DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Biennial Report on Substance Abuse Services
Per Code of Virginia § 37.2-310

to the Governor and
Members of the Virginia General Assembly

January 10, 2014

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COMMONWEALTH of VIRGINIA

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January 10, 2014

To: The Honorable Robert F. McDonnell

and

Members, Virginia General Assembly

I am pleased to present to you the Biennial Report on Substance Abuse Services, required by the *Code of Virginia* § 37.2-310 Subsection 4.

This report provides information on the public funds allocated to the department for the treatment and prevention of substance abuse and epidemiological information about the incidence and prevalence of substance use disorders in the Commonwealth, the resources available to address these needs, and highlights of the activities undertaken by this department in the past two years to provide services for prevention and treatment.

Substance use disorders, a group of disabling illnesses characterized by continued use of alcohol, drugs, and other substances in the face of known harm, affect all residents of Virginia, even those who do not imbibe or use any drugs, with widespread consequences for public health, safety, and economic loss. However, with appropriate help and support, recovery is possible. Persons in recovery can lead full lives as contributing tax-paying citizens who are fully engaged in the communities in which they live.

This report describes the major initiatives of this department in the last two years. I hope you will find it useful.

Sincerely,

James W. Stewart, III

Biennial Report on Substance Abuse Services
Per Code of Virginia § 37.2-310
to the Governor
and Members of the Virginia General Assembly

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EXECUTIVE SUMMARY

Overview
Title 37.2 of the *Code of Virginia* establishes the Virginia Department Behavioral Health and Developmental Services (DBHDS) as the state authority for alcoholism and drug abuse services. DBHDS works to ensure efficient, accountable and effective services available for citizens with substance use disorders. The department is responsible for the administration, planning and regulation of services for substance use disorders in the Commonwealth.

This biennial report is submitted in accordance with § 37.2-310 Subsection 4 which requires DBHDS:

> *4. To report biennially to the General Assembly on the comprehensive interagency state plan for substance abuse services and the Department's activities in administering, planning, and regulating substance abuse services and specifically on the extent to which the Department's duties as specified in this title have been performed.*

This report provides epidemiological information about the extent to which substance use disorders affect the residents of the commonwealth, information about services provided and the individuals who received these services, and reports on major activities of the department on their behalf.

Nature, Scope and Degree of Substance Abuse in Virginia
Epidemiological information about the numbers of residents using, abusing and dependent on alcohol and other drugs in Virginia is derived from the National Survey on Drug Use and Health (NSDUH), conducted annually under the auspices of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH data, collected from individuals age 12 and older, can be analyzed regionally and by age groups. Another source of information is the Office of the Chief Medical Examiner at the Virginia Department of Health (OCME) which reports drug-caused deaths on an annual basis.

Over half (54.6%) of Virginians drink alcohol, and nearly half of these (23.21% of all Virginians) engaged in binge drinking (drinking five or more drinks in one occasion) in the month prior to the survey. This increases to 44.56% for those 18-25. Nearly seven percent (6.92%) of Virginians meet the criteria for abuse or dependence on alcohol (see Appendix C for definitions), and this rises to 16.27% for those 18-25. The proportion needing but not receiving treatment for alcohol use is 6.42% for the general population, rising to 15.32% in the 18-25 age group.

Illicit drugs include legal drugs that are used illicitly as well as drugs that are illegal. While fewer than eight percent (7.98%) of Virginians age 12 and older used illegal drugs in the month

prior to the survey, that figure rises to 9.45 % for those 12-17 and 21.02% for those 18-25. In the past year, 9.98% Virginians used marijuana but, following the same pattern, 12.88% of those between 12-17 and 28.92% of those 18-25 used this drug. The rate of nonmedical use of pain relievers in the past year is 4.6% for the Commonwealth, higher than the national rate of 4.57%. Age data indicate that this is a significant problem among youth in Virginia, with 5.95% of those 12-17 and 11.39% of those 18-25 reporting nonmedical use of pain relievers in the past year. The proportion of Virginians needing but not receiving treatment for illegal drug use is slightly less (2.18%) than the national rate of 2.40%, but the rate among those 12-17 is 4.25%, climbing to 6.74% for young adults ages 18-25.
(http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/NSDUHsaeStateTabs2011.htm#Tab104)

