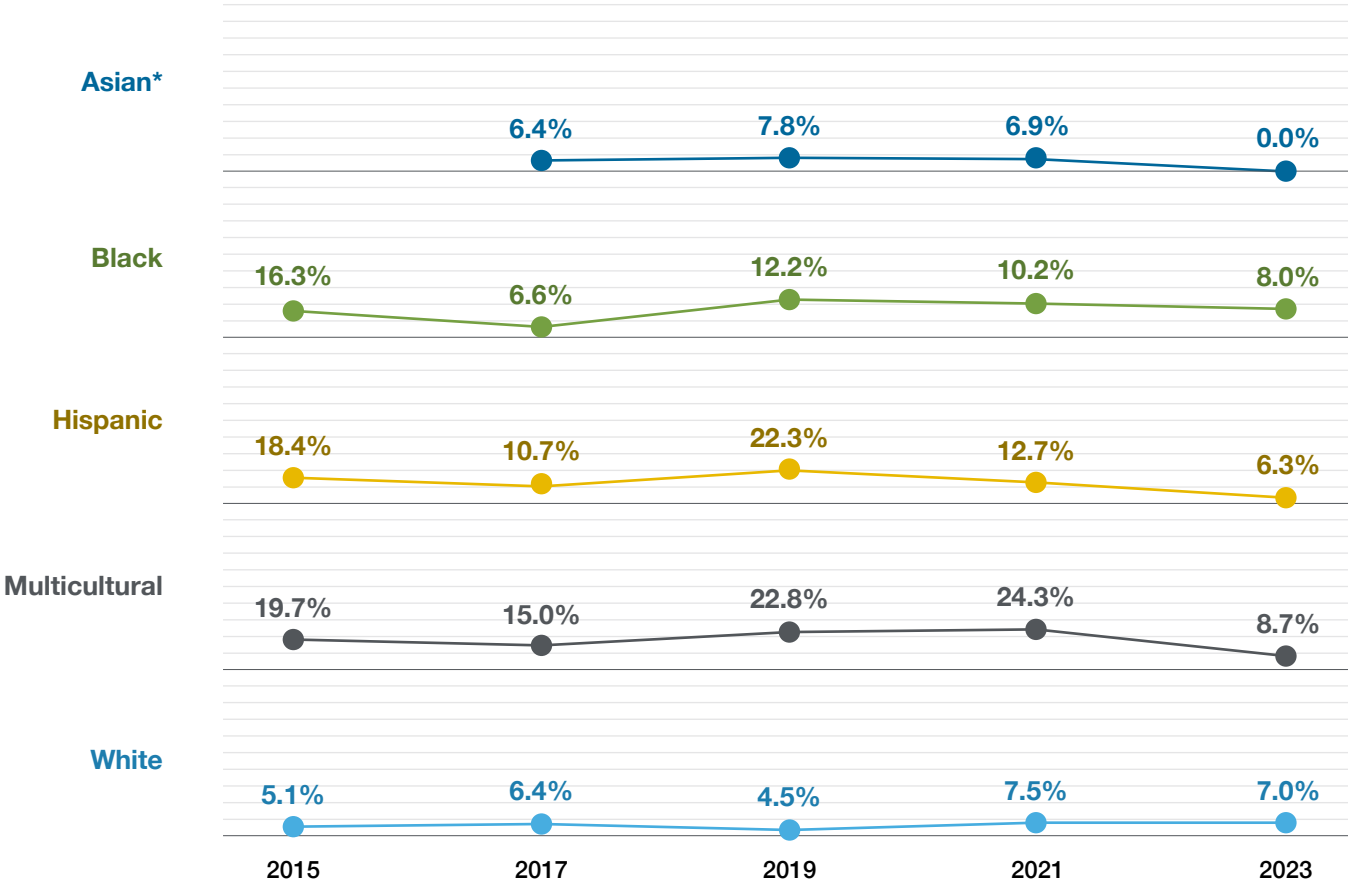


The number of high school youth who attempted suicide at least once in the past year has also decreased, from 9.0% (n=2,630, [7.1, 11.2]) in 2021 to 7.7% (n=1,790, [6.0, 9.7]).[(VYS, 2021)] [(VYS, 2023)] When examining trends by race and ethnicity, youth identifying as Multiracial consistently have the highest rates of past year suicide attempts. [(VYS, 2023)]

Percent of High School Youth Who Attempted Suicide in the Past 12 Months



Percent of High School Youth Who Reported Attempting Suicide in the Past 12 Months, By Race/Ethnicity

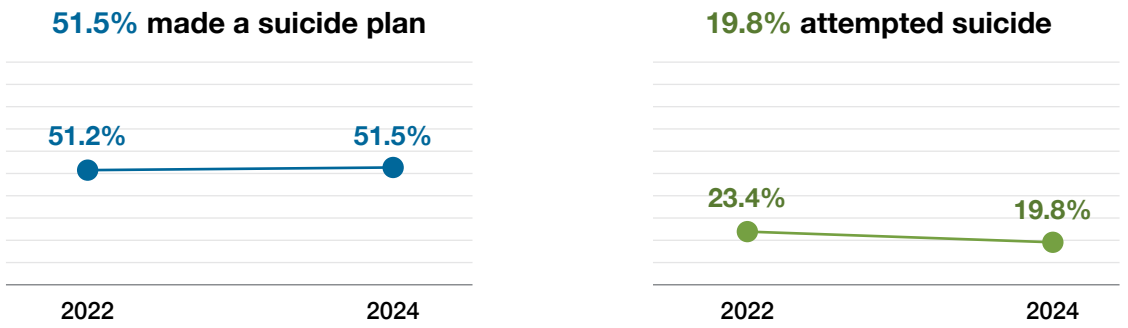


*Data not avilable in 2015

YOUNG ADULTS

In 2024, among young adult respondents who had seriously considered suicide within the past year, 51.5% (n=725, [47.8, 55.1]) had made a suicide plan.(YAS, 2024) This was similar to the previous rate of 51.2% in 2022. 19.8% (n=723, [16.9, 22.7]) of young adults who had seriously considered suicide in the past year reported having made at least one suicide attempt during that time.(YAS, 2024) This was a decrease from 23.4% in 2022.

Of young adults who seriously considered suicide in the past 12 months…

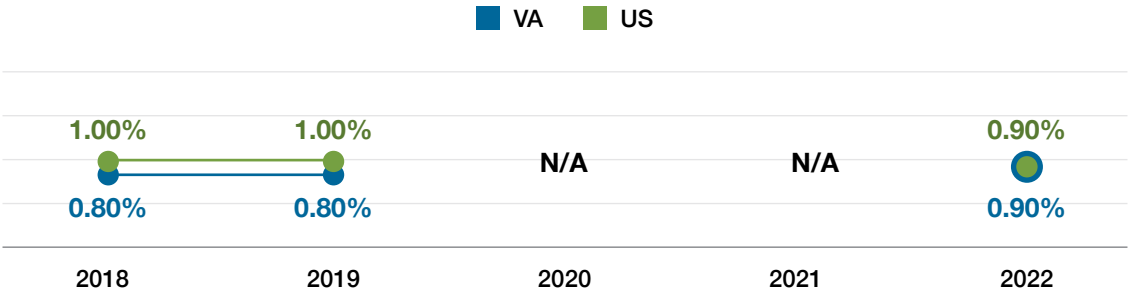


When looking across all the young adult respondents, not just those who seriously considered suicide, 6.6% (n=5,666, [5.9, 7.2]) of young adults had developed a suicide plan in the past year, a decrease from 8.8% (n=5,008, [8.0, 9.5]) in 2022.(YAS, 2024) 2.5% (n=5,664, [2.1, 2.9]) of all young adult respondents had attempted suicide at least once in the past year in 2024, down from 4.0% (n=5,013, [3.5, 4.6]) in 2022.

ADULTS

Adults ages 26 and older in Virginia report lower rates of developing suicide plans in the past year (0.9%, [0.6, 1.2]) which aligned with the national average (0.9%, [0.8, 1.0]).[(NSDUH, 2021)]

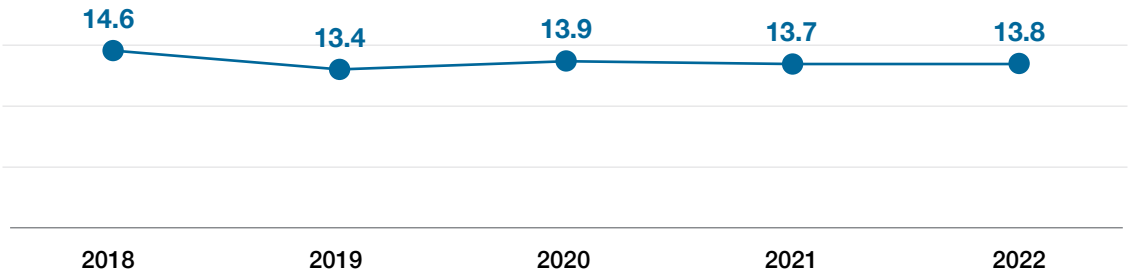
Percent of Adults Ages 26+ Who Made a Suicide Plan in the Past 12 Months



Deaths By Suicide

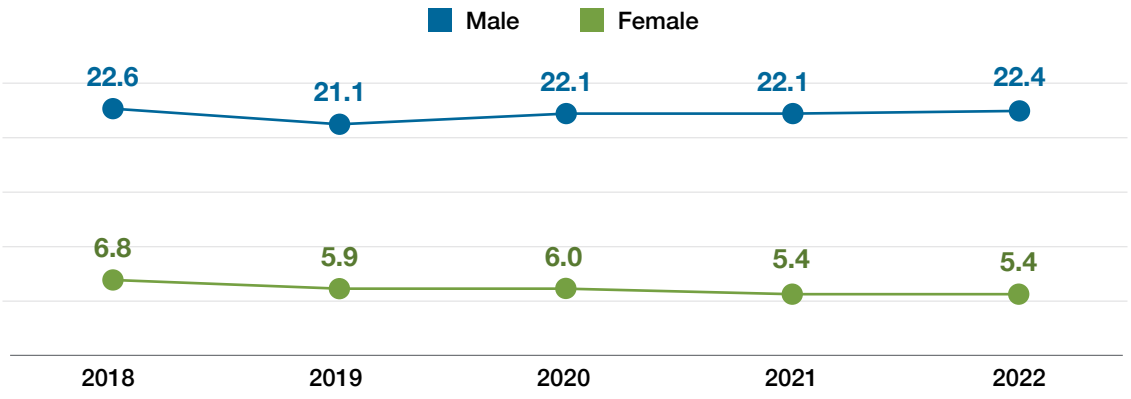
Data on suicide deaths is collected at the state level by the Office of the Chief Medical Examiner. In 2022, the suicide death rate per 100,000 people was 13.8.[(OCME, 2022)] While there has been some slight variation in rates year to year, they have stayed relatively consistent over the last several years, following a downturn between 2018 and 2019.

Suicide Death Rate Per 100,000 People



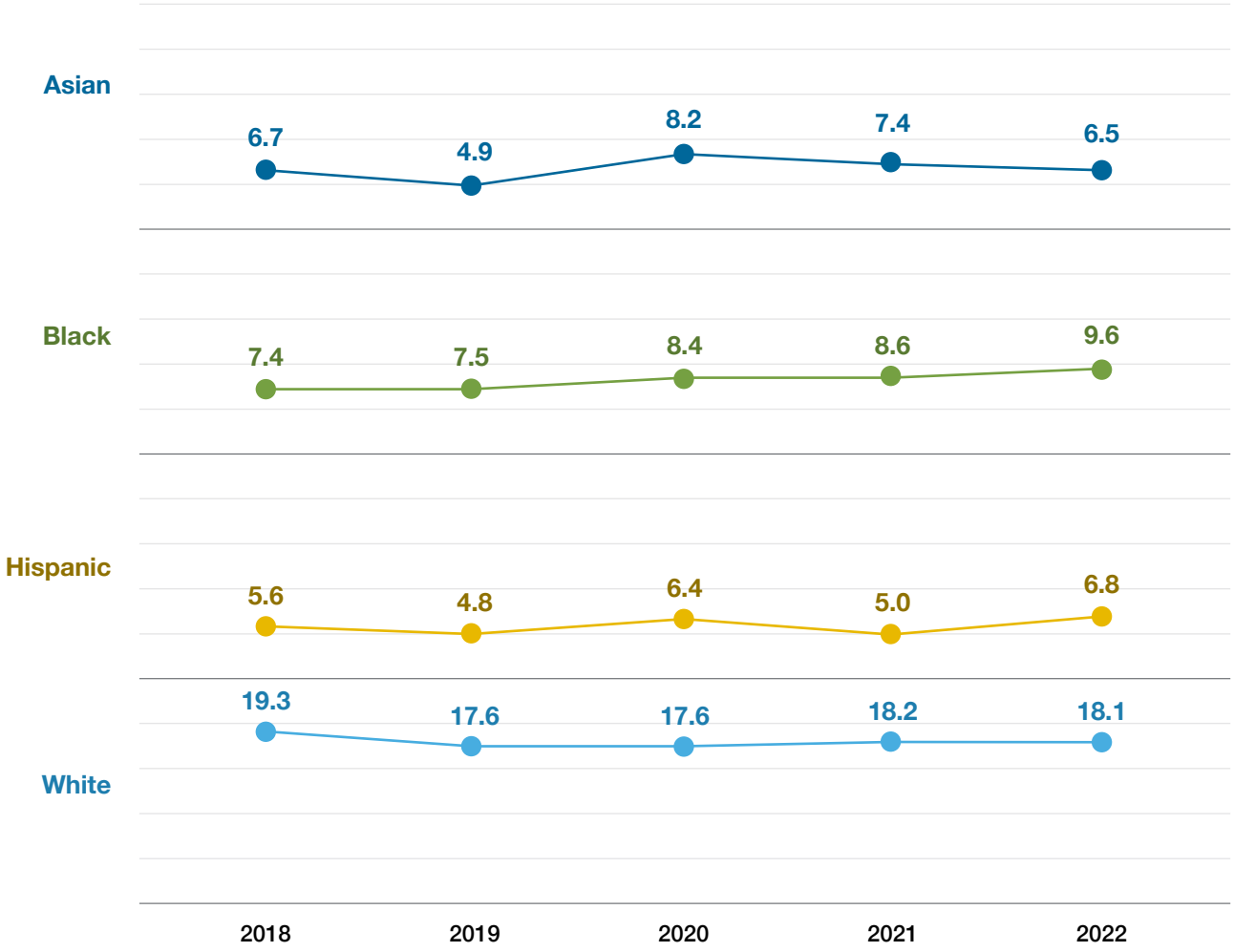
Falling in line with national trends, males in Virginia have a much higher rate of death by suicide than females – 22.4 deaths per 100,000 people among males compared to 5.4 per 100,000 people among females.[(OCME, 2022)] The suicide death rate for females has decreased over time, while the rate for males has remained fairly consistent. When looking at sex, suicide rate trends are reversed when compared with poor mental health data, with males reporting lower rates of poor mental health but higher rates of suicide and suicidal ideation when compared to females.

Suicide Death Rate Per 100,000 People, by Sex



The suicide death rate among individuals who are White is consistently higher compared to other racial and ethnic groups.[(VDH, 2022)] In 2022, the suicide rate for White individuals was almost twice as high as for Black individuals. Since 2018, rates for White and Asian individuals have decreased, while rates for individuals who are Black or Hispanic have increased.[(VDH, 2022)]

Rate of Suicide Per 100,000 People, by Race/Ethnicity



Virginia has a high number of military veterans residing in the Commonwealth. In 2021, over 641,000 residents were veterans, which was about 9.7% of the larger population in Virginia.[(USAFacts, 2024)] Veterans are generally considered to be at higher risk of suicide. In 2021, the suicide rate of veterans was 27.5 per 100,000 people – much higher than the reported rate of 13.7 for all suicides in Virginia. Rates of Veteran suicide in Virginia, though high, are lower than the national average for Veteran suicide deaths at 33.9 per 100,000.[(Department of Veteran's Affairs, 2023)]

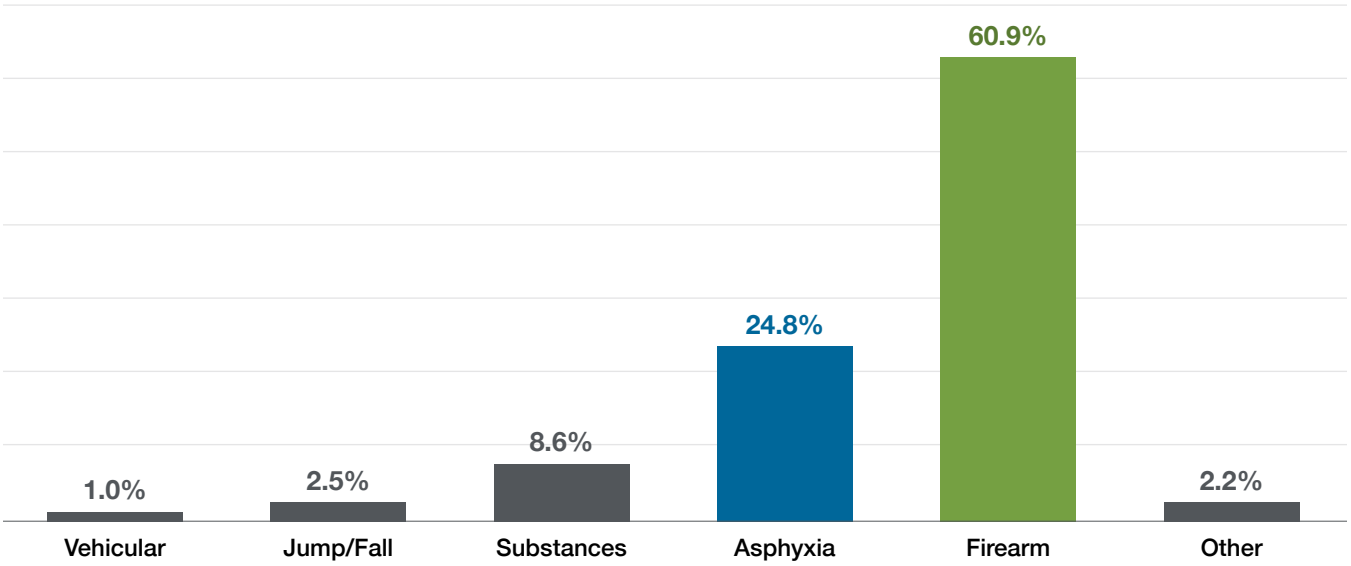
Deaths by Suicide Per 100,000 People (2021)

13.7	27.5	33.9
All Virginia Suicide Rate	Virginia Veteran Suicide Rate	National Veteran Suicide Rate

Suicide Deaths By Cause

In Virginia, firearms are the leading cause of suicide deaths, accounting for 60.9% of all suicide deaths in 2022. (VDH, 2024) Firearms remain as the greatest cause of suicide deaths since being first reported on in 2006, aligning with national data highlighting firearms as being the most likely method of suicide (54.9% of suicide deaths in the United States in 2021 were associated with the use of a firearm).(Department of Veteran's Affairs, 2023)

Cause of Suicide Death in 2022, All Suicides



Veterans in Virginia have a higher rate dying by suicide that involves a firearm than the general population – 68.4% of suicide deaths among Veterans in Virginia involved a firearm compared to 59.7% of suicide deaths in the general population in 2021.(Department of Veteran's Affairs, 2023) These trends may be influence by higher gun ownership rates among veterans compared to non-veterans. A 2022 nationally representative sample of military veterans in the United States found that 50.9% (n=2,326, [48.0, 53.9]) of veterans reported owning firearms, compared to approximately 32% of U.S. adults overall.(Fischer et al., 2023, PEW Research Center, 2023)

Of suicide deaths where toxicology reports were completed (63.0% of all suicide deaths), 28.8% had some level of alcohol present. (VDH, 2024) When looking closer at firearm-related suicide deaths, 35.8% suicides with completed toxicology reports had alcohol involved.(VDH, 2024)

Risk and Protective Factors: Adverse Childhood Experiences (ACEs)

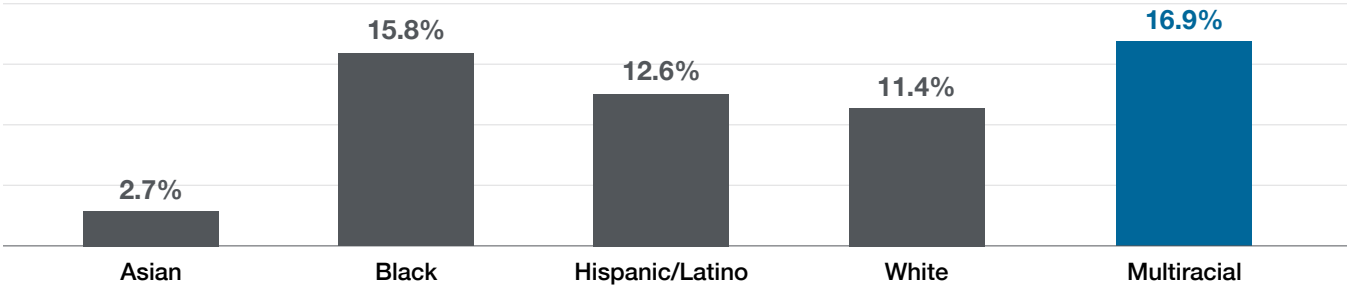
Adverse Childhood Experiences (ACEs) are potentially stressful or traumatic events that happen during childhood/adolescence. Some of these experiences include experiencing or witnessing violence, abuse, or neglect.(CDC, 2024) A large body of evidence establishes the relationship between increased exposure to adverse childhood experiences (ACEs) and higher likelihood of engaging in substance use.(Leza, et. Al, 2021)

YOUTH

Parental/Guardian Separation

Being separated from a parent or guardian is considered an ACE. Among high school youth in Virginia, 12.5% (n=1,875, [9.7, 16.0]) were separated from a parent due to going to jail, prison, or a detention center.(VYS, 2023) This was a slight increase from 12.3% (n=2,874, [9.7, 15.6]) in 2021.(VYS, 2021) Rates were higher among youth who identify as multiracial (16.9%, n=194, [11.2, 24.6]).(VYS, 2023)

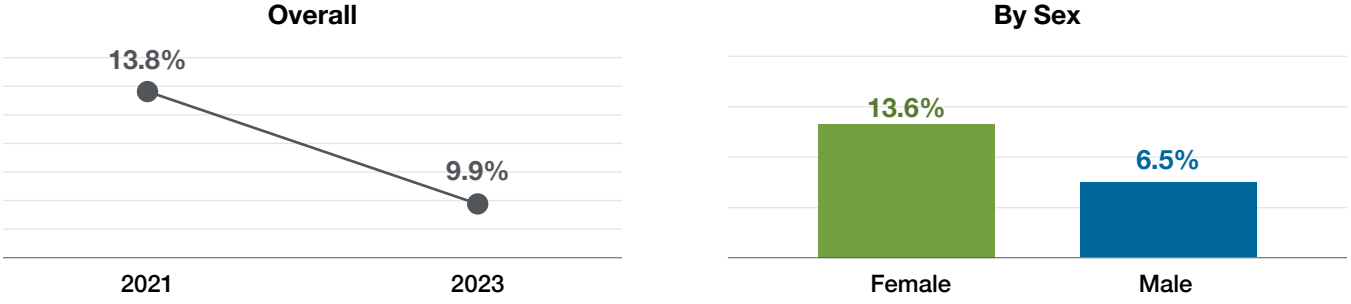
Percent of High School Youth Who Reported Separation from Parent due to Jail, Prison or Detention Center, by Race/Ethnicity



Emotional Abuse

Being insulted or put down can be considered a form of emotional abuse and an ACE. Hearing negative comments from parental figures can lead to poor mental health among youth. Among high school youth in Virginia, 9.9% (n=1,951, [8.8, 11.2]) indicated most of the time or always being put down by a parent or adult.(VYS, 2023) This rate decreased from 13.8% (n=3,064, [11.8, 16.1]) in 2021, which could be connected to children being at home more due to the pandemic.(VYS, 2021) 2023 survey data found that rates of verbal abuse by parents were significantly higher among female high school students (13.6%, n=991, [11.9, 15.5]) compared to males (6.5%, n=956, [5.0, 8.4]).(VYS, 2023)

Percent of High School Youth Who Reported Being Put Down or Insulted by Parents or Adults Most of the Time or Always



Physical Abuse

Experiencing or witnessing violence in the home is considered a form of child abuse and neglect. Among high school youth, 30.1% (n=1,950) reported that a parent of adult in their home has hit, beat, kicked, or physically abused them at least once.[(VYS, 2023)] 2.0% (n=1,950, [1.4, 2.9]) of youth reported that a parent or adult in their home most of the time or always physically hurt them.[(VYS, 2023)]

30.1%
experienced physical abuse

Domestic Violence

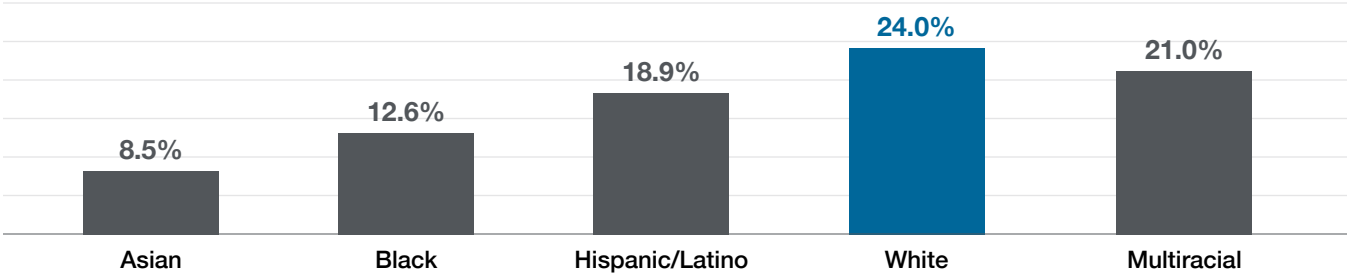
Considering their home environment, 15.9% of high school youth reported witnessing at least one instance of domestic violence in their home, where their parents of other adults in the home hit, kicked, slapped, or punched each other. 1.3% (n=1,951, [0.9, 1.9]) who reported most of the time or always seeing physical violence between parents or other adults.[(VYS, 2023)]

15.9%
witnessed physical abuse in the home

Substance Use in the Household

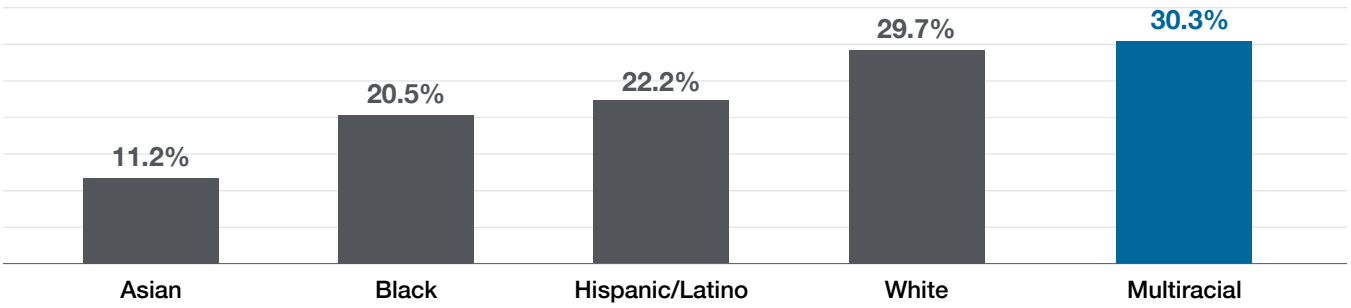
Living with a parent or guardian who problems with substance use can affect youth's sense of safety and stability, leading to poor mental health outcomes for youth and increasing the likelihood that youth will engage in the substance use themselves by modeling harmful behaviors. Among high school students, 19.4% (n=1,874, [15.9, 23.5]) lived with a parent who had a substance use problem.[(VYS, 2023)] Nearly one in four of White high school students have a parent or guardian with mental health or substance use concerns (24%, n=630, [18.5, 30.4]).[(VYS, 2023)]

Percent of High School Youth Who Reported Ever Living with a Parent Who Had Severe Depression, Anxiety, or Another Mental Illness, or was Suicidal



Mental Health Concerns in the Household

Just over a quarter of high school youth (25.3%, n=1,869, [21.9, 29.0]) lived with a parent or guardian that has severe mental health symptoms such as depression, anxiety, or suicidality.[(VYS, 2023)] At a similar level, close to one-third of students who identify as multracial lived with a parent or guardian with these concerns (30.3%, n=193, [24.5, 36.9]).[(VYS, 2023)]

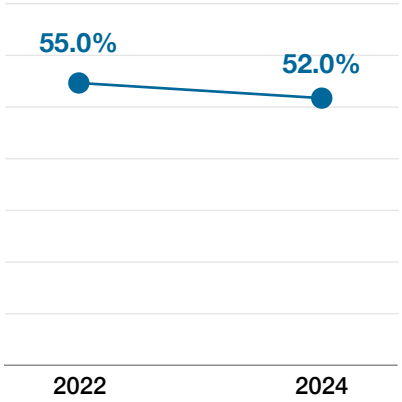


YOUNG ADULTS

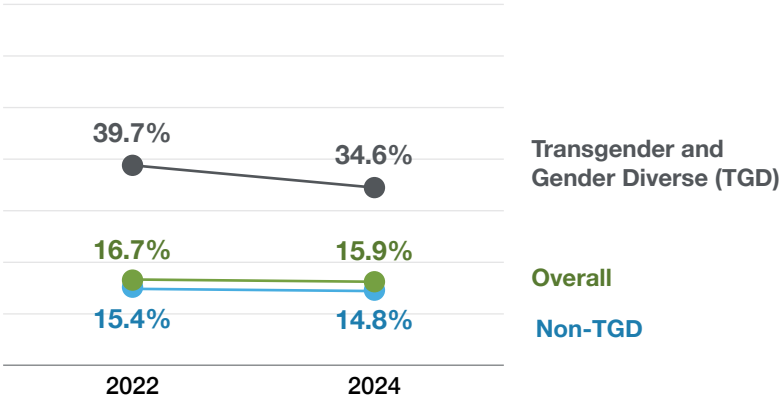
52.0% (n=5,614, [48.6, 55.4]) of young adults in Virginia aged 18-25 have experienced at least one ACE in their life. 15.9% (n=5,614, [14.9, 16.8]) of young adults in Virginia aged 18-25 have experienced four or more ACEs in their life.[(YAS, 2024)]

Among young adult respondents, 34.6% (n=257, [28.81, 40.5]) of Trans, Gender Diverse, or Questioning individuals indicated experiencing four or more ACEs. Within this community, non-binary individuals have the highest rate of experiencing 4 or more ACEs growing up at 35.1% (n=248, [29.14, 41.0]).[(YAS, 2024)]

Percent of Young Adults with at least 1 ACE

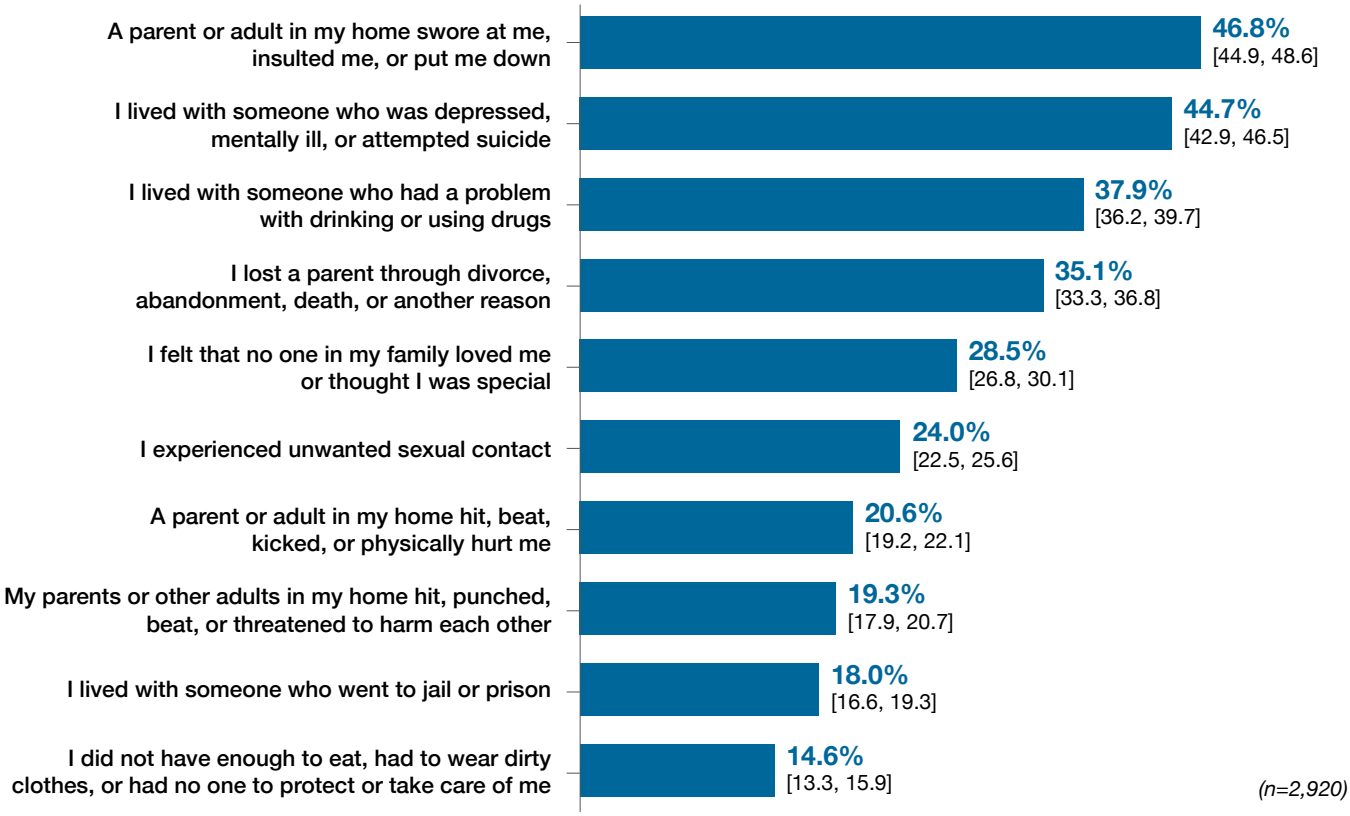


Percent of Young Adults Reporting Experiencing 4 or More ACEs, by Gender Identity



Among young adults who have experienced at least one ACE, the most common were verbal abuse and living with someone who had mental health concerns or a substance use problem.

Frequency of ACEs Among Young Adults who Reported at Least One ACE, by Type



(n=2,920)

ADULTS

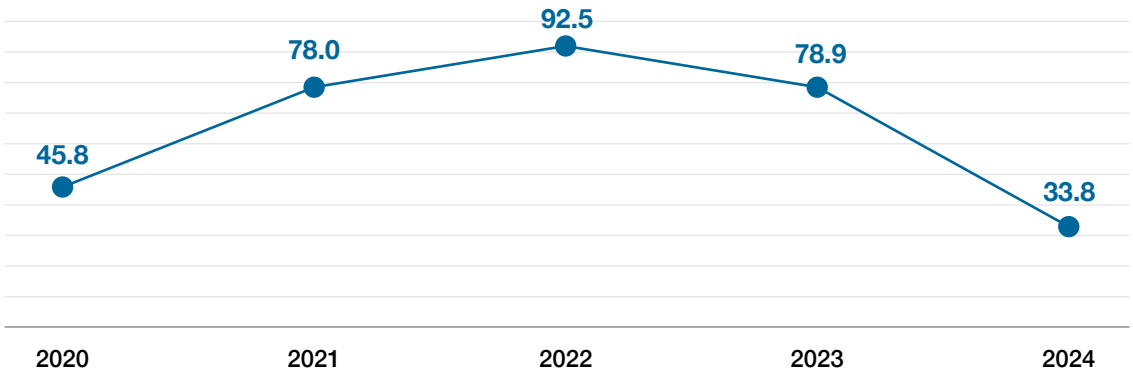
Over half (61.0%) of adults in the US have experienced at least one ACE in their life. One in six individuals in the US have experienced four or more ACEs in their life.(Urgent. Related. Preventable) The impacts of experiencing four or more ACEs can negatively affect health outcomes, such as reducing the quality of life and making individuals more prone to mental and physical health conditions.

61.0%
of US Adults Have at least 1 ACE

Trauma

Trauma is a response to a severe event such as unexpected experiences like sudden death or violence, accidents, or experiencing physical or emotional neglect. Experiencing trauma not only impacts mental health but can also affect the quality of physical health.(APA, 2024) The rate of individuals who identify as trauma survivors in Virginia decreased dramatically from 92.5 per 100,000 People in 2022 to 33.8 in 2024, per 100K.(MHA, 2024)

Number of Individuals Who Identify as a Trauma Survivor Per 100,000 People



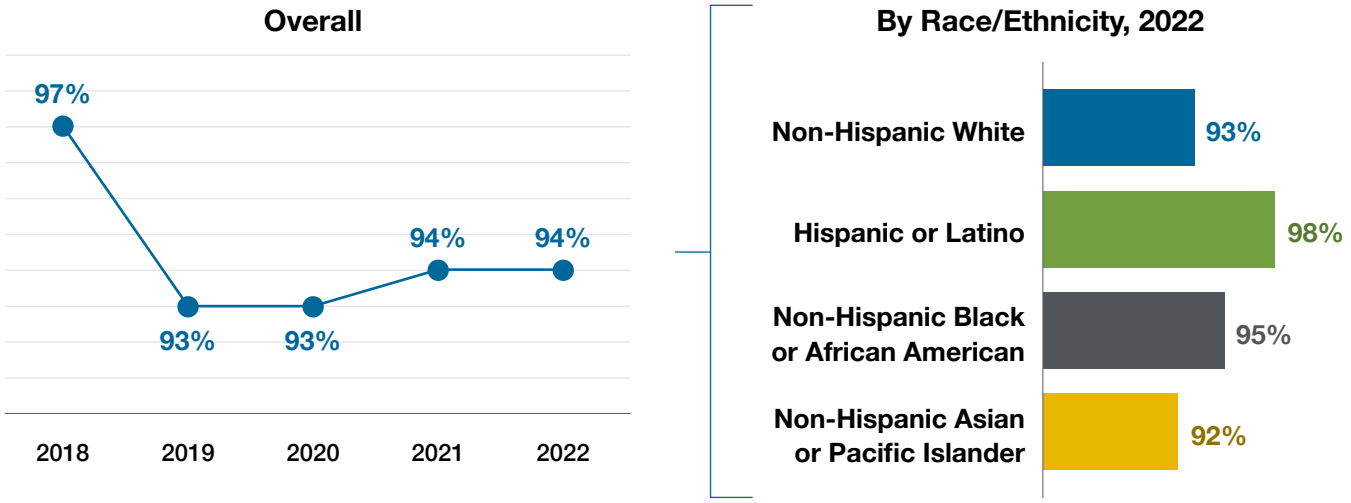
Risk and Protective Factors: Active Parenting and Parental Involvement

Active parenting and parental involvement includes how present a parent, guardian, or other trusted adult is in the life of children and youth they care about. This can also include the perception of their interactions by youth – how youth believe their parent or guardian is interacting with them. When a parent or a parental figure is actively involved, this is a protective factor and can help create stronger, healthier bonds between individuals. In Virginia, 5.0% of children did not live with either parent in 2022.(Kids Count, 2022)

YOUTH

The continuous healthy presence of parental figures is vital for the development of the youth. Feeling safe and comfortable to tell parents what matters to them can help lead to positive self-esteem and healthy behaviors. In Virginia, the majority (93.8%, [91.1, 96.5]) of youth ages 14-17 indicated they can share ideas or talk about things that really matter to them with their parents.(Kids Count, 2022) This aligns with the national level of 92.7% [91.9, 93.5]. (Kids Count, 2022) Throughout the 4-year span of 2018-2022, there were minimal differences across race and ethnicities. Nearly all (98.0%) Hispanic or Latino youth indicated they can share with their parents.(Kids Count, 2022)

Percent of Youth Who Can Talk with a Trusted Adult, 2018-2022



Parental involvement can play a role in attachment styles and how they develop throughout adulthood. Living in a single-parent household can impact social, emotional and economic factors. Single parents my be more constrained for time and resources as result of having to independently manage and support their family, impacting how they are able to engage with their children. In Virginia, nearly a quarter (23.7%, [22.6, 25.0]) of children live in single-parent households, which is very similar to the national rate (24.6%, [24.4, 24.9]).(Kids Count, 2022) In Virginia, 4.7% [4.3, 5.2] of children live in father-only households, and 19.0% [18.3, 19.8] live in mother-only households.(Kids Count, 2022)

23.7%
Of Virginia Youth Live in Single-Parent Households

In 2023, over one in ten (12.1%, n=1,875, [10.3, 14.1]) high school youth reported that they did not have a parent, guardian, or other adult in their home who most of the time or always tried to ensure their basic needs were met. This is a slight increase from 2021 (10.9%, n=2,882, [9.3, 12.6]).

Risk and Protective Factors: Healthy Coping Skills, Emotional Regulation and Resiliency

Healthy coping skills are necessary to regulate mental health concerns and reduce the likelihood of engaging in problematic behaviors, such as substance use. Healthy coping skills can include positive activities on one's own, such as meditation, but also prosocial activities with friends, family, or peers.

YOUTH

No youth data is available specifically on coping skills, emotional regulation and resiliency.

YOUNG ADULTS

Coping skills can vary from healthy to problematic behaviors. Some unhealthy behaviors that are often connected with coping during stressful events is turning to substance use. In 2024, young adults 18-25 were asked how they respond to stressful events. The most mentioned coping skills included:[YAS,2024]

Journaling

Creative Expressions and Hobbies
(e.g., drawing, music, playing video games)

Social Support and Interactions
(e.g., talking with family or friends)

Out of the 4,618 respondents, 253 (5.5%) indicated using substances to cope with stress.[YAS,2024]

ADULTS

No adult-specific data available.

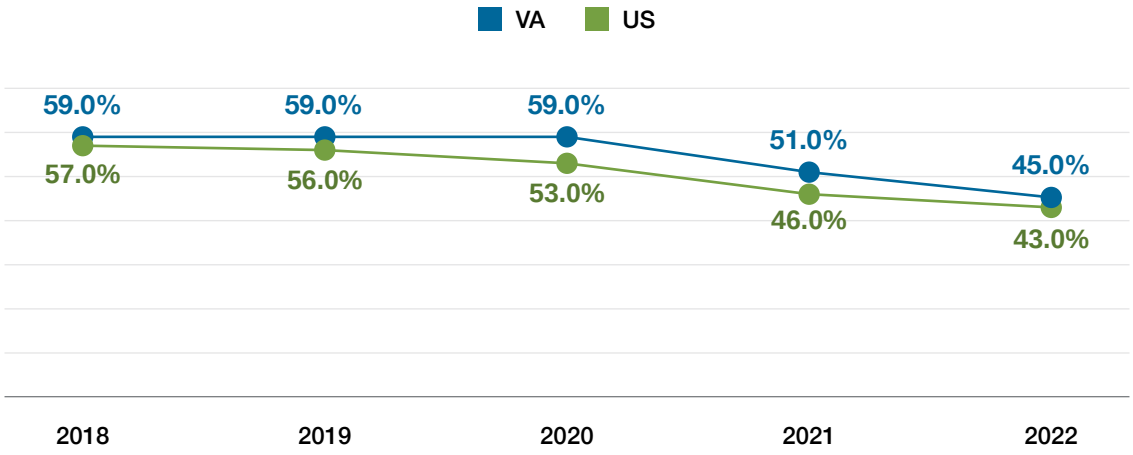
Risk and Protective Factors: Prosocial and Extracurricular Involvement

Participation in prosocial activities or extracurricular activities can have positive effects on mental health, for youth and adults alike. Some of these activities include involvement in clubs, after-school programs, or recreational activities. These activities tend to offer a positive environment with peers, often focusing on specific activities and hobbies. For many, participation in team sports also provides the added benefit of physical exercise.

YOUTH

Prosocial activities can take place in a variety of settings such as school, church, or in other parts of the communities. In Virginia nearly half of youth ages 14 to 17 (45.0%) participated in activities or volunteered in these settings in the past year. (Kids Count, 2022) Since the pandemic, the rate of youth involvement in prosocial activities has reduced, mirroring a national decline in participation, which may be result of an overall reduction in available or accessible opportunities during the COVID-19 pandemic. Prosocial engagement among youth in Virginia is lower than the national average.

Percentage of Youth Involved in Community Service or Volunteer Work



YOUNG ADULTS

Data related to young adults was not available.

ADULTS

No adult-specific data available.

Risk and Protective Factors: Self-Esteem

High self-esteem is connected with improved mental health symptoms and decreased risk of substance use. Although community organizations are doing work that can support with increased self-esteem, such as leadership programs and media campaigns, there is no data that is directly tied to self-esteem for youth, young adults or adults. Rather most data is connected to mental health symptoms such as depression, anxiety, or poor health.

Risk and Protective Factors: Social Isolation and Social Supports

Social isolation can be connected to negative health outcomes, such as substance use and mental distress. Having a community of support and feelings of belonging can help counteract these negative possibilities. Strong, supportive social networks can improve how individual approach and navigate stressful or traumatic situations.

YOUTH

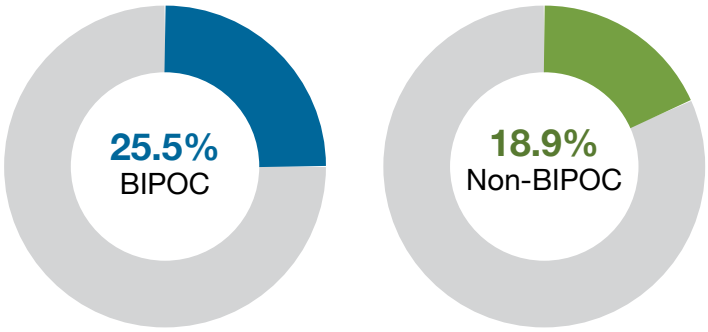
No youth data is available, indicating a need to expand data collection efforts in this area.

YOUNG ADULTS

One in five young adults (21.9%, n=1,250, [20.9, 23.0]) reported never getting the support they needed when they felt sad, empty, hopeless, angry, or anxious.(YAS, 2024) Only 12.7% (n=723, [11.8, 13.5]) of young adult respondents reported always getting the support they needed.(YAS, 2024)

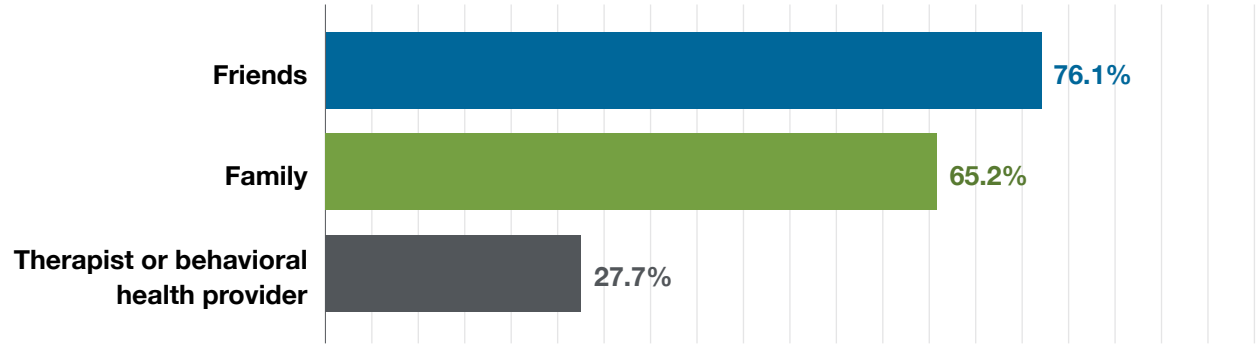
Black, Indigenous, and other People of Color (BIPOC) reported higher rates of 'never' being able to get the support they need compared to their non-BIPOC peers – 25.5% (n=664, [23.8, 27.1]) vs 18.9% (n=567, [17.5, 20.2]).(YAS, 2024) Stigma can contribute to a lack of knowledge about resources and barriers to accessing available resources, treatment, or other substance use or mental health services.(YAS, 2024)

Percentage of Young Adults Who Never Receive the Support They Need, Black, Indigenous and People of Color (BIPOC) and non-BIPOC



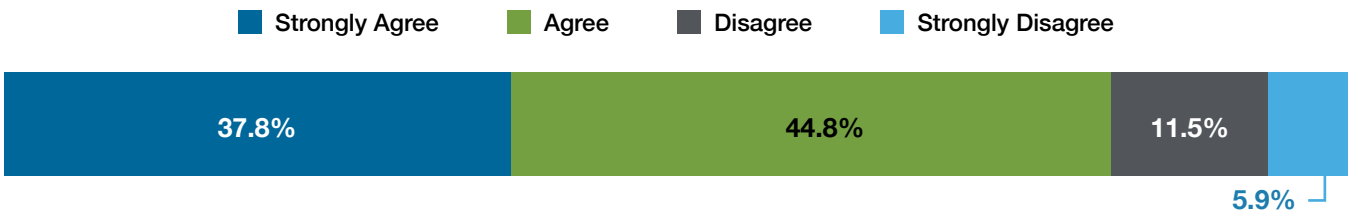
When looking across genders, young adults who identify as men reported much higher rates of never getting the help they need (27.2%, n=2,035, [25.2, 29.1]) compared to their peers who identify as women (18.9%, n=3,371, [17.6, 20.2]) or non-binary (18.3%, n=252, [13.5, 23.0]).(YAS, 2024)

When young adults in this sample feel overwhelmed, they turn to those closest to them for support. Over two-thirds of young adult respondents indicated turning to friends (76.1%, n=4,255, [75.0, 77.2]) and family (65.2%, n=3,646, [63.9, 66.4]).[(YAS, 2024)] This indicates the importance of social networks for maintaining healthy coping skills.



A majority of young adult respondents (82.6%, n=4,746 [80.1, 85.2]) aged 18-25 agree or strongly agree they are aware of where to access mental health resources.[(YAS, 2024)]

Percent of Young Adults Who Are Aware of How to Access Mental Health Resources

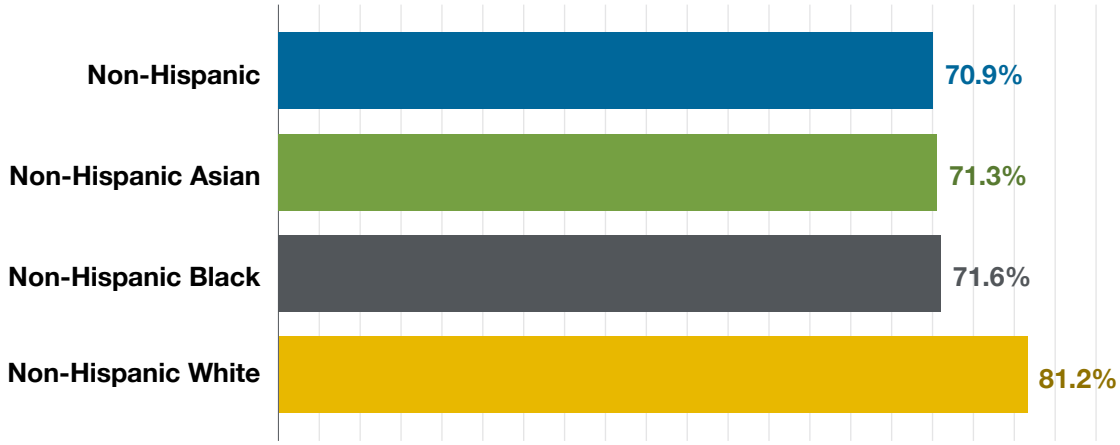


ADULTS

Receiving Support

Having friends, family, or any form of community that can support you during stressful times is an important protective factor. When observing how often various ethnicities receive support, at a national level, Non-Hispanic White adults were more likely to 'always' or 'usually receive' social and emotional support compared to people of color.[(CDC, 2020)]

Percent of Adults Who Report Usally or Always Receive Social and Emotional Support When Needed, by Race/Ethnicity



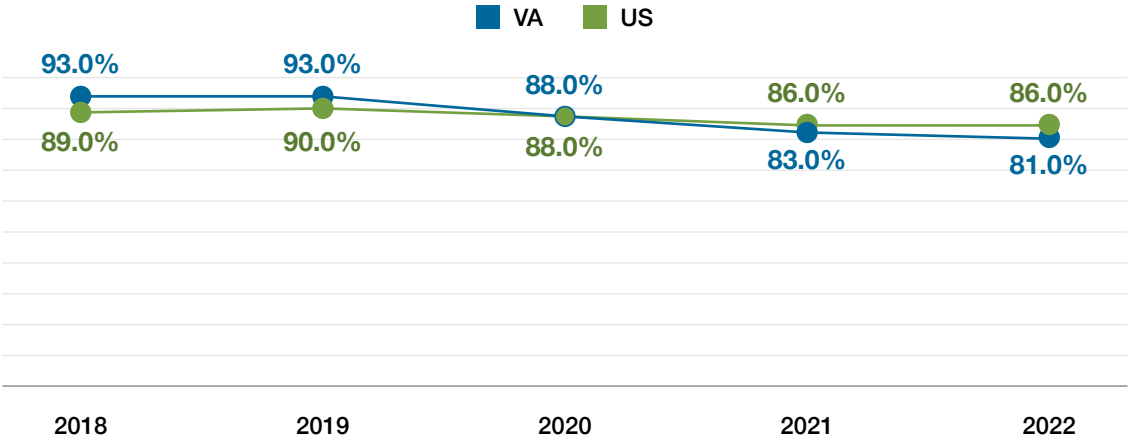
Mentors

Healthy relationships with adults or peers can help decrease the risk of substance use and increase other protective factors such as healthy coping skills and self-esteem. Being around positive community members can help reduce the availability or approval of substances as these trusted adults and peers are in growth-related programs or settings, such as leadership programs. Adult mentors may also be especially important to youth belonging to marginalized identities, such as transgender and gender diverse, or LGBQ+ individuals.

YOUTH

Having a mentor in the community that can provide guidance can be an important aspect of youth development that directly impacts their ability to receive support outside of the home for stressful events. In Virginia, 81% of youth 14-17 years old indicated having at least one adult mentor in the community that provides guidance.[(Kids Count, 2022)] The rates of trusted adults in the community has steadily decreased since the pandemic, possibly the result of social distancing and adjustments to a more virtual way of interacting with others. It is also worth noting that rates in Virginia were at or above national levels of youth having an adult mentor, until the pandemic. Since 2020, rates in Virginia have been lower than the national average and have fallen at a faster rate.

Percent of Youth With At Least One Adult Mentor



Conclusion

While Virginia's state prevention framework currently aligns itself with SAMHSA's SPF model and considers other frameworks in the delivery of their prevention efforts, we recommend that OBHW integrate prevention frameworks with a focus on risk and protective factors to create greater alignment with the findings of this needs assessment and emerging trends in the field. Further connecting state priorities with established prevention frameworks can support Virginia's prevention workforce in creating a cohesive prevention narrative and allow for more strategic selection of interventions. Doing so would also create greater alignment with the priorities of the funder, SAMHSA, as well as the National Institute on Drug Abuse, which have shifted to a shared risk and protective factor approach to substance use and suicide prevention, rather than focusing on individual substances in isolation. Aligning the OBHW strategic plan with these established frameworks would also provide a connection to a larger body of evidence demonstrating the impact of these models on behavioral health outcomes.

This shift toward a shared risk and protective factor approach is aligned with the perspectives and needs of the prevention workforce in Virginia. Although community needs and priorities range across CSB prevention programs, there is consensus that both CSBs and communities feel overwhelmed by information and workload, which can be partially attributed to the existing substance-specific prevention approach. CSB staff who participated in the needs assessment indicated their support for a shift in Virginia's prevention approach, expressing hope that it relieves some of the current burden CSBs and communities are experiencing and shifts prevention messaging to a whole person-centered approach. CSB- and state-level prevention staff believe that as a collective group, improved storytelling can help further promote prevention goals and engagement by communities.

As mental health outcomes worsen in Virginia and across the nation, a shift to focusing on shared risk and protective factors allows for a reallocation of resources away from strategies that only address substance use to those that address the factors underlying both substance use and mental health concerns. Research clearly establishes the link between mental health and substance use – and that strategies that seek to address shared risk and protective factors are likely to impact both substance use and mental health concerns. Breaking down substance- and problem-specific siloes and prioritizing efforts that more broadly, but no less meaningfully, address behavioral health and wellness can create a stronger, more well-rounded approach to prevention.

As the findings of this needs assessment are integrated into the upcoming strategic planning process, the risk factors that are targeted in the current prevention strategic plan should be revisited and assessed based on their alignment with prioritized outcomes and identified frameworks. Moving forward with a shared risk and protective factor approach will re-focus prevention efforts more upstream, strengthening protective factors and reducing risk factors so that substance use is not where individuals turn when facing adversity. In addition to re-examining risk factors, the strategic planning process should also focus on the identification of key priority populations along dimensions such as age, racial/ethnic identity, gender identity, sexual orientation, income level, and more. Focusing future efforts on priority populations will increase the impact of prevention programming on the communities with the highest need.

Virginia's current strategic plan includes several priority strategies, such as ACEs Interface trainings, Mental Health First Aid, and Lock and Talk, that are already aligned with a shared risk and protective factor approach. Upcoming strategic planning conversations should include additional examination of current strategies to identify which strategies should remain part of the plan, which strategies may be good candidates for expansion, as well as what new strategies may align with prioritized risk and protective factors, outcomes, and identified frameworks.

Findings from this assessment also suggest a desire and need to increase focus on protective factors, which are not highlighted within the current strategic plan. A greater focus on protective factors would allow CSBs to more easily navigate the stigma that may prevent community engagement in substance use-focused programs and also allow them to invest more of their capacity in community-facing work. Currently, community members may opt out of events or presentations focused on substance use or suicide specifically because they do not see these issues as relevant to their lives. Whereas they may more readily attend events that are focused on personal health, wellness, and self-care. Substance-specific messaging can still be incorporated into these approaches, but by making them a part of – rather than the primary focus of – efforts, prevention programs can become more approachable to a larger audience, including communities that have been marginalized and who may be navigating additional stigma or barriers related to substance use and mental health. The CSAP strategies of Education and Alternatives, which are particularly well-suited to addressing these protective factors (along with risk factors), are not currently prioritized in the state strategic plan and would require increased investment. Focus on these types of efforts would be well-suited to meet the desires of CSBs seeking to prioritize community-facing work over larger, environmental efforts while also allowing the state to take a more holistic approach to behavioral health and wellness.

Partnerships at the community- and state-level are considered critical to the success of prevention work and findings demonstrate a strong desire across the prevention workforce to increase investment and resource allocation towards developing and maintaining these relationships. Increased investment in coalition capacity building would allow CSBs to increase community engagement in efforts and develop prevention champions within their communities who can support their work. OBHW should also explore opportunities to develop stronger partnerships with other state-level agencies to ensure that the broad range of prevention efforts being undertaken across Virginia are mutually reinforcing rather than duplicative. Strong partnerships across all levels allow for meaningful and efficient allocation of resources and increases the overall capacity of the prevention workforce.

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Appendix A:
Risk & Protective Factor Research Overview

Shared Risk and Protective Factor	Focus Area	Summary	Source
Active parenting and parental involvement	All	An examination of 2013 NSDUH data found that participation in extracurricular activities found that parental involvement reduced youth substance use.	Kenney, A., & Dennis, C. B. (2019). Environmental paths that inform adolescent substance use prevention. *Journal of Human Behavior in the Social Environment, 29*(7), 897–908. https://doi.org/10.1080/10911359.2019.1633982
	All	A multivariable analysis found that connectedness to family was associated with 48% to 66% lower odds of health risk behaviors and experiences into adulthood, including emotional distress, prescription drug misuse, and other illicit drug use.	Steiner, R. J., Sheremenko, G., Lesesne, C., Dittus, P. J., Sieving, R. E., & Ethier, K. A. (2019). Adolescent Connectedness and Adult Health Outcomes. *Pediatrics, 144*(1), e20183766. https://doi.org/10.1542/peds.2018-3766
	Alcohol	A randomized controlled trial of an intervention with middle school students found that parenting self-efficacy and positive relationships between parents and children reduced early onset of alcohol use.	Bergman, P., Dudovitz, R. N., Dosanjh, K. K., & Wong, M. D. (2019). Engaging Parents to Prevent Adolescent Substance Use: A Randomized Controlled Trial. *American journal of public health*, 109(10), 1455–1461. https://doi.org/10.2105/AJPH.2019.305240
	Cannabis	A randomized controlled trial of an intervention with middle school students found that parenting self-efficacy and positive relationships between parents and children reduced early onset of cannabis use.	Bergman, P., Dudovitz, R. N., Dosanjh, K. K., & Wong, M. D. (2019). Engaging Parents to Prevent Adolescent Substance Use: A Randomized Controlled Trial. *American journal of public health*, 109(10), 1455–1461. https://doi.org/10.2105/AJPH.2019.305240

Shared Risk and Protective Factor	Focus Area	Summary	Source
Active parenting and parental involvement	Gambling	A large scale study of 33 European countries found that parental monitoring of youth free time and use of money were associated with decreased likelihood of youth gambling.	Molinaro, S., Benedetti, E., Scalese, M., Bastiani, L., Fortunato, L., Cerrai, S., Canale, N., Chomynova, P., Elekes, Z., Feijão, F., Fotiou, A., Kokkevi, A., Kraus, L., Rupšienė, L., Monshouwer, K., Nociar, A., Strizek, J., & Urdih Lazar, T. (2018). Prevalence of youth gambling and potential influence of substance use and other risk factors throughout 33 European countries: first results from the 2015 ESPAD study. *Addiction (Abingdon, England)*, 113(10), 1862–1873. https://doi.org/10.1111/add.14275
	Mental Health & Suicide	Perceptions of parental involvement by youth reduced mental health distress and suicidal thoughts and behaviors among middle school students in Georgia.	Liu K. (2023). Middle school students' mental unwellness and academic performance in China: The effects of parental involvement. *PloS one*, 18(11), e0294172. https://doi.org/10.1371/journal.pone.0294172
	Vaping	The study examined the influences of youth perceptions of parental knowledge of their activities and parental mediation of media engagement influence vape use and perceptions. Findings indicated that increased parental knowledge led to higher perceptions of risk, lower perceptions of parental and social approval. Higher parental mediation of media use was associated with decreased lifetime vape use.	Jeong Choi, H., Miller-Day, M., Hecht, M., Glenn, S. D., Lyons, R. E., & Greene, K. (2022). A snapshot of parenting practices useful for preventing adolescent vaping. *Addictive behaviors reports*, 15, 100418. https://doi.org/10.1016/j.abrep.2022.100418
Adverse Childhood Experiences (ACEs)	All	A scoping review found consistent evidence of a positive association between ACEs and the presence and severity of Substance Use Disorders in adolescence through adulthood.	Leza, L., Siria, S., López-Goñi, J. J., & Fernández-Montalvo, J. (2021). Adverse childhood experiences (ACEs) and substance use disorder (SUD): A scoping review. *Drug and alcohol dependence, 221*,108563. https://doi.org/10.1016/j.drugalcdep.2021.108563

Shared Risk and Protective Factor	Focus Area	Summary	Source
Adverse Childhood Experiences (ACEs)	Alcohol	A systemic review found cumulative ACEs to be associated with increased adolescent alcohol use across all sexes.	Bozzini, A. B., Bauer, A., Maruyama, J., Simões, R., & Matijasevich, A. (2021). Factors associated with risk behaviors in adolescence: a systematic review. *Revista brasileira de psiquiatria (Sao Paulo, Brazil: 1999), 43*(2), 210–221. https://doi.org/10.1590/1516-4446-2019-0835
		Increased exposure to ACEs has a lasting impact on alcohol use that persists into adulthood.	Leung, J. P., Britton, A., & Bell, S. (2016). Adverse Childhood Experiences and Alcohol Consumption in Midlife and Early Old-Age. *Alcohol and alcoholism (Oxford, Oxfordshire), 51*(3), 331–338. https://doi.org/10.1093/alcalc/agv125
		Increased exposure to ACEs is linked with increased alcohol use among college students.	Šulejová, K., Líška, D., Liptáková, E., Szántová, M., Patarák, M., Koller, T., Batalik, L., Makara, M., & Skladaný, Ľ. (2022). Relationship between alcohol consumption and adverse childhood experiences in college students-A cross-sectional study. *Frontiers in psychology, 13*, 1004651. https://doi.org/10.3389/fpsyg.2022.1004651
	Cannabis	Exposure of five or more ACEs increases one's likelihood for vaping cannabis.	Boccio, C. M., Meldrum, R. C., & Jackson, D. B. (2022). Adverse childhood experiences and adolescent nicotine and marijuana vaping: Findings from a statewide sample of Florida youth. *Preventive medicine*, 154, 106866. https://doi.org/10.1016/j.ypmed.2021.106866
	Gambling	There is a distinct association between ACEs and problem gaming and gambling behavior, the exception was found with emotional neglect and mental illness in the home.	Bristow, L. A., Afifi, T. O., Salmon, S., & Katz, L. Y. (2022). Risky Gambling Behaviors: Associations with Mental Health and a History of Adverse Childhood Experiences (ACEs). *Journal of Gambling Studies*, 38(3), 699–716. https://doi.org/10.1007/s10899-021-10040-3

Shared Risk and Protective Factor	Focus Area	Summary	Source
Adverse Childhood Experiences (ACEs)	Mental Health & Suicide	Research of LGB and heterosexual individuals in Utah found that both Aces and sexual orientation uniquely predicted suicidality, including recent suicidal/self-harming thought and lifetime suicide attempt prevalence.	McGraw, J. S., McManimen, S., Chinn, J., Angoff, H. D., Docherty, M., & Mahoney, A. (2022). Adverse Childhood Experiences, Suicidal/Self-Harming Thoughts, and Suicide Attempts Among LGB and Heterosexual Utahns. *Journal of homosexuality, 69*(7), 1141–1159. https://doi.org/10.1080/00918369.2021.1909396
		Analyses of a nationally representative sample of US adults found that the accumulation of ACEs increase the likelihood of lifetime suicidal ideation and suicide attempts.	Thompson, M. P., Kingree, J. B., & Lamis, D. (2019). Associations of adverse childhood experiences and suicidal behaviors in adulthood in a U.S. nationally representative sample. *Child: care, health and development, 45*(1), 121–128. https://doi.org/10.1111/cch.12617
	Opioids	Exposure to ACEs was positively associated with prescription opioid misuse.	Merrick, M. T., Ford, D. C., Haegerich, T. M., & Simon, T. (2020). Adverse Childhood Experiences Increase Risk for Prescription Opioid Misuse. *The journal of primary prevention, 41*(2), 139–152. https://doi.org/10.1007/s10935-020-00578-0
		A systematic review demonstrated that exposure to ACEs was positively associated with increased likelihood of lifetime Opioid Use Disorder.	Regmi, S., Kedia, S. K., Ahuja, N. A., Lee, G., Entwistle, C., & Dillon, P. J. (2024). Association Between Adverse Childhood Experiences and Opioid Use-Related Behaviors: A Systematic Review. *Trauma, violence & abuse, 25*(3), 2046–2064. https://doi.org/10.1177/15248380231205821
	Stimulants	A strong relationship was found between the number of ACEs and stimulant use and stimulant use disorders among adults, including use of amphetamines and cocaine.	Tang, S., Jones, C. M., Wisdom, A., Lin, H. C., Bacon, S., & Houry, D. (2021). Adverse childhood experiences and stimulant use disorders among adults in the United States. *Psychiatry research, 299*, 113870. https://doi.org/10.1016/j.psychres.2021.113870

Shared Risk and Protective Factor	Focus Area	Summary	Source
Adverse Childhood Experiences (ACEs)	Tobacco	Exposure of up to five or more ACEs increases one's likelihood for vaping nicotine.	Boccio, C. M., Meldrum, R. C., & Jackson, D. B. (2022). Adverse childhood experiences and adolescent nicotine and marijuana vaping: Findings from a statewide sample of Florida youth. *Preventive medicine*, 154, 106866. https://doi.org/10.1016/j.ypmed.2021.106866
		Increase exposure to ACEs was associated with higher odds of cigarette use, particularly e-cigarette use.	Martinasek, M. P., Wheldon, C. W., Parsons, C. A., Bell, L. A., & Lipski, B. K. (2021). Understanding Adverse Childhood Experiences as Predictors of Cigarette and E-Cigarette Use. *American journal of preventive medicine, 60*(6), 737–746. https://doi.org/10.1016/j.amepre.2021.01.004
		Increased exposure to ACEs was associated with increased tobacco use.	Osibogun, O., Erinoso, O., Li, W., Kalan, M. E., Bursac, Z., & Osibogun, A. (2024). Adverse Childhood Experiences and Tobacco Use Patterns Among Adults in the United States: Exploring sex differences. *Health education & behavior: the official publication of the Society for Public Health Education, 51*(1), 54–61. https://doi.org/10.1177/10901981231178696
	Vaping	Exposure of five or more ACEs increases one's likelihood for vaping nicotine and marijuana.	Boccio, C. M., Meldrum, R. C., & Jackson, D. B. (2022). Adverse childhood experiences and adolescent nicotine and marijuana vaping: Findings from a statewide sample of Florida youth. *Preventive medicine*, 154, 106866. https://doi.org/10.1016/j.ypmed.2021.106866
		Increase exposure to ACEs was associated with higher odds of e-cigarette use.	Martinasek, M. P., Wheldon, C. W., Parsons, C. A., Bell, L. A., & Lipski, B. K. (2021). Understanding Adverse Childhood Experiences as Predictors of Cigarette and E-Cigarette Use. *American journal of preventive medicine, 60*(6), 737–746. https://doi.org/10.1016/j.amepre.2021.01.004

Shared Risk and Protective Factor	Focus Area	Summary	Source
Easy Access	Alcohol	The study found that the presence of stores within a 0.5 mile radius of neighborhoods significantly increased risk for heavy alcohol use	Shih, R. A., Mullins, L., Ewing, B. A., Miyashiro, L., Tucker, J. S., Pedersen, E. R., . . . D'Amico, E. J. (2015). Associations between neighborhood alcohol availability and young adolescent alcohol use. *Psychol Addict Behav*, 29(4), 950-959. doi:10.1037/adb0000081
		A systematic review found easy access to alcohol was associated with early onset of alcohol use (by age 14).	Bozzini, A. B., Bauer, A., Maruyama, J., Simões, R., & Matijasevich, A. (2021). Factors associated with risk behaviors in adolescence: a systematic review. *Revista brasileira de psiquiatria (Sao Paulo, Brazil: 1999), 43*(2), 210–221. https://doi.org/10.1590/1516-4446-2019-0835
	Cannabis	A study of early initiators of cannabis use found early use was associated with higher ease of access.	Korn, L., Haynie, D. L., Luk, J. W., Sita, K., & Simons-Morton, B. G. (2021). Attitudes, Subjective Norms, and Perceived Behavioral Control Associated with Age of First Use of Cannabis among Adolescents. *The Journal of school health, 91*(1), 50–58. https://doi.org/10.1111/josh.12977
		Study found that proximity to cannabis retailers and exposure to cannabis advertising were associated with increased likelihood of cannabis use among youth.	Firth, C. L., Carlini, B., Dilley, J., Guttmannova, K., & Hajat, A. (2022). Retail cannabis environment and adolescent use: The role of advertising and retailers near home and school. *Health & place, 75*, 102795. https://doi.org/10.1016/j.healthplace.2022.102795
	Gambling	Ease of access was predictive of the onset and maintenance of gambling behaviors among adolescents.	Botella-Guijarro, Á., Lloret-Irles, D., Segura-Heras, J. V., Cabrera-Perona, V., & Moriano, J. A. (2020). A Longitudinal Analysis of Gambling Predictors among Adolescents. *International journal of environmental research and public health, 17*(24), 9266. https://doi.org/10.3390/ijerph17249266

Shared Risk and Protective Factor	Focus Area	Summary	Source
Easy Access	Mental Health & Suicide	A modeling of suicide rates using an ecological time series cross-section design found that each 10 percentage point increase in state firearm ownership was associated with a 39.3% increase in suicides involved firearms and subsequent increase of overall suicides (by any means). The association was twice as strong when considering adolescents, meaning an increase in firearm ownership led to a greater increase in suicides among 14 to 18 year olds. Gun lock and storage policies were associated with a 13.1% decrease in adolescent suicide involving a firearm.	Kivisto, A. J., Kivisto, K. L., Gurnell, E., Phalen, P., & Ray, B. (2021). Adolescent Suicide, Household Firearm Ownership, and the Effects of Child Access Prevention Laws. *Journal of the American Academy of Child and Adolescent Psychiatry, 60*(9), 1096–1104. https://doi.org/10.1016/j.jaac.2020.08.442
		Restricting access to pharmaceuticals was found to decrease suicides by overdose in six of seven studies. Suicides by other means either decreased or did not change after intervention.	Lim, J. S., Buckley, N. A., Chitty, K. M., Moles, R. J., & Cairns, R. (2021). Association Between Means Restriction of Poison and Method-Specific Suicide Rates: A Systematic Review. *JAMA health forum, 2*(10), e213042. https://doi.org/10.1001/jamahealthforum.2021.3042
	Stimulants	A systematic review of qualitative literature found that when amphetamine-type stimulants are “accessible, available, and normalized in social spaces, likelihood of initiation “ is increased.	O’Donnell, A., Addison, M., Spencer, L., Zurhold, H., Rosenkranz, M., McGovern, R., Gilvarry, E., Martens, M. S., Verthein, U., & Kaner, E. (2019). Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature. *Addiction (Abingdon, England)*, 114(1), 24–47. https://doi.org/10.1111/add.14434
Healthy Coping Skills, Emotional Regulation, and Resilience	All	A systematic review evidenced that individuals with a Substance Use Disorder diagnosis demonstrated poorer emotional regulation than those without a SUD.	Stellern, J., Xiao, K. B., Grennell, E., Sanches, M., Gowin, J. L., & Sloan, M. E. (2023). Emotion regulation in substance use disorders: a systematic review and meta-analysis. *Addiction (Abingdon, England)*, 118(1), 30–47. https://doi.org/10.1111/add.16001

Shared Risk and Protective Factor	Focus Area	Summary	Source
Healthy Coping Skills, Emotional Regulation, and Resilience	All	LGBTQ+ populations are at a higher risk of experiencing stigma and discrimination and engage in substance use as a coping strategy to avoid seeking services and experiencing discrimination by providers.	Xin, Y., Schwarting, C. M., Wasef, M. R., & Davis, A. K. (2023). Exploring the intersectionality of stigma and substance use help-seeking behaviours among lesbian, gay, bisexual, transgender, queer, questioning or otherwise gender or sexuality minority (LGBTQ+) individuals in the United States: A scoping review. *Global Public Health, 18*(1). https://doi.org/10.1080/17441692.2023.2277854
		A meta-analysis showed that emotion regulation abilities were strongly related to substance use.	Weiss, N. H., Kiefer, R., Goncharenko, S., Raudales, A. M., Forkus, S. R., Schick, M. R., & Contractor, A. A. (2022). Emotion regulation and substance use: A meta-analysis. *Drug and alcohol dependence, 230*, 109131. https://doi.org/10.1016/j.drugalcdep.2021.109131
		A path analysis examining self-stigma, help-seeking behaviors and alcohol and other drug use found self-stigma around help seeking contributed to substance use was mediated by help-seeking attitudes.	Gutierrez, D., Crowe, A., Mullen, P. R., Pignato, L., & Fan, S. (2020). Stigma, help seeking, and substance use. *The Professional Counselor, 10*(2), 220–234. https://doi.org/10.15241/dg.10.2.220
		A review found evidence of the relationship between coping skills and substance use, as well as the demonstrated effectiveness of programs addressing coping skills on reducing substance use and mediating the impact of ACEs.	Grummitt, L., Kelly, E., Barrett, E., Keyes, K., & Newton, N. (2021). Targets for intervention to prevent substance use in young people exposed to childhood adversity: A systematic review. *PloS one, 16*(6), e0252815. https://doi.org/10.1371/journal.pone.0252815
	Alcohol	Evidence shows that there is a protective role that healthy coping skills play in alcohol use behavior.	Jenzer, T., Cheesman, A. J., Shaw, R. J., Egerton, G. A., & Read, J. P. (2022). Coping Flexibility and Alcohol-Related Outcomes: Examining Coping Motives as Mediators. *Substance use & misuse*, 57(14), 2031–2041. https://doi.org/10.1080/10826084.2022.2125274