The Office of the Chief Medical Examiner's 2011 Annual Report indicated 818 people died due to drug/poison caused deaths, an increase of 18.2% since 2010. Prescription drugs accounted for 61.74% of these deaths while 17.48% were caused by illegal (street) drugs. Per capita rates of drug caused deaths were higher (9.6 per 100,000) than motor vehicle crashes (9.4 per 100,000) in the Commonwealth in 2011. One-third of all drug-caused deaths in the Commonwealth happened in the western part of the state, but the prevalence of prescription drug deaths has risen dramatically in other regions of the state as well, specifically in the northern and central regions. (http://www.vdh.state.va.us/medExam/documents/2013/pdf/Annual%20Report%202011.pdf)

Characteristics of the Public Service System

Public community-based substance abuse services are provided through the 40 community services boards (CSBs) established in Title 37.2 of the *Code of Virginia*. CSBs provide services either directly or through contracts with other services providers. In State Fiscal Year 2012 (the most recent data available), the CSB system provided clinical substance abuse services to 36,743 individuals at a total cost of $106,561,525. Sources of funding include federal grants ($43,956,776), state general funds ($46,629,700), local government ($38,889,682) and fees and third party payors ($2,875,071). Two-thirds of those served are male and over one-third (38.1%) are between the ages of 26-40. Sixty percent are White, nearly one-third (28.89%) are Black, slightly more than six percent represent other groups, and two percent identified themselves as multi-racial. Over one-third (36.69%) are referred by the criminal justice system. Alcohol is the primary drug for which most individuals are seeking treatment (40.42%), followed by marijuana (22.87%), closely followed by opiates (21.85%).

Major Activities

Treatment

Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development. DBHDS prepared a strategic plan for substance abuse services and presented it in October 2011. This plan was the result of a two-stage, two-year process involving advocates and individuals receiving services, providers, and other key state agencies. The resulting plan, *Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development* (http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf), indicates that nearly $54 million is needed to improve access to services, address gaps in the array of services and provide adequate support services to those in need of substance abuse treatment.

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS). In 2012, DBHDS received competitive grant funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in a federally-sponsored policy initiative focused on implementing recovery-oriented systems of care (ROSC) for people with both mental illness and substance use disorders. DBHDS used part of the $50,000 award to sponsor a statewide Recovery Forum in Roanoke on June 9-11, 2013. Approximately 110 persons representing all seven regions of the state and CSBs, state facilities, DBHDS staff, and the substance abuse and mental health peer and advocacy services communities participated. A steering committee has been organized to continue work on these goals and to plan a second Recovery Forum.

National Governors Association Prescription Drug Prevention Project. As abuse of prescription drugs continues to be a problem for the nation and in Virginia, the Commonwealth was competitively selected, along with six other states, to participate in the initial policy conference focusing on this topic sponsored by the National Governors' Association (NGA). The Department of Health Professions (DHP) was the lead agency for the Virginia team, joined by the Secretary of Public Safety, Secretary of Health and Human Resources, the Superintendent of State Police and the Commissioner of DBHDS. The team attended two national meetings to receive technical assistance and participate in discussions led by experts to assist the team in developing a strategy for Virginia. The team developed four subgroups to focus on enforcement, disposal, monitoring, and training and education. The training and education subgroup was chaired by the DBHDS Director of the Office of Substance Abuse Services (OSAS). Each subgroup included a variety of expertise related to the subject matter. The team hosted a statewide meeting in March 2013 that was attended by over 100 participants and facilitated by staff from the NGA. Each subgroup presented its draft plan at the meeting and received comment. The team has since finalized its plan, which has been accepted by the Governor and forwarded to the NGA.

Juvenile Justice Behavioral Health Diversion Pilot. In the fall of 2012, Virginia was competitively selected to participate in a national policy academy co-sponsored by SAMHSA and the MacArthur Foundation to develop strategies for diverting youth with behavioral health issues from the juvenile justice system. DBHDS collaborated with the Department of Juvenile Justice (DJJ), the Office of Comprehensive Services (CSA), the 24th District Court Service Unit and Horizon Behavioral Health Services to develop a strategy to screen youth for behavioral health concerns whose parents were requesting petitions for Children in Need of Services or domestic violence issues. The team used the $25,000 award to implement the project. Those youth who qualified were referred to Horizon Behavioral Health Services for assessment and services. The result was a significant decrease in the number of petitions filed and accompanying increase in the numbers of children receiving appropriate behavioral health services.

Synar: Tobacco Law Compliance. As a condition for receiving the federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG) states must (1) statutorily prohibit and enforce the sale of tobacco products to minors; (2) conduct random, unannounced inspections of tobacco retailers to ensure that they are complying with the law; and (3) annually report

findings to the U.S. Department of Health and Human Services. Federal law requires a noncompliance rate of no more than 20%. Failure to comply with any part of the law can result in a loss of up to 40% of the total award, which would be a loss of $16 million for Virginia. DBHDS contracts with the Department of Alcoholic Beverage Control (ABC) to conduct these inspections using trained youth under the supervision of an ABC agent. Virginia achieved a compliance rate of 13.0% in 2011 and 13.5% in 2012. DBHDS also works closely with CSBs to develop and provide effective tobacco use prevention programming focused on youth.

Screening Women for Substance Use and Mental Health Disorders. DBHDS website includes information, including specific screening tools appropriate for different populations, to help professionals identify people who may need substance abuse services. These include tools for women, adolescents and other adults.

Medication Assisted Treatment. DBHDS is responsible for providing regulatory oversight and technical assistance to programs that utilize methadone in the treatment of opioid addiction. The number of these programs is growing significantly throughout the state.

Professional Development. To improve the quality of services offered in the community, DBHDS offered a variety of knowledge and skill building workshops on a regional level. These include training in providing services to adolescents, substance abuse screening for women seeking prenatal care, development of peer and recovery services, clinical supervision, training health care providers and other providers of addiction services. These events were funded by the federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG). The largest of these events include:

> Services to Adolescents Who Have Experienced Trauma. DBHDS sponsored two events to train counselors to provide treatment services to adolescents who have experienced trauma, such as witnessing or being the victim of a violent crime. Research indicates that a significant proportion of individuals with behavioral health problems have experienced serious traumatic events that have not been addressed. The longer these events remain unaddressed, the more emotional damage occurs, often leading to substance abuse, as well as depression, poor emotional control, and other serious behavioral issues. The training provided an opportunity to increase knowledge and skills in assessment and treatment practices designed to help adolescents who have experienced trauma. The 105 participants attending a two-day event learned about providing trauma-informed services for adolescents with co-occurring substance abuse and mental health problems.
>
> Informing Parents and Caregivers about Adolescent Substance Abuse. DBHDS sponsored training to help parents and caregivers understand adolescent development, identify when an adolescent may be using drugs or alcohol, and learn how to get help. This three hour session provided information about the signs and symptoms of substance use, the treatment process, and strategies that family members can employ to take care of themselves during adolescent using episodes.
>
> Virginia Summer Institute for Addiction Studies (VSIAS). Held in Williamsburg, VSIAS provides an opportunity for Virginia substance abuse professionals to learn from

national experts through lectures and participatory workshops in an intensive learning environment. VSIAS is a collaborative effort of the Virginia Association of Drug and Alcohol Programs, the Virginia Association of Drug and Alcohol Counselors, and the Substance Abuse Certification Alliance of Virginia. DBHDS provided staff and financial resources for the institute. In 2011, 189 persons participated, and 366 persons participated in 2012.

Virginia Association of Medication Assisted Recovery Programs (VAMARP). This annual training event provides current information to professionals working with opiate-dependent individuals. DBHDS provided staff support and funding. In 2011, 225 persons participated, and 240 persons participated in 2012.

Prenatal Care Providers. In conjunction with the University of Virginia (UVA), the Department of Medical Assistance Services (DMAS), the Department of Health (VDH) and DBHDS received a grant from the U.S. Department of Health and Human Services to provide training in screening pregnant women for substance abuse, mental illness and domestic violence.

Clinical Supervision**.** DBHDS provided skill and knowledge training in clinical supervision to assure best practices and fidelity to treatment models. Approximately 91 new and experienced clinical supervisors from 21 community services boards, five state facilities, and several opiate treatment programs attended a five-day training and skill development program, "Clinical Supervision Workshop and Clinic," in 2011. This training met the requirements of the Virginia Department of Health Professions (DHP) Board of Counseling and Board of Social Work for supervisors of candidates for either the professional counselor license (LPC) or clinical social worker license (LCSW).

Psychiatrists and Other Medical Staff. In collaboration with the University of Virginia (UVA) and the Virginia Association of Community Services Boards (VACSB), DBHDS provided training for psychiatrists and other health care providers who work with community services boards or state mental health facilities to improve their knowledge about treating people with addictions or co-occurring mental health disorders. DBHDS also collaborated with the Virginia Health Practitioners Monitoring Program (within the Department of Health Professions) to provide training about pain management for people who are recovering from addiction.