Shared Risk and Protective Factor	Focus Area	Summary	Source
Healthy Coping Skills, Emotional Regulation, and Resilience	Alcohol	Findings of a study examining emotional regulation, alcohol use, cannabis use, and nicotine use among high risk youth identified that increased regulatory abilities were linked with decreased alcohol use. The study found that substance use may be a result of issues in emotional regulation and/or can supplant or disrupt normal patterns of regulation.	McKee, K., Russell, M., Mennis, J., Mason, M., & Neale, M. (2020). Emotion regulation dynamics predict substance use in high-risk adolescents. *Addictive behaviors, 106*, 106374. https://doi.org/10.1016/j.addbeh.2020.106374
	Cannabis	Findings of a study examining emotional regulation, alcohol use, cannabis use, and nicotine use among high risk youth identified that increased regulatory abilities were linked with decreased cannabis use, however the impact was lowest for cannabis use compared to the other two substances examined. The study found that substance use may be a result of issues in emotional regulation and/or can supplant or disrupt normal patterns of regulation.	McKee, K., Russell, M., Mennis, J., Mason, M., & Neale, M. (2020). Emotion regulation dynamics predict substance use in high-risk adolescents. *Addictive behaviors, 106*, 106374. https://doi.org/10.1016/j.addbeh.2020.106374
	Gambling	The study found that emotional dysregulation mediated the relationships between ACEs and disordered gambling in adults.	Poole, J. C., Kim, H. S., Dobson, K. S., & Hodgins, D. C. (2017). Adverse Childhood Experiences and Disordered Gambling: Assessing the Mediating Role of Emotion Dysregulation. *Journal of gambling studies*, 33(4), 1187–1200. https://doi.org/10.1007/s10899-017-9680-8
		A systematic review and meta-analysis found consistent and significant associations between disordered gambling and emotional regulation.	Velotti, P., Rogier, G., Beomonte Zobel, S., & Billieux, J. (2021). Association between gambling disorder and emotion (dys)regulation: A systematic review and meta-analysis. *Clinical psychology review*, 87, 102037. https://doi.org/10.1016/j.cpr.2021.102037
	Mental Health & Suicide	Use of coping strategies was considered effective by participants with an existing mental health diagnosis who expressed suicidal ideation – baseline suicidal ideation decreased with use of coping strategies.	Stanley, B., Martínez-Alés, G., Gratch, I., Rizk, M., Galfalvy, H., Choo, T. H., & Mann, J. J. (2021). Coping strategies that reduce suicidal ideation: An ecological momentary assessment study. *Journal of psychiatric research, 133*, 32–37. https://doi.org/10.1016/j.jpsychires.2020.12.012

Shared Risk and Protective Factor	Focus Area	Summary	Source
Healthy Coping Skills, Emotional Regulation, and Resilience	Opioids	Individuals with lower levels of resilience experienced significantly higher demands for opioid prescriptions.	Paniagua, A. R., Cunningham, D. J., LaRose, M. A., Morriss, N. J., & Gage, M. J. (2022). Psychological resilience as a predictor of opioid consumption after orthopaedic trauma. *Injury,* 53(6), 2047-2052. https://doi.org/10.1016/j.injury.2022.03.021
	Tobacco	Findings of a study examining emotional regulation, alcohol use, cannabis use, and nicotine use among high risk youth identified that increased regulatory abilities were linked with decreased nicotine use. The study found that substance use may be a result of issues in emotional regulation and/or can supplant or disrupt normal patterns of regulation.	McKee, K., Russell, M., Mennis, J., Mason, M., & Neale, M. (2020). Emotion regulation dynamics predict substance use in high-risk adolescents. *Addictive behaviors, 106*, 106374. https://doi.org/10.1016/j.addbeh.2020.106374
Parental Approval/ Disapproval	Alcohol	Parental disapproval, particularly when combined with having a confidant, decreased the odds of alcohol use.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse*, 43(1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439
		Findings found that increased alcohol-specific household rules reduced the risk of early onset heavy drinking, which decreased the odds of individuals meeting diagnostic criteria for Alcohol Use Disorder in early adulthood.	Yuen, W. S., Chan, G., Bruno, R., Clare, P., Mattick, R., Aiken, A., Boland, V., McBride, N., McCambridge, J., Slade, T., Kypri, K., Horwood, J., Hutchinson, D., Najman, J., De Torres, C., & Peacock, A. (2020). Adolescent Alcohol Use Trajectories: Risk Factors and Adult Outcomes. *Pediatrics, 146*(4), e20200440. https://doi.org/10.1542/peds.2020-0440
	Cannabis	A study of early initiators of cannabis use found early use was associated with low parental disapproval.	Korn, L., Haynie, D. L., Luk, J. W., Sita, K., & Simons-Morton, B. G. (2021). Attitudes, Subjective Norms, and Perceived Behavioral Control Associated with Age of First Use of Cannabis among Adolescents. *The Journal of school health, 91*(1), 50–58. https://doi.org/10.1111/josh.12977

Shared Risk and Protective Factor	Focus Area	Summary	Source
Parental Approval/ Disapproval	Cannabis	Parental disapproval, particularly when combined with having a confidant, decreased the odds of cannabis use.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse, 43(*1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439
		Findings demonstrated that parental negative expectancies related to cannabis use were associated with reduced youth marijuana use.	Ramer, N. E., Read, J. P., & Colder, C. R. (2021). Parents' Cannabis-Related Attitudes and Emerging Adult Offspring Cannabis Use: Testing the Mediating Effect of Perceived Parental Approval. *Substance use & misuse, 56*(2), 308–317. https://doi.org/10.1080/10826084.2020.1868004
		Findings demonstrated that parental disapproval has a high direct effect on youth cannabis use and influences youth perceptions of risk associated with cannabis.	Yang, E. S., Oh, S. K., Kim, S., & Chung, I. J. (2022). The influence of parent and peer disapproval on youth marijuana use mediated by youth risk perception: Focusing on the state comparison. *Drug and alcohol dependence*, 240, 109641. https://doi.org/10.1016/j.drugalcdep.2022.109641
	Gambling	A UK review of the current evidence regarding youth and child gambling behaviors found that parent gambling was a key interpersonal risk factor influencing adolescent gambling behaviors.	Emond, A. M., & Griffiths, M. D. (2020). Gambling in children and adolescents. *British Medical Bulletin*, 136(1), 21–29. https://doi.org/10.1093/bmb/ldaa027
	Tobacco	Parental disapproval, particularly when combined with having a confidant, decreased the odds of tobacco use.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse*, 43(1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439

Shared Risk and Protective Factor	Focus Area	Summary	Source
Parental Approval/ Disapproval	Tobacco	Parental attitudes were linked with decreased intentions to use e-cigarettes.	Trucco, E. M., Cristello, J. V., & Sutherland, M. T. (2021). Do Parents Still Matter? The Impact of Parents and Peers on Adolescent Electronic Cigarette Use. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 68*(4), 780–786. https://doi.org/10.1016/j.jadohealth.2020.12.002
	Stimulants	A systematic review of qualitative literature found that relationships with friends, family, and intimate partners who use ampethamine-type stimulants is a common risk factor contributing to initiation of use, particularly in urban settings.	O'Donnell, A., Addison, M., Spencer, L., Zurhold, H., Rosenkranz, M., McGovern, R., Gilvarry, E., Martens, M. S., Verthein, U., & Kaner, E. (2019). Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature. *Addiction (Abingdon, England)*, 114(1), 24–47. https://doi.org/10.1111/add.14434
	Vaping	Parental attitudes were linked with decreased intentions to use e-cigarettes.	Trucco, E. M., Cristello, J. V., & Sutherland, M. T. (2021). Do Parents Still Matter? The Impact of Parents and Peers on Adolescent Electronic Cigarette Use. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 68*(4), 780–786. https://doi.org/10.1016/j.jadohealth.2020.12.002
Peer Approval/ Disapproval, and Use	Alcohol	Greater perceived alcohol use among peers was associated with increased alcohol use among peers. Susceptibility to peer influence, fear of rejection by peers, importance of peer status and popularity were contributing factors to alcohol use. Those demonstrating average to high levels of susceptibility to peer influence perceived greater peer alcohol use and reporting increased alcohol use upon follow up.	Duell, N., Clayton, M. G., Telzer, E. H., & Prinstein, M. J. (2022). Measuring peer influence susceptibility to alcohol use: Convergent and predictive validity of a new analogue assessment. *International journal of behavioral development, 46*(3), 190–199. https://doi.org/10.1177/0165025420965729

Shared Risk and Protective Factor	Focus Area	Summary	Source
Peer Approval/ Disapproval, and Use	Alcohol	Peer alcohol use was associated with increased risk of early-onset heavy drinking, which increased odds of meeting the diagnostic criteria for Alcohol Use Disorder in early adulthood.	Yuen, W. S., Chan, G., Bruno, R., Clare, P., Mattick, R., Aiken, A., Boland, V., McBride, N., McCambridge, J., Slade, T., Kypri, K., Horwood, J., Hutchinson, D., Najman, J., De Torres, C., & Peacock, A. (2020). Adolescent Alcohol Use Trajectories: Risk Factors and Adult Outcomes. *Pediatrics, 146*(4), e20200440. https://doi.org/10.1542/peds.2020-0440
	Cannabis	A study of early initiators of cannabis use found early use was associated with higher peer cannabis use.	Korn, L., Haynie, D. L., Luk, J. W., Sita, K., & Simons-Morton, B. G. (2021). Attitudes, Subjective Norms, and Perceived Behavioral Control Associated with Age of First Use of Cannabis among Adolescents. *The Journal of school health, 91*(1), 50–58. https://doi.org/10.1111/josh.12977
		Peer disapproval was a protective factor in decreasing youth cannabis use, particularly when combined with the presence of a confidant. Peer disapproval was more proactive in protecting against cannabis use than parental disapproval, though both were impactful.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse*, 43(1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439
		A systematic review found that cannabis use was most often/strongly associated with peer use.	Torrejón-Guirado, M. C., Baena-Jiménez, M. Á., Lima-Serrano, M., de Vries, H., & Mercken, L. (2023). The influence of peer's social networks on adolescent's cannabis use: a systematic review of longitudinal studies. *Frontiers in psychiatry, 14*, 1306439. https://doi.org/10.3389/fpsyt.2023.1306439
		Study findings demonstrated that peer disapproval has a high indirect effect on youth cannabis use and influences youth perceptions of risk associated with cannabis use.	Yang, E. S., Oh, S. K., Kim, S., & Chung, I. J. (2022). The influence of parent and peer disapproval on youth marijuana use mediated by youth risk perception: Focusing on the state comparison. *Drug and alcohol dependence*, 240, 109641. https://doi.org/10.1016/j.drugalcdep.2022.109641

Shared Risk and Protective Factor	Focus Area	Summary	Source
Peer Approval/ Disapproval, and Use	Gambling	Peer pressure to participate in gambling and peer gambling norms were predictive of the onset and maintenance of gambling behaviors among adolescents.	Botella-Guijarro, Á., Lloret-Irles, D., Segura-Heras, J. V., Cabrera-Perona, V., & Moriano, J. A. (2020). A Longitudinal Analysis of Gambling Predictors among Adolescents. *International journal of environmental research and public health, 17*(24), 9266. https://doi.org/10.3390/ijerph17249266
	Stimulants	A systematic review of qualitative literature found that relationships with friends, family, and intimate partners who use ampethamine-type stimulants is a common risk factor contributing to initiation of use, particularly in urban settings.	O'Donnell, A., Addison, M., Spencer, L., Zurhold, H., Rosenkranz, M., McGovern, R., Gilvarry, E., Martens, M. S., Verthein, U., & Kaner, E. (2019). Which individual, social and environmental influences shape key phases in the amphetamine type stimulant use trajectory? A systematic narrative review and thematic synthesis of the qualitative literature. *Addiction (Abingdon, England)*, 114(1), 24–47. https://doi.org/10.1111/add.14434
	Vaping	Exposure to peer e-cigarette use increased the odds of susceptibility to use among middle and high school youth.	Mantey, D. S., Omega-Njemnobi, O., Ruiz, F. A., Vaughn, T. L., Kelder, S. H., & Springer, A. E. (2021). Association between observing peers vaping on campus and E-cigarette use and susceptibility in middle and high school students. *Drug and alcohol dependence, 219*, 108476. https://doi.org/10.1016/j.drugalcdep.2020.108476
Perceptions of Risk	Alcohol	A study of Midwestern university students ages 19-28 found that high perceptions of risk was associated with decreased binge drinking.	Hanauer, M., Walker, M. R., Machledt, K., Ragatz, M., & Macy, J. T. (2021). Association between perceived risk of harm and self-reported binge drinking, cigarette smoking, and marijuana smoking in young adults. *Journal of American college health: J of ACH, 69*(4), 345–352. https://doi.org/10.1080/07448481.2019.1676757
	Cannabis	A systematic review of studies evaluating knowledge and risk perceptions related to cannabis use among children and adolescents found increased perceptions of risk to often correlate with lowers levels of current use and future intention to use.	Harrison, M. E., Kanbur, N., Canton, K., Desai, T. S., Lim-Reinders, S., Groulx, C., & Norris, M. L. (2024). Adolescents' Cannabis Knowledge and Risk Perception: A Systematic Review. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine, 74*(3), 402–440. https://doi.org/10.1016/j.jadohealth.2023.09.014

Shared Risk and Protective Factor	Focus Area	Summary	Source
Perceptions of Risk	Cannabis	A study of Midwestern university students ages 19-28 found that high perceptions of risk was associated with decreased cannabis use, particularly among younger participants.	Hanauer, M., Walker, M. R., Machledt, K., Ragatz, M., & Macy, J. T. (2021). Association between perceived risk of harm and self-reported binge drinking, cigarette smoking, and marijuana smoking in young adults. *Journal of American college health: J of ACH*, 69(4), 345–352. https://doi.org/10.1080/07448481.2019.1676757
	Gambling	Risk perception was predictive of the onset and maintenance of gambling behaviors among adolescents.	Botella-Guijarro, Á., Lloret-Irles, D., Segura-Heras, J. V., Cabrera-Perona, V., & Moriano, J. A. (2020). A Longitudinal Analysis of Gambling Predictors among Adolescents. *International journal of environmental research and public health*, 17(24), 9266. https://doi.org/10.3390/ijerph17249266
	Opioids	Study findings demonstrated that lower perceived risk of harm was associated with increased prescription pain reliever misuse – adults were more likely to perceive great risk of harm from heroin use compared to youth.	Kapadia, S. N., & Bao, Y. (2019). Prescription painkiller misuse and the perceived risk of harm from using heroin. *Addictive behaviors*, 93, 141–145. https://doi.org/10.1016/j.addbeh.2019.01.039
	Tobacco	A study of Midwestern university students ages 19-28 found that high perceptions of risk was associated with decreased cigarette smoking.	Hanauer, M., Walker, M. R., Machledt, K., Ragatz, M., & Macy, J. T. (2021). Association between perceived risk of harm and self-reported binge drinking, cigarette smoking, and marijuana smoking in young adults. *Journal of American college health: J of ACH*, 69(4), 345–352. https://doi.org/10.1080/07448481.2019.1676757
		A large scale study of youth ages 12 to 17 from the PATH study found a bidirection association between perceived harm and tobacco use, with high perceptions of risk decreasing likelihood of use and low risk perceptions increasing likelihood of use.	Strong, D. R., Leas, E., Elton-Marshall, T., Wackowski, O. A., Travers, M., Bansal-Travers, M., Hyland, A., White, M., Noble, M., Cummings, K. M., Taylor, K., Kaufman, A. R., Choi, K., & Pierce, J. P. (2019). Harm perceptions and tobacco use initiation among youth in Wave 1 and 2 of the Population Assessment of Tobacco and Health (PATH) Study. *Preventive medicine, 123*, 185–191. https://doi.org/10.1016/j.ypmed.2019.03.017

Shared Risk and Protective Factor	Focus Area	Summary	Source
Prosocial and Extra-Curricular Involvement	All	Data is indicative of prosocial involvement/positive socialization acting as a protective factor for both addictive behavior and negative mental health.	Pomrenze, M. B., Paliarin, F., & Maiya, R. (2022). Friend of the Devil: Negative Social Influences Driving Substance Use Disorders. *Frontiers in behavioral neuroscience*, 16, 836996. https://doi.org/10.3389/fnbeh.2022.836996
		An examination of 2013 NSDUH data found that participation in extracurricular activities decreased substance use among youth ages 12 to 17. Impacts were greater among female adolescents than male adolescents.	Kenney, A., & Dennis, C. B. (2019). Environmental paths that inform adolescent substance use prevention. *Journal of Human Behavior in the Social Environment, 29*(7), 897–908. https://doi.org/10.1080/10911359.2019.1633982
	Alcohol	Low participation in sports programs was associated with increased risk of binge drinking among youth.	Bozzini, A. B., Bauer, A., Maruyama, J., Simões, R., & Matijasevich, A. (2021). Factors associated with risk behaviors in adolescence: a systematic review. *Revista brasileira de psiquiatria (Sao Paulo, Brazil: 1999), 43*(2), 210–221. https://doi.org/10.1590/1516-4446-2019-0835
	Mental Health & Suicide	Participation in extracurricular activities was demonstrated to have a positive effect on mental health, especially when associated with decreased screen time.	Oberle, E., Ji, X. R., Kerai, S., Guhn, M., Schonert-Reichl, K. A., & Gadermann, A. M. (2020). Screen time and extracurricular activities as risk and protective factors for mental health in adolescence: A population-level study. *Preventive medicine, 141*, 106291. https://doi.org/10.1016/j.ypmed.2020.106291
	Opioids	Participation in extracurricular activities was found to lower the risk for opioid use by 36%. However, Black youth were not found to receive protective effects from involvement.	Rigg, K. K., & Johnson, M. E. (2022). Preventing Adolescent Opioid Misuse: Racial/Ethnic Differences in the Protective Effects of Extracurricular Activities. *Journal of studies on alcohol and drugs, 83*(3), 402–411. https://doi.org/10.15288/jsad.2022.83.402

Shared Risk and Protective Factor	Focus Area	Summary	Source
Self-Esteem	Alcohol	Higher levels of self-esteem were a protective factor in decreasing rates of alcohol use and misuse.	Schick, M. R., Nalven, T., & Spillane, N. S. (2022). Drinking to Fit in: The Effects of Drinking Motives and Self-Esteem on Alcohol Use among Female College Students. *Substance use & misuse,* 57(1), 76–85. https://doi.org/10.1080/10826084.2021.1990334
	Mental Health & Suicide	A meta-analysis of longitudinal studies found that a low level of self-esteem increased the likelihood of lifetime suicide attempts among adolescents and young adults.	Soto-Sanz, V., Piqueras, J. A., Rodríguez-Marín, J., Pérez-Vázquez, T., Rodríguez-Jiménez, T., Castellví, P., Miranda-Mendizábal, A., Parés-Badell, O., Almenara, J., Blanco, M. J., Cebriá, A., Gabilondo, A., Gili, M., Roca, M., Lagares, C., & Alonso, J. (2019). Self-esteem and suicidal behaviour in youth: A meta-analysis of longitudinal studies. *Psicothema, 31(*3), 246–254. https://doi.org/10.7334/psicothema2018.339
		The study identified a relationship between low levels of self-esteem and increased suicidal ideation and risk among older adults.	Eades, A., Segal, D. L., & Coolidge, F. L. (2019). Suicide Risk Factors Among Older Adults: Exploring Thwarted Belongingness and Perceived Burdensomeness in Relation to Personality and Self-Esteem. *International journal of aging & human development, 88*(2), 150–167. https://doi.org/10.1177/0091415018757214
	Opioids	Findings from this study show that low self-esteem was associated with higher risk for opioid use.	Hendy, H. M., Black, P., Can, S. H., Fleischut, A., & Aksen, D. (2018). Opioid Abuse as Maladaptive Coping to Life Stressors in U.S. Adults. *Journal of Drug Issues, 48*(4), 560-571. https://doi.org/10.1177/0022042618783454
	Tobacco	Researchers found that individuals with lower levels of self-esteem were at higher odds of tobacco use.	Szinay, D., Tombor, I., Garnett, C., Boyt, N., & West, R. (2019). Associations between self-esteem and smoking and excessive alcohol consumption in the UK: A cross-sectional study using the BBC UK Lab database. *Addictive behaviors reports, 10*, 100229. https://doi.org/10.1016/j.abrep.2019.100229

Shared Risk and Protective Factor	Focus Area	Summary	Source
Social Isolation	All	A study of older adult substance use and perceptions of social isolation and loneliness found that individuals described as “alone and lonely” (experiencing high levels of social isolation and feelings of loneliness) had the highest odds of nonmedical drug use compared to less isolated, less lonely peers.	Farmer, A. Y., Wang, Y., Peterson, N. A., Borys, S., & Hallcom, D. K. (2022). Social Isolation Profiles and Older Adult Substance Use: A Latent Profile Analysis. The journals of gerontology. *Series B, Psychological sciences and social sciences, 77*(5), 919–929. https://doi.org/10.1093/geronb/gbab078
		A study of designed to identify the relationship between loneliness and proclivity for substance use at a treatment center for children and adolescents found that children and adolescents description higher levels of loneliness were at higher proclivity for engaging in substance use.	Kayaoğlu, K., Okanlı, A., Budak, F. K., & Aslanoğlu, E. (2021). The correlation between loneliness and substance use proclivity in child and adolescent substance users. *Journal of Substance Use, 27*(1), 70–73. https://doi.org/10.1080/14659891.2021.1894495
	Alcohol	A systematic review found that low school connectedness was significantly associate with youth alcohol use.	Bozzini, A. B., Bauer, A., Maruyama, J., Simões, R., & Matijasevich, A. (2021). Factors associated with risk behaviors in adolescence: a systematic review. *Revista brasileira de psiquiatria (Sao Paulo, Brazil: 1999), 43*(2), 210–221. https://doi.org/10.1590/1516-4446-2019-0835
		A study of older adult substance use and perceptions of social isolation and loneliness found that individuals who described feeling “alone but not lonely” had the highest odds of alcohol use and high risk drinking.	Farmer, A. Y., Wang, Y., Peterson, N. A., Borys, S., & Hallcom, D. K. (2022). Social Isolation Profiles and Older Adult Substance Use: A Latent Profile Analysis. The journals of gerontology. *Series B, Psychological sciences and social sciences, 77*(5), 919–929. https://doi.org/10.1093/geronb/gbab078
		A six month study found that individuals reporting moderate or severe loneliness had a significantly higher frequency of alcohol use at follow up compared to those who were never lonely.	Gutkind, S., Gorfinkel, L. R., & Hasin, D. S. (2022). Prospective effects of loneliness on frequency of alcohol and marijuana use. *Addictive behaviors, 124*, 107115. https://doi.org/10.1016/j.addbeh.2021.107115

Shared Risk and Protective Factor	Focus Area	Summary	Source
Social Isolation	Cannabis	A systematic review found that cannabis use increased when adolescents did not feel close to school peers, had low neighborhood ties. Cannabis use also increased when adolescents did not report belonging to a group but associated with individuals who were members of groups.	Torrejón-Guirado, M. C., Baena-Jiménez, M. Á., Lima-Serrano, M., de Vries, H., & Mercken, L. (2023). The influence of peer's social networks on adolescent's cannabis use: a systematic review of longitudinal studies. *Frontiers in psychiatry*, 14, 1306439. https://doi.org/10.3389/fpsyt.2023.1306439
		A six month study found that individuals reporting moderate or severe loneliness had a significantly higher frequency of cannabis use at follow up compared to those who were never lonely.	Gutkind, S., Gorfinkel, L. R., & Hasin, D. S. (2022). Prospective effects of loneliness on frequency of alcohol and marijuana use. *Addictive behaviors, 124*, 107115. https://doi.org/10.1016/j.addbeh.2021.107115
	Mental Health & Suicide	A review of 40 unique observational studies found strong associations between social isolation and suicidal outcomes, with feelings of loneliness having a major impact among individuals across various cultures.	Calati, R., Ferrari, C., Brittner, M., Oasi, O., Olié, E., Carvalho, A. F., & Courtet, P. (2019). Suicidal thoughts and behaviors and social isolation: A narrative review of the literature. *Journal of affective disorders, 245*, 653–667. https://doi.org/10.1016/j.jad.2018.11.022
		A review of 46 studies found a causal relationship between social isolation and suicide.	Motillon-Toudic, C., Walter, M., Séguin, M., Carrier, J. D., Berrouiguet, S., & Lemey, C. (2022). Social isolation and suicide risk: Literature review and perspectives. *European psychiatry : the journal of the Association of European Psychiatrists*, 65(1), e65. https://doi.org/10.1192/j.eurpsy.2022.2320
	Opioids	Individuals experiencing social isolation are at particularly high risk of experiencing prescription opioid misuse.	Cruden, G., & Karmali, R. (2021). Opioid misuse as a coping behavior for unmet mental health needs among U.S. adults. *Drug and alcohol dependence*, 225, 108805. https://doi.org/10.1016/j.drugalcdep.2021.108805

Shared Risk and Protective Factor	Focus Area	Summary	Source
Social Isolation	Opioids	Evidence found a bidirectional link between social isolation and opioid use. Opioid use was indicated as a means of mitigating feelings of social isolation and lack of belonging.	Christie N. C. (2021). The role of social isolation in opioid addiction. *Social cognitive and affective neuroscience, 16*(7), 645–656. https://doi.org/10.1093/scan/nsab029
Social Supports	All	Healthy relationships can influence an individual's decision to abstain from substance use.	Pettersen, H., Landheim, A., Skeie, I., Biong, S., Brodahl, M., Oute, J., & Davidson, L. (2019). How Social Relationships Influence Substance Use Disorder Recovery: A Collaborative Narrative Study. *Substance abuse: research and treatment, 13*, 1178221819833379. https://doi.org/10.1177/1178221819833379
	Alcohol	In a study observing the impact of peer networks among diverse populations of college students, researchers found healthy peer networks serve as a protective factor in reducing alcohol use.	Ott, M. Q., Clark, M. A., Balestrieri, S. G., Gamarel, K. E., & Barnett, N. P. (2022). Social Networks and Sexual and Gender Minority Disparities in Alcohol Use and Consequences Among First-Year College Students. *LGBT health, 9*(7), 489–495. https://doi.org/10.1089/lgbt.2019.0225
		Lower social support was linked with significantly higher lifetime alcohol use among incarcerated individuals.	Rapier, R., McKernan, S., & Stauffer, C. S. (2019). An inverse relationship between perceived social support and substance use frequency in socially stigmatized populations. *Addictive behaviors reports, 10*, 100188. https://doi.org/10.1016/j.abrep.2019.100188
	Cannabis	Lower social support was linked with significantly higher lifetime cannabis use among incarcerated individuals.	Rapier, R., McKernan, S., & Stauffer, C. S. (2019). An inverse relationship between perceived social support and substance use frequency in socially stigmatized populations. *Addictive behaviors reports, 10*, 100188. https://doi.org/10.1016/j.abrep.2019.100188

Shared Risk and Protective Factor	Focus Area	Summary	Source
Social Supports	Mental Health & Suicide	A review of 46 studies found the presence of social supports to serve as a protective factor preventing suicide.	Motillon-Toudic, C., Walter, M., Séguin, M., Carrier, J. D., Berrouiguet, S., & Lemey, C. (2022). Social isolation and suicide risk: Literature review and perspectives. *European psychiatry : the journal of the Association of European Psychiatrists*, 65(1), e65. https://doi.org/10.1192/j.eurpsy.2022.2320
	Opioids	A systematic review established that social connection is an important correlate of opioid misuse. However, there were some limitations in the review as a result of a lack in the standardization of measurementand lack of larger studies.	Cance, J. D., Saavedra, L. M., Wondimu, B., Scaglione, N. M., Hairgrove, S., & Graham, P. W. (2021). Examining the Relationship between Social Connection and Opioid Misuse: A Systematic Review. *Substance use & misuse, 56*(10), 1493–1507. https://doi.org/10.1080/10826084.2021.1936056
		Evidence established a bidirectional link between social isolation and opioid use. Increased social connection and feelings of belonging decrease the likelihood of opioid use.	Christie N. C. (2021). The role of social isolation in opioid addiction. *Social cognitive and affective neuroscience, 16*(7), 645–656. https://doi.org/10.1093/scan/nsab029
	Stimulants	Lower social support was linked with significantly higher lifetime methamphetamine use among men who have sex with men.	Rapier, R., McKernan, S., & Stauffer, C. S. (2019). An inverse relationship between perceived social support and substance use frequency in socially stigmatized populations. *Addictive behaviors reports, 10*, 100188. https://doi.org/10.1016/j.abrep.2019.100188
	Tobacco	A study of older adult substance use and perceptions of social isolation and loneliness found that individuals who are “connected and active” had the lowest odds of cigarette use compared to those experiencing some feeling of isolation or loneliness.	Farmer, A. Y., Wang, Y., Peterson, N. A., Borys, S., & Hallcom, D. K. (2022). Social Isolation Profiles and Older Adult Substance Use: A Latent Profile Analysis. *The journals of gerontology. Series B, Psychological sciences and social sciences, 77*(5), 919–929. https://doi.org/10.1093/geronb/gbab078

Shared Risk and Protective Factor	Focus Area	Summary	Source
Social Supports	Tobacco	Lower social support was linked with significantly higher lifetime tobacco use among incarcerated individuals.	Rapier, R., McKernan, S., & Stauffer, C. S. (2019). An inverse relationship between perceived social support and substance use frequency in socially stigmatized populations. *Addictive behaviors reports, 10*, 100188. https://doi.org/10.1016/j.abrep.2019.100188
Trusted Adults, Peers, and Mentors	All	The presence of mentoring in adolescence acts as a protective factor against substance use.	Mentoring for Preventing and Reducing Substance Use and Associated Risks Among Youth | 1 National Mentoring Resource Center Outcome Review MENTORING FOR PREVENTING AND REDUCING SUBSTANCE USE AND ASSOCIATED RISKS AMONG YOUTH. (2020). Nelson, L. F., Weitzman, E. R., & Levy, S. (2022). Prevention of Substance Use Disorders. *The Medical clinics of North America, 106*(1), 153–168. https://doi.org/10.1016/j.mcna.2021.08.005
		A meta-analysis of outcome studies found that mentor programs have an overall positive effect on youth outcomes and can reduce youth substance use across numerous substances.	Raposa, E. B., Rhodes, J., Stams, G. J. J. M., Card, N., Burton, S., Schwartz, S., Sykes, L. A. Y., Kanchewa, S., Kupersmidt, J., & Hussain, S. (2019). The Effects of Youth Mentoring Programs: A Meta-analysis of Outcome Studies. *Journal of youth and adolescence, 48(*3), 423–443. https://doi.org/10.1007/s10964-019-00982-8
	Alcohol	Presence of a confidant, particularly a peer confidant, attenuated the protective association between peer and parental disapproval in reducing youth alcohol use.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse*, 43(1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439
	Cannabis	Presence of a confidant, particularly a peer confidant, attenuated the protective association between peer and parental disapproval in reducing youth cannabis use.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse*, 43(1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439

Shared Risk and Protective Factor	Focus Area	Summary	Source
Trusted Adults, Peers, and Mentors	Mental Health & Suicide	The study found that schoolwide rates of suicidal ideation were lower at schools where multiple students identified the same trusted adult(s) and when higher concentration of youth-adult relationships were present.	Wyman, P. A., Pickering, T. A., Pisani, A. R., Rulison, K., Schmeelk-Cone, K., Hartley, C., Gould, M., Caine, E. D., LoMurray, M., Brown, C. H., & Valente, T. W. (2019). Peer-adult network structure and suicide attempts in 38 high schools: implications for network-informed suicide prevention. *Journal of child psychology and psychiatry, and allied disciplines*, 60(10), 1065–1075. https://doi.org/10.1111/jcpp.13102
		A study in K-12 schools found found that a lack of a trusted adult was linked with students' increased internalization of problems over time.	Reinke, W. M., Herman, K. C., Huang, F. L., Glenn-Perez, A. L., Raut, P., Aguayo, D., Venkat, S., Boddie, D., Harris, J. M., & Owens, S. (2024). Having a Trusted Adult in School: Concurrent and Predictive Relations With Internalizing Problems Across Development. *Journal of Positive Behavior Interventions*, 0(0). https://doi.org/10.1177/10983007241276534
	Tobacco	Presence of a confidant, particularly a peer confidant, attenuated the protective association between peer and parental disapproval in reducing youth tobacco use.	Marziali, M. E., Levy, N. S., & Martins, S. S. (2022). Perceptions of peer and parental attitudes toward substance use and actual adolescent substance use: The impact of adolescent-confidant relationships. *Substance abuse*, 43(1), 1085–1093. https://doi.org/10.1080/08897077.2022.2060439
	Vaping	Youth interacting with trained peer mentors and messaging campaigns developed by peer mentors were less likely to report recent vape use or intention of vaping.	Wyman, P. A., Rulison, K., Pisani, A. R., Alvaro, E. M., Crano, W. D., Schmeelk-Cone, K., Keller Elliot, C., Wortzel, J., Pickering, T. A., & Espelage, D. L. (2021). Above the influence of vaping: Peer leader influence and diffusion of a network-informed preventive intervention. *Addictive behaviors, 113*, 106693. https://doi.org/10.1016/j.addbeh.2020.106693

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Virginia Community Services Boards (CSBs) offer most of the services in #2 below, with some variations depending on location and resources.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational services	(●) Yes ( ) No
g)	Substance use prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Recovery Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

All of Virginia's 40 Community Services Boards offer the majority of the services on the list above with varying levels of accessibility.

STEP-VA was initiated in Virginia with the intent to make widely available services and supports to individuals with mental illness and/or substance use disorders. One of the goals of this program, which is modeled after CCBHC, is to reduce the need for inpatient settings and allow individuals to function outside of these settings to the best of their abilities. STEP-VA services include many of the above-mentioned services within its 9 identified “steps,” as described below. When combined appropriately to address individuals’ needs and treatment plans, these services help to provide a comprehensive system of care that allows individuals to function outside of inpatient or residential institutions to the greatest extent possible.

Physical health: Conducting primary care screenings and assisting individuals with referrals as needed in order to overcome barriers to accessing primary healthcare services, given that this population is at increased risk of physical health

problems. Primary care may be offered at some CSBs; however, care coordination is conducted to facilitate communication with external primary healthcare providers, as needed.

Mental health, Substance use disorder, Co-occurring MHSUD treatment: Outpatient services are provided, along with other services throughout the remaining steps to support individuals in their mental health and/or substance use recovery. This may also include targeted case management, peer support services, psychiatric rehabilitation, supported employment, crisis services, and considerations for service members, veterans, and their families. Some CSBs may additionally offer services specific to the SUD population, such as medication assisted treatment (MAT), peer support services, targeted case management, or SUD IOP, etc. Services may be provided through CSBs or through private community providers in order to leverage all appropriate available resources to address an individual's needs.

Rehabilitation: Psychiatric rehabilitation programming provides evidence-based and person-directed services to help enhance individuals' quality of life and support long-term recovery. It is inclusive of a variety of services, such as ACT, Supported Employment, Permanent Supportive Housing, Clubhouse, and Peer Support, etc. Of note, these services may be offered at CSBs or by private community-based mental health providers.

In addition to STEP-VA, physical health and behavioral health integration is currently being addressed in Virginia through the implementation of the Adult Psychiatric Access Line (APAL) and Collaborative Care Model (CoCM), in partnership with the Medical Society of Virginia. APAL is a resource for primary care providers throughout Virginia and consists of a three-tiered approach to supporting primary care providers who are treating individuals with behavioral health concerns in their practices. The three components of APAL are: 1) case consultation line where PCPs can connect directly with a psychiatrist or addiction medicine specialist to advise on treatment for specific cases in the PCP practice; 2) care navigation assistance through the call line and regional hubs, provided to PCPs and/or to patients directly to connect them with behavioral health resources in their communities; 3) continuing education opportunities for PCPs to learn more about the assessment, diagnosis, and treatment of behavioral health disorders. Currently, APAL has one regional hub and supports PCPs treating individuals with SUD; however, the program will gradually expand over the coming years to include regional hubs across Virginia and serve additional populations (including geriatric, young adult, and general adult mental health). The CoCM was initiated following receipt of the SAMHSA PIPBHC CoCM grant in 2024, and leverages APAL resources in addition to embedding Behavioral Health Care Managers in three primary care practices in Virginia. The model is anticipated to launch in the participating practices beginning in July 2025. Given the behavioral health workforce shortage, along with the established, trusting relationships many patients have with their primary care providers, these two programs help bridge a critical gap in supporting individuals in need of behavioral health care, which will help them to thrive in their community, and ideally reduce the need for inpatient or residential institutions.

3. Describe your state's case management services

Targeted case management is a Medicaid-billable service in Virginia for adults with SMI/SUD and children with SED which is also licensed by DBHDS under Title 12, Chapter 105 of the Virginia Administrative Code, "Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services." These regulations require that providers of case management services provide the following services: 1. Enhance community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public; 2. Make collateral contacts with the individual's significant others and system of support with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment; 3. Assess needs and planning services to include developing a case management individualized services plan; 4. Link the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as developed in the Individualized Services Plan (ISP); 5. Assist the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits; 6. Assure the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments; 7. Monitor service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual; 8. Provide follow up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP; 9. Advocate for individuals in response to their changing needs, based on changes in the individualized services plan; 10. Plan for transitions in the individual's life; 11. Know and monitor the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed; and 12. Understand the capabilities of services to meet the individual's identified needs and preferences and serve the individual without placing the individual, other participants, or staff at risk of serious harm.

4. Describe activities intended to reduce hospitalizations and hospital stays.

A wide variety of clinical and recovery support services are provided in the community and in our state psychiatric facilities to reduce hospitalizations and hospital stays. Most of the services in item 1 above continue to be offered in the community having been initially designed to prevent or reduce psychiatric crisis. For adults with SMI in particular, important services include psychiatric and medication management services, psychosocial rehabilitation, peer supports, and permanent supportive housing. As the need for appropriate response to psychiatric crisis continues to grow STEP VA as system transformation process is examining a significant number of these services to improve access to services as well as to better support maintaining consumers in the community. Additionally, as described above, DBHDS has worked with the Medical Society of Virginia to establish two

programs aimed at integrating primary and behavioral healthcare and to expand knowledge and best practices for primary care providers treating individuals with mental health or SUD in their practices. This helps to close critical gaps in behavioral healthcare in our communities, thereby enabling more Virginians to maintain in the community to the greatest extent they are able.

5. Please indicate areas of technical assistance needs related to this section.

None at this time

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	359,467 (5.4% of adult pop)	83,888 (1.3% of adult pop)
2.Children with SED	97,781 (10% of child pop)	26,646 (2.7% of child pop)

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The prevalence data and rates for adults with SMI and children with SED are directly from the most current state-level prevalence data provided by NRI. The incidence data and rates for adults with SMI and children with SED are the figures we submitted in URS Table 15A to NRI for the last FY.

3. Please indicate areas of technical assistance needs related to this section.

None at this time

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	◉ Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

None at this time

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The Commonwealth of Virginia covers a wide range of geographic regions. Depending on its location, one CSB might serve a combined population of urban, suburban and ex-urban or rural areas. According to the most recent decennial census, the Census Bureau indicated that 75.5% of the population in Virginia resided in urban areas and 24.5% in rural areas. Twenty-six of the 40 CSBs contain one or more counties in their jurisdiction that are majority rural. During SFY 2018, these twenty-six CSBs served 68% of all mental health consumers and 61% of individuals receiving substance abuse treatment. Individuals in need of behavioral health services in rural areas face special challenges. Many in rural areas do not have the infrastructure to support the services that are needed in the community. Access to transportation, especially for those individuals found to be ineligible for Medicaid, is frequently an issue. In some cases, access to simple daily tasks remains challenging or impossible for those with minimal support. CSBs in these rural areas vary widely in their funding and staff capacity. They use different approaches, such as sharing services regionally with other CSBs and collaborating with local and regional contract agencies to meet the service needs of their consumers. Telepsychiatry and telecommunication, for example, are in use in some rural areas to facilitate specialty psychiatric services for adult consumers, children and their families, and veterans. In response to the COVID-19 pandemic rural areas were in some cases heavily impacted. Lack of network infrastructure, intermittent/inconsistent cell phone service, and increased stressors further complicated what was often already a strained system of care. In order to continue addressing these complex challenges, Virginia has also begun the process of implementing APAL and CoCM services. APAL aims to establish its second regional hub in the Southwest region of Virginia in 2025, and CoCM has targeted primary care practices in South-Central and Western areas of the state, in an effort to further target services towards individuals living in rural areas. Many individuals living in rural areas have limited access to behavioral health providers, as all of Virginia's 133 localities are federally-designated Mental Health Professional Shortage Areas. As a result, DBHDS has partnered with MSV to establish the above-mentioned programs, geared towards improving access to behavioral health care. This is particularly beneficial to rural populations in Virginia.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

ndividuals with serious mental illness (SMI) and those with co-occurring substance use disorders (SUD) are at disproportionately high risk of homelessness. According to Virginia's 2020 annual Point in Time Count of individuals experiencing homelessness, nearly 1,000 individuals with SMI are homeless on any given night. In the 14 areas of the state with the highest prevalence rates, DBHDS allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) Program to CSBs provide outreach, engagement and case management services to homeless persons with SMI/SUD. Through collaborative relationships with the continuum of homeless service providers in their catchment areas, Virginia's PATH programs assist consumers to access housing, mental health and substance abuse treatment services, entitlement benefits and other needed services to assist them in the process of recovery. Those who are literally homeless – meaning either living on the streets, in encampments, or other locations that are unfit for human habitation -- are the priority population served by Virginia's PATH providers.The majority of Virginia's 14 PATH programs operate in urban areas and spend significant time conducting street and shelter outreach to identify individuals with SMI who meet the PATH definition of homeless. Those programs operating in suburban and rural areas conduct outreach to homeless individuals in woods, encampments, under bridges and in other places where unsheltered persons congregate. The end goal of PATH is always to assist the individual to obtain housing, engage in behavioral health services, and access disability and other benefits. The SSI/SSDI Outreach, Access and Recovery (SOAR) model of benefits acquisition is an additional service provided across the state and led by DBHDS. Through a unique process of community-level collaboration with the Social Security Administration and Virginia's Disability Determination Services, the SOAR model provides homeless persons with SMI a greater chance of approval for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits. Access to Social Security benefits also provides access to medical insurance, making it more likely that PATH consumers, many of whom are medically vulnerable, can access medical treatment as well as behavioral healthcare.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

DBHDS allocates $1 million in MHBG funds each year to support two regional geriopsychiatric services initiatives, one in Northern Virginia operated by Arlington CSB and one in Hampton Roads operated by Hampton-Newport News CSB. These partnerships provide mental health services specific to older adults, including care coordination, case management, psychiatric services, screening for assisted living, and other behavioral health services to prevent institutionalization and assist the older adult to remain in their home to the extent possible. Additionally, as APAL expands to serve additional populations, geriatric mental health will be a population of focus within the next year. APAL aims to add geriatric mental health specialists, ideally including access to a PharmD to advise on medication needs specific to this population, to the case consultation line for two regional hubs within the upcoming year.

d. Please indicate areas of technical assistance needs related to this section.

None at time

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

Please refer to pages 10-33 of the 2024 DBHDS Annual Report attached with the application

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Although the pandemic has subsided, we are still navigating the system and everchanging need and workforce. At the start of the pandemic DBHDS was able to help support CSB partners with the transition to telehealth services, which had not been available in most cases statewide prior. Block grant funds aided providers in the heavy lift for telehealth allowing services to remain open and available throughout the course of Virginia's COVID-19 response. As Virginia's system of care continues to struggle to recruit and maintain workforce especially in more rural areas, the use of telehealth to maintain access for individuals who may not have transportation as well as to allow a more hybrid work environment for staff who are still struggling with childcare or care of the elderly telehealth remains an important part of the services system.

.

***Within a section of the governor's 2023 Right Help Right Now strategic plan of Virginia, developed with the goal of expanding and exploring telehealth modalities that would also benefit K-12 students in need of BH support and explore a state level contract model that local school districts could opt-in to purchase chosen telehealth modalities through the Department of Education.

***Right Help Right Now Pillar 15 #3 specifically states: "Expand tele-behavioral health access. Tele-behavioral health can provide behavioral health supports and service and decrease wait times to seek care. This initiative will assess the geographic need and broadband capabilities of communities to access tele-behavioral health. It will also assess where and how tele-behavioral health capabilities can be provided across the continuum and expand school-based tele-health services for K-12 and higher education students."

***These changes to a telehealth available system of care are still developing. Within the next few years DBHDS hopes to ensure a robust telehealth available system of care to Virginians of all ages and needs while sustaining and growing face to face care as well.

Mobile crisis services utilizing telehealth under STEP-VA are being implemented under the broader umbrella of Virginia's Crisis System transformation. Funding has been distributed regionally to form regional mobile crisis hubs, which ultimately integrate existing mobile crisis supports for individuals with developmental disabilities with STEP-VA funds for mental health and substance use crisis response in the community. Children's mobile crisis teams were prioritized in 2020 and have responded via telehealth and in person when needed throughout the pandemic and those systems continue to function. Funding for adult mobile crisis teams is becoming available this year and will be distributed in a similar manner. Recently, Virginia invested in a crisis call center data platform to support the implementation of STEP-VA as well as federal 9-8-8 legislation.

**Call centers are being implemented statewide in compliance with SAMHSA 988 guidelines and can now connect calls to mobile crisis in available regions. The goal is to continue to expand mobile crisis statewide as funding and staffing allows.

3. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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Fax (804) 371-6638
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January 1, 2024

To: The Honorable Glenn A. Youngkin, Governor
The Honorable Janet D. Howell, Chair, Senate Finance & Appropriations Committee
The Honorable Barry K. Knight, Chair, House Appropriations Committee

Fr: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

Item 311.J of the 2023 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to submit an annual report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees of the General Assembly by December 1 each year for the preceding fiscal year.

> *J. The Department of Behavioral Health and Developmental Services shall submit a report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees no later than December 1 of each year for the preceding fiscal year that provides information on the operation of Virginia's publicly funded behavioral health and developmental services system. The report shall include a brief narrative and data on the numbers of individuals receiving state facility services or CSB services, including purchased inpatient psychiatric services, the types and amounts of services received by these individuals, and CSB and state facility service capacities, staffing, revenues, and expenditures. The annual report also shall describe major new initiatives implemented during the past year and shall provide information on the accomplishment of systemic outcome and performance measures during the year.*

Subsection 12 of § 37.2-304 of the Code of Virginia establishes the annual report requirement in state statute. The section lists the duties and powers of the DBHDS commissioner.

> *12. To submit a report for the preceding fiscal year by December 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finances Committees that provides information on the operation of Virginia's publicly funded behavioral health and developmental services system. The report shall include a brief narrative and data on the number of individuals receiving state facility services or community services board services, including purchased inpatient psychiatric services;*

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the types and amounts of services received by these individuals; and state facility and community services board service capacities, staffing, revenues, and expenditures. The annual report shall describe major new initiatives implemented during the past year and shall provide information on the accomplishment of systemic outcome and performance measures during the year.

In accordance with these requirements, please find enclosed the fiscal year 2023 DBHDS annual report.

CC:
The Honorable John Littel
Susan Massart
Mike Tweedy

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Fiscal Year 2023 Annual Report

(Item 311.J)

January 1, 2024

DBHDS Vision: A Life of Possibilities for All Virginians

Preface

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Table of Contents

Introduction 3

Individuals Who Received Public Services 5

Staffing of CSBs and DBHDS 10

Funding for CSBs and DBHDS 11

New Major Initiatives and Accomplishments 12

- Administrative Services 13
- Clinical Services 16
- Community Services 18
- Facility Services 29
- Human Rights and Licensing 33

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Introduction

Virginia's public behavioral health and developmental services system provides services to individuals with mental illness, developmental disabilities, or substance use disorders through state-operated state hospitals and centers, and 39 community services boards and one behavioral health authority (CSBs).

In FY 2023, **207,092** unduplicated people received public behavioral health or developmental disability services: **206,153** unduplicated people received CSB services and **5,804** unduplicated people received services in DBHDS facilities. Many people received services from both.

CSBs are the single points of entry into public behavioral health and developmental services, including access to state facilities through preadmission screening, case management, and discharge planning for individuals leaving state facilities. While not part of the Department of Behavioral Health and Developmental Services (DBHDS), locally-operated CSBs are established in cities or counties pursuant to the Code of Virginia. DBHDS negotiates a performance contract with each CSB for the delivery of services, and provides state funds, monitors, licenses, regulates, and provides direction to the CSBs. DBHDS also licenses 1,830 private providers of behavioral health and developmental services in 10,904 locations throughout Virginia.

DBHDS operates 12 state hospitals and centers. State hospitals provide highly structured and intensive inpatient services, including psychiatric, nursing, psychological, psychosocial rehabilitation, support, and specialized programs for older adults, children and adolescents, and individuals with a forensic status. A state training center provides highly structured habilitation and residential care for individuals with intellectual disability, and a medical center provider medical services for patients in state hospitals or other centers. DBHDS also provides rehabilitation services for persons court-determined to be sexually violent predators.

State Hospitals - DBHDS operates nine state hospitals for adults: Catawba Hospital (CH) in Salem, Central State Hospital (CSH) in Petersburg, the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Eastern State Hospital (ESH) in Williamsburg, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Piedmont Geriatric Hospital (PGH) in Burkeville, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton.

State Centers - DBHDS operates Southeastern Virginia Training Center (SEVTC) in Chesapeake, Hiram Davis Medical Center (HDMC) in Petersburg, and the Virginia Center for Behavioral Rehabilitation (VCBR) in Burkeville for sexually violent predators.

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The DBHDS central office provides leadership to promote partnerships among CSBs and state hospitals and centers with other agencies and providers. The central office supports the provision of accessible and effective services by CSBs and other providers, directs the delivery of services in state hospitals and centers, protects the human rights of individuals receiving services, and assures that public and private providers adhere to licensing regulations. The DBHDS mission and vision statements are found in the image to the right:

Governor Youngkin's transformational *Right Help, Right Now* plan offers a road map to ensure every Virginian experiencing crisis, behavioral health disorders or developmental disabilities the help they need, right when they need it. The plan is carefully crafted and comprehensive, making historic investments in crisis services, growing our workforce, expanding community capacity, and innovating service delivery.

In FY 2023, DBHDS made significant strides advancing the goals of *Right Help, Right Now,* accomplished targets on its internal strategic plan to support transformation and other system modernization efforts, and completely restructured the DBHDS facility services division. Virginia's system intersects with many different facets of the Commonwealth's vast and varied service delivery system: private hospitals and health systems, Medicaid, law enforcement, education, social services, the criminal justice and courts systems, and providers, among others. DBHDS is values its many partnerships and is working hard to increase collaboration across the system of care. Although meaningful system change is challenging, Virginia is poised to support and develop tangible and achievable means to close capacity gaps, with the goal that every individual will have access to the quality services they need, regardless of where they live.

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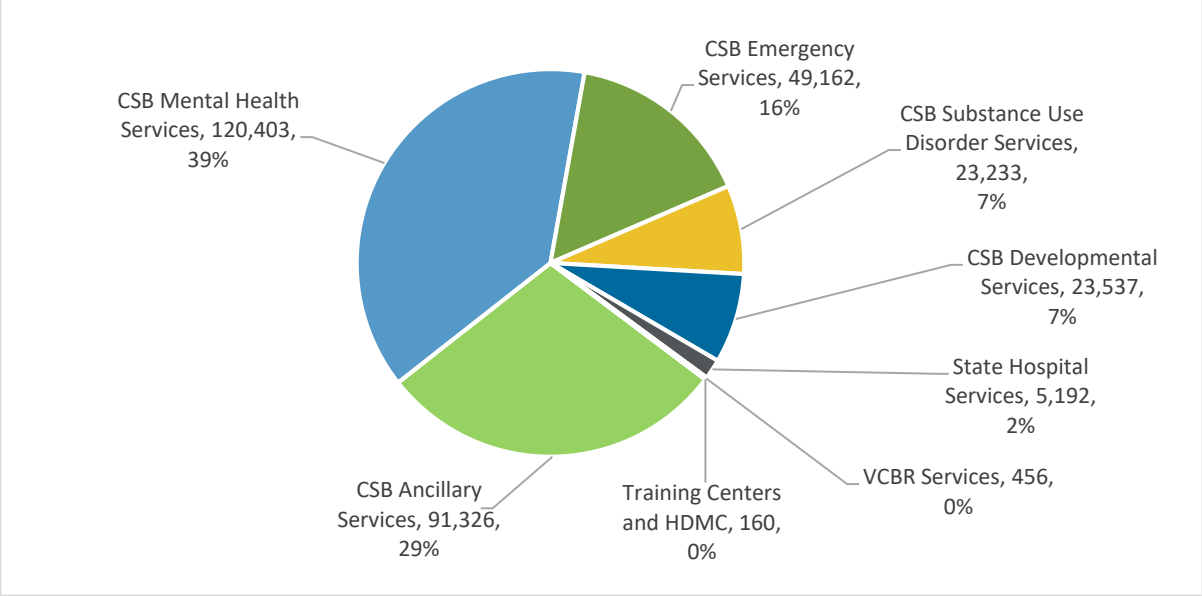
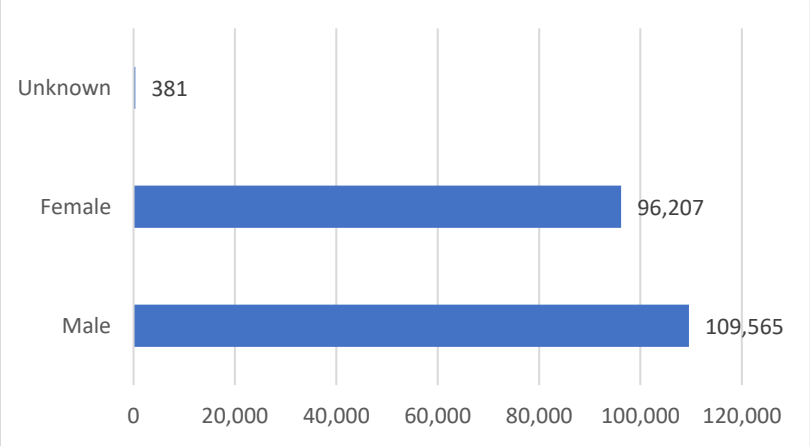
Individuals Who Received Services

In FY 2023, **207,092** *unduplicated* people received public behavioral health or developmental disability services: **206,153** unduplicated people received CSB sesrvices and **5,804** unduplicated people received services in DBHDS facilities. Many people received services from both. **CSBs served 307,661 people across behavioral health, developmental disability, emergency and ancillary services**. Ancillary services are motivational treatment, consumer monitoring, early intervention, and assessment and evaluation. Appendix A provides numbers of people who received services in each core service from CSBs or state hospitals and centers. The image below shows the numbers of individuals who received services from CSBs or state hospitals and centers during FY 2023.

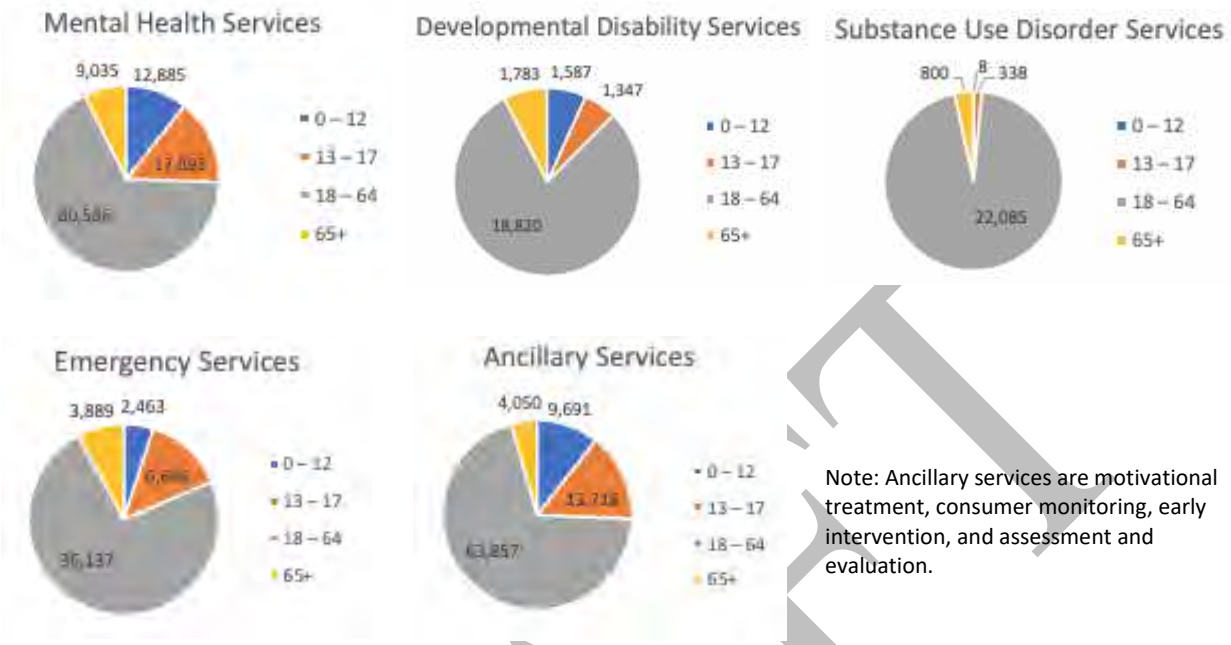


The following charts show more information about the individuals served by CSBs across the Commonwealth.

Gender of individuals receiving CSB services in FY 2023

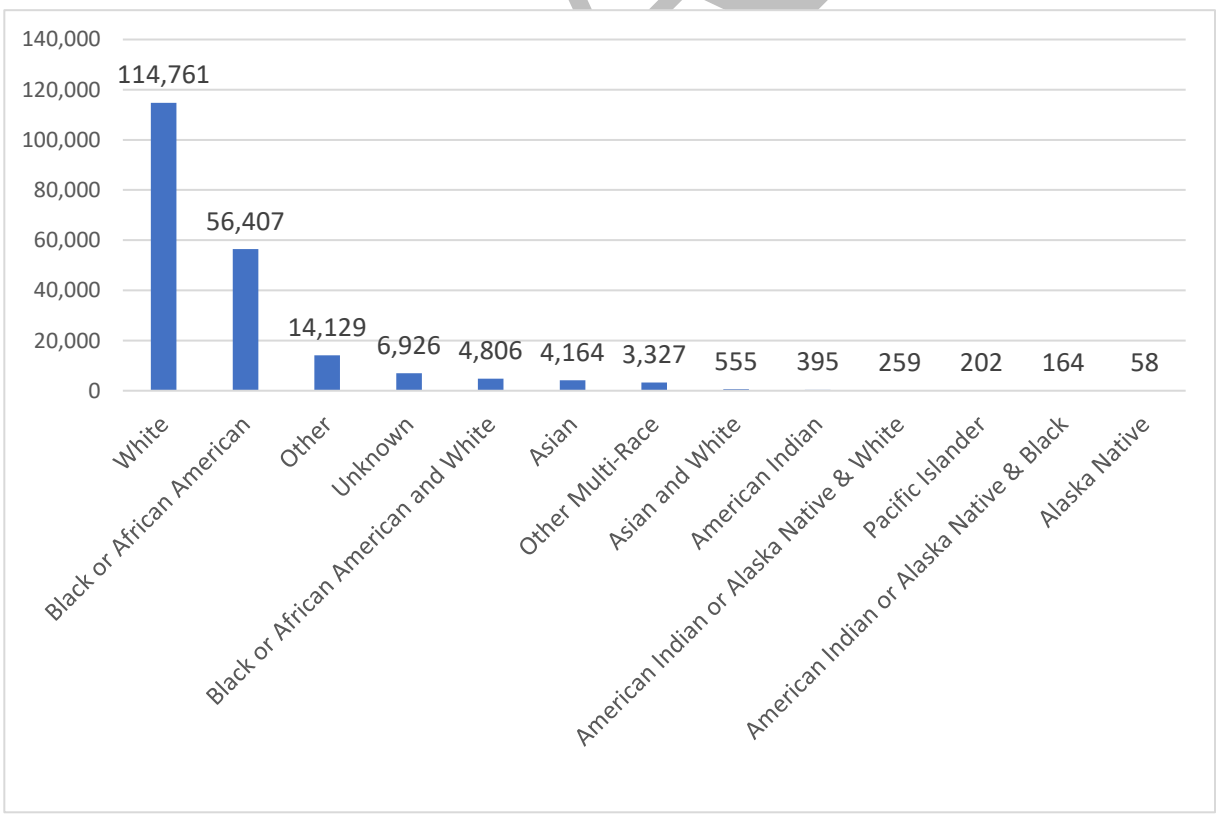


Age by CSB service area in FY 2023



Note: Ancillary services are motivational treatment, consumer monitoring, early intervention, and assessment and evaluation.

Races of individuals receiving CSB services in FY 2023



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The chart below shows the individuals who received services in each core service from CSBs or state facilities. It displays numbers for emergency and ancillary services and for the mental health (MH), developmental (DD), and substance use disorder (SUD) services program areas, and the total numbers of individuals receiving a core service across the three program areas.

Individuals Who Received CSB or State Facility Services in FY 2023		
Total Emergency Services	**52,543**	Community Consumer Submission 3 (CCS 3) does not include data on individuals in consumer-run services, so other tables do not include them. CARS collects a count of participants; in this FY, 4,873 individuals participated in these services.
Motivational Treatment Services	2,873	
Consumer Monitoring Services	16,928	
Early Intervention Services	2,292	
Assessment and Evaluation Services	80,130	
Total Ancillary Services	102,223	

Services Available in Program Areas	**MH**	**DD**	**SUD**	**Total[2]**
CSB SUD Inpatient Medical Detox Services			501	501
CSB MH or SUD Inpatient Services (LIPOS)	748		65	812
Total CSB Inpatient Services	**748**		**557**	**1,303**
Training Center ICF/ID Services		69		69
State Hospital ICF/Geriatric Services	412			412
State Hospital Acute Psychiatric Inpatient Services	3,331			3,331
State Hospital Extended Rehabilitation Services	1,520			1,520
State Hospital Forensic Services	1,038			1,038
HDMC				91
VCBR				456
Total State Facility Inpatient Services	**5,739**	**69**		**5,804**
Outpatient Services	55,683	15	15,910	68,973
Medical Services	74,360	187	2,275	76,358
Intensive Outpatient Services			2,867	2,867
Medication Assisted Treatment			4,878	4,878
Assertive Community Treatment	3,528			3,528
Total Outpatient Services[1]	**104,081**	**202**	**20,395**	**117,087**
Total Case Management Services	**57,200**	**21,658**	**7,627**	**84,803**
Day Treatment or Partial Hospitalization	1,124		133	1,126
Rehabilitation or Habilitation	2,531	2,072		4,597
Total Day Support Services	**3,614**	**2,072**	**129**	**5,809**
Sheltered Employment	7	329		335
Individual Supported Employment	1,056	1,015	43	2,108
Group Supported Employment	4	368		372
Total Employment Services	1,067	1,624	43	2,727
Highly Intensive Residential Services	80	252	1,448	1,780
Residential Crisis Stabilization Services	2,253	210	63	2,499
Intensive Residential Services	215	517	1,044	1,773
Supervised Residential Services	1,147	466	379	1,989
Supportive Residential Services	3,433	657	50	4,132
Total Residential Services	**6,825**	**2,052**	**2,514**	**11,187**

Notes: *1) The DBHDS data warehouse identifies uniquely each individual who receives services. These are unduplicated: If someone received services at more than one CSB or at CSBs and state facilities, the individual is counted once. 2) Individuals in Figure 1 total more than the unduplicated number of individuals because many received services in multiple areas.*

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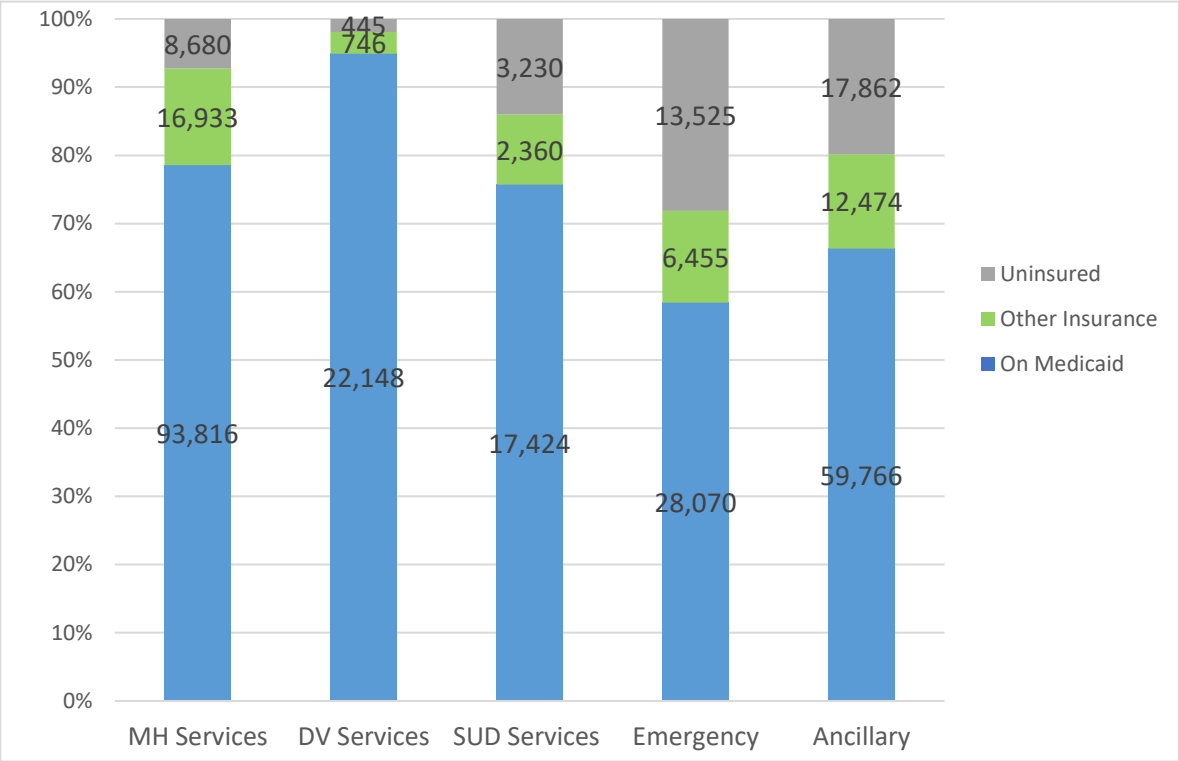
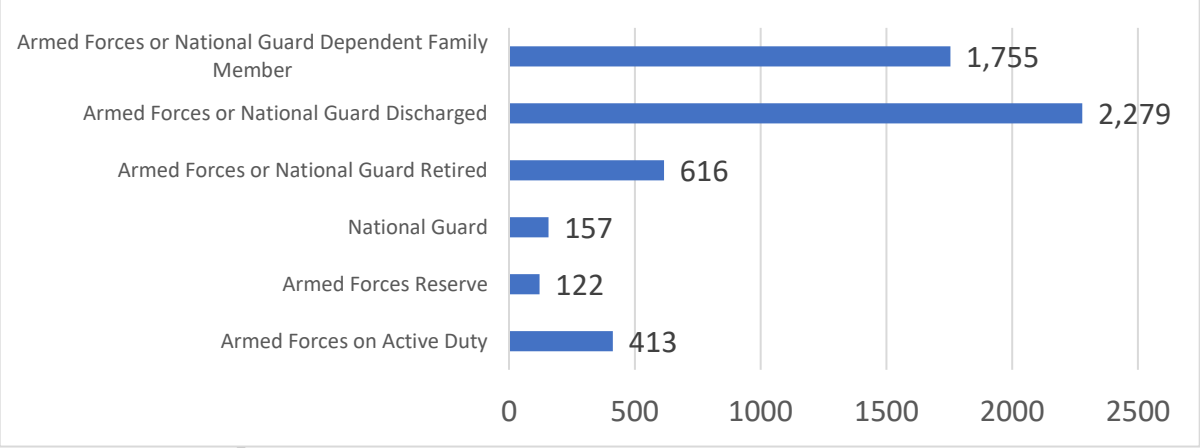
Individuals enrolled in Medicaid or uninsured who received CSB services in FY 2023



Military status of individuals receiving CSB services in FY 2023



Residential status for individuals who received CSB mental health, developmental, substance use disorder, or emergency services in FY 2023

Residential Status	MH	DV	SA	ES
Private Residence/Household	97,416	16,317	18,406	3,0003
Homeless/homeless shelter	8,142	1,112	1,049	11,708
Veterans Health Administration	2,701	274	851	2,312
Community Residential	1,970	3,772	158	416
Local Jail/Correctional Facility	1,592	9	783	1,595
Licensed Home for Adults (CSB or non-CSB)	2,087	576	23	443
Shelter	781	20	269	393
Boarding Home	465	118	118	146
Foster Home/Family sponsor	833	755	10	179
Residential Treatment/ Alcohol and Drug Rehabilitation	467	123	274	227
Inpatient Care	311	29	17	427
Nursing Home/Physical Rehabilitation	231	100	4	150
State Correctional Facility	231	100	4	150
Juvenile Detention Center	348	2	10	53
Other Institutional Setting	193	134	29	71
Adult Transition Home	129	5	96	53
Other Residential Status	13,554	1577	3,028	14,990

Employment status for individuals who received CSB services in FY 2023

Employment Status	MH	DD	SUD	Emergency	Ancillary	Undupl.
Total Adults (18+) Who Received Services	89,621	20,603	22,885	40,026	67,907	160,564
Employed Full Time (35+ hr./wk.)	12,765	266	6,040	4,137	12,040	22,540
Employed Part Time(<35 hr./wk.)	9,375	1,503	2,519	2,388	65,88	14,360
In Supported Employment	399	1,072	31	80	415	1,365
In Sheltered Employment	186	470	23	29	144	551
Total Adults Employed	**22,725**	**3,311**	**8,613**	**6,634**	**19,187**	**38,816**
Unemployed	14,769	1,617	6,678	6,101	13,382	24,953
Not In Labor Force: Homemaker	1,358	22	240	309	671	1761
Not In Labor Force: Student/Job Training	6,026	2,848	265	2,009	4,895	11,476
Not In Labor Force: Retired	2,390	301	308	1,031	1,505	3,810
Not In Labor Force: Disabled	24,961	6,908	2,587	5,604	10,317	33,649
Not In Labor Force: Institution or inmate	3012	886	858	2,869	4,155	7,706
Not In Labor Force: Other	8,814	3,782	1,987	2,786	5,323	14,788
Total Adults Unemployed	**61,330**	**16,364**	**12,923**	**20,709**	**40,248**	**98,143**
Unknown	1,584	140	572	2,565	1,618	4,597
Not Collected	3,982	788	777	10,118	6,854	19,008

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Specialized Initiatives

Individuals Who Received Services in Specialized Initiatives in FY 2023	
Medicaid Developmental Disability (DD) Waiver Services	16,324
Developmental Enhanced Case Management (ECM) Services	6,456
Substance Use Disorder Medication Assisted Treatment (MAT)	3,408
Mental Health Child and Adolescent Services Initiative	2,630
Program of Assertive Community Treatment (PACT)	2,468
Mental Health Services for Children in Juvenile Detention Centers	2,024
Projects for Assistance in Transition from Homelessness (PATH)	1,410
Discharge Assistance Program (DAP)	1,306
Project LINK	1,237
Mental Health Mandatory Outpatient Treatment (MOT) Orders	235
Substance Use Disorder Recovery Support Services	754

Staffing of CSBs and DBHDS

The staffing data below is expressed as numbers of full time equivalents (FTEs).

	Direct Care Staff	Peer Staff	Support Staff	Total Staff
DBHDS Staff				
DBHDS Central Office (CO)	22	2	497	521
State Hospitals	2,290	6	1,472	3,804
Training Centers	152	0	150	302
HDMC	126	0	48	175
VCBR	251	0	305	320
Total State Hospital and Center and CO, FY 2023	**2,841**	**8**	**2,472**	**5,122**
CSB Staff				
CSB Mental Health Services	4,393	184	74	5,322
CSB Developmental Services	2,950	16	379	3,345
CSB Substance Use Disorder Service	1,182	112	270	1,564
CSB Emergency & Ancillary Service	1,074	64	173	1,311
CSB Administration	0	0	1,582	1,582
Total CSB FY 2023	**9,599**	**376**	**3,148**	**13,123**

Notes: *A full-time equivalent is not the same as a position; a 20-hour/week part-time position is one position but ½ FTE. FTEs are a more accurate indicator of available personnel resources. Peer staff receive or have received services and are employed as peers to deliver services. Only FTEs in programs CSBs directly operate are included; contract agencies are not represented.*

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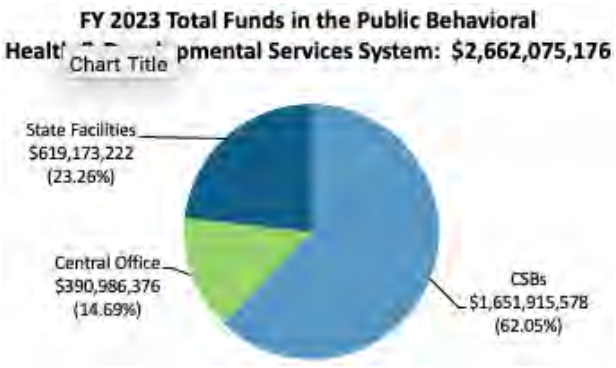
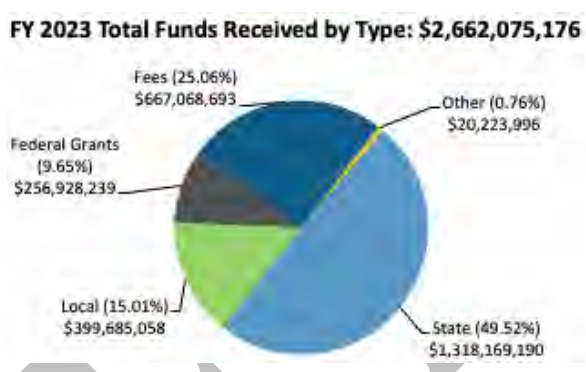
Funds Received by CSBs and DBHDS

The charts below shows the total funds in Virginia's public system, and the funds received for by type. Fees include Medicaid payments, which consist of federal and state funds. DBHDS submits a separate report on Part C services to the General Assembly.



FY 2023 Total Funds in the Public Behavioral Health & Developmental Services System: $2,662,075,176



FY 2023 Total Funds Received by Type: $2,662,075,176

The tables below display the funds from all sources reported by CSBs and state facilities. CSBs reported receiving more than $1.6 billion from all sources to provide community services. For the CSBs, local funds include local government appropriations, charitable donations, and in-kind contributions. The localities that established the 40 CSBs provide the majority of local funds. Fees include Medicaid, Medicare, private insurance payments and payments from individuals. Other funds include workshop sales, retained earnings, and one-time funds.