Creating Opportunities Goal to Further Develop Recovery and Peer Services. In collaboration with the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), DBHDS provided funding from the federal Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) block grants to present the third annual conference focused on peer and recovery support services for persons with substance use disorders and/or mental illness. Over 200 attendees, including peer providers, supervisors and clinical staff from the community services boards, and state agency staff, participated in the conference.

Interagency Relationships. DBHDS is represented on a number of state-level committees to ensure collaboration and improve access to services. These include:

> Commission on the Virginia Alcohol Safety Action Program. Established as a legislative agency, the commission establishes and implements policy regarding operating standards and criteria for the 24 local agencies that provide services to individuals charged with driving under the influence of alcohol or other drugs. By statute (§18.2-271.2.A), DBHDS is represented on the commission.

> Drug Treatment Court Statewide Advisory Committee. Established by the Supreme Court of Virginia, the committee focuses on evaluation of applications to establish local drug treatment courts. By statute (§18.2-254.1.F), DBHDS is represented on the committee.

> Home Visiting Consortium and the Maternal, Infant and Early Childhood Home Visiting Grant. This collaboration of early childhood home visiting programs that serve families who are pregnant or who have children up to five years of age also serves as the advisory committee for a federal grant managed by the Virginia Department of Health (Maternal, Infant and Early Childhood Home Visiting grant). DBHDS provides access to technical assistance concerning behavioral health, including providing training.

> Substance Abuse Services Council. Established by statute (§ 2.2-2696), this council, staffed by DBHDS/OSAS, consists of 29 members including two senators and four delegates, as well as representatives from provider and advocacy organizations, and state agencies. The purpose of the council is to advise the Governor and the General Assembly on policies concerning substance abuse. The council meets four times per year.

Prevention

Strengthening Families Prevention Grants. DBHDS used funds from the federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG) to support Strengthening Families in 16 communities. The program provides a weekly family meal as an opportunity for at-risk families to meet with a facilitator and improve communication and other skills necessary to parent in a healthy family. These programs are used to help families increase cohesion, a research-based strategy that helps protect children from substance abuse and other problems.

Interagency Relationships

> Strategic Prevention Framework State Infrastructure Grant. As a member of the Governor's Office for Substance Abuse Prevention (GOSAP) Collaborative [currently the Virginia Office for Substance Abuse Prevention (VOSAP) Collaborative], DBHDS was a partner with 12 other state agencies in the Commonwealth's application to the federal Substance Abuse and Mental Health Services Administration for funding to identify, study and implement a major prevention initiative for the state. SAMHSA awarded grant funds in the amount of $2,135,724 annually through 2015. These funds

are being used to develop a statewide systematic approach to the prevention of underage alcohol use. This is the first time that these efforts have been based on epidemiologic data.

Prevention and Promotion Advisory Council (PPAC). This interagency council consists of 12 members and advises the State Board of DBHDS on matters related to prevention and promotions. Members are appointed by the board to receive and review information on prevention efforts. The council developed a white paper on how changes in federal government prevention policy will broaden programs and services to encompass all of behavioral health as opposed to the previous singular focus on substance abuse.

Professional Development

Suicide Prevention. DBHDS staff provided a training of trainers focusing on suicide prevention skills to 24 trainers, using the Applied Suicide Intervention Skills Training (ASIST) curriculum. Those trainers then trained 796 individuals. An additional 97 individuals also participated in an ASIST training. DBHDS staff chaired a workgroup that drafted a statewide suicide prevention strategic plan, currently in review.

Substance Abuse Prevention Specialist Training. DBHDS provided a five-day training to 14 CSB prevention staff to improve their knowledge and skill in developing and providing community-based prevention programs and services that are based on scientific research. A total of 53 individuals participated in the training during the biennium. This curriculum has recently been selected by SAMHSA for distribution to other states.

Prevention Supervisor Mentorship Program. DBHDS sponsored five experienced CSB supervisors to function as mentors to newly hired CSB prevention supervisors. These mentors have provided over 200 hours of consultation since July 2012.

Off-site Prevention Supervision Program. This program provides the necessary supervision to become designated as an Internationally Certified Prevention Specialist to individuals who do not have local access to the appropriately credentialed professional who can provide this type of assistance. To date, this program has been piloted with one site.

Other Prevention Training. DBHDS provided 360 scholarships for CSB prevention staff and community coalition members to attend training provided by the Virginia Foundation for Healthy Youth to improve knowledge and skill in general prevention knowledge and coalition building.