FY 2023 CSB Funds Received by Program Area

Funding Source	Mental Health Services	Developmental Services	Substance Use Disorder Services	Total Funds	Percent of Total
State Funds	$424,143,184	$50,386,700	$71,654,561	$546,184,445	33.06%
Local Funds	$215,976,983	$127,550,676	$56,157,399	$399,685,058	24.20%
Medicaid Fees	$211,546,764	$258,181,910	$28,135,467	$497,864,141	30.14%
Other Fees	$46,990,588	$16,987,668	$7,920,217	$71,898,473	4.35%
Federal Funds	$48,394,404	$1,074	$68,879,320	$117,274,797	7.10%
Other Funds	$11,049,433	$2,418,620	$5,540,611	$19,008,664	1.15%
Total Funds	$958,101,356	$455,526,648	$238,287,575	$1,651,915,579	100.00%
Percent of Total	58.00%	27.58%	14.42%	100.00%	

FY 2023 State Facility Funds Received by Type of State Facility

Funding Source	State Hospitals	Other State Facilities[1]	Training Center	Total Revenues	Percent of Total
State General Funds	$445,822,438	$62,948,867	$4,870,605	$513,641,910	82%
Federal Funds	$17,509,635	$6,928,391	$1,936,775	$26,374,801	4%
Medicaid	$11,078,459	$16,426,289	$28,368,689	$55,873,437	9%
Medicare	$12,624,593	$345,967	-	$12,970,560	2%
Commercial Insurance	$11,260,614	$7	-	$11,260,621	2%
Private Payments	$2,547,842	$293,938	$636,449	$3,478,229	1%
Other Revenues	$1,031,512	$12,750	$43	$1,044,305	0%
Total Revenues	**$501,875,093**	**$86,956,209**	**$35,812,561**	**$624,643,863**	**100%**

[1] *Other State Facilities are HDMC and VCBR.*

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Expenditures by CSBs and DBHDS

The tables below show expenditures reported by CSBs, state facilities, and central office. **About 65 percent of central office funds are spent on contracts for community services.**

Figure 20: FY 2023 CSB Expenditures by Program Area				
	Mental Health Services	Developmental Services	Substance Use Disorder Services	Total Expenditures[1]
CSB Services	$811,811,549	$416,830,603	$211,393,227	$1,440,035,379
Percent of Total	56.37%	28.95%	14.68%	100.00%

[1] This figure includes $193,148,933 for CSB administrative expenses, 13.41 percent of the total CSB expenditures.

FY 2023 State Facility and Central Office Expenditures		
	Expenses	Percent of Total
State Hospitals	$500,959,153	62%
Other State Facilities[1]	$86,016,807	11%
Training Centers	$31,449,931	4%
Central Office	$183,692,580	23%
Total Expenditures	$**802,118,471**	100%

[1] Other State Facilities are HDMC and VCBR.

Major New Initiatives and Accomplishments

FY 2023 marked major progress and development across DBHDS.

Most importantly, an unprecedented level of support from Governor Youngkin to transform Virginia's behavavioral health and developmental services led to an announcement of his multi-year *Right Help, Right Now* plan along with $230 million plan to address gaps in how the state cares for adults and children facing behavioral health disorders in year one. *Right Help, Right Now* is a comprehensive and carefully crafted plan to address Virginia's behavioral health challenges through initiatives that ensure better crisis care access, reduce law enforcement burdens, provide substance use disorder support, strengthen the behavioral health workforce, and deliver service innovations.The Governor's plan will give Virginians someone to call, someone to respond, and a place to go, and allow them to get critical help closer to home. In FY 2023, staff throughout DBHDS and multiple agencies and stakeholders worked hard ensure the success of *Right Help, Right Now.*

In addition, in FY 2023, DBHDS advanced implementation of its strategic plan to 1) strengthen the workforce systemwide, 2) expand the comprehensive continuum of care, and 3) modernize DBHDS business systems and processes. DBHDS launched a public dashboard to allow internal and external stakeholders track progress on achieving strategic plan goals. The dashboard can be found at dbhds.virginia.gov/about-dbhds/strategic-plans.

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In early FY 2023, DBHDS Commissioner Nelson Smith announced a new organizational structure to fortify DBHDS' position for transformational success, improve internal operations, better support staff, and help achieve a strong customer service focus both internally and externally. Changes included creating a new Chief of Staff position, moving all crisis-related services under a new Assistant Commissioner, adding a new workforce position, and strengthening marketing and communications capabilities.

Additionally, the Commissioner restructured the Facility Services division to support the operation of the 12 state facilities as a high-performance hospital system to deliver care that is high quality, efficient, and coordinated to meet current and future challenges. The new structure will allow the state facilities to operate as a high-performance hospital system in the delivery of quality, recovery-focused, person-centered behavioral health and developmental services as part of Virginia's continuum of care. The 12 state facilities are now operating as one system with standardization across all workflows and functions. The new structure is ensuring economies of scale and increased productivity by identifying inefficiencies, maximizing revenue generation across all settings, and producing data-driven performance reports to better support decision making and resource requests.

Throughout FY 2023, DBHDS prioritized *Right Help, Right Now* efforts, made critical strategic plan implementations, underwent significant organizational restructuring, particularly for Facility Services, modernized the way crisis services are delivered, developed the capacity for continued progress throughout the system of care, and continued to make meaningful progress in exiting the DOJ settlement agreement and developing the DD system Virginians deserve.

The following sections describe major new initiatives and accomplishments throughout DBHDS Central Office and facilities during FY 2023.

Administrative Services

Human Resources Management

DBHDS continued to integrate human capital policies, programs, and practices into human resources management. This includes expanding learning management opportunities, developing additional career pathways, enhancing recruitment and retention strategies, evaluating compensation tools, and succession planning. Initiatives and accomplishments include:

- Developed a DBHDS workforce planning framework, an internal Workforce Steering Committee, and an external behavioral health workforce collaborative to improve workforce development.
- Created HR dashboards to help streamline reporting for vacancies, disciplinary actions, hires/transfers, workers compensation.
- HR has successfully implemented a new recruitment management system, Page Up, and was able help navigate this change with minimal effects on the recruitment results.
- Worked with DHRM to change the pay bands of Counselor I roles from a pay band 3 to a pay band 4; and the Counselor II role from a pay band 4 to a pay band 5. This creates a social work and counseling career ladder that is similar to nursing.

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- Increased Direct Service Associates (DSAs) from 1509 to 1669, a net increase of 160 employees; Increased overall nursing headcount from 691 to 700, a net gain of 9, and increased the Security headcount from 212 to 254, a net gain of 42 employees.
- SystemLEAD, a long-term organizational strategy, clearly defines a leader's roles, abilities, and pathway to improvement. DBHDS offers this nine-month program annually. There were 24 employees who started SystemLEAD in FY 2023. Since the start of the program in 2015, 227 people have participated in the SystemLEAD programs.
- The Virginia Public Sector Leadership VPSL Certificate program is a leadership development program of Virginia Tech. DBHDS staff members completed a total of 98 VPSL Certificates in FY 2023. Of that total, 51 completed VPSL I, 25 completed VPSL II and 22 completed VPSL III. The cumulative total of VPSL certificates completed by DBHDS employees since the start of the program in 2015 increased to 799 of which 447 are VPSL I, 232 VPSL II and 120 VPSL III certificates.

Information Technology/Security

DBHDS Information Technology made significant progress during FY 2023 towards IT modernization. The organization is actively working to establish a Data Governance Model, a solicitation for a new Enterprise Data Warehouse and a timeline of adherence to these new principles within the next two years. With the introduction of Data Governance, the agency will have guidelines it can provide to vendors who provide IT solutions to the agency so that adherence to data validity standards, modern interfaces and a trustworthy Data Warehouse can become reality. The office has continued to deliver on a wide variety of initiatives including:

- Overall modernization of IT Solutions: the number of applications in the IT Portfolio was reduced to fewer than 100. New procurements will continue to drive modernization in the overall IT environment with a continued focus for Facility IT solutions to be Enterprise vs. Individual facility focused.
- Website redesign (all facility websites are now incorporated within a comprehensive agency website).
- Versatrack critical environment monitoring solution for DBHDS facilities.
- Migration to a single data analytics tool (PowerBI) from four different reporting solutions.
- Procurement of a new facilitywide nutrition system (CBORD).
- Migration to the MS Outlook solution.
- Implemented Electronic Mortality Review Application.
- Implemented a new Policy Management solution.
- Migrated the old Forensic IT Solution from MS Access to be fully integrated with DBHDS' Electronic Health Care record system.

Numerous enhancements were also completed by the Electronic Health Record Team (EHR) in response to requests from facilities. Examples are listed below:

- Built and implemented a new Forensic Information Management System (FIMS) application that replaced the legacy standalone application.
- SynMed Pharmacy Automation integration with the Millennium EHR at Virginia Center for Behavioral Rehabilitation (VCBR) and Piedmont Geriatric Hospital (PGH).
- Oracle 19C Upgrade – Best practice platform upgrade.

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- Train Domain Rebuild – Refresh of the train domain to mimic production environment.
- Learning Framework Portal – Learning Management System for Millennium EHR Users at all facilities.
- 67 percent increase in Millennium Lights On® EHR metric dashboard usage (indicates improved facility interest and involvement).

Internal Audit

- Five facility audits, primarily in administrative areas, including Human Resources, Payroll, Procurement, Accounts Payable, Financial Reconciliation and Fixed Assets.
- Audit reviews are based on the DBHDS policy requirements, facility policies & procedures and state requirements including DHRM, APSPM and CAPP manual.
- Eight IT system security audits and one facility physical security control audit.
- Four CSB audits: Each audit consists of 17 areas of programmatic and administrative review, largely tied to expectations outlined in the Performance Contract.
- Nine virtual CSB follow-up reviews and three facility follow-up reviews. These reviews focus on areas where there are findings from previous years that have yet to be resolved:
    - 34 of 50 (68 percent) findings reviewed during the CSB follow up reviews have been corrected and corresponding recommendations were implemented.
    - 33 of 49 (67 percent) findings reviewed during the facility follow up reviews have been corrected and corresponding recommendations were implemented.

The following table depicts the audit and investigation results during FY 2023:

FY2023 Facility Audit Summary Results	
Number of Findings	85
Number of Recommendations for Improvement	199
Number of Commendations Written	1
FY2023 CSB Audit Summary Results	
Number of Findings	44
Number of Recommendations for Improvement	73
Number of Commendations Written	28
FY2023 Follow up Review Results	
Number of findings reviewed	99
FY2023 Information Technology Audit Summary Results	
Number of Findings	122
Number of Recommendations for Improvement	176
Number of Commendations Written	2
FY 2023 Special Investigations and Projects	
Number of Findings	9
Number of Recommendations for Improvement	9
Number of Commendations Written	0
Other Results	
OSIG Fraud, Waste, and Abuse Hotline Reports Issued	12

DRAFT

Procurement and Administrative Services

- Executed and managed 309 contracts totaling more than $204 million of contractual obligations on behalf of DBHDS.
- Provided procurement and administrative support for newly organized Opioid Abatement Authority (OAA) and Health and Human Resources Secretariat.
- Initiated critical enterprise solutions solicitations for Incident Management System and Enterprise Data Warehouse.
- Consolidated procurement records into one source, eliminating outdated Access database.
- Developed active contract listing; to be used to track renewals, obligations, and source data for import for tracking expenditures in planned financial solutions.
- Finalized eVA transition to new eVA procurement platform for agency records.

Diversity, Opportunity and Inclusion

The DBHDS Office of Diversity Opportunity and Inclusion implemented initiatives with a continued focus on bolstering workforce development, community engagement partnerships and health equity advocacy during FY 2023. Accomplishments included:

- Provided and sponsored trainings to promote inclusive workplace cultures that embrace global diversity, while also enhancing accessible, respectful patient care.
- Supported the successful planning and implementation of a Behavioral Health Tech Certification program in partnership with Germanna Community College, the Rappahannock Community Service Board (CSB) and other statewide leaders. The certification program initiated its first cohort of participants in FY 2023. It is a model "learn and earn" program providing students opportunities for clinical and workforce experiential learning, healthcare credentialing and facilitates employment within behavioral healthcare environments.

Clinical and Quality Management

The Division of Clinical and Quality Management provides cross disability clinical and technical expertise and support across all program areas of the agency, to aid in leading system-wide transformation and enhance cross disability collaboration. The aim of the division is to support the agency in ensuring that all individuals receive high quality care and integrates evidence-based practices and data driven decision making to inform behavioral health and developmental disability policy and identify opportunities and implement solutions for system enhancement.

Clinical Quality Management and Community Quality Improvement

- Cross-Disability Quality Management – Provided technical assistance to over 60 CSBs, licensed service providers, and DBHDS central office personnel across 600 instances of technical assistance throughout the year. Developed and distributed an array of resources to help enhance DBHDS employee, CSB, and licensed provider quality improvement process and procedural knowledge and skills. Expanded the *Consultation and Technical Assistance* (CTA) pilot project to include an additional 35 licensed DD service providers. This project increased compliance with licensing requirements for monitoring and evaluating service quality (2VAC35-105-620 C.2) among participating providers.

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- DD Quality Management System – Implemented 31 statewide and regional quality improvement initiatives. Tracked and analyzed data for over 26 performance measure indicators for health, safety, well-being, community inclusion and integration of individuals receiving DD waiver services, as well as DD service provider competency and capacity.
- DD Services Quality Reviews – DBHDS partnered with VCU Project Living Well to conduct over 700 National Core Indicator (NCI) interviews with individuals receiving DD waiver services. NCI are standard measures used across states to assess the outcomes of services provided to individuals and families.
- Regional Quality Councils (RQC) – RQC membership and DBHDS subject matter experts devoted over 1030 hours to meetings, orientation, and training. Hosted 90 presentations related to KPAs (Key Performance Areas) and PMIs (Performance Measure Indicators) (SMEs) to aid RQCs analyzing data, identifying trends, and making recommendations for improvement in their regions. BHDS and the VCU Partnership for People with Disabilities co-sponsored the RQC Summit with participation from 102 RQC members.
- Behavioral Health (BH) Quality Management – The core infrastructure for the BH Quality Management System was developed and implemented, including the establishment of the BH Quality Improvement Committee, the BH Risk Management Review Committee, and the BH Key Performance Area Committee.

Mortality Review
The Mortality Review Committee reviewed 396 deaths of the 416 that occurred, a 4.7 percent increase in deaths reviewed from FY 2022.

Quality Assurance and Healthcare Compliance
Conducted first systemwide compliance assessment, through the newly restructured Office of Quality Assurance and Healthcare Compliance. Five focus areas were evaluated to identify opportunities for enhancement and gaps in current DBHDS establishment and oversight of processes, procedures, protocols, and tools: 1) DI/Policy & Procedure Management Process, 2) Virginia Administrative Code (VAC) Regulatory Process Review, 3) Complaint Process Review, 4) External Reviews Process, 5) Identify Baseline Compliance Measures.

Pharmacy Services
Provided clinical support across multiple DBHDS programs to enhance clinical cost effectiveness, technical advancements (through pharmacy automation), cost savings access to necessary therapeutics, and clinical decision support tools to support the safe and effective use of medical and psychiatric medications.

- Established 24/7 medication access in DBHDS licensed crisis programs by securing necessary approval from the Va. Board of Pharmacy, securing sole source approval, and assisting with the establishment of a statewide contract to secure access to automated dispensing technology in DBHDS crisis settings.
- Coordinated with community programs to provide Naloxone nasal spray to Revive training participants. Over 500 units of naloxone nasal spray have been distributed to Revive trained participants, at community health clinics in the southwestern Virginia.

COVID-19 Mitigation Team
The focus of this team over the past year was to 1) Develop expertise in public health and

Printed: 8/1/2025 4:14 PM - Virginia - OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

infection prevention within the behavioral health system; 2) Integrate infection prevention and control principles specific to the behavioral health settings; 3) Support full re-opening of behavioral health services post-pandemic while implementing sound health and safety practices.

Community Services

Behavioral Health Community Services

System Transformation Excellence and Performance (STEP-VA)

DBHDS continued working with the Administration, the General Assembly, and stakeholders to implement STEP-VA, an initiative that features a uniform set of services with consistent availability and improved oversight of services across all Virginia communities. A full annual report on STEP-VA implementation is provided to the General Assembly each November. Some highlights from the FY 2023 STEP-VA report include:

- Same Day Access – There were 51,568 Same Day Access assessments completed and 82 percent of those needing follow-up services after the assessment kept that first appointment within 30 days (up from 80 percent in FY 2022).
- Primary Care Screenings – A total of 72,814 primary care screenings were conducted for 32,868 individuals. A total of 33,823 metabolic screens were conducted for 13,008 individuals.
- Outpatient Services – The Columbia suicide screening was implemented for all individuals receiving mental health and substance use services. In FY 2023, 74 percent of children ages 6 to 17 received a screening (up from 65 percent in FY 2022) and 71 percent of adults received a screening (up from 61 percent in FY 2022). Also, of the 2,072 eligible staff, 1,958 met the minimum eight-hour trauma training requirement (93 percent), which is a significant increase from the previous year (79 percent).

Implementation follows a three-phase approach, with phase one representing the initial stage and phase three representing full implementation:

STEP	Phase 1 CSBs	Phase 2 CSBs	Phase 3 CSBs
Same Day Access	0	0	40
Primary Care Screening	0	0	40
Outpatient Services	0	0	40
Crisis Services	0	0	40
SMVF (Veterans)	0	0	40
Peer and Family Supports	0	40	0
Case Management	0	40	0
Psychiatric Rehabilitation	0	40	0
Care Coordination	0	40	0

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Community Adult Behavioral Health Services

- Coordinated Specialty Care – CSC is a team-based, collaborative, recovery-oriented treatment model that emphasizes outreach to identify and engage people experiencing a first episode of psychosis into treatment. An additional CSC program was added in FY 2023 to Virginia's behavioral healthcare system, bringing the total number of CSBs offering this service to 11.
- Assertive Community Treatment (ACT) – ACT is an evidence-based practice proven to improve outcomes for people with severe mental illness. The program consists of a self-contained trans-disciplinary team. Treatment is assertive in that the team is proactive and persistent in efforts to engage individuals and retain them in services. Virginia operates 41 ACT teams with 26 CSB teams and another six teams operated by non-CSB providers. DBHDS reported the following from a two-year pre/post study for ACT in FY 2023:
    - The average cost per individual served by ACT teams in FY 2022 was $15,453, representing a consistent trend with the previous fiscal year.
    - State hospitalization usage for all ACT-served individuals admitted in FY 2020 was reduced by 42 percent, a cost avoidance of $11,484,010 for this population.
    - All new FY 2020 ACT-served individuals accounted for 24,091 state hospital bed days in the two years prior to ACT admission, and just 13,873 in the two years post admission.
    - Across the FY 2016 to FY 2020 cohorts, ACT contributed to an overall cost avoidance of $55,064,180 in state hospital costs in the two years following initiation of ACT services.
    - Local psychiatric hospitalization utilization for all ACT-served individuals admitted in FY 2020 had a 43 million reduction, a cost avoidance of $2,938,996 for this population.
    - Across the FY 2016 to FY 2019 cohorts, the ACT program contributed to an overall cost avoidance of $2,929,363 in jail costs in the two years post initiation of ACT services.

Community Child and Family Behavioral Health Services

The Virginia Mental Health Access Program (VMAP)

- Continues to operate fully staffed regional hubs providing behavioral health consultation and care navigation services to the region's primary care providers (PCPs) who treat children and adolescents (North, East, Central, West, and Southwest).
- To date the VMAP line completed 2,799 mental/behavioral health consultations, 2,036 care navigation requests and has served 3,360 Virginia pediatric patients.
- VMAP began adding multiple early childhood physicians (e.g. early childhood child and adolescent psychiatrists, developmental/behavioral pediatricians) to the VMAP line. These early childhood physicians are available to consult with PCPs on patients aged 0-5 (8 percent of calls in 2022).
- Data specialists and evaluators were hired to support an increase in analysis demands and to demonstrate the impact of VMAP across Virginia. Transitioned all data collected for the VMAP Line to a Customer Relations Management platform that allows real-time program management, data visualization, and reporting in 2022.

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Early Intervention/Part C

- Early Intervention's six-year State Systemic Improvement Plan focuses on improving positive social-emotional skills for infants and toddlers.
- Served 23,139 infants and toddlers in FY 2023 through Early Intervention/Part C. This is an increase of almost 10 percent over the previous year.
- Awarded school-based mental health grants to six school divisions.
- Funded two CSBs to provide one-time start-up funds to expand or establish comprehensive treatment and recovery services for adolescents ages 12-18 with substance use disorders (SUDs) and/or co-occurring disorders (CODs), and their families.
    - Region 5 will provide an ASAM Level 2.1 Intensive Outpatient Service for adolescents.
    - Region 3 will provide and ASAM Level 3.7 Medially Monitored High-Intensity Inpatient Service for adolescents.

Behavioral Health Wellness and Suicide Prevention

Mental Wellness Community Trainings

- Lock and Talk Virginia Lethal Means Safety Initiative – Lock and Talk promotes safe and responsible care of lethal means while encouraging community conversations around mental wellness and suicide prevention.Over 18,000 medication safety devices and over 17,500 gun locks were distributed with education across all 40 participating CSBs this year.
- Applied Suicide Intervention Skills Training (ASIST) – ASIST helps caregivers recognize risk for suicide, intervene to prevent immediate harm and link persons at risk to the next appropriate level of care. Trained 747 individuals in ASIST in FY 2023 (increased from 138 trained last year) bringing total individuals trained up to 4,730 since 2015.
- SafeTALK (Suicide Alertness for Everyone) – SafeTALK increases participants awareness of suicide and preparedness to connect individuals with suicidal thoughts appropriate resources. Trained 3,022 individuals in SafeTALK (increase from 205 trained last year) bringing the total trained to 5,766 individuals since 2015.
- Mental Health First Aid (MHFA) – Trained 7,565 individuals in MHFA bringing the total number trained up to 93,717 since 2014. MHFA is available in-person and virtually.

Behavioral Health Equity

- Language Access – Developed a system for DBHDS and CSB staff to request translations by DBHDS or CSB staff step-by-step guides. Created educational materials defining language access and reviewing legal requirements.
- Awarded over $350,000 in behavioral health equity grants for the 2023 cycle to ten CSBs and 16 community organizations.
- Collaborated with VCU to create the Virginia Wellbeing Dashboard to visualize the behavioral health index and the social determinants of behavioral health.
- Virginia Refugee Healing Partnership – Provided 11 mini-grants for youth substance use prevention training for refugees and immigrants. Conducted a statewide needs analysis survey on refugees. Led training on trauma-informed care for 39 facilitators and 216 community members and translated the module into multiple languages. Completed behavioral health interpreter training with 741 successful participants to date.

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Adverse Childhood Experiences (ACE) & Trauma Informed Care

- Delivered 412 ACE presentations to 6,315 participants. Led three presenter cohorts training a total of 38 new facilitators across the state to deliver the ACE Interface curriculum.
- Provided financial support to The United Way of Southwest Virginia for its Trauma-informed Schools Pilot program.
- Supported VDOE in their Peer Support School Pilot program in Fairfax County, providing education and program development on trauma-responsive approaches to social connection and youth mental health prevention.
- Funded Lift Up Virginia platform focusing on capturing and recording the growth of community resilience across the state.

Problem Gambling Prevention

- Formed and hosted the first two meetings of the new Problem Gambling Treatment and Support Advisory Committee composed of state government and community stakeholders.
- Of the total $2,000,378 budget allocation for problem gambling services half ($1,000,189) was dedicated to prevention and half ($1,000,189) to treatment and recovery services. Prevention spent 91 percent of its budget allotment and Treatment/ Recovery spent 30 percent of its allotment.
- All 40 CSBs have disseminated information on safer gambling practices, preventing underage gambling, and problem gambling. 20 CSBs have added problem gambling merchant education to their strategic plans and are currently in process of implementation.

Synar

The federal Synar Amendment requires states to have laws prohibiting the sale and distribution of tobacco products to minors.

- There were 2,454 store assessments conducted by the CSBs. This represents 34 percent of Virginia's retailers.
- 721 retailers, from a statewide, random sample of 834, received a Synar compliance check resulting in a Retailer Violation Rate (RVR) of 16.5 percent. This is down by 1.8 percent from the previous year.

Youth Cannabis Use Prevention

- In FY 2023, 17 CSB prevention teams implemented 54 marijuana-focused activities with a reach of 808,516 adults and 49,518 youth.
- Convened a Youth Cannabis Advisory Workgroup to ensure that all agencies involved in the oversight and prevention of youth cannabis use were coordinated and working together and aligning strategies.

Substance Use Disorders

In FY 2023, DBHDS re-established the Office of Substance Use Services. The office includes the following programs: State Opioid Response (SOR), Harm Reduction, Women's Services, REVIVE, State Opioid Treatment Authority (SOTA) which governs Medications for Opioid Use Disorder programs, and Substance Use Treatment.

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State Opioid Response (SOR) Activities

DBHDS has received a federal State Opioid Response (SOR) grant funding beginning October 2018 through September 2024 for prevention, treatment, and recovery. In FY 2022 and 2023, Virginia received $27.9 million in SOR funding.

- Prevention SOR grant accomplishments included:
  - Funded the purchase of 18,457 Naloxone kits for distribution by CSBs, local health departments and numerous other treatment and recovery services providers.
  - Funded nearly 17,000 fentanyl test strips for CSBs and local health departments.
  - Developed the Commonwealth's first Naloxone Saturation and Distribution Plan through partnership with the Virginia Department of Health (VDH).
  - Increased the number of safe storage and disposal efforts to decrease the availability of prescription and over the counter drugs for misuse. These efforts included distribution of drug deactivation packets, prescription drug lockboxes, and smart pill bottles. Communities also participated in drug take-back events and arranged for the installation of permanent drug drop boxes or drug incinerators.
  - Media campaigns included: 1) Utilized DEA's One Pill Can Kill campaign to educate communities, especially youth, across the Commonwealth about fake prescription pills containing fentanyl, xylazine, and other deadly additives. Translated the Fake Pill Fact Sheet into ten languages this year. Increased community awareness of local opioid overdose problems. 2) The SOR-funded "Activate Your Wellness" statewide media campaign, based on SAMHSA's Eight Dimensions of Wellness, launched in July 2022. The focus audience is communities of color, primarily Black, African American, Hispanic, Latino, bi-racial or multi-racial. The initial three-month campaign delivered almost 18 million impressions across all media outlets and reached more than one million individuals.
- Treatment SOR grant accomplishments included:
  - Provided funding for 7,865 individuals to receive SUD treatment services in the commonwealth. Treatment clients also received other services, such as transitional housing, residential treatment, or wellness support.
  - Awarded three mini-grants to CSBs for the purchase of mobile vehicles to provide SUD treatment and comprehensive harm reduction services. SOR has now funded a total of five mobile units for SUD services.
- Recovery SOR grant accomplishments included:
  - Provided funding and resources for 30,633 Virginians to receive recovery services. 88 percent of these services were provided by SOR-funded peer recovery specialists.
  - Expanded collegiate recovery to three new colleges/universities – University of Lynchburg, Wytheville Community College, New River Valley Community College, making a total of ten higher education schools with SOR-funded collegiate recovery communities.
  - 21 regional jails are now providing SOR-funded medicatin assisted treatment (MAT) and/or recovery services.

Harm Reduction Programs

Harm reduction is an evidence-based approach in overdose prevention, risk reduction, and health promotion. DBHDS harm reduction services included providing overdose and infectious diseases

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education, referrals to medical, treatment, and recovery services, reduction of stigma campaigns, first aid kits, gun locks, and REVIVE! kits.

- REVIVE! – REVIVE! provides training on how to recognize and respond to an opioid overdose emergency using naloxone. In FY 2023, approximately 18,000 people were trained, and 13,425 received no-cost naloxone at the trainings (submitted information from trainers). Provided monthly REVIVE! Training of Trainers sessions (TOT) to increase number of trainers statewide capable of leading basic REVIVE! training. Increased certification of Master Trainers by 30 percent, with concentration in rural areas of need.
- State Opioid Treatment Authority (SOTA) – Expanded to 48 OTPs in FY 2023 (two OTPs closed and five new OTPs were licensed). All 48 OTPs have become naloxone only distribution sites in accordance with VDH requirements to receive free naloxone for distribution to clients.

Women's Services

In FY 2023, all 40 CSBs provided SUD services to women. There was a total of 12,420 women served in SUD services across the CSBs: Women Treatment: 9440; Pregnant and Parenting: 136; Pregnant: 172; Parenting Only: 2672.

- Project LINK is an interagency, community-based collaborative program designed to coordinate and enhance existing services to help meet the extensive and multiple needs of women and their children whose lives have been affected by substance use. Two additional Project LINK programs were implemented in FY 2023: Alleghany Highlands CSB (Region 1) and Alleghany Highlands CSB (Region 3). There are now a total of 14 Project Link programs in the Commonwealth. Expanded all Project Link programs to include services for pregnant and parenting substance using individuals under the age of 18.
- Provided CAA supplemental funds to enhance and support five residential SUD treatment programs for women licensed by DBHDS.
- Enhanced seven CSBs' women's services programs through ARPA and CAA funding allocations.

Recovery Support Services

Trained and certified Peer Recovery Specialist (PRS) workforce. There are currently 1,113 individuals in active Certified Peer Recovery Specialist (CPRS) status with the Virginia Certification Board and 576 of those are registered with the Board of Counseling. In addition:

- 966 people took the DBHDS 72-hour Peer Recovery Specialist training in FY 2023. Over 4,560 people have completed the training since January 2017. 130 people completed the online, on demand supervisor training in FY 2023.
- Regional Recovery-Oriented Services Coordinator trained a total of 1,408 individuals across the Commonwealth. The trainings included peer staff within the public behavioral health system, recovery communities, non-profit organizations, and private providers. Trainings included but were not limited to: DBHDS 72-Hour PRS Training, Action Planning for Prevention and Recovery (APPR), Peer Support in the Workplace, Ethical Decision-Making, Trauma Informed Peer Supervision, Peer Group Facilitation, CPRS Prep Exam Training, and Crisis Services.

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Developmental Community Services

U.S. Department of Justice Settlement Agreement

- Virginia is in the 12th year of a Settlement Agreement with the U.S. Department of Justice to improve and expand services and supports for individuals with developmental disabilities (DD) and to create a comprehensive system of home and community-based services that promotes community integration and quality improvement. Reports associated with the DOJ Settlement Agreement are published here: https://dojsettlementagreement.virginia.gov.
- As of the Independent Reviewer's June 2023 report, Virginia is in compliance with (or in compliance pending data validation) with 238 of 317 (75 percent) of compliance indicators. The report also found Virginia in compliance or sustained compliance with 83 of 122 provisions of the Settlement Agreement (68 percent).
- In July 2023, Virginia was relieved of 35 compliance indicators in sections III.C.7.a, III.D.6, V.E.2, V.I.1., V.I.2, and V.I.3. Relief of these indicators also resulted in the Commonwealth being relieved of four provisions of the Settlement Agreement: III.D.6, V.I.1, V.I.2, and V.I.3. As a reporting cycle has not yet been completed since relief of these provisions and indicators in July 2023, the data on compliance in the first two bullet points do not reflect these updates.

Supported Employment Services

Virginia is an "Employment First" state and continues to promote the value of employment for all persons with disabilities. DBHDS published two semi-annual reports on employment with 100 percent participation from employment service organizations. The percent of individuals with a DD waiver employed increased from a low of 17 percent up to 22 percent in FY 2023.

Medicaid Waiver Services for Individuals with Developmental Disabilities (DD)

- The Medicaid Home and Community-Based Services (HCBS) waivers prescribe the types of services Virginia may offer based on approved applications to the U.S. Centers for Medicare & Medicaid Services (CMS). HCBS waivers provide the funding for most children and adults receiving services through a combination of state and federal funding.
- Waiver Services and Waitlist – As of August 1, 2023, there were 16,638 individuals assigned a waiver slot. The total wait list was 15,019 and included:
    - Priority One (services needed within one year): 3,536;
    - Priority Two (services needed in 1-5 years): 6,437; and
    - Priority Three (services needed in 5+ years): 5,046
- Virginia's HCBS Waivers (DD Waivers) are subject to the 2014 HCBS Settings Regulation (Final Rule) which prescribes specific characteristics that must be present in settings where waiver services are provided to demonstrate a community experience versus an institutional one. HCBS settings nationwide were required to demonstrate compliance with the rule by December 31, 2025 to continue participating in the Medicaid waivers program. There are approximately 4,450 of these settings serving children and adults in Virginia. Each group home, group day, sponsored residential, supported living, and group-supported employment setting was required to be assessed for compliance with the requirements. Virginia received a corrective action plan (CAP) allowing the state to continue validating

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settings on a staggered timeline. As of FY 2023, DBHDS and DMAS have completed approximately 79 percent of the reviews.

Supports Intensity Scale®

The Supports Intensity Scale (SIS®) is a comprehensive assessment used to identify the practical supports required for individuals enrolled in DD waivers. In Virginia, external organizations accredited to perform the SIS contract with DBHDS to conduct the assessment.

- SIS vendors completed a total of 3,006 SIS assessments.
- Surveys showed an overall satisfaction rate in FY 2023 of 98 percent.

DD Waivers Customized Rate Program

The DD Waiver customized rate program helps individuals successfully live in the community and avoid unnecessary hospitalization or involvement with the criminal justice system by providing funding for additional staffing supports, and/or funding to support staff with higher levels of education and training which is necessary to support the individual's unique needs. From the start of the program in 2017 to date, 1,403 applications have been received and processed of which 1,037 were approved. In FY22, there were 255 applications processed, of which 207 were approved. Application processing remained stable in FY 2023 with 252 applications processed of which 169 were approved.

Integrated Health

The Office of the Integrated Health Support Network (OIH-HSN) focuses on improving access to health and safety services through the commonwealth by identifying barriers and working toward filling gaps in services to improve quality of life and overall health.

- Health Support Network Mobile Rehab Engineering – Performed 6,700 repairs to 4,567 pieces of durable medical equipment and assistive technology items (i.e. wheelchairs). The team completed a total of 2,838 appointments and completed 28 custom adaptations.
- Community Nursing – Facilitated 57 regional community nursing meetings with a combined 973 attendees. Presented 86 educational trainings with 4,347 attendees on topics addressing challenges in health and safety and reducing risk of injury or fatal outcomes. Circulated 22 monthly newsletters and health and safety alerts promoting best practices in the health care and promoting safety interventions that can mitigate risk.
- Dental – There are currently 1,960 active individuals with DD in the dental program. The Mobile Dental Team completed 404 appointments in FY 2023. Completed quality reviews of 217 behavior support plans.
- Preadmission Screening and Resident Review (PASRR) – The PASRR process is a federally mandated process that ensures individuals with DD or severe mental illness admitted to nursing facilities meet criteria for admission. The PASRR team completed 943 evaluations for individuals who were referred to or seeking admission to nursing homes.

Provider Network Supports

The Office of Provider Development is now called the Office of Provider Network Supports. This change was made to better reflect collaboration with providers and our intention to be a resource in accomplishing their missions in Virginia. The office focuses on developing and

DRAFT

sustaining a qualified community of providers so people with DD and their families have choice and access to options that meet their needs. FY 2023 accomplishments include:

- Awarded $181,175 to create integrated service options in underserved areas.
- Held quarterly provider round table and support coordinator meetings attended by 2,018 representatives to share updates, initiatives, and obtain stakeholder feedback.
- Met with 100 unique providers seeking to diversify or expand services.

Individual and Family Support Program (IFSP)

IFSP is designed to assist individuals on the DD Waivers Waiting List and their families access short-term, person/family-centered resources, supports, and services to establish and maintain an independent life in the community. Since its initiation in 2013, the IFSP has grown to extend varying types of supports to over 15,000 individuals. FY 2023 accomplishments include:

- Received 4,914 applications and awarded funds to 3,770 applicants. The total amount of funding awarded was $2,499,620.20.
- IFSP emergency regulations were approved and new funding guidelines were developed based on the regulations.
- The IFSP network-funded *Family to Family* contract through the VCU The Center for Family Involvement (CFI), reported 635 unduplicated calls for support in FY 2023. From January through June 2023, CFI reported 69 requests for support from families on Waitlist, and 23 from families with DD Waiver funding. Those families received mentoring support.
- The My Life My Community (MLMC) website received 76,260 visits from 66,009 users.
- Outreach materials were distributed to 95 percent of individuals on the Waitlist via the Annual Waitlist Notification mailer.

Waiver Management System (WaMS)

WaMS is the DBHDS waiver management system. FY 2023 updates included:

- Release Regional Support Team (RST) module and enhancements to automate RST process and data reporting.
- Update to ISP (version 3.4) to enhance electronic health record integration and to align with DOJ compliance indicators.

Single Point of Entry and Children's ICF Initiatives

DBHDS, along with DMAS, began the single point of entry process in May 2018. Through this process, any Virginian seeking placement in an intermediate care facility (ICF) is screened to determine eligibility. In FY 2023, 58 Virginians with intellectual disabilities were screened for ICF placement (29 adults and 29 children).

Community Housing

- Invested $45 million to establish and sustain 27 permanent supportive housing (PSH) providers across the state to serve more than 1,900 individuals with SMI. DBHDS annual report on PSH can be viewed on the Reports to the General Assembly website.
- Contracted with three non-profit service providers to work with owners of Low Income Housing Tax Credit properties to provide on-site services to tenants with SMI or I/DD.
- Invested $3.4 million to serve 150 households with a pregnant or parenting woman with substance use disorders.

DRAFT

- Allocated $1.5 million in federal Projects for Assistance in Transition from Homelessness (PATH) funds to 14 CSBs to provide outreach and case management services to people with SMI experiencing homelessness. Virginia PATH providers engaged more than 2,000 homeless individuals through street outreach and shelter in-reach.
- By the end of the fiscal year, nearly nine percent of adults in the Settlement Agreement population were living independently. Their housing opportunities were provided primarily through DBHDS's State Rental Assistance Program funding and through 227 housing choice vouchers committed through housing authority preferences. Since these housing efforts were initiated, 2,084 individuals have been assisted to live independently.

Crisis Services

Formed FY 2023, Crisis Services is focused on the development and implementation of an integrated continuum of community-based crisis intervention services. Over the past year, Crisis Services has grown by nine staff and undergone considerable re-organization. This includes the creation of two offices, one focused on the operational infrastructure and systems of the integrated continuum, and the other focused on the support and monitoring of service providers.

Office of Crisis Services

The Office of Crisis Services supports, oversees, and evaluates core components of the integrated continuum of services, including Mobile Crisis Response, Crisis Stabilization Unit and Crisis Receiving Center, CSB Emergency Services, Children's Crisis Services, and REACH (Regional, Education, Assessment, Crisis Services, Habilitation).

- Mobile Crisis Response (MCR) – Cross-trained behavioral health and developmental services specific mobile teams to ensure adequate statewide 24/7 coverage. Early in 2023 each team type was around 40 percent staffed and there were under 40 behavioral health teams. Now combined, the teams are over 65 percent staffed, with over 90 teams. Collaborated in the build out and implementation of the Virginia Crisis Connect portal to facilitate the MCR dispatch function and access to authorization codes for billing.
- Crisis Receiving Centers and Crisis Stabilization Centers – DBHDS has supported the establishment of four operational CRCs. An additional 11 have been provided funding and are in various stages of development. FY 2024 projects are being advanced in 2023, and are expected to bring a combination of over 200 new 23-hour chairs and crisis stabilization beds into development in 2023 and 2024, specifically:
    - New River Valley Community Services opened the first adult Crisis Receiving and Stabilization Center in the state with the capacity for 16 adult residential beds when fully staffed.
    - Hampton-Newport News is expanding from an 11-bed to a 16-bed CSU, to be combined with a CRC.
- Community Services Board Emergency Services – During FY 2023, the emergency services (ES) programs saw 57,962 individuals in crisis. Of those, 37,684, or 65 percent, were not hospitalized under a civil temporary detention order following an evaluation conducted by a certified preadmission screening clinician (CPSC). There were 666 criminal temporary detention orders executed following the recommendation of a CPSC. The requirements for CPSCs were changed in September 2022 in response to the growing concern over workforce shortages. The changes allow individuals with a minimum of a bachelor's degree and a QMHP registration to be eligible to become CPSCs.

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- REACH - (Regional, Education, Assessment, Crisis Services, Habilitation) – The REACH program provides crisis services for individuals with a developmental disability. In FY 2023, REACH received a total of 1,903 adult referrals and 1,259 referrals for the youth. The REACH regional programs' staff combined to complete a total of 1,809 crisis assessments with adults and 1,025 crisis assessments with the youth as part of their continued mobile crisis response service. REACH supports individuals with DD by providing community crisis stabilization, non-residential and residential (Crisis Therapeutic Homes) services. In FY 2023:
    - 434 adults and 347 youth were admitted or readmitted into the non-residential service during this fiscal year.
    - In residential homes, 124 individuals were admitted for crisis stabilization, 72 for crisis prevention, and 51 individuals were stepped down post psychiatric hospitalization for further stabilization.
    - Provided 20,469 hours of prevention services for adults and 11,466 hours for youth.
    - Trained 4,815 community partners in prevention and in decreasing stressors that may lead to a crisis for the individual or family/provider.

Office of Crisis Operations

The office of crisis operations has worked to expand reporting, analytic, and system development crisis infrastructure. The office led expansion across the following service areas:

- Regional Crisis Call Centers – The five DBHDS regions in Virginia sought and selected proposals for call center services. PRS CrisisLink was contracted to serve Regions 1, 2, 4, and 5, while Frontier was contracted for region 3. Continued infrastructure build out has a primary focus on workforce development, capacity enhancement, and chat/text services. In Virginia, each participating call center has successfully increased its capacity to meet the anticipated rise in demand, as indicated by the current in-state answer rate of 92 percent.
- Alternative Transportation and Custody – There has been an overall decline in the percentage of TDO transports since FY 2022. The reasons for this decline are multifaceted including staff recruitment and retention challenges, increasing clinical acuity of individuals under a TDO making it unsafe for them to be transported without restraints and systemic challenges resulting in state facility bed shortages and waiting lists. The initial contract period with Allied (which purchased G4S) will end in September of 2024 and DBHDS will issue a new Request for Proposals as required. DBHDS submits a separate report for Alternative Transportation which can be found on the General Assembly website.
- Virginia Crisis Connect (VCC) (formerly the Crisis Data Platform) – VCC acts as a centralized tool for crisis services provided through the continuum. VCC expanded in FY 2023 to include enhanced Risk Assessment capabilities for the Call Centers and the ability to geolocate and dispatch Mobile Crisis Responders.
- Marcus Alert/Co-Responder Program – Marcus Alert is a statewide framework that was developed alongside community stakeholders. The Marcus Alert legislation required five areas to implement the Marcus Alert by December 1, 2021. The next five areas that were required to implement Marcus Alert launched their local programs on July 1, 2023.
- Crisis Intervention Team – The CIT Assessment Site program operates 37 locations in all Virginia regions. These locations are supported by 38 of 40 CSBs (the remaining two have

DRAFT

access to sites in neighboring localities). Referrals to the CIT Assessment sites by law enforcement continue to surpass 10,000 per year.

Enterprise Management Services

Enterprise Management Services includes a portfolio of programs that are critical in nature, broad in scope, and not well-placed within any particular section of the organizational chart.

Management Services

- Finalized the FY 2024-2025 Community Services Performance Contract and supplemental documents, effective July 1, 2023.
- Expanded team size to better support our internal and external stakeholders.

Emergency Management

- Supported response to 18 emergencies impacting DBHDS facilities and Virginia.
- Provided technical assistance and training regarding disaster behavioral health planning and provision of services throughout Virginia: 60 facility visits to provide guidance, assistance, and training; conducted ten Stop the Bleed classes for facility staff; facilitated five Stress First Aid orientations to colleagues from prevention services, CSBs, social services, victim services, DBHDS hospital facilities and the Virginia Department of Health; delivered Disaster Behavioral Health Orientation to New River Valley CSB.

Community Operations Program

In September 2022, a Deputy Director of Enterprise Management Services position was created and staffed for Oversight of Community Operations. The focus on this office is on improving the intersection of the DBHDS Community Services Divisional offices and the community-based safety net of publicly funded services. Achievements for this fiscal year include:

- Completed a full personnel accounting of the Administrative Corrective Action Plans (CAPs) related to all six block grants.
- Implemented State Fiscal Agreement (SFA) tracking across offices for the supplemental block grants allowing for better access to funds.

Facility Services

Transformation of Facility Services

The DBHDS Facility Services Division has restructured to support the operation of the 12 state facilities as a high-performance hospital system to deliver care that is high quality, efficient, and coordinated to meet current and future challenges. This transformation includes the development of a data management position and establishment of four new offices to provide oversight of essential state facility administrative and programmatic operations. The new offices include the Office of Administrative Services, the Office of

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Environment of Care, the Office of Quality Improvement, and the Office of Program Services. FY 2023 Facility Services accomplishments include:

State Behavioral Health Hospitals and Centers

- Western State Hospital (WSH) increased bed capacity following critical staffing levels and COVID pandemic impacts, restoring 55 beds to the state hospital system.
- Commonwealth Center for Children & Adolescents (CCCA), achieved Joint Commission accreditation as a Behavioral Health Hospital in June 2022 and renewal in August 2023.
- Southern Virginia Mental Health Institute (SVMHI) remained fully accredited with deemed status by The Joint Commission on July 14, 2023.
- Eastern State Hospital (ESH) again received the Malcolm Baldrige National Quality Award (MBNQA). Established by the U.S. Congress in 1987 to recognize U.S. companies with successful quality management systems, the award is the nation's highest presidential honor for performance excellence.
- Central State Hospital (CSH), located in Dinwiddie County, Virginia was awarded the 2023 Outstanding Business Partner of the Year by Petersburg High School.
- Southwestern Virginia Mental Health Institute (SWVMHI) met the requirements for the Mental Health America Bell Seal Award, Bronze Level.
- The nurse aide educatin program training site and curriculum at Hiram W. Davis Medical Center (HDMC) was approved by the Virginia Board of Nursing.
- Virginia Center for Behavioral Rehabilitation, located in Burkeville (VCBR) continues to lead the nation in the number of individuals safely and successfully discharged from a sexually violent predator civil commitment facility. The facility's expansion project received LEED Silver rating from the United States Green Building Council.

Environment of Care *(formerly Architecture and Engineering Services)*

The Office of Environment of Care (OEOC) was created during FY 2023 to house operational oversight for Emergency Services, Public Safety and Security, and Environmental Services while maintaining management of Capital and Maintenance Reserve projects, Food Services, and Operations Management. The OEOC team collaborates with facility leadership and the Department of General Services (DGS) to manage all aspects of physical plant maintenance, nutrition services, housekeeping, and safety. Captial Projects in FY 2023 include but are not limited to VCBR expansion, ESH safety and hardening, surplused land (CSH, CVTC), DGS managed umbrella projects – fire alarm, access controls, and window replacements.

Clinical Program Services

The Office of Clinical Program Services (OCPS), created in FY 2023, consolidated DBHDS' clinical consultant services into one office. The OCPS team serves as technical advisors and subject matter experts who work directly with and in the state facilities. The office consists of the clinical program director, a clinical operations consultant, a behavioral analyst (pending funding), as well as pharmaceutical and medical consultants. Among other initiatives, the office is supporting the facilities' efforts to conform to and maintain certification and accreditation standards with the Joint Commission, Centers for Medicare and Medicaid Services, and other regulatory oversight bodies, and supporting with recruitment and retention initiatives.

Facility Administrative Services

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Office was created in FY 2023 with two full-time executives, the Director of Facility Administrative Services in January 2023 and Business Process Improvement Manager, February 2023. The emergent areas for improvement identified include:

- Completed review of all enterprise applications, including reduction of outdated or unsecure applications, RFP process for Avatar replacement, and implementation of governance structure on how to address any new enterprise solution.
- Human capital management and payroll process review.
- Developed a monthly scorecard for each facility with the following categories: Financial, Safety, Human Capital Management, and Operations.

Quality Improvement

Created in FY 2023, the purpose of the OQI is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities at all levels of the DBHDS operated facilities. The OQI team provides support and leadership to the facilities to ensure a systemic approach in quality patient care, utilization review, infection control, incident management, safety, electronic health record optimization, and operational compliance. The following initiatives have already been implemented:

- Developed a tool that requires facility directors to validate the facility's compliance as it relates to regulatory and agency standards.
- Developed a mock survey tool and assembled a team of subject matter experts to conduct an unannounced audit at one facility each month. The survey is conducted in the same way regulatory surveyor's complete audits and aims to better prepare facility staff for certification and/or accreditation reviews.
- Developed a tool that tracks external complaint cases and documentation requests, regulatory reviews, and plan of correction compliance.

Patient Continuum of Services

The Office of Patient Continuum Services provides development and oversight of state hospital admissions and discharges, including management of the hospital waitlists, and discharge planning and community integration of individuals discharging from state hospitals. The team assists and trains state hospital admissions staff, CSB preadmissions screeners, state hospital social workers, and CSB discharge planners. The team administers Discharge and Diversion funding, including Discharge Assistance Plan (DAP) funds and Local Inpatient Purchase of Service (LIPOS) funds. FY 2023 accomplishments include:

- State Hospital Admissions: The team added a full-time position to provide management and triage of the state hospital waitlists (civil and forensic) as well as to provide guidance in the streamlining of admissions processes among the state hospitals.
- Extraordinary Barriers to Discharge List (EBL) – Individuals on the EBL have been clinically ready to leave the hospital for at least seven days; however, cannot be discharged safely due to non-clinical barriers. The average number of individuals on the EBL grew from 153 in FY 2015 to a high of 250 in FY 2019. In FY 2022 the average number of individuals on the EBL was 199 and in FY 2023 it was 164.
- Discharge and Diversion – DAP is a major tool for overcoming barriers to discharge for individuals in state mental health hospitals who are clinically ready to leave but unable to do so due to the lack of needed community services. Total DAP funding amount is

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approximately $86 million. In FY 2023, DAP funds served nearly 1,700 individuals, of which approximately 530 were new discharges from state hospitals. Additional projects and partnerships included:

- Supported 145 assisted living facility beds in three locations.
- Supported 110 transitional group home beds in locations throughout the state. All of these beds are used exclusively for individuals discharging from or diverting from state hospitals.
- Served 122 individuals in transitional group homes.
- Served 173 individuals in assisted living facilities.
- Serve approximately 65 individuals through partnerships with Mount Rogers CSB and Western Tidewater CSB to provide enhanced behavioral support at local nursing homes for individuals discharging from state hospitals.
- Supported three programs that focus on assisting individuals with dementia who have been hospitalized at or are at risk of state hospitalization, and their families and caregivers in Northern Virginia, Southwest Virginia, and Tidewater.

Forensic Services

In FY 2023, there were 2,293 forensic admissions to state hospitals, which is 365 more than in FY 2022. However, community treatments for forensic patients is slowly growing: In FY 2023, there were 32 outpatient temporary custody orders, resulting in significant cost savings and bed days used. In addition, CSBs requested reimbursement for 418 outpatient restoration cases. Two additional accomplishments for FY 2023 was 1) establishing the Central Office Forensic Evaluation Team, which completely 202 evaluations for DBHDS facilities, and 2) launching the new Forensic Information Management System (FIMS) on June 22, 2023. In addition:

- Jail Diversion – Provided oversight and support to 15 jail diversion programs. Provided oversight and support to 11 forensic discharge planning programs at six regional jails, 11 local jails, and in collaboration with 19 CSBs. Partially funded behavioral health dockets at Arlington, Blue Ridge, Richmond, and Valley CSBs.
- Juvenile Competency Restoration and Evaluation – During FY 2023, there was no waiting list for the provision of Juvenile Restoration Services. At the close of FY 2023, the Juvenile Competency Restoration Program had 193 new court orders to provide juvenile restoration services across the Commonwealth.
- Sexually Violent Predator (SVP) Program – Continued to facilitate a multi-agency committee to coordinate sex offender treatment services across DBHDS, Department of Corrections (DOC), and community treatment providers to improve improving treatment consistency and build out a continuum of care and supervision across Virginia. In addition, the updated SVP screening protocol developed in collaboration with DOC appears to be successfully reducing the number of SVP evaluations requested and increasing the accuracy of the screening process.

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Licensing and Human Rights

Licensing

The Office of Licensing had several key initiatives this year including 1) streamlining the initial application process so that at least 85 percent of completed applications for high priority/high need services are licensed within 90 days and 2) streamlining the location and service modification process so that at least 85 percent of completed applications for modifications are licensed within 30 days.

- Between January 1, 2023 when the initiative began and June 30, 2023, 387 new providers were licensed with over 98 percent of applications being approved within 90 days, which far exceeds the goal of 86 percent. Average time on the waitlist for applications of priority services was 2 business days, compared to approximately 18 months, the previous year.
- Between January 1, 2023 when the initiative began and June 30, 2023, 1,014 location and service modifications were approved.
- The number of licensed providers increased by 31 percent and the number of licensed services increased by 15 percent during the first 6 months of the initiative
- Incident Management Unit (IMU) – The IMU supports OL's ability to implement the recommendations contained within the Office of the State Inspector General's Review of Serious Injuries and allows for better monitoring of providers' compliance with the serious incident reporting requirements contained within the Licensing Regulations. In addition, there are a number of settlement agreement provisions and indicators that tie to the timely and accurate reporting of incidents. The IMU provides regular training and technical assistance to providers, and monitors data including specific individual, provider, and system trends related to serious incidents and deaths. The IMU triaged 22,672 serious incidents and deaths in FY 2023.
- The Specialized Investigation Unit (SIU) – The SIU was developed to supplement the efforts of licensing specialists in conducting investigations to protect the health and safety of individuals with DD; and to ultimately improve the overall quality of services and supports. During FY 2023, the SIU completed 557 death investigations for individuals with developmental disabilities. The Office of Licensing completed at total of 1,157 death/complaint/serious incident investigations during the year.
- During FY 2023, the OL processed 970 complaints which is a 10 percent increase in the number of complaints compared to FY 2022:

Overview of Licensing Statistics in FY 2023*							
Fiscal Year Change:	**2012**	**2014**	**2016**	**2018**	**2020**	**2022**	**2023**
Licensed Providers	744	917	1,041	1,071	1,290	1,434	1,830
Licensed Services	1,860	2,218	2,608	2,780	3,200	3,664	4,189
Licensed Locations	6,302	7,519	8,447	8,778	10,753	11,660	10,904

*FY2022 data includes data from the previous licensing system (OLIS) and the new system (CONNECT) and may be impacted by the conversion of data and difference in categorization of information.

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Services in FY 2023 - Providers may be licensed for multiple services			
Residential Crisis Stabilization 7	35	Nonresidential Crisis Stabilization/crisis intervention	365
Inpatient Psychiatric Unit (41 adults/14 children)	56	SA Medically Monitored Intensive Inpatient Srv-adult (3.7) - 04-015	32
SA Medically Managed Intensive Inpatient Srv - adult (4.0) – 04-013	1	SA Medically Managed Intensive Inpatient Srv (4.0) – children/adolescent -04-014	0
SA Medically Monitored High-Intensity Inpatient Services children/adolescent (3.7) 04-016	3	SA Clinically Managed High-Intensity Residential Srv - 3.5 Adult -01-043	29
SA Specific High-Intensity Residential Srv Adult (3.3) – 01-044	3	SA Clinically Managed Low-Intensity Residential Srv adult– (3.1) -01-045	24
SA Clinically Managed, Medium-Intensity Residential Srv for Children and adolescents (3.1)-children/adolescents – 14-060	2		
DD Supportive In-Home	318	MH Intensive In-Home children/adolescents	387
Supervised Living	33	Sponsored Residential	175
Brain Injury Residential Tx Service	2	MH correctional Facility RTC	3
MH skill building	541	Case Management	209
Psychiatric Residential Treatment Facility children/adolescents	26	Therapeutic Group Home children/adolescents	81
Group Home Service and ICF/IID for adults	652	DD Children Group Home Residential and ICF/IID	21
Substance abuse partial hospitalization	79	Mental health partial hospitalization	39
Substance abuse intensive outpatient	216	Mental health intensive outpatient	52
Substance abuse outpatient	138	Mental health outpatient	133
MH Psychosocial Rehabilitation	85	Therapeutic Day Treatment	64
DD Day Support	396	Respite (residential, in-home, centered based	22
ACT/ICT	41	Medication Assisted Opioid Treatment	40

Human Rights

Virginia Code authorizes the Human Rights Regulations (HRR) to further define and protect specific assured rights for individuals receiving services in DBHDS operated facilities and programs that are licensed and/or funded by DBHDS in the community. Significant activities in FY 2023 included:

- Completed 352 AIM (Assess safety, Initiate process, Monitor compliance) review to ensure the safety of individuals receiving services following substantiated cases of serious abuse involving sexual assault, restraint with serious injury, and physical abuse with injury.
- Collaborated with Adult Protective Services (APS) and Child Protective Services (CPS) to validate accurate reporting of allegations of abuse and neglect in licensed and operated DBHDS provider settings. Received over 1,200 referrals, 272 (27 percent) were determined to be known by the provider but not reported in the human rights database, "CHRIS."
- Issued a total of 1,535 OHR-Only licensing reports. 884 specifically for violations to 12VAC35-115-50(B)(2) - abuse, neglect and/or exploitation.
- Issued 127 Violation Letters to DBHDS facilities: 62 percent were identified through the DI 201 Investigation process and resulted from substantiated complaints of abuse, neglect or exploitation.
- Facilitated 23 statewide training seminars to approximately 1,971 licensed provider & facility staff participants.

DRAFT

- Provided 58 distinct consultation and targeted technical assistance/training sessions attended by 452 licensed provider and facility staff.
- Reviewed and approved Human Rights Complaint Resolution Policies for 264 new licensed community providers, and conducted additional 19 onsite reviews to new HCBS waiver providers to ensure compliance with HRR and HCBS.

Abuse/Neglect and Human Rights Complaint Statistics (July 1, 2022 – June 30, 2023) for community providers and DBHDS state hospitals and centers:

FY 2023 Human Rights Complaint Data Reported by Community Providers				
Total Number of Complaint Reports				1,199
Total Number of Complaint Reports that resulted in a human rights violation				132
Total Number of Abuse Reports				9,438
Total Number of Abuse Reports that resulted in a human rights violation				1,252
Substantiated Abuse Reports by Type		Exploitation	35	
Physical Abuse	116	Neglect	895	
Verbal Abuse	132	Neglect (Peer-to-Peer)	69	
Sexual Abuse	6	Unauthorized use of Seclusion or Restraint	17	
Resolution Levels for All Reports				
Director	10,622			
Local Human Rights Committee	9	State Human Rights Committee		6

FY 2023 Human Rights Complaint Data Reported by DBHDS Hospitals and Centers				
Total Number of Complaint Reports				771
Total Number of Complaint Reports that resulted in a human rights violation				103
Total Number of Abuse Reports				585
Total Number of Abuse Reports that resulted in a human rights violation				114
Substantiated Abuse Reports by Type		Exploitation	3	
Physical Abuse	16	Neglect	45	
Verbal Abuse	25	Neglect (Peer-to-Peer)	12	
Sexual Abuse	1	Unauthorized use of Seclusion or Restraint	2	
Resolution Levels for All Reports				
Director	1,340	State Human Rights Committee		3
Local Human Rights Committee	4	SHRC Appeals Subcommittee*		9

Notes: The Human Rights Regulations define complaint to mean an allegation of a violation of the Human Rights Regulations or a provider's related policies and procedures. For the purposes of this section, complaints that alleged a violation other than abuse, neglect and/or exploitation are referred to as "Complaint Reports". Human Rights complaints that alleged abuse, neglect and/or exploitation are referred to as "Abuse Reports". A Report that resulted in a violation is also referred to as a substantiated complaint. A critical function of the OHR is due process via the Local and State Human Rights Committees. Of the 11,993 total complaints (including those alleging abuse, neglect and exploitation), individuals escalated 31 complaints to the Local and State Human Rights Committee. This is less than one percent and an indicator of resolution to individuals' complaints at the lowest/earliest level of the process. **9 complaints resolved at the SHRC level were reviewed by the SHRC Appeals Subcommittee per a variance allowing alternative procedures for addressing complaints by individuals in maximum security at CSH and residents of VCBR, when the individual is not satisfied with the director's response.*

DRAFT

DRAFT

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? ( ) Yes (●) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DBHDS participated in the National Governors Association, Improving Maternal and Child Health (MCH)in Rural America team 2024 -2025. The MCH Learning Collaborative Virginia team included DBHDS, the Department of Health, and the Department of Medical Assistance (DMAS). Likewise, the Virginia team was placed in the NGA Substance Use and Behavioral Health track. The state received technical assistance on effective models of perinatal substance use disorder programs from SAMSHA, Learning Collaborative Cohort teams (Pennsylvania ans Illinois) and the Association of Maternal and Child Health Programs (AMCHP) Virginia selected and identified goals for the state based upon the Governor's Executive Order 32 which reestablished the Maternal Health Data Quality Task Force and will compile a final report December 2025. Additionally, Executive Order 11 includes the creation of Maternal and Child Health dashboards and a central resource hub or website to provide family resources and other parent resources. DBHDS Women's Services and Specialty Population Manager represented Virginia at the MCH Learning Collaborative and Healthcare Workforce Policy Academy Closeout Convening (Tempe, Arizonia), in December 2025, and provided updates on perinatal addiction and goals for the state.

DBHDS remains an active member and serves as a maternal addiction subject matter expert on the Virginia Maternal Mortality Review Team, Office of the Medical Examiner's Office, Virginia Department of Health. Twenty percent of maternal mortality in the state of Virginia is attributed to substance use (accidental overdose) and behavioral health issues. DBHDS Women's Services was the team lead for recommendations for the 2024 Maternal Mortality Review report, which includes availability of NARCAN at WIC, libraries, and other public entities that women frequent.

DBHDS, Project LINK sites, and the Virginia Department of Social Services, Child Fatality Prevention, partnered to reduce child fatality as a result of unsafe sleep practices. Project LINK sites provided training on safe sleep and educated parents on safe sleep practices via, "Sleep Baby Safe and Snug" board books during home visits and group therapy. The goal is to continue this initiative after the conclusion of the VDSS grant.

Project LINK

Since its launch in 1992 with five sites, Project LINK has continued to expand steadily. As of 2025, it operates across 14 Community Services Boards (CSBs) in regions 1, 3, 4, and 5 of the Commonwealth. In FY2024, the program was funded through the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Office of Substance Use Services (OSUS), and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Women's Set-Aside.

Project LINK remains a vital and innovative program that supports women and families affected by substance use disorders, co-occurring conditions, and trauma. The program specifically serves pregnant and postpartum women, parenting women with dependent children, and women of childbearing age. As one of the few gender-specific initiatives in Virginia, Project LINK provides access to comprehensive, trauma-informed substance use disorder services.

Project LINK's mission is to remove barriers to treatment, prevention, and recovery for women affected by substance use and their children. This mission is realized through service coordination, stakeholder education, and the expansion of holistic offerings.

The targeted population for Project LINK includes the following:

Pregnant women impacted by substance use disorder are a priority population and are admitted into services within 48 hours

Postpartum women who deliver Substance Exposed Infants (SEI)

Parenting women with dependent children (0-18 years old) or seeking reunification with dependent children

Women of childbearing age (12-45 years), including pregnant and parenting adolescents, diagnosed with SUDs or co-occurring disorders

Target case management services for children (0-7 years old) for programs that employ children and adolescent case managers

The goals of this program include the following:

Decrease the incidence of alcohol, tobacco, and other substance use among pregnant, postpartum, parenting, and "at-risk" women.

Increase early identification, referrals, and follow-up of women and children

Enhance the availability and accessibility of prevention, early intervention,treatment services, and recovery services.

Optimize the healthy growth and development of infants born to Project LINK mothers

Strengthen the family unit, promote positive parenting, and support the optimal social, emotional, and physical development of the children in the family unit

Increase interagency service collaboration

The strategies to achieve the program's goals:

Intensive case management services

Home and community visits

Recovery and family-based activities

Evidence-Based programs:

Nurturing Parenting for Families in Substance Abuse Treatment and Recovery program

Trauma programs such as Seeking Safety, Healing Trauma, or Eye Movement Desensitization and Reprocessing (EMDR)

Linkage to Medication Opioid Use (MOUD) Services

Peer Recovery Support Services

Gender-specific clinical services such as individual psychotherapy, group therapy, co-occurring treatment, Intensive Outpatient (IOP), residential programs, or other services as deemed necessary per ASAM criteria.

Child development screenings (Ages and Stages) or referral to Early Intervention Services

Partnerships with local obstetricians and gynecologists, midwives, pediatricians, birthing hospitals, the Local Department of Social Services (LDSS), community colleges, vocational programs, and other community programs that serve families in their respective planning districts.

The mandatory staffing requirements for Project LINK include:

Program Manager

Case Manager and or

Clinician

It is important to note that service availability and staff vary by program.

The number of individuals served increased by 36.2% in FY2024, primarily due to the implementation of two new Project LINK programs, Alleghany Highlands CSB and Highlands CSB, in FY2023. The target for FY2026 is a 15% increase, supported by changes in program admission criteria. All programs will admit women with children aged 0-18 years old.

Monitoring and Oversight

OSUS Women's Services and Specialty Populations Managers oversee Project LINK, providing technical assistance, training, and policy updates to ensure compliance with SAMHSA regulations. Project LINK Managers meet quarterly to address challenges, share best practices, and collaborate on regional strategies.

Each site must submit two "Service Delivery and Outcomes at Discharge" reports annually:
a. Mid-Year Report: Covers October 1 – March 30 (due April 30)
b. Annual Report: Covers October 1 – September 30 (due November 1)

These reports include narratives, data summaries, and financial documentation.

Looking ahead, DBHDS aims to secure additional federal funding to launch two new Project LINK programs by 2028.

Right Help Right Now

RHRN Initiative 1929 Project LINK expansion included the following goals that were funded via CAA and APRA block grant pregnant women set aside funds:

Implementation of Two Additional Project LINK programs. Highlands CSB and Alleghany Highlands CSB Project LINK programs were implemented in FY22 and fully staffed in FY23. These programs were funded via Pregnant and Parenting Women (PPW) Set Aside Funds for the SABG CAA and APRA federal grants that were time-sensitive for expenditures. As of July 1, 2024, both programs will receive the base Project LINK ongoing funding of $100,000.00 from the SUBG Women's Set Aside.

VT Contract for Best Practices for Substance Use Disorder Treatment for the Maternal Population. Women's Services partnered with VT Workforce Development, Dr. Dace Svikis, Deputy Director of the VCU Institute for Women's Health in the School of Medicine and Director of Addiction and Women's Health: Advancing Research and Evaluation) , Dr. Caitlin Martin, Director of OBGYN Addiction Services, OB Motivate Clinic VCU Health and clinical team for a 90 minutes webinar: "Best Practices for Substance Use Disorder Treatment for the Maternal Population. 498 professionals attended this webinar.

Project LINK Manual. The manual was edited by an outside contractor.

Strategic Plan

CSB level overview of services

Virginia's 40 Community Services Boards serve more than 95 counties and 38 independent cities. SUBG Women's Set-Aside and state general funds support a range of services for pregnant, postpartum, and parenting women with dependent children, including:

Substance Use Outpatient Services

Case management

Medication-assisted treatment

Psychatric Services

4. Medical and detoxification services

Intensive residential treatment

Peer Recovery Services

Day treatment and partial hospitalization

The Department utilizes the following guidelines to monitor CSBs' compliance with the required SUBG women's set-aside funds and services for the PPWDC population:

Programs must treat the family as a unit and admit both women and their children into services if appropriate. CSBs provide clinical services to women and the children in their custody. Therapeutic services for children 0-3 years old may include developmental screenings and assessments as well as early intervention services. Behavioral health services provided to children address such issues as mental illness, behavioral issues, and or related clinical issues related to child abuse, neglect, or trauma via CSBs, children/family services, or referred to appropriate community providers. Additionally, children have the option of school-based mental health services provided by some CSBs.

Gender specific services that address specific women's issues, such as the role of relationships, parenting, sexual abuse, and trauma. Specialized treatment groups, intensive outpatient programs, and individual therapy are offered internally or through referrals to community providers. The CSBs offer evidence-based trauma treatment modalities.

Primary medical care. Clients' medical needs are assessed at intake, quarterly, and annually. Case management services ensure that women are linked and referred to the Department of Social Services for medical insurance, local health departments, or Federally Qualified Health Centers (FQHCs) for obstetrical, prenatal, postnatal, reproductive health, and overall physical health services. Children are connected to case management services for linkage to pediatricians

Transportation and Childcare. Transportation continues to remain a barrier to individuals accessing treatment services in rural areas. The funding of vehicles and drives would enable access for families to attend treatment and recovery services. As a result of the Pandemic, Virginia is experiencing a decrease in affordable and licensed childcare facilities. Additionally, block grant funding to assist CSBs with developing child-minded services would increase access to treatment.

Street Outreach. The CSBs advertise services via websites, brochures, and community events.

Interim Services. The CSBs provide counseling and education to clients on HIV, tuberculosis and Hepatitis C, as well as referrals to the local health department for services as needed. Additional intermin services include the following: risk of needle sharing, transmission of sexually transmitted infections to infants and partners, and potential risk of using alcohol and illicit substances on the developing fetus. Clients are referred to prenatal and medical services, offered peer support, case management, individual psychotherapy, or Medication Opioid Use Disorder (MOUD) services until appropriate level of services are available.

According to Virginia Code §32.1-127 B6, CSBs are responsible for care coordination and discharge planning for women who give birth to substance-exposed infants.

Additional funding for women's services would enable CSBs to train and hire staff who specialize in maternal mental health to improve outcomes for families and decrease maternal morbidity and mortality.

The Office of Adult Community Behavioral Health and Adult Behavioral Health Coordinators conduct site visits and block grant reviews.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement?	(●) Yes	( ) No
b)	14-120 day performance requirement with provision of interim services?	(●) Yes	( ) No
c)	Outreach activities?	(●) Yes	( ) No
d)	Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**?	(●) Yes	( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached?	( ) Yes	(●) No
b)	Automatic reminder system associated with 14-120 day performance requirement?	( ) Yes	(●) No
c)	Use of peer recovery supports to maintain contact and support?	(●) Yes	( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	( ) Yes	(●) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Regional Block Grant Specialists assigned to the five areas of the state communicate frequently with the CSBs in their respective regions to monitor compliance with SUPT BG Requirements.

The Performance Contract that all CSBs have executed with DBHDS includes the following requirements related to services for PWID:

1. Preference in admission;
2. Admission within 14 days of the person requesting services
a. If unable to admit within 48 hours, provide interim services
i. Counseling and education about HIV and TB;
ii. Risks of needle sharing, risk of transmission of HIV to sexual partners
iii. Steps to prevent transmission of HIV and TB; referral for HIV/TB treatment, if necessary.
3. Must notify DBHDS within seven days if the program reaches 90 percent capacity
4. Admit PWID within 14 days of the person requesting services, or within 120 days if the program lacks capacity and make interim services available
5. Maintain an active waiting list that includes a unique identifier for each PWID
6. Have an active means of maintaining contact with individuals awaiting admission and admit the individual to treatment at the earliest possible time. Individuals may only be removed from the waiting list if the person cannot be located or if the person refuses treatment.
7. Must encourage PWID to engage in treatment using outreach methods that:
a. Are utilized by trained outreach workers using scientifically sound methods including contacting, communicating, and following up with PWID and their support systems with the constraints of 42 CFR Part 2;
including contacting, communicating, and following up with PWID and their support systems with the constraints of 42 CFR Part 2;
b. Promote awareness among PWID about the relationship between injecting drugs and communicable disease, such as HIV;
c. Recommending steps that can be taken to ensure that HIV transmission does not occur; and
d. Encouraging entry into

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ( ) Yes (●) No

2. Has your state identified a need for any of the following:

a) Business agreement/MOU with primary healthcare providers? ○ Yes ● No

b) Cooperative agreement/MOU with public health entity for testing and treatment? ● Yes ○ No

c) Established co-located SUD professionals within FQHCs? ○ Yes ● No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Facilities licensed by the Department of Behavioral Health Services
Employees - Virginia Regulation 12VAC35-105-510 requires that all employees who will have direct contact with individuals receiving services are required to obtain a statement of certification by a qualified licensed practitioner indicating the absence of tuberculosis in a communicable form within 30 days of employment or initial contact with individuals receiving services and be certified as tuberculosis free on an annual basis by a qualified licensed practitioner.

Residents/participants in children's residential settings - Virginia Regulation 12VAC35-46-250 requires that each individual submit the results of a screening assessment for tuberculosis annually.

The CSB Administrative Regulations require that all CSBs follow the following requirements related to TB services.
1. Counseling individuals with respect to TB;
2. Testing to determine if the individual has been infected with mycobacteria tuberculosis to identify the appropriate form of treatment;
oftreatment;
3. Providing for or referring the individual who is infected for appropriate medical evaluation and treatment;
4. Follow protocols established by VDH for screening, detecting and providing access to treatment for TB
5. Report individuals with active TB to VDH/Division of TB Control, in compliance with 42 CFR Part 2.
6. Ensure that all individuals receive these services and refer individuals who are unable to access SUD treatment services to other providers of TB services
otherproviders of TB services

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas? ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services? ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? ○ Yes ○ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? ● Yes ○ No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? ( ) Yes (●) No

c) A system to maintain a list of referrals made by religious organizations? ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? ( ) Yes (●) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients? (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records? ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

37 CSBs have undergone IPRs since 2005

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review? (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? (●) Yes ( ) No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ○ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ◉ Yes ○ No

c) Performance-based accountability? ◉ Yes ○ No

d) Data collection and reporting requirements? ◉ Yes ○ No

If the answer is No to any of the above, please explain the reason.

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) SMI Adviser ◉ Yes ○ No

c) Addiction TTC? ○ Yes ◉ No

d) State Opioid Response Network? ○ Yes ◉ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ○ Yes ◉ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

The following are relevant links:
1. Title 37.2 of the Code of Virginia, which is the state law establishing our public behavioral health and developmental services system and establishing DBHDS as the responsible state agency: http://law.lis.virginia.gov/vacode/title37.2/
services system and establishing DBHDS as the responsible state agency: http://law.lis.virginia.gov/vacode/title37.2/

2. Virginia Administrative Code Chapter 105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services: http://www.dbhds.virginia.gov/library/licensing/ol%20%20chapter%20105%20rules%20and%20regulations%20for%20licensing%20providers%20by%20the%20department%20of%20behavioral%20health%20and%20developmental%20services%203.pdf

3. 2024-25 Community Services Board Performance Contract
https://dbhds.virginia.gov/wp-content/uploads/2024/11/0000.-P1636.1-AMDFY24-25PC-COM-7.1.2024FY25.pdf

4. Overview of Community Services in Virginia
https://dbhds.virginia.gov/wp-content/uploads/2024/11/FY2023-CSB-Overview-Revised10.04.2023.pdf

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

   Virginia has transitioned to a new data collection system effective July 1, 2025. Community Service Boards (CSBs) are now transmitting client level data via a HL7 transfer to DBHDSs Enterprise Data Warehouse (EDW) that occurs multiple times a day. This captures all client and service level information provided by the CSBs. Prior to this, CSBs were submitting their data via a sFTP monthly upload.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

DBHDSs current data collection is specific to mental health and substance use services with the CSBs. DBHDS is in the process of incorporating other data sources into the EDW including Medicaid, private hospital data, criminal/juvenile justice data, state developmental services. This will allow data analytics across multiple data sources and matching individuals across those systems.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

Currently, DBHDS has data sharing agreements with Medicaid and private hospital data. The process of identifying individuals across data sources is currently a manual process.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

DBHDS works collaboratively with CSBs to capture information on evidence-based practices, including ESMI. At this time, this information is captured at an aggregate level. Behavioral Health Crisis Services is captured through DBHDS' Virginia Crisis Connect (VCC). This includes 988 call center data, community stabilization services, crisis stabilization units and mobile crisis response. VCC will also be incorporated into the EDW.

5. Briefly describe the limitations of the SMHA 's existing data system.

During this first year of implementation of the new data collection system, DBHDS and providers will identifying data quality issues and making improvements/adjustments to the new system as needed. This will be an ongoing process to ensure that all boards are submitting accurate data.

6. What strategies are being employed by the SMHA to enhance data quality?

DBHDS will be developing close to real-time dashboards available to DBHDS staff and CSBs to monitor and track any data quality issues including transmission issues and invalid data values. DBHDS will be working with provider closely providing technical assistance and guidance as needed.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

DBHDS worked closely with CSBs and their electronic health records (EHR) vendors during the transition to the new HL7 data reporting process. During this transition, all CSBs transitioned during the last two months of state fiscal year 2025. While all CSBs were able to transition successfully, some EHRs identified that they were not able to support separate reporting processes at the same time. While DBHDS is working with CSBs to capture all the necessary reporting information for state FY25, there may be some gaps in reporting with some providers due to this limitation. However, FY26 and future reporting will be coming from the new data collection system.

8. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed identified at this time. DBHDS is meeting with SAMHSA's contractor, Hendall, on a monthly basis to ensure the transition to the data collection system has been going as smooth as possible.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

1. Virginia's crisis system is a statewide, regionalized model designed to ensure 24/7 access to behavioral health crisis services for all residents. The system includes crisis contact centers, mobile crisis response, and crisis receiving and stabilization services.