Biennial Report on Substance Abuse Services
Per Code of Virginia § 37.2-310
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OVERVIEW

Purpose
This biennial report provides information about the extent to which Virginians are affected by substance use disorders and the activities supported by the Department of Behavioral Health and Developmental Services (DBHDS) to address these needs during the biennium (2010-2012). National statistical information analyzed at the state level and available state data were used to identify state, regional and age-related issues.

The Department of Behavioral Health and Developmental Services
Title 37.2 of the *Code of Virginia* establishes the Virginia Department of Behavioral Health and Developmental Services (DBHDS) as the state authority for alcoholism and drug abuse services. DBHDS works to make efficient, accountable and effective services available for citizens with substance use disorders. The department is responsible for the administration, planning and regulation of services for substance use disorders in the commonwealth.

This biennial report is submitted in accordance with § 37.2-310 Subsection 4 which requires DBHDS:

> *4. To report biennially to the General Assembly on the comprehensive interagency state plan for substance abuse services and the Department's activities in administering, planning, and regulating substance abuse services and specifically on the extent to which the Department's duties as specified in this title have been performed.*

This report provides epidemiological information about the extent to which substance use disorders affect the residents of the commonwealth, information about services provided and the individuals who received these services, and reports on major activities of the Department on their behalf.

DBHDS supports substance use disorder prevention and treatment services provided in local communities through the allocation of State General Funds (GF) and federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funds to 40 community services boards and behavioral health authorities (collectively referenced as CSBs). These organizations are entities of local government. The department's relationship with all CSBs is based on the community services performance contract. DBHDS funds, monitors, licenses, and regulates the CSBs which function as:

- The single point of entry into the publicly-funded substance abuse services system;
- Providers of treatment and prevention services, directly and through contracts with other providers;
- Advocates for individuals receiving services and individuals in need of services; and

- Advisors to the local governments.

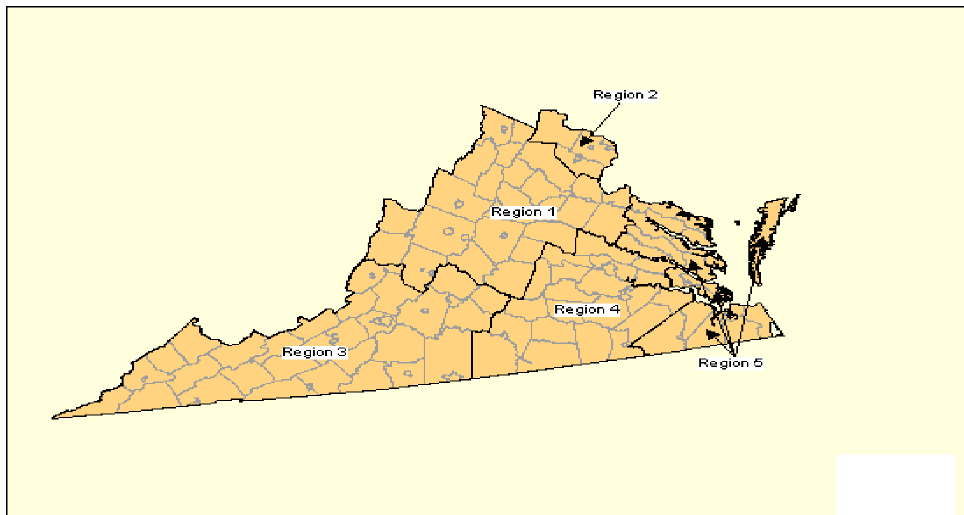
Substance Related Disorders
Substance use disorders involve the dependence on or abuse of alcohol and other drugs, which include the non-medical use of prescription drugs, as defined using the American Psychiatric Association's criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Revised (DSM-IV-R). There are two distinct levels of substance use disorders: substance dependence (addiction) and substance abuse. Dependence reflects a more severe substance problem than abuse. The National Survey of Drug Use and Health (NSDUH, 2010[1]), conducted by the federal government, indicates that 9.63% of Virginians, or approximately 620,000 individuals, meet criteria for dependence on or abuse of illicit drugs or alcohol in the past year.

NATURE, SCOPE AND DEGREE OF SUBSTANCE ABUSE IN VIRGINIA

Sources of Information
Information about the types and extent of substance abuse in the commonwealth comes from several resources. A major source of epidemiological information (the measure of the occurrence of the disorder) is the National Survey on Drug Use and Health (NSDUH) conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Another important source of information is provided by the Office of the Chief Medical Examiner (OCME) at the Virginia Department of Health (VDH) concerning causes of death related to substance abuse.