• Crisis Contact Centers:

Virginia has two contracted crisis contact centers that support the Commonwealth's 988 and regional mobile response operations. HopeLink Behavioral Health serves Regions 1, 2, 4, and 5, while Frontier Behavioral Health covers Region 3. Frontier also functions as the backup contact center for HopeLink to ensure smooth rollover during high call volume. These centers handle triage, risk assessment, service registration in

Virginia Crisis Connect (VCC), and dispatch mobile crisis teams.
• Currently, there are 98 Mobile Crisis Teams operating across the state, with the goal of providing 24/7 response to behavioral health emergencies in all five regions. These teams consist of clinicians and peer support specialists trained to perform real-time assessments, de-escalate situations, and connect individuals to ongoing services in community settings. Mobile teams are dispatched directly through crisis contact centers and serve as the frontline response for behavioral health crises.
While more urban and populous regions are consistently able to meet 24/7 response expectations, rural areas such as Regions 1 and 3 face persistent challenges in maintaining staffing levels to support full 24/7 coverage. The Department continues to work with providers in these areas to strengthen workforce capacity and expand equitable access to timely crisis response statewide.
• Crisis Receiving and Stabilization Centers:
Virginia is actively increasing access to facility-based crisis care. Currently, there are 10 Crisis Receiving Centers (CRCs) operating across the state, with more centers in various stages of development to enhance regional capacity. Additionally, the Commonwealth has 20 Crisis Stabilization Units (CSUs) offering short-term residential care for individuals in crisis. Of these, 7 are specifically dedicated to serving individuals with Intellectual and Developmental Disabilities (ID/DD), providing tailored support for those with unique needs.

Together, these services are integrated through Virginia's technology platform, Virginia Crisis Connect, to provide a coordinated, data-informed, and person-centered response to behavioral health crises across the state.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

3. Virginia has made significant strides toward building a fully integrated behavioral health crisis continuum aligned with the "Someone to Contact, Someone to Respond, and A Safe Place to Be" framework.
Someone to Contact – Program Sustainment:
Virginia has established two regional crisis contact centers to support 988 and statewide crisis call operations. Regions 1, 2, 4, and 5 are served by Hopelink Behavioral Health, while Region 3 is served by Frontier Health. These two contact centers work in tandem, with Frontier serving as a backup for call rollover from Hopelink. The centers operate 24/7 and serve as the first point of access for individuals experiencing a behavioral health crisis, offering phone-based triage, assessment, and dispatch of mobile crisis teams.
To promote equity and accessibility, the state is actively pursuing additional funding sources to fully support crisis contact center operations, with a specific emphasis on expanding staffing for chat and text functions. These efforts are intended to ensure that all Virginians—regardless of communication preference or ability—have inclusive, reliable access to crisis support.

Someone to Respond – Majority Implementation (≥75% of Counties):

Virginia currently supports 98 Mobile Crisis Teams operating across all five regions. These teams, comprised of licensed clinicians and peer recovery specialists, provide real-time, in-person crisis response and de-escalation services directly in the community. Teams are dispatched by regional crisis contact centers and are available 24/7 in most of the state.
To bolster staffing and regional responsiveness, Mobile Crisis Response has been supported with 10 million one-time state general funds to aid each region in the recruitment and retention of Mobile Team Members (MTMs). All MTMs receive cross-training to serve individuals across the lifespan, including children, adults, and older adults, and are equipped to respond to individuals with co-occurring intellectual/developmental

disabilities and other complex needs.
While urban and suburban regions are largely meeting 24/7 response expectations, rural regions—particularly Regions 1 and 3 continue to face challenges in maintaining sufficient staffing to ensure uninterrupted coverage. Nonetheless, more than 75% of counties statewide are covered by active mobile crisis teams, meeting the threshold for majority implementation.

A Safe Place to Be – Majority Implementation (≥75% of Counties):

Virginia continues to expand its network of Crisis Receiving Centers (CRCs) and Crisis Stabilization Units (CSUs) as part of its effort to provide individuals with a safe, clinically appropriate alternative to emergency departments or law enforcement involvement.
Currently, there are 10 operational CRCs and 20 CSUs serving individuals experiencing behavioral health crises, in addition to 7 CSUs specifically designed to support individuals with intellectual and developmental disabilities (I/DD).
Furthermore, 19 localities are actively working to establish new CRCs to serve their communities, and 15 additional CSUs are in various stages of development and planning. These investments reflect the state's ongoing commitment to building a system where individuals can access care in settings that are welcoming, recovery-oriented, and responsive to individual needs.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

4. Virginia is actively developing its behavioral health crisis system in accordance with the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, with a strong focus on ensuring accessibility, responsiveness, and inclusivity across the lifespan.
To support children and youth in crisis, Virginia has implemented Mobile Crisis Response (MCR) teams statewide. All team members are trained to serve individuals across the lifespan, including children and adolescents. This training ensures that youth receive developmentally appropriate crisis interventions from professionals equipped to address their unique emotional, behavioral, and situational needs.
As part of the state's commitment to building a child- and family-centered system of care, Virginia has also invested in expanding facility-based crisis stabilization options for youth:
Three youth-specific Crisis Stabilization Units (CSUs) are currently operational, providing short-term, intensive support in therapeutic, home-like environments.
Three additional youth CSUs are under development to further increase access to age-appropriate stabilization services.
Additionally, two youth-dedicated Crisis Receiving Centers (CRCs) are now operational, with three more in development. These centers serve as welcoming, low-barrier alternatives to emergency departments, designed specifically for children and adolescents.
To enhance continuity of care beyond initial crisis response, Virginia has launched the FOCUS pilot project, which expands the traditional model of mobile crisis and community-based stabilization. Under this pilot, participating youth and their families may access extended stabilization services for up to 45 days, ensuring sustained support and engagement in community-based care. This model mirrors the New Jersey Mobile Response and Stabilization Services (MRSS) approach promoted in national best practices, emphasizing family involvement, strength-based planning, and long-term stability.
Together, these efforts reflect Virginia's deliberate strategy to create a comprehensive, inclusive, and youth-responsive crisis system that is equipped to meet the needs of all individuals, regardless of age, ability, or geographic location.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 0
b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 0
   ii. Not in the suicide lifeline network: 0
c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 0
b. Integrated with public safety first responder structures (police, paramedic, fire): 0
c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 0
b. Number of Emergency Departments that operate a specialized behavioral health component: 3
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 30

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also

describe any state-led coordination between the 988 system and CCBHCs.

Virginia will utilize the 5% Mental Health Block Grant set-aside to strengthen its Mobile Crisis Response (MCR) infrastructure by revamping the current MCR training curriculum. This initiative will focus on converting the training into an on-demand, modular format to allow for faster onboarding and skill development, particularly in light of the workforce shortages and high turnover facing many behavioral health providers. The new training format will preserve essential content and core service expectations while offering flexibility to meet the varying needs of providers and regions.

Currently, Virginia has three Certified Community Behavioral Health Clinics (CCBHCs) in operation. While the CCBHC presence is limited at this time, all Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs) across the Commonwealth are actively working toward full implementation of Step-VA, a system transformation initiative that is in direct alignment with CCBHC requirements. This includes enhanced access, same-day assessments, crisis services, and care coordination—key pillars that mirror the goals of the CCBHC model.

While coordination between the 988 crisis system and CCBHCs is still emerging in Virginia, the state has taken initial steps to improve integration across systems. This includes:

• Exploring the role of CCBHCs in crisis follow-up care, helping to bridge the gap between emergency response and long-term treatment.
• Encouraging data-sharing and warm handoffs between 988 contact centers, mobile teams, and CCBHCs where applicable.
• Including CCBHC and CSB/BHA stakeholders in broader planning conversations related to the 988 system and crisis continuum redesign.

As the crisis system evolves, Virginia anticipates that CCBHC-aligned CSBs/BHAs will continue to play a critical role in the delivery of crisis and stabilization services, especially in enhancing coordination, ensuring service continuity, and supporting individuals with complex behavioral health needs.

7. Please indicate areas of technical assistance needs related to this section.

Technical assistance would be beneficial in developing a sustainable payment structure for Mobile Crisis Response services. Specifically, support is needed to explore models that account for readiness costs, on-call capacity, response time expectations, and alignment with Medicaid and commercial reimbursement standards. Guidance on braided funding approaches and strategies for ensuring equitable payment across rural and urban areas would also be valuable.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Under prompt 5- Someone to Talk To- Virginia has 4 regions covered but technically not localities which is why we responded with zero. We can change if needed

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

See EF 10- Recovery

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

See EF 10- Recovery

5. Does the state have any activities that it would like to highlight?

See EF 10- Recovery

6. Please indicate areas of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Does the state support (d) involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Yes. As a result of DBHDS's strategic planning efforts to expand the participation of peers, family members, and service recipients in implementing the agency's vision and mission, in January 2015, DBHDS established the Office of Recovery Services (ORS). The ORS Director and the ORS staff are individuals with lived experience. ORS is a small but mighty assembly of six. It has an AmeriCorps Recovery Corps Project Coordinator assigned to the office who has lived experience and supports ORS' capacity building across the state. ORS staff facilitates the continuing development of strategies that use person-centered, participant-led care in our system's public and private sectors, including peer-run organizations and agencies that use peer supporters within their continuum of care. ORS is proactive in meeting the diverse needs of a rapidly increasing and evolving workforce of peer supporters. In addition, the lived and living experience voice of the statewide peer-led workgroup called the Recovery Professionals and Community Partners Roundtable is sought to ensure decisions regarding federal allocations and the development of projects and services are directly influenced by the individuals in service.

Individuals and families with lived experience participate in a variety of state-level councils, committees, and work groups. Similarly, the same happens at the local level. One important mechanism to ensure this happens is outlined in Title 37.2 of the Code of Virginia, providing that at least one-third of the members of the State Board of Behavioral Health and Developmental Services be consumers or family members of consumers, with at least one member being a direct consumer of services. The State Board has the statutory authority to establish policy for DBHDS, our state facilities, and the Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs). Members of the State Board are appointed by the Governor and confirmed by the General Assembly. The Code has the same requirement as the CSBs' oversight boards (also called Community Services Boards). In this way, DBHDS, and our primary partners in the public behavioral health system, have substantive input by peers/consumers and family members.

The DBHDS Strategic Plan in 2023 included an initiative to increase Virginia's certified peer workforce by 10% by the end of the year (1 KR-1D). Several Office of Recovery Services projects were developed and funded to ensure success. The first was creating a pathway from training to certification within the public behavioral health system. Federal dollars allowed a Request for Proposal to CSBs

to begin Peer Recovery Specialists (PRS) internship programs. Internships allow CSBs to increase the peer workforce, provide access to training and education, and the 500 hours needed to sit for the certification exam. Internship development has increased access to this evidence-based service across the public BH system. The DBHDS strategic goal to increase the certified peer workforce was reached within 6 months of its initiation. Due to this strategic objective, a staggering 1500 Certified Peer Recovery Specialists (CPRS) have been added to Virginia's workforce. As internships for peer providers increased, positioning the behavioral health system to bill Medicaid for this service became a priority and funding was provided to increase the billing infrastructure within the public system to reimburse for these services.

Internship programs were also developed within the Virginia Recovery Community Organizations (RCO). Five VA RCOs aligned with the state to support this initiative: The McShin Foundation, Strength in Peers, Robins Hope, Chris Atwood Foundation, and Family Support Partners of Virginia.

Block Grant funding was utilized to develop the Recovery Leadership Academy (RLA). The Academy is a 10-month training opportunity to empower peer recovery specialists and family supporters to become effective emerging industry leaders and agents of change by providing organizational leadership skills and experiences. Monthly training sessions focus on leadership skills and strategies development, emotional intelligence, coalition building, team building, and problem-solving with Capstone projects and presentations. Over 120 CPRS' have participated in the RLA which includes a mentor and skills practice in the field.

DBHDS and the CSBs collaborate with a wide variety of stakeholder groups in the development of public policy, programs and services. The following are some examples; additional groups exist at the local level which may not be reflected here:

Organization	Constituency
Department of Aging and Rehabilitation	Older adult individuals and family members
Chris Atwood Foundation	Individuals, family, advocates
McShin Foundation	Individuals and advocates
Mental Health America of Virginia	Individuals and family members
NAMI Virginia	Individuals and family members

Roads to Recovery	Individuals and family members
Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA)	Individuals and family members
Virginia Association of Community Services Boards	Providers
Virginia Behavioral Health Advisory Committee (formerly The Mental Health Planning Council)	Individuals, family members, providers, advocates
Virginia Certification Board	Provider - Individuals
Oxford Houses of Virginia	Individuals and family members
Virginia Family Network	Parents of children with behavioral health challenges
Honoring Choices of Virginia	Families, providers, advocates
Strength in Peers	Individuals, Providers, and Advocates
Virginia Organization of Consumers Asserting Leadership (VOCAL)	Individuals
On Our Own Roanoke Valley	Individual and family members
Virginia Association for Recovery Residences	Individuals, Providers
On Our Own Charlottesville	Individuals, advocates, and family members
YouthMOVE	Young adults with behavioral health challenges

Virginia Recovery Initiative

The Virginia Recovery Initiative is an extension of the SAMSHA 2012 initiative, in which DBHDS was selected by SAMHSA to participate in the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Policy Academy to develop a framework for recovery-oriented care and expand peer services within CSBs, facilities, and peer-run advocacy and service groups. This initiative focuses on building and expanding a recovery-oriented system of care for people with behavioral health challenges, their families, and those who care about them.

The Virginia Recovery Initiative (VRI) has developed an official statement of recovery and recovery values that captures the vision of recovery, resiliency and self-determination for all populations served by the Virginia public behavioral health and developmental services system. The official definition meets Virginia's unique characteristics while aligning with SAMHSA's definition. The work of the state-level team is supplemented by regional VRI teams across the state, which are collaborating locally and regionally to implement the DBHDS vision of a recovery-oriented system of care.

The Virginia Recovery Initiative moved to revise and update its mission and vision statements to align with the current priorities and needs of Virginia more accurately. The VRI identifies itself as a body that brings interested stakeholders together to focus on incorporating the voices of people in recovery in all aspects of behavioral health service delivery. Recovery champions, representing organizations throughout the Commonwealth, meet bi-monthly to develop community-based strategies to expand the recovery footprint in Virginia. Vision: Creating a Recovery-Oriented System of Care throughout Virginia. Mission: Through advocating, networking, collaborating, education, and communicating, the VRI creates system change by implementing recovery-oriented practices that support community action.

Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Adults with SMI

Our state system includes a wide variety of recovery support services. CSBs, state hospitals, justice involved settings, and private providers offer access to recovery support groups, peer support services, telephone warmlines, recovery-oriented clinical and rehabilitative services, crisis, wellness plan development, and prevention services. In January 2017, Virginia recognized the Certified Peer Recovery Specialist in State code, and Medicaid reimbursement for peer support in behavioral health services became effective.

Certification standards have been essential to developing peer support services as a reimbursable mainstream service option in our system. DBHDS adopted the International Certification and Reciprocity Consortium (IC&RC) co-occurring Certified Peer Recovery Specialist (CPRS) certification for this initiative. Per IC&RC standards, performance competencies, professional ethics, and training standards are fundamental to the certification. Virginia partners with state-based IC&RC certifying entity to provide scholarships toward certification by which the PRS workforce has increased from 864 in 2023 to over 1583 in May 2025. DBHDS has also included Family Support Services by Family Support Partners (FSPs) under the Peer Recovery Support program. Implementing Family Support Partners across Virginia's behavioral health system has heightened the voice of and provisions for family members supporting loved ones navigating the system and increased outcomes for adults seeking recovery pathways The performance contract between DBHDS and the CSBs includes using Certified PRSs and FSPs in many settings, including crisis intervention, assertive community treatment, jail diversion, same-day access, emergency departments, inpatient settings, judicial and correctional settings, and recovery education.

DBHDS also provides significant financial support for peer-run organizations through the MH and SUPTR block grants and state general funds. With MHBG funds, DBHDS contracts with sixteen providers, nine of whom are independent recovery community organizations, to deliver behavioral health recovery-

oriented peer support services. BG funds have been used to educate, train, and mentor emerging leaders in the recovery space with the development of a 10-month Recovery Leadership Academy (RLA). The RLA is currently training its fifth cohort of new recovery leaders.

In addition, MHBG funds support statewide organizations such as NAMI Virginia; which provides programming such as the Family to Family, In Our Own Voice and Connection programs; Mental Health Virginia, which offers, among other services, the Consumer Empowerment Leadership Training curriculum and a statewide peer ran warm line; Vocal Virginia which offers programs such as advocacy building and is Virginia's SAMHSA-designated state consumer network, which provides technical assistance for peer-run programs, trains Action Planning for Prevention and Recovery (APPR) facilitators, and supports a statewide peer network and an annual conference for individuals receiving services; Funding for co-occurring disorders continues to be vital as it supports integrated treatment and recovery approaches that address both mental health and substance use issues. These efforts lead Virginia to better recovery outcomes. Without adequate funding, individuals may receive fragmented care, increasing the risk of recurrence of use, overdose, hospitalization, and incarceration. Virginia's sustained investment in organizations such as On Our Own Charlottesville, Mental Health Virginia, and On Our Own Roanoke Valley ensures access to trained peer professionals, evidence-based practices, and community-based recovery-oriented support services critical for long-term recovery and wellness.

Virginia's Advance Directives Initiative, overseen by Honoring Choices of Virginia, provides individuals the ability to pre-plan for a mental health crisis through the use of an Advance Care Plan (ACP). Virginia incorporated mental health care planning into its ACP format as an alternative to developing a separate Psychiatric Advance Directive (PAD). In 2020, through a partnership with Honoring Choices of Virginia and a variety of stakeholders that included peer supporters, service providers, and advocacy organizations, the implementation of this initiative began to educate consumers, family members, and service providers about the importance of pre-planning for mental health crisis care. This state level partnerships trains Qualified Advance Directive Facilitators across the BH system of care. This initiative has equipped the peer workforce within the community services boards to facilitate the creation of an Advance Care Plan for those seeking the resource.

The DBHDS Office of Child and Family Services (OCFS) supports the Statewide Family Network, known as the Virginia Family Network (VFN). VFN is a grassroots network of families committed to providing opportunities to support, educate, and empower other families with children and youth with mental health needs while promoting family-driven and youth-guided policy throughout the child-serving systems. The initiative is designed to "meet the family where they are" through activities such as providing support groups, training, resources, and mentorship from other families with children and youth with mental health needs. The VFN has grown over the past years statewide by

developing groups, trainings, and other resources for families.
Parents/caregivers are also welcome to attend family support groups

The parent groups facilitate the following activities:

- Identifying and referring families to training and other community groups.
- Expanding and utilizing Listservs to provide families with information, education, training, and support opportunities.
- Mentoring and training youth and families through information and resources shared at monthly support group meetings.
- Community networking with local agencies.
- Providing information and resources on how to utilize natural support.
- Providing training, mentoring, and support on how parents/families can work effectively with their service providers.
- Mentoring, supporting and preparing parents/families to participate in workgroups, boards, and commissions.
- Serving as parent representatives for their local Family Assessment and Planning Teams, which assist children and youth with emotional disturbances and other issues to obtain needed community services, and various CSB committees and councils.

Young Adults with Lived Experience

Virginia supports Youth MOVE Virginia. Youth MOVE (Motivating Others through Voices of Experience) is a national youth-led organization devoted to improving services and systems that support growth and development by uniting the voices of individuals who have lived experience in various systems, including mental health, juvenile justice, education, and child welfare.

While working in partnership with youth and young adult leaders, NAMI affiliates, and other community organizations, the goal is to have at least one youth group in every region with an array of trainings being offered throughout the year, all of which are available and within reach of our affiliates. The vision is to be a resource to youth, young adults, affiliates and other organizations, as they grow their efforts to reach youth and young adults.

Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

DBHDS allocates MH and SUPTR block grant funds to support peer-run programs and family and consumer advocacy organizations. In addition, DBHDS has appropriated additional State General Funds to contract for recovery support services for individuals with SUD. Organizations supported with state and federal funds include peer-run recovery centers, resource centers, recovery residence organizations, and advocacy organizations operated by, and for, people with mental health, substance use disorder, and co-occurring disorder, utilizing lived experience that fosters the development of skills related to self-directed care

and informed choice. These organizations offer various peer recovery support services, including individual and group peer support, Action Planning Prevention and Recovery (APPR), recovery coaching, medication-assisted recovery supports, peer-led help groups, mutual aid groups, and telephone warm lines.

DBHDS currently either contracts with or has provided financial support to a variety of organizations that provide peer and family supports, all of which are designed to enhance individuals' skills and ability to engage in informed self-directed care and intervention. Substance Abuse and Addiction Recovery Alliance, Roads to Recovery, Strength in Peers, the Chris Atwood Foundation, and the McShin Foundation are Virginia-based grassroots organizations whose missions are dedicated to providing risk reduction services, recovery supports and services to individuals with substance use disorders. DBHDS has also fostered the development of peer recovery support services into more mainstream settings such as the CSBs, non-profit non-governmental agencies, federally qualified health centers, public health centers, private providers, etc. Housing, employment, and responsive access to services are foundational throughout the state.

Addiction Recovery Treatment Services Medicaid Waiver

Through the ARTS initiative, Virginia Medicaid will reimburse organizations eligible for ARTS reimbursement for peer and family support services. To qualify for ARTS funding, organizations must be licensed by DBHDS and meet service level criteria established by the American Society of Addiction Medicine Criteria or a hospital emergency department licensed by VDH. Peer services can be integrated into any ASAM level of care.

In addition, peer support services will be reimbursed in the following settings where people may be entering care because of mental health challenges and may also have addiction challenges:

- Acute Care General Hospitals licensed by the Virginia Department of Health
- Freestanding psychiatric hospital and inpatient psychiatric units licensed by DBHDS
- Outpatient mental health clinic services licensed by DBHDS
- Outpatient psychiatric services provider (where the practitioner is licensed by DHP
- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
- Day Treatment/ Partial Hospitalization licensed by DBHDS
- Psychosocial Rehabilitation licensed by DBHDS
- Crisis Intervention licensed by DBHDS
- Intensive Community Treatment licensed by DBHDS
- Crisis Stabilization licensed by DBHDS
- Mental Health Skill-building Services licensed by DBHDS.
- Mental Health Case Management licensed by DBHDS.

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ○ Yes ○ No

b) The resilience of children and youth with SED? ○ Yes ○ No

c) The recovery of children and youth with SUD? ○ Yes ○ No

d) The resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ○ Yes ○ No

b) Health care? ○ Yes ○ No

c) Juvenile justice? ○ Yes ○ No

d) Education? ○ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ○ Yes ○ No

b) Costs? ○ Yes ○ No

c) Outcomes for children and youth services? ○ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ○ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ○ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ○ Yes ○ No

b) for youth in foster care? ○ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ○ Yes ○ No

d) Is the state providing trauma informed care? ○ Yes ○ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

7. Does the state have any activities related to this section that you would like to highlight?

8. Please indicate areas of technical assistance needs related to this section.

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

6. Describe how the state provides integrated services through the system of care.

For over thirty years Virginia has had the opportunity to participate in several initiatives to expand and implement Systems of Care (SOC) statewide. Some of the most successful of past initiatives are summarized below:

Children's Services Act (CSA)

- Landmark legislation, to create a collaborative system of services and funding that is child-centered, family-focused, community-based and cost-effective when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth *(Code of Virginia § 2.2-5200).*
- A primary purpose of the law is to preserve and strengthen families through providing appropriate services in the least restrictive environment, enabling children to remain in their homes and communities, when possible, while protecting the welfare of children and maintaining public safety.
- Funding streams placed in the CSA funds pool came from the Departments of Education (DOE), Department of Social Services (DSS), Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Juvenile Justice (DJJ).
- The State Executive Council (SEC) is the Supervisory council that provides leadership for CSA *(Code of Virginia §2.2-2648).* It oversees the development and implementation of state interagency program and fiscal policies. The SEC is chaired by the Secretary of Health and Human Resources or a designated deputy.
- The State and Local Advisory Team (SLAT) is required by statute to advise the SEC by managing cooperative efforts at the state level and to provide support to community efforts. It is comprised of a parent, private provider association representative, representatives from six state agencies, juvenile and domestic relations judge, local CSA Coordinator and local CPMT representatives from community service boards, local departments of social services, court service units, health departments, and schools.
- Community Policy and Management Teams (CPMTs) have the statutory authority and accountability for developing interagency policies that govern CSA in the community. They manage local CSA fund allocations and coordinate community wide planning to develop needed resources and services. They are comprised of a parent, local government official, agency heads from local child serving agencies (community services boards, courts service units, health, social services, and public schools) and private provider. Community agency representatives are authorized to make policy and funding decisions for their agencies. Localities must have a utilization management process and report minimum data on child demographics, services and funding.
- Family Assessment and Planning Teams (FAPTs) are established by CPMTs to provide for family participation, assess the strengths and needs of children and their families, and develop individual family services plans. They

make recommendations to the CPMTs. They are comprised of a parent, representatives from local child serving agencies (community services boards, courts service units, social services, and public schools). They may include a local health department and private provider representatives.

- CSA Coordinators are hired by many communities to manage local implementation, including program, fiscal, and administrative responsibilities.

Services and Supports rooted in System of Care Principles:

Virginia has previously received a SOC Expansion and Sustainability Grant that supported targeted efforts to enhance and expand system of care principles. Current efforts continue to focus on the use of High-Fidelity Wraparound, increasing Family Support and Youth Support services, and providing support to families and youth through the Virginia Family Network and Youth MOVE Virginia.

DBHDS currently supports the Virginia Wraparound Implementation Center (VWIC). VWIC is responsible for the training and ongoing coaching support for all High-Fidelity Wraparound (HFW) workforce members including Intensive Care Coordinators, Youth Support Partners, and Family Support Partners. HFW is an evidence-based approach to working with youth and their families that have multiple system involvement focusing on maintaining the youth in the home/community and supporting the family to develop their system of support and ability to manage the needs of their youth/family. Virginia Department of Social Services has recently partnered with DBHDS to support the use of HFW by adding this service to their Family First Prevention plan. With this new relationship, it has allowed VWIC to partner with the Center for Evidence Based Partnerships (CEP-VA) to begin gathering data from HFW providers specific to fidelity and outcomes. Data gathering began in May 2025 for all providers of HFW. This oversight will help enhance the ongoing coaching efforts in Virginia to support teams in providing this service to fidelity.

Additionally, the Office of Child and Family Services supports Virginia NAMI to maintain the Virginia Family Network and Youth MOVE Virginia that provide targeted supports to youth and families in Virginia. They offer trainings to parents on children's challenging behaviors, offer workshops and webinars, host support groups, have a yearly summit, and support the NAMI VA helpline. Youth MOVE Virginia has been focused on growing local chapters that were impacted by COVID-19 and increasing their presence on college campuses through the NAMI on Campus program. Lastly, parents and youth are offered leadership training options and the ability to serve on the Virginia Family Network of Youth MOVE advisory boards which provides direction, oversight and execution of network activities.

Working with other State Agencies

The Office of Child and Family Services (OCFS) at DBHDS actively participates and collaborates with many state agencies.

The following chart provides a sample of some of the partnerships:

Name of Entity	Meeting Frequency	Lead Agency	Purpose of DBHDS Participation
FAMIS Advisory Committee	Quarterly	DMAS	The purpose of the committee is to assess the policies, operations and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus (children's Medicaid) and to evaluate enrollment, utilization of services, and health outcomes of children eligible for such programs. DBHDS is mandated by the Code of Virginia to have a member serve on CHIPAC.
Child Welfare Advisory Committee	Quarterly	DSS	The Advisory Committee will be the primary organization to advise the Director of the Division of Family Services on child welfare issues including policy and CFSR Plans of Improvement. The Advisory Committee should ensure that all child welfare activities are child centered, family focused, and community based. Child welfare programs include Adoption, Child Protective Services, Family Preservation, Foster Care, and Interstate Compact on the Placement of Children (ICPC).

Commission on Youth	Quarterly	Legislative Branch	Issues impacting children. Serve on COY study committees when needed.
Center for Evidence-Based Partnerships Governance Committee	Monthly	DBHDS/OCS/DMAS/DJJ/DSS/VCU	Governance committee representing child-serving agencies and VCU in a partnership to advance EBP standards, quality, training and outcomes across shared children's initiatives such as Family First, Project BRAVO and STEP VA.
Advisory Committee on Juvenile Justice and Prevention	Quarterly	DCJS	Representation by DBHDS is mandated in Virginia Code
Family First Workgroup	Monthly	DSS	Workgroup convening to keep children safe, strengthen families and reduce the need for foster care whenever it is safe to do so
State and Local Advisory Team	Quarterly	OCS	Representation by DBHDS is mandated in Virginia Code

Outcomes for Children and Youth in Services

DBHDS adopted measurement-based care, using the standardized, Daily Living Activities- 20 (DLA-20), instrument to monitor treatment progress. The DLA-20 beginning on January 1, 2019, will be completed for each child aged 6 and up and adults receiving a behavioral health service in a CSB. This includes mental health, substance use disorders, and co-occurring issues. On March 1, 2019, Community Services Boards fully implemented the DLA-20.

The DBHDS Office of Enterprise Management Services (OMS), formerly known as the Office of Support Services, negotiates and administers performance contracts and monitors the accomplishment of contract objectives, performance and outcome measures, and compliance with contract assurances directly and in conjunction with other DBHDS offices. In addition, OMS facilitates the receipt of CSB data, consults on CSB administrative and management issues, interprets policies and procedures, fosters mutual understanding and cooperation between CSBs and DBHDS, and works with advocacy organizations and stakeholders.

Evidence Based Practice Training

The Office of Child and Family Services at DBHDS has been committed to offering evidence-based practice trainings for several years. Here are the current efforts:

- The Center for Evidence Based Partnerships-Virginia (CEP-VA) is a collaborative effort between Virginia's child serving agencies and Virginia Commonwealth University. Through thoughtful use of evidence, CEP-VA provides scientific input to stakeholders on the performance of the behavioral health system and paths for enhancing workforce capacity. Alongside its partners, CEP-VA co-designs plans to move Virginia toward equitable, accessible, and evidence-informed behavioral health services. Currently, CEP-VA is providing training in several Family First Prevention and Services Act well supported EBPs including Multisystemic Therapy, Functional Family Therapy, Brief Strategic Family Therapy and Parent Child Interaction Therapy. In addition to providing training support, CEP-VA is providing technical assistance (TA) to Virginia's Family First Prevention and Services Act, which has recently expanded to providing fidelity and outcome monitoring for High-Fidelity Wraparound.
- DBHDS is collaborating with DMAS for the behavioral health redesign project. This redesign is focused on replacing previous rehabilitative services in Virginia available to youth and their families with services that are rooted in person-centered, recovery focused, and evidence-based practices. DBHDS is in the process of developing critical training basic standards and identifying specific evidence-based models that could benefit Virginia (such as CBT, Motivational Interviewing, etc.).

Adolescent to Transition Age Substance Use Treatment

The Office of Child and Family Services at DBHDS has made significant progress toward enhancing and expanding the adolescent substance use treatment continuum in Virginia. A thorough needs assessment was finalized in 2022 and strategic planning on the regional and state level has now resulted in some clear areas of growth. Some common themes included peer services for adolescents, supports for parents, prevention/education/screening efforts, and access to services.

DBHDS completed a Youth Support Partner training curriculum in 2024, this curriculum is specifically designed for young adult peer providers looking to provide peer support services to adolescent or young adults. It has been designed to supplement the existing 72-hour Peer Recovery Specialist training that is established in Virginia and provides additional information specific to working with adolescents. The training was offered for the first time in March 2025 with additional training scheduled for the fall of 2025. The Youth Support Partners can work across the continuum of behavioral health care to help young people with their path to wellness and recovery. Currently, the Youth Support Partner service cannot be billed to Medicaid; however, support from the general assembly provides funding for ten positions beginning in July 2025 to help grow this workforce while DBHDS and DMAS work together to explore potential reimbursement in the future.

Some barriers and challenges have been consistent regarding adolescent substance use services. During the assessment and strategic planning process both providers and families felt that the appropriate level of care was not always available, detox supports were lacking, and accessing care were all identified. DBHDS has attempted to partner with local health care providers to implement and sustain higher levels of treatment for adolescents (ASAM level 2.1 and above). However, these services have been underutilized and may highlight a

greater challenge specific to transportation, family engagement/involvement, and ongoing stigma toward treatment.

Workforce shortages were noted as a reason for not being able to access care or care not being available. DBHDS contracted with clinical supervisors with expertise on adolescent substance use services to provide supervision to licensed or licensed eligible staff throughout Virginia that were providing substance use services to adolescents. This was received well; however, utilized American Rescue Plan Act (ARPA) dollars and there is no current ability to sustain this support for the workforce. Additionally, DBHDS was looking to provide technical assistance and training for medical providers and staff specific to Medication for Opiate Use Disorder (MOUD) treatment for adolescents; however, due to ARPA funding cuts this is no longer available. A survey will be going out from DBHDS to Physicians, Nurse Practitioners, and Physician Assistants to assess level of comfort assessing and treating adolescent substance use.

Virginia Youth SBIRT (VA-YSBIRT) Project

In the Fall of 2021, DBHDS launched the SAMHSA-funded Virginia Youth SBIRT (VA-YSBIRT) Project which is based on the screening, brief intervention, and referral to treatment (SBIRT) protocol. Designed to expand/enhance the continuum of care for substance use disorder (SUD) services and reduce alcohol and other drug (AOD) consumption and its negative health impact, VA-YSBIRT provides a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Risk stratification is followed by an abbreviated version Motivational Interviewing – the Brief Negotiated Interview (BNI) and an Active Referral to Treatment (ART) if needed. BNI is a specialized brief intervention with a focus to generate behavior change plans in a brief amount of time. ART involves finding the appropriate and affordable resources and services and ensuring a warm hand-off.

Currently, DBHDS is working with Children's Hospital of the King's Daughters in Norfolk, Virginia to implement SBIRT protocol. This is supported by a DBHDS partnership with the University of Maryland. Additionally, DBHDS is currently looking for school districts interested in piloting VA-YSBIRT in the school setting.

Recovery High Schools

Virginia launched the first recovery high school, Chesterfield Recovery Academy, in the fall of 2022. This regional program offers high school students seeking recovery from substance use a school setting that prioritizes educational goals and recovery principles. Through collaborations such as Right Help Right Now and the Opioid Abatement Authority, DBHDS is now working closely with The Virginia Department of Education (VDOE) to support three more regional programs in Virginia.

Department of Social Services, Services for Older Youth

Fostering Futures is a foster care program offered by the Virginia Department of Social Services available to teens and young adults in foster care after they turn 18. This voluntary program allows local departments of social services (LDSS) to provide financial and social support and services until youth and young adults up to 21 years of age. It can cover things like

- housing (with foster parents, room and board at school, or supervised independent living when you are ready),
- education and/or job training assistance, and
- other independent living needs.

Great Expectations is also available to youth and young adults in foster care. It is a nationally recognized

program that helps Virginia's foster youth earn the postsecondary credentials they need to achieve an independent and successful life. Great Expectations is currently available at 21 of Virginia's Community Colleges.

Great Expectations was created in 2008 as a partnership between Virginia's Community Colleges and philanthropists supporting the Virginia Foundation for Community College Education. The program launched at five Virginia Community Colleges, each of which received a grant to pilot components of the program. Since then, the program has expanded to 18 community colleges across the Commonwealth.

Great Expectations helps Virginia's foster youth complete high school, gain access to a community college education and transition successfully from the foster care system to living independently.

Key components include:

- Individualized tutoring
- Help applying for college admission and financial aid
- Career exploration and coaching
- Help applying for and keeping a job
- Life skills training, including managing finances
- Personalized counseling
- Student mentors

Family First Prevention and Services Act

Virginia used a Three Branch approach for Family First Prevention and Services Act implementation. This approach brought together multiple stakeholders from child serving agencies as well as legislative members. At present, the Virginia Department of Social Services, by providing training to qualified providers, is expanding the evidence-based service (EBS) array in the Commonwealth in order to meet the needs of Virginia's families.

School-based Mental Health

DBHDS has used federal funding through the Consolidated Appropriations Act and the American Rescue Plan Act to address the mental health needs resulting from the COVID-19 pandemic. These funds were specifically used to support the mental health needs of students at risk of/or with Serious Emotional Disturbance as a priority. DBHDS issued grants to Community Services Boards (CSBs) and non-profit providers to contract with schools to support mental health services. Ten (10) CSBs received American Rescue Plan Act Funding and five (5) received Consolidated Appropriations Act Funding. With this funding, CSBs and nonprofits were able to provide a range of services in schools. Currently, there are state general funds available for school-based mental health. DBHDS is working with VDOE and local healthcare providers to continue the focus on mental health services in the school setting.

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

See attached EF 12- Suicide Prevention

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ( ) Yes (●) No

If yes, please describe how barriers are eliminated.

See attached EF 12- Suicide Prevention

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

See attached EF 12- Suicide Prevention

6. Please indicate areas of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors

12. Suicide Prevention

Describe activities intended to reduce incidents of suicide in your state.

Activities Intended to Reduce Incidents of Suicide in Virginia

Suicide is a leading public health concern in Virginia, as evidenced by the 1,211 lives lost in 2022 alone (Office of the Chief Medical Examiner Annual Report, 2022). The Department of Behavioral Health and Developmental Services (DBHDS) recognizes the complex and multi-faceted nature of suicide and has made concerted efforts to address it through various regional and statewide initiatives. These initiatives focus on reducing risk factors such as mental illness, substance use disorders (SUD), social isolation, and trauma exposure while also providing critical care and recovery support services for individuals with serious mental illness (SMI) and serious emotional disturbances (SED).

Have you begun any targeted or statewide initiatives since the FFY 2024-FFY 2025 plan was submitted?

If so, please describe the population targeted.

Key Activities and Initiatives:

Regional Suicide Prevention Initiative (RSPI): The RSPI is a cornerstone of Virginia's strategy to address suicide prevention regionally. The initiative focuses on increasing awareness, providing training for key stakeholders, and developing tailored local interventions to reduce suicide rates. Activities have included targeted outreach, educational workshops, and community partnerships, particularly in high-risk areas.

The Key Goals and Implementation of the RSPI are as follows:

Goal 1: Increase Knowledge of Warning Signs and Equip the Community to Respond
To effectively address the warning signs of suicide or a mental health crisis, the initiative provides community members with the tools they need to recognize these signs and respond appropriately. This includes offering Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, safeTALK, and QPR (Question, Persuade, Refer) courses and other suicide prevention courses listed in the Suicide Prevention Resource Center’s Best Practices Registry. These resources equip individuals to offer support and connect those at risk with the necessary behavioral health services.

Goal 2: Promote Lethal Means Safety for All Virginians
This goal emphasizes the importance of limiting access to lethal means for individuals in mental health crisis. Participating Community Services Boards (CSBs) are required to distribute at least 300 safety devices, such as gun locks, locking medication boxes, and medication disposal pouches throughout local communities. The distribution of safety devices is accompanied by lethal means safety education, tips, and

mental health resources through Virginia's Lock and Talk initiative, supported by DBHDS. Using this multi-faceted initiative with thirteen targeted campaigns ensures a unified message around the importance of securing potentially dangerous items, including firearms and medications. Additionally, CSBs collaborate with firearms dealers, safety instructors, and ranges to provide connections between their clientele and mental health services and partners to promote lethal means safety for suicide prevention.

Goal 3: Tailor Projects to Meet Specific Community Needs

Understanding that each community is unique, the initiative allows CSBs to implement tailored projects that resonate with local needs. This flexibility enables each region to address specific social nuances, community readiness, and the challenges faced by community members. By fostering this localized approach, the initiative promotes community engagement and ensures that suicide prevention efforts align with the values and realities of the population being served.

The Role of Community Services Boards and Prevention Teams

Each CSB is home to a Behavioral Health Wellness (Prevention) Team that plays a vital role in promoting mental health and preventing suicide in its catchment area. These teams are deeply embedded in the community, serving on coalitions, attending events, and providing education and resources. They deliver prevention programs, such as after-school programs, parenting groups, and prevention education in jails, to build connectedness and offer support to individuals at risk of suicide.

These teams are funded by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), and their work extends beyond suicide prevention to also address issues like opioid overdose, gambling, substance misuse, and emotional injury related experiences. They are uniquely skilled and well-positioned to provide suicide prevention services because of this interconnected approach to prevention. By engaging with local communities and coordinating with other regional initiatives, they create a safety net that helps identify and respond to suicidal ideation and behaviors.

CSBs Continue to Focus on those Most Vulnerable to Suicide

Since the submission of the FFY 2022-FFY 2023 plan, Virginia has expanded its suicide prevention efforts with a focus on specific vulnerable populations, including veterans, physically impaired individuals, blue-collar workers, young mothers, rural residents, agricultural workers, and youth who have lost a loved one to suicide.

For example, many Community Services Boards (CSBs) and health districts prioritize outreach and service provision to physically impaired individuals, offering tailored support through programs like case management, peer services, and integrated behavioral health care. Efforts to reach blue-collar and unemployed populations are supported by initiatives that bring mental health education and services into nontraditional settings—such as job centers, trade schools, and workplaces—and by partnerships with organizations that serve veterans, justice-involved individuals, and those impacted by economic instability. Many CSBs also do extensive outreach to members of the military community, hosting health and wellness events specifically for veterans, service members and their families.

In schools, Virginia supports postvention efforts through the *K-12 Suicide Prevention Guidelines* developed

by the Virginia Department of Education. These guidelines provide comprehensive guidance for schools responding to a student suicide or suicide attempt, focusing on crisis response, communication with families and students, staff support, and grief-sensitive practices. Many CSBs actively promote these guidelines and partner with school divisions to help implement postvention procedures, provide consultation and training, and offer in-school counseling or referral support following critical incidents.

Regarding challenges and opportunities in Virginia, the Commonwealth could benefit from the development of LOSS (Local Outreach to Suicide Survivors) Teams, which provide immediate, in-person support to individuals who have lost a loved one to suicide. These teams—typically made up of trained peer survivors and mental health professionals—help reduce isolation, connect survivors with resources, and support healing in the critical hours and days following a loss. Establishing LOSS Teams statewide would strengthen Virginia's postvention infrastructure and reduce long-term suicide risk among loss survivors.

Additionally, funding programs like teenMHFA, and bereavement camps for children and youth who have experienced the loss of a parent, sibling, or close loved one is a powerful early intervention strategy. Training gives youth a language to discuss mental health and seek early intervention. These camps offer age-appropriate grief support, peer connection, and mental health education, helping children build resilience and emotional regulation skills that can significantly lower their risk for depression and suicide later in life.

There are also opportunities to train parents and providers about signs of mental health problems earlier in childhood (ages 10 and younger) as signs and symptoms in very young children often get missed or dismissed. More research is needed in this field to develop programs and interventions focused on supporting younger youth.

RSPI is Part of a Comprehensive Suicide Prevention Strategy

The RSPI aligns with the comprehensive approach to suicide prevention outlined in Virginia's 2023 Suicide Prevention Across the Lifespan Plan. This framework integrates strategies for identifying and assisting those at risk of suicide or a mental health crisis, increasing help-seeking behaviors, and reducing access to lethal means. The initiative also contributes to building a community safety net by training individuals to recognize signs of suicidality and respond effectively.

A cornerstone of the initiative's success is its emphasis on collaboration. CSBs are encouraged to work together within their regions to run awareness campaigns and assist each other in meeting training requirements. This collaborative model strengthens the overall suicide prevention framework, ensuring that resources and support are available across different communities.

The initiative's flexibility allows each CSB to leverage its knowledge of local populations, ensuring that suicide prevention efforts are not only informed by best practices but also by the specific needs of the community. The emphasis on training, education, and community engagement reinforces the shared responsibility of all members of the community in preventing suicide.

One of the ongoing challenges in suicide prevention is the limited availability of real-time data and research. Virginia's current data system lags by two years or more, making it difficult to respond to emerging suicide clusters promptly. Furthermore, the absence of a Suicide Mortality Review Team in Virginia and the

emotional weight of studying suicide present additional barriers to effective research. However, by investing in this initiative and focusing on evidence-based strategies, Virginia can begin to reduce suicide risk factors and create safer environments.

In summary, the Regional Suicide Prevention Training & Suicide-Aware Communities Initiative represents a critical component of Virginia's broader suicide prevention efforts. By increasing public awareness, promoting lethal means safety, and fostering community collaboration, this initiative aims to reduce suicide rates and create a network of support for individuals at risk across the Commonwealth.

Suicide Prevention Interagency Advisory Group (SPIAG)

The **Suicide Prevention Interagency Advisory Group (SPIAG)** plays a crucial role in advancing suicide prevention efforts across Virginia. Formed as a part of the state's broader suicide prevention strategy, SPIAG is a collaborative body that brings together various stakeholders and agencies committed to reducing suicide rates and promoting mental health across the Commonwealth. Its primary focus is to coordinate efforts, enhance the effectiveness of existing programs, and ensure that strategies align with state and federal suicide prevention guidelines.

Role and Purpose of SPIAG

SPIAG serves as a guiding force for the development and implementation of suicide prevention initiatives in Virginia. By meeting regularly to discuss important topics, share resources and best practices, SPIAG helps shape the direction of state-level programs and ensures that suicide prevention efforts are aligned with public health priorities.

The group is composed of representatives from a wide range of sectors, including public health, mental health, substance abuse treatment, education, law enforcement, veterans' services, and community organizations. This diverse membership ensures that the perspectives of different communities and professions are considered when making decisions about suicide prevention strategies. The goal is to foster collaboration across multiple sectors to create a cohesive and comprehensive response to suicide prevention.

Key Functions of SPIAG

1. **Coordinating Statewide Efforts:**
   One of SPIAG's main functions is to coordinate and align suicide prevention efforts across various agencies and organizations in Virginia. This ensures that resources are used efficiently, and strategies are not duplicated, but rather complement each other. The group works to enhance communication and collaboration between public health officials, mental health providers, local governments, law enforcement, and other stakeholders to create a unified front in addressing the suicide crisis.
2. **Monitoring and Reporting:**
   SPIAG contains membership from the Virginia Department of Health which helps monitor the effectiveness of suicide prevention programs and initiatives across the state. By tracking suicide rates and the impact of various interventions, VDH can provide the group with key data to ensure that Virginia's approach remains data-driven and responsive to emerging trends. This ongoing evaluation helps to identify areas where

further intervention is needed and highlights successful strategies that could be expanded or replicated in other parts of the state.

3. **Promoting Public Awareness and Education:**
   One of SPIAG's key priorities is raising public awareness about suicide prevention. SPIAG members work to reduce stigma around mental health and suicide by providing education on warning signs, risk factors, and the importance of early intervention. By promoting understanding and reducing barriers to help-seeking behavior, SPIAG aims to increase the number of people who recognize when they or others need help and are empowered to seek support.
4. **Engaging Community Stakeholders:**
   A key part of SPIAG's success is its focus on engaging local communities. The group fosters relationships with community-based organizations, schools, and local government agencies to build grassroots support for suicide prevention initiatives. This collaborative approach ensures that suicide prevention efforts are not top-down but are informed by the needs and priorities of local communities.

Major Initiatives Supported by SPIAG

1. **Comprehensive Suicide Prevention Plan:**
   SPIAG is instrumental in supporting the development and implementation of Virginia's statewide **Suicide Prevention Across the Lifespan Plan**. This comprehensive framework outlines specific strategies to prevent suicide across all stages of life, from children and adolescents to older adults.
2. **Crisis Services and Intervention:**
   SPIAG advocates for the development of robust crisis response systems, including hotlines, crisis centers, and mobile crisis teams. These services are vital for individuals who may be in immediate danger of suicide. By improving access to these resources, SPIAG ensures that individuals in crisis can get the help they need when they need it the most.
3. **Training and Education:**
   Group members support programs that train professionals and community members to identify and respond to signs of suicide risk. This includes offering Mental Health First Aid training, Applied Suicide Intervention Skills Training (ASIST), and Question, Persuade, Refer (QPR) courses. SPIAG ensures that these training opportunities are accessible across Virginia, equipping a wide range of individuals—ranging from teachers to law enforcement officers—with the skills to intervene and connect individuals to appropriate resources.

Challenges and Opportunities for SPIAG

SPIAG faces several challenges, including limited access to timely and actionable data, competition for funding among agencies and initiatives, and the ongoing difficulty of securing dedicated time and capacity from members to actively invest in group initiatives. These limitations can hinder the group's ability to respond swiftly and effectively to emerging needs.

However, SPIAG is uniquely positioned to turn these challenges into opportunities. With its well represented and engaged coalition of stakeholders, the group has the potential to engage in more cohesive, strategic planning across systems. One key opportunity lies in formalizing SPIAG's role in issuing reports and recommendations at the state level—an area where consistent, coordinated input could help shape stronger, evidence-based policies and resource allocation in suicide prevention. Establishing this function

could significantly enhance SPIAG's influence and impact.

Through strengthened collaboration, policy development, and public education, SPIAG can further advance Virginia's efforts to reduce suicide and support mental health and wellbeing statewide. Its work remains an essential piece of building a resilient, coordinated, and suicide-safer Commonwealth.

Conclusion

SPIAG's contributions to suicide prevention in Virginia are vital to ensuring that initiatives are aligned, evidence-informed, and responsive to community needs. The group plays a critical role in convening cross-sector partners, advocating for essential resources, and identifying strategic gaps and priorities. By focusing on prevention, intervention, and postvention—and exploring ways to formalize its advisory capacity—SPIAG continues to foster a culture where mental health is prioritized, and suicide prevention is embraced as a shared, statewide responsibility.

Lock and Talk: A Comprehensive Suicide Prevention Strategy

Lock and Talk is an innovative and comprehensive suicide prevention initiative that has made a significant impact in Virginia and beyond. It focuses on limiting access to lethal means, a key factor in suicide prevention, while encouraging open conversations about mental wellness and suicide risk. Launched in May 2016 as a Region 1 suicide prevention initiative with support from Regional State Suicide Prevention Initiative funds, *Lock and Talk* has grown to be implemented across all 40 Community Services Boards (CSBs) in Virginia, with expansions into eleven counties in New York and one county in Maryland as of 2025. The initiative is based on the principles outlined in the National Strategy for Suicide Prevention and benefits from insights provided by national experts in suicide prevention.

Key Goals and Components of Lock and Talk:

Lethal Means Safety: One of the core elements of *Lock and Talk* is promoting the safe and responsible care of lethal means, particularly firearms and medications. Research has consistently shown that limiting access to lethal means during a crisis significantly reduces the risk of suicide. The initiative encourages community members to temporarily remove firearms, medications, and other dangerous items from the environment of someone at risk. These objects—whether firearms, weapons, medications, household chemicals, ligatures, other materials used in suicide attempts—should not be easily accessible to individuals in crisis.

Engagement in the Lethal Means Safety Conversation: A critical part of *Lock and Talk* is engaging individuals at risk and their families in conversations about lethal means safety. Ensuring that these individuals, as well as their loved ones, understand the importance of securely storing potentially dangerous items is vital in preventing impulsive suicide attempts. Even after a crisis has passed, it is important for these conversations to continue, as they lay the foundation for long-term safety.

Distribution of Safety Devices and Education: To assist in the safe handling and storage of lethal means, *Lock and Talk* provides community members with safety devices and instructional materials. These include

gun trigger locks, gun cable locks, medication safety devices (such as boxes, pouches, timer-top pill bottles, and medication deactivation kits). These tools empower individuals and families to protect themselves and their loved ones from harm, contributing to a safer environment in times of crisis.

Fostering Community Conversations about Suicide Prevention: In addition to physical safety measures, *Lock and Talk* is dedicated to fostering open conversations about suicide prevention and mental health. By encouraging discussions around mental wellness and the signs of suicide risk, the initiative works to reduce the stigma surrounding mental health challenges. Talking about suicide is shown to promote help-seeking behaviors, reduce feelings of isolation, and encourage individuals to seek the support they need. This is especially crucial for survivors of suicide attempts and those who have experienced the loss of a loved one to suicide, as these conversations help support their healing journeys.

Education and Empowerment: At the heart of *Lock and Talk* is community education. The initiative provides training for individuals, families, and communities to recognize the signs of suicide risk and take appropriate action. By educating the public about the dangers of easily accessible lethal means and the importance of safe storage, *Lock and Talk* empowers people to act as catalysts for care. Participants learn how to identify warning signs, offer support, and guide individuals at risk to the appropriate resources. This collective effort helps build a network of informed and compassionate individuals who are prepared to intervene and support others in times of crisis.

Expanding the Impact

The *Lock and Talk* initiative continues to grow and evolve, having expanded to all regions of Virginia and reaching into communities in New York and Maryland. It is part of a broader effort to make suicide prevention a shared responsibility across all sectors of society. Through collaboration with local community service boards, healthcare providers, schools, and other stakeholders, *Lock and Talk* is creating a network of prevention efforts that span the Commonwealth and beyond.

As a part of Virginia's overall suicide prevention strategy, *Lock and Talk* complements other efforts like the Regional Suicide Prevention Initiative (RSPI), ASIST, and safeTALK programs. Together, these initiatives work toward a comprehensive approach to suicide prevention, where lethal means safety is a central pillar, and community engagement and education play a key role in addressing this growing public health crisis.

Needs

While significant progress has been made, several needs remain in Virginia's suicide prevention efforts. These include:

- **Access to care**: While training and programs are expanding, geographic disparities and limited access to mental health services in rural areas continue to hinder the ability to reach all at-risk populations.
- **Stigma**: Stigma surrounding mental health and suicide remains a challenge, particularly in certain cultural and community contexts. Increased public education and outreach are essential to overcoming these barriers.
- **Data limitations**: While the state has made strides in collecting suicide-related data, there is still a need for more comprehensive, real-time data collection to guide targeted interventions and resources.

Conclusion

Virginia's suicide prevention efforts are grounded in a commitment to evidence-based strategies and addressing the needs of vulnerable populations. By focusing on regional initiatives, training programs, and new partnerships, the state is making significant progress in reducing suicide rates and providing the necessary support to those at risk. However, continued efforts are needed to ensure that no one is left behind in these critical initiatives.

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Please see attached EF- 13 Support of State Partners

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Please see attached EF- 13 Support of State Partners

4. Please indicate areas of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

13. Support of State Partners -Required for MHBG

Has your state identified the need to develop new partnerships that you did not have in place? Y / N ? YES

If yes, with whom?

Adult Behavioral Health

Assertive Community Treatment (ACT): The Office of Adult Community Behavioral Health (OACBH) has maintained a contractual relationship with the University of North Carolina's (UNC) Institute for Best Practices since 2016. OACBH has identified three areas of emphasis within this effort to include training, technical assistance, and fidelity monitoring utilizing the Tool for Measurement of Assertive Community Treatment (TMACT).
OACBH staff and ACT providers have access to the Institute's expert staff, led by co-author of the TMACT, Dr. Lorna Moser, through formal/scheduled meetings and topic-specific trainings as well as impromptu consultation on a range of both practice and policy matters.
Perhaps more so than any other EBP, the quality and cost-effectiveness of ACT is directly related to the degree to which key elements of the service are implemented. To this end, DBHDS has prioritized high-fidelity ACT across the Commonwealth by integrating fidelity evaluations of all ACT programs into state policy. Currently the Institute leads this effort but has begun to train OACBH staff with the goal that eventually most, if not all such activities will be supported internally utilizing DBHDS infrastructure.

MSV/APAL: DBHDS has contracted with Medical Society of Virginia (MSV) for the implementation of the Adult Psychiatric Access Line (APAL). MSV is a professional association representing medical doctors from all specialties across Virginia. With over 10,000 physician members, MSV provides administrative, membership, and legislative services to members, and serves as a liaison between various agencies/organizations and its members. As previously described, APAL is a resource for primary care providers treating individuals with SUD in their practices, and consists of three components: 1) Provider education program on screening, diagnosis, management, and treatment of SUDs; 2) Access to telephonic consultations via regional hubs comprised of addiction medicine specialists and psychiatrists, psychologists, social workers, and/or prescribing providers; and 3) Care navigation assistance to help identify additional regional behavioral health services and resources. While currently specializing in SUD in Central Virginia, APAL will ultimately aim to serve all regions of Virginia and expand to additional populations, including geriatric, young adult, and general adult mental health. In addition to APAL, DBHDS has partnered with MSV for a newly awarded SAMHSA PIPBHC grant for the Collaborative Care Model (CoCM). This will allow for the implementation of CoCM in three primary care practices in Virginia, in part by leveraging APAL resources. MSV has helped to facilitate relationships with various partners throughout the implementation and expansion of these

programs, including physician organizations that assist with developing continuing medical education trainings, addiction treatment centers and hospitals with addiction programming, and primary care practices throughout Virginia.

DARS/Supported Employment: DBHDS has strengthened an existing relationship with the Department for Aging and Rehabilitative Services (DARS) related to supported employment efforts. DARS serves as a liaison with DBHDS and CSBs and provides consultation on vocational rehabilitation services for individuals with behavioral health disorders. DBHDS participates in an Employment First Advisory Group, consisting of DARS, Department of Education, CSBs, and Employment Service Organizations (ESOs) in Virginia. Recently, DBHDS has incorporated additional behavioral health representation from the CSBs in planning with DARS, in an effort to more widely implement and strengthen supported employment services for individuals with behavioral health needs in Virginia. Supported employment is a component of the Psychiatric Rehabilitation step of STEP-VA and provides consumers with opportunities to find and keep competitive employment, thereby increasing positive outcomes for individuals engaged in these services. Through a partnership with DARS and the above-mentioned organizations and agencies, DBHDS aims to strengthen the readiness of CSBs to implement, expand, or enhance supported employment services in alignment with best practices. For some CSBs, this may include the implementation or enhancement of Individual Placement and Support (IPS SE), an evidence-based practice for individuals with SMI. DBHDS will work with DARS, who monitors the fidelity of these programs.

Substance Use

DBHDS continues to support the CSBs/BHAs to provide excellent care to the residents of the Commonwealth. There is an effort to build a Faith Based system to assist with substance use issues within the various communities. There is a great deal of technical assistance that is provided by OSUS to assist the communities with receiving funding. CSBs that have Office Based Opioid Treatment (OBOT) programs, DBHDS offers technical assistance with continuing or setting up the program. DBHDS will give information to resources to other businesses that are interested in opening an OBOT. DMAS/ARTS began in 2017, and the current waiver expires in December 2025, but a renewal has been applied for by DMAS.

VDH and DBHDS partners together with opioid overdose prevention program (REVIVE) and Naloxone distribution. DBHDS provides funding to support VDH's project that makes naloxone available through the local health departments.

Department of Corrections (DOC) and DBHDS are working together to get Methadone clinics open in the incarceration facilities.
Virginia Commission on Alcohol Safety Action Programs (VASAP)

Virginia Association of Chiefs of Police (VACP) and DBHDS have a partnership to provide resources and train first responders on Naloxone treatment for suspected overdoses in an emergency.

The State Supreme Court, Virginia Tech, and the Opioid Abatement Authority along with DBHDS/OSUS collaborate to aid technical assistance regarding treatment and addiction in the Recovery Courts of Virginia.

Virginia Addiction and Recovery Council: DBHDS provides staff to support the Addiction and Recovery Council, which focuses on matters regarding addiction and recovery.

Virginia Drug Treatment Court Advisory Committee: The Virginia General Assembly established special docket drug treatment courts under the Drug Treatment Court Act (§18.2-254.1). The goals of drug treatment courts in Virginia include reducing drug addiction and drug dependency among offenders, reducing the incidence of drug use, drug addiction, family separation due to parental substance abuse, and drug related crimes. As cited by the Drug Treatment Court Act, the state drug court advisory committee is established to evaluate and recommend standards for the planning and implementation of drug treatment courts; assist in the evaluation of their effectiveness and efficiency; and encourage and enhance cooperation among agencies that participate in their planning and implementation. The committee membership includes executive branch agencies (DBHDS, DCJS, DJJ, DOC, & DSS), and local community-based probation and pretrial services agencies, legal and law enforcement entities, and representatives from the Virginia Drug Court Association includes executive branch agencies (DBHDS, DCJS, DJJ, DOC, & DSS), and local community-based probation and pretrial services agencies, legal and law enforcement entities, and representatives from the Virginia Drug Court Association.

The It Only Takes One fentanyl awareness initiative has a simple message —" it only takes one mistake to take a life: but one conversation or intervention to save a life,”

State legislation has been developed for mobile OTPs. DBHDS is working with the Department of Corrections to open Methadone clinics within the incarceration facilities. DBHDS and the State Opioid Treatment Authority (SOTA) are also focusing on providing Technical Assistance for companies/agencies that want to open OTPs in the desert areas.

A central registry is being developed to ensure that in the case of a state of emergencies no one must miss a dose of medication. It will also serve to verify that no one is enrolled in more than one OTP.

Virginia Tech and DBHDS/OSUS partner on two separate projects. The first project is with the ASAM training being conducted across the Commonwealth. ASAM Criteria is a tool that assists with standardizing the assessment process of diagnosing and finding the appropriate level of care for people with SUDs. This includes recognizing where OTPs would benefit the population with OUD. ASAM also promotes collaboration between all levels of care, allowing for a more holistic approach to substance use treatment. The second is a Judicial Training project that is engaging with the Supreme Court, VA Tech, and OAA. This training is focused on providing educational materials to the Specialty Dockets, specifically Recovery Court, on addiction and various evidence-based practices for treatment.

Child and Family Services

The Office of Child and Family Services is participating in or leading several new workgroups or

taskforces. They include the following:

Reclaiming Childhood Taskforce**:** The Task Force is convened by the Secretary of Health and Human Resources, and includes parents and kids from around Virginia, as well as pediatricians, mental health experts, educators, faith leaders, community leaders, private sector technology experts, and public safety leaders to:

1. Raise awareness about the potentially harmful effects of social media on children's physical and mental health.
2. Recognize that government cannot solve this problem alone and therefore must collaborate and create opportunities and avenues for private sector cultural change to ensure healthy child development.
3. Convene experts and thought leaders to highlight the best practices and approaches to improving children's mental health outcomes.
4. Make recommendations to the Governor and General Assembly on additional government solutions.

Center for Evidence-Based Partnerships Virginia Coordinating Committee: CEP-Va is a partnership between executive branch agencies of the Commonwealth of Virginia and Virginia Commonwealth University (VCU), and was established to support the development, implementation, promotion, sustainability, and evaluation of evidence-based and evidence-informed behavioral health and related services (EBPs) for children, families, and young adults through age 25. The Center is housed at VCU.

House Bill 1760 Early Childhood Mental Health Workgroup**:** Directs the Virginia Department of Health (VDH), in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Education (DOE), to convene a work group to develop a plan to:
(i) create a mental health screening and assessment tool for children in early childhood care and
(ii) provide mental health consultation resources and training to early childhood education providers, pediatric health providers, and families.

DBHDS, as the Lead Agency, has curated a group of Commonwealth Stakeholders with expertise in Infant and Early Childhood Mental Health and Consultation that will lead the work. Partners include Virginia Commonwealth University (VCU) Health Systems Pediatrics, Early Intervention, VCU Partnership for People, Virginia Mental Health Access Program (VMAP), Virginia Department of Health and more.

The work group shall report its findings and recommendations to the Chairs of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by November 1, 2025.

Virginia Mental Health Access Program (VMAP) Care Navigation Regional Advisory Meetings: Over the past two years, the Virginia Mental Health Access Program (VMAP) established quarterly regional care navigation advisory committees. These external committees facilitate regional conversations between individuals who work in pediatric community services (school providers, mental health workers, those with lived experience, etc.) and the VMAP Regional Hub teams. Committee meetings involve opportunities to share local service updates, discuss mental health concerns and trends in the

community, and explore new advocacy opportunities. There are committees established in every region, including our newest VMAP expansion, VMAP for Moms+.

Youth Substance Use Strategic Plan: The Office of Child and Family Services recently concluded a multi-year, needs assessment, capacity assessment, strategic planning and implementation guide process on the Adolescent Substance Use continuum of care with the OMNI Institute. As part of this process, meetings were convened with experts representing various sectors of the adolescent substance use system of care across the Commonwealth. These experts participated in strategic planning sessions to identify future strategies that could be implemented to reduce the gaps and barriers identified during the capacity assessment stage of the process.

Recovery

The DBHDS Strategic Plan in 2023 included an initiative to increase Virginia's certified peer workforce by 10% by the end of the year (1 KR-1D). Several Office of Recovery Services projects were developed and funded to ensure success. The first was creating a pathway from training to certification within the public behavioral health system. Federal dollars allowed a Request for Proposal to CSBs to begin Peer Recovery Specialists (PRS) internship programs. Internships allow CSBs to increase the peer workforce, provide access to training and education, and the 500 hours needed to sit for the certification exam. Internship development has increased access to this evidence-based service across the public BH system.

The DBHDS strategic goal to increase the certified peer workforce was reached within 6 months of its initiation. Due to this strategic objective, a staggering 1500 Certified Peer Recovery Specialists (CPRS) have been added to Virginia's workforce. As internships for peer providers increased, positioning the behavioral health system to bill Medicaid for this service became a priority and funding was provided to increase the billing infrastructure within the public system to reimburse for these services.

Internship programs were also developed within the Virginia Recovery Community Organizations (RCO). Five VA RCOs aligned with the state to support this initiative: The McShin Foundation, Strength in Peers, Robins Hope, Chris Atwood Foundation, and Family Support Partners of Virginia.

Block Grant funding was utilized to develop the Recovery Leadership Academy (RLA). The Academy is a 10-month training opportunity to empower peer recovery specialists and family supporters to become effective emerging industry leaders and agents of change by providing organizational leadership skills and experiences. Monthly training sessions focus on leadership skills and strategies development, emotional intelligence, coalition building, team building, and problem-solving with Capstone projects and presentations. Over 120 CPRS' have participated in the RLA which includes a mentor and skills practice in the field.

Crisis

DBHDS has recognized the critical need to expand and formalize partnerships to ensure that the statewide Crisis Continuum is responsive to the unique needs of all populations, including individuals with Developmental Disabilities (DD) and Traumatic Brain Injury (TBI). Within the Division of Crisis Services, we have launched an initiative titled Project Link to specifically address this gap.

Project Link is a structured collaboration designed to enhance the accessibility, equity, and quality of crisis services for individuals with DD and TBI. Through this initiative, DBHDS convenes a bi-monthly stakeholder workgroup that brings together representatives from state agencies and private advocacy organizations. These meetings serve as a platform to identify and address systemic barriers to crisis care, assess training needs for crisis providers, and support the development of policies and practices that promote person-centered, trauma-informed service delivery.

Key partners in Project Link include Department for Aging and Rehabilitative Services (DARS); Department of Medical Assistance Services (DMAS); Community Brain Injury Services; The Arc of Virginia; Virginia Board for People with Disabilities; Virginia Commonwealth University's Partnership for People with Disabilities.

Through this coordinated effort, we are building a more inclusive Crisis Continuum that can meet the diverse needs of Virginians with complex support requirements. Project Link is not only fostering new partnerships but also laying the groundwork for improved service alignment, increased provider competency, and ultimately, better outcomes for underserved populations.

Housing & Homelessness

DBHDS oversees the SAMHSA Projects for Assistance in Transition from Homelessness (PATH) grant and directly funds nearly three thousand slots of state-funded Permanent Supportive Housing (PSH) for both adults with SMI and Pregnant or Parenting Women with Substance Use Disorders (SUD).

An interagency Permanent Supportive Housing Steering (PSH) Committee develops and implements strategies to increase PSH to address important state priorities, including homelessness and Olmstead compliance.

The Committee includes representation from DBHDS, Virginia Housing (VH, the Commonwealth's Housing Finance agency), Department of Housing and Community Development (DHCD) and the Department of Medical Assistance Services (DMAS).

In addition to DBHDS's PSH funding, other agencies have made significant resource commitments to increasing housing development. For example, VH secured a HUD Section 811 grant to provide rental assistance to the target population and established a commitment for a leasing preference for DBHDS referrals for 10% of all units produced by Virginia's Low Income Housing Tax Credit Program (LIHTC).

VH and DBHDS collaborate with local CSBs and property managers to coordinate referrals and ensure connections to supportive services. Virginia's Right Help, Right Now plan includes activities to ensure the long-term sustainability of this interagency partnership. As a result, a formal interagency MOU has been executed to ensure each agency's commitment to the Permanent Supportive Housing Steering

Committee.

Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Programs offices for crisis, adult community mental health and SUD services, and child and family services have been a key stakeholder in Governor Youngkin's Right Help Right Now reform in the efforts to increase the ability to assist people before crises and prevent those who have been discharged from inpatient facilities from being re-hospitalized.

Among those programs that have helped increase capacity to ensure individuals can receive services in the community as opposed to more restrictive inpatient settings are:

Assertive Community Treatment (ACT): Virginia has 56 ACT teams which are collaborative units that consist of behavioral health workers and medical staff who assist individuals with serious mental illnesses (SMI) to access and maximize mental and medical health care. This is done through intensive services that can include daily follow-up as needed.

988, Co-Response and Marcus Alert Implementation: Virginia currently has 50 local 911 centers that are integrated with 988 helpline services to increase efficiency and improve the overall effectiveness and appropriateness of services rendered in response to potential crises.

Additionally, Virginia also now has 23 co-response teams with police and behavioral health staff collaborating to calls for emergencies rather than in silos which historically has resulted in increased hospitalization and incarceration of people experiencing SMI

Furthermore, the Commonwealth currently has over 100 mobile crisis teams which consist of behavioral health staff who can be deployed in the community and respond locally to people in crises as opposed to individuals or families navigating how to bring someone into a facility for response to the emergency.

School Based Mental Health: The Office of Child and Family Services (OCFS) provides grants to school divisions to partner with providers to offer School Based Mental Health (SBMH) services. These services are provided by clinicians inside schools during the school day and are provided based on a Multi-Tiered System of Support (MTSS) approach with both group and individual supports available. Providing these services in the school setting helps to allow youth to remain in their comprehensive school while receiving the appropriate mental health assistance which can mitigate the need for a higher level of care.

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

The Council is provided with drafts of the application and reporting and holds a meeting on August 20 2025 to discuss both a provide needs/concerns and recommendations for the block grants and state behavioral health plan and initiatives. Those are then included in a letter to the DBHDS Commissioner and is attached to this application. The Commissioner will then draft a response to provide input on the feedback provided by the Council.

The Council continues to try to improve its process towards providing feedback to the application and state plan by having DBHDS Research & Evaluation come to meetings early in the year to share updates on priority areas and performance indicators. Committees are also meeting prior to the August meeting to begin formulating recommendations for the letter to the Commissioner.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — (●) Yes ( ) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

DBHDS in addition to the State Block Grant Planner has provided individuals from the Office of Community Behavioral Health Services, Office of Child and Family Services, Office of Recovery Services, to staff the Council. Individuals with lived experience in a variety of backgrounds participate in the Council as members many also represent organizations that do community work in mental health, substance misuse, and recovery. This provides multi-faceted perspectives on key issues across behavioral health.

In 2025, DBHDS is planning to begin technical assistance with Advocates for Human Potential again, this time to work on strengthening the internal policies and procedures to align with federal best practices. Delays occurred in getting this started but the plan is to begin in July 2025.

In response to SAMHSA's expectations that states integrate their Mental Health Planning Councils to include substance abuse and addiction recovery perspectives, DBHDS began discussing the integration of Virginia's Mental Health Planning Council in the summer of 2011. The Council embraced the idea, and December 2011, voted to change its name from the Virginia Mental Health Planning Council to the Virginia Behavioral Health Advisory Council (BHAC). The Council subsequently voted to modify its bylaws to add seats specifically for individuals who have lived experience with substance use disorders or with co-occurring mental health and substance use disorders, their family members, substance abuse/addiction recovery advocates, and providers of substance abuse treatment services. Seats also were added for state agencies that had particular relevance for addiction services that were not represented on the Council, including the Virginia Department of Health and the Department of Criminal Justice Services.

Nevertheless, there is still a significant need to recruit individuals with lived experience regarding substance use disorders to help balance the representation of the Council. The hope is that the federal TA will also assist with recruitment and onboarding strategies so that the Council can operationalize its budget more effectively and broaden its membership and expertise.

BHAC has worked diligently following receiving federal technical assistance to rework bylaws and policies and procedures as there are still several areas where there is need for improvement. The council has identified the need to recruit new members especially including those from diverse backgrounds and from different parts of the state. Additionally, it has identified the need for improved onboarding, training, committee and meeting structure to help narrow scope and empower the council to provide meaningful input on state behavioral health services.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ( ) Yes (●) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Vision: Effective, efficient, and accessible behavioral health services for all Virginians.

Mission: To transform Virginia's behavioral health system to reflect the highest quality of health, recovery, and wellness across the lifespan.

Per its bylaws, the Council serves as an advisory and information-sharing body which meets six times each year. In that role, the Council is responsible for reviewing and providing input to Virginia's annual behavioral health plan. As the combined Single State Agency and State Mental Health Authority, DBHDS retains responsibility for planning, allocating and managing the Mental Health and Substance Abuse Prevention and Treatment block grants. As an advisory and information-sharing body, the Council's role currently is to provide input on those components from a peer-led and multidisciplinary perspective as well as to advocate regarding behavioral health issues across the Commonwealth.

The council has continued to work on policies and procedures and bylaws and has waited for technical assistance from SAMHSA to make some more finalized changes. However, the Council has been effective in drafting letters to the Commissioner's Office requesting information and follow ups to Commissioner's responses. Currently, the council drafts a yearly letter to the DBHDS commissioner which is attached to this application once completed. Additionally, the council drafts a letter to relevant legislative committees at the end of the year advocating for issues that the council has identified as critical to effective behavioral health services.

In 2025, there is significant work that needs to be done for the council to have a more robust diverse membership, provide consistent meaningful feedback that has an impact on the decisions of DBHDS, and advocate for services for those in need in Virginia. There are still needs for members from rural settings, members from representing different communities, members who have disabilities, etc. Additionally, there is the need for better bylaws and policies and procedures to formalize processes and allow for more consistent output from the council. The hope is that technical assistance starts soon because the Council is committed to working on strengthening its internal composition and standardizing practices for onboarding and recruitment.

7. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Patrice Beard	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			pabeard@vcu.edu
Robin Binford-Weaver	State Employees			robin.binford@djj.virginia..gov
Dietrich Bragg	Providers			dbragg@bdmhsva.com
Rhonda Bryant	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			rhondambryantphd@gmail.com
Cristy Corbin	Parents of children with SED			cristycorbin@fspofva.com
Adam Creveling	State Employees			adam.creveling@dss.virginia.gov
Bruce Cruser	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			bcruser@mentalhealthvirginia.org
Karen Grabowski	State Employees			k.grabowski@dbhds.virginia.gov
Jason Lowe	State Employees			jason.lowe@dmas.virginia.gov
Nick Macrini	Advocates/representatives who are not state employees or providers			nmacrini@namivirginia.org
Martin Mash	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			martin@vocalvirginia.org
Mary McQuown	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			mary.mcquown@dbhds.virginia.gov
Margie Millner	State Employees			margie.millner@dars.virginia.gov
	Family members of individuals in			

Sandra Nichols	recovery (family members of adults with SMI and family members who are not parents of children with SED)			sandra@panaceabhwc.com
Heather Orrock	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			hsorrock@mentalhealthvirginia.org
Nicholas Pappas	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			nicholasjpappas@hotmail.com
Heather Pate	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			heather@robinshope.com
Dreamel Spady	Providers			dreamel@renewalgrowthhealing.com
Kristinne Stone	State Employees			kristinne.stone@doe.virginia.gov
Kristin Vaughn	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			kristinrvaughn@gmail.com
Justin Wallace	State Employees			justin.wallace@vdh.virginia.gov
Susan Williams	State Employees			susan.williams@vadoc.virginia.gov
Bently Wood	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			bentlywood@gmail.com

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	7	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	4	
3. Parents of children with SED	1	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**12**	**46.15%**
6. State Employees	8	
7. Providers	2	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**10**	**38.46%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	1	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	3	
15. Total non-required but encouraged members	**4**	**15.38%**
16. Total membership (all members of the council)	**26**	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Membership has been closed while awaiting technical assistance to ensure that bylaws and policies and procedures were aligned with best practices and that onboarding was in place to ensure recruitment and retention of prospective members. Therefore vacancies were listed as zero in multiple categories but still could benefit from increased representation.

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://dbhds.virginia.gov/behavioral-health/mental-health-services/
https://commonwealthcalendar.virginia.gov/Event/Details/71471

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dbhds.virginia.gov/behavioral-health/mental-health-services/

https://commonwealthcalendar.virginia.gov/Event/Details/68239

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

DBHDS partners w/ VDOH for syringe services