National Household Survey of Drug Use and Health
This survey is conducted annually by interviewing enough individuals age twelve and older in the population to allow statistically valid generalizations to be made. In Virginia, a valid sample of individuals representing each of five regions of the state is interviewed, which is helpful in tracking regional trends to assist in planning and allocating resources. A list of Virginia cities and counties grouped by these five regions is included as Appendix B.

Figure 1: Map of Virginia Displaying Five NSDUH Regions



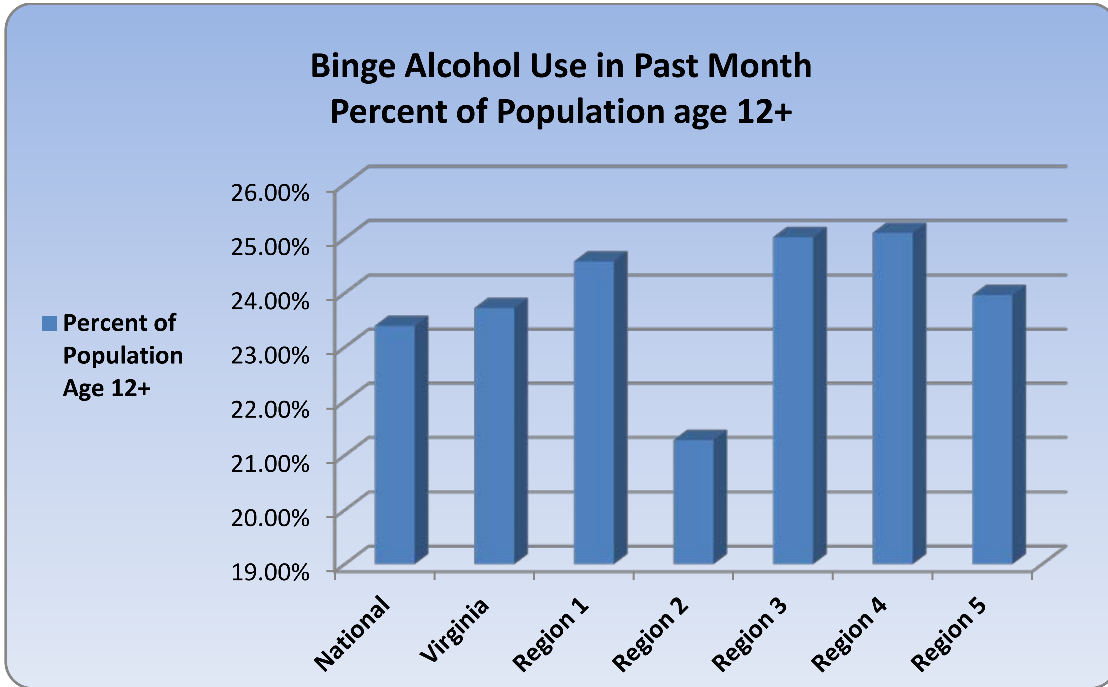
In addition, valid samples are collected by age groups so that developmental trends can be identified. To strengthen the power of the data analysis of these smaller groups, SAMHSA combines two or three years of data for analysis when it issues its official reports. The NSDUH data that is reported in this document provides regional analysis of data collected in 2008, 2009, and 2010. The age-group data was collected in 2010 and 2011. The population figures are for Virginia in 2010, based on the U. S. Census. These differences in reporting years may cause data reported in this document to conflict with other numbers published by DBHDS in different publications as well as within this publication itself, but are necessary to provide the most current and detailed regional and age-related data.

NSDUH collects data on the same issues each year. The charts below depict the responses to selected questions in three ways. The first chart shows the proportion of the population impacted by nation, state and region. The second chart shows the actual population impacted displayed by state region. The regions are not equal in population size, and in some instances a larger number of individuals may be affected by an issue even when the proportion of the population affected is smaller. The third chart displays the responses by percent of population divided by age groups of 12-17, 18-25, and 26 and older. Analysis by age is important, as substance use disorders can have long-term effects if not addressed.

Alcohol is both the most used and abused drug in the nation. NSDUH data indicate that, nationally, 51.8% of the population older than twelve years used alcohol in the month prior to the survey. In Virginia, the rate of alcohol use, 54.6%, is slightly higher.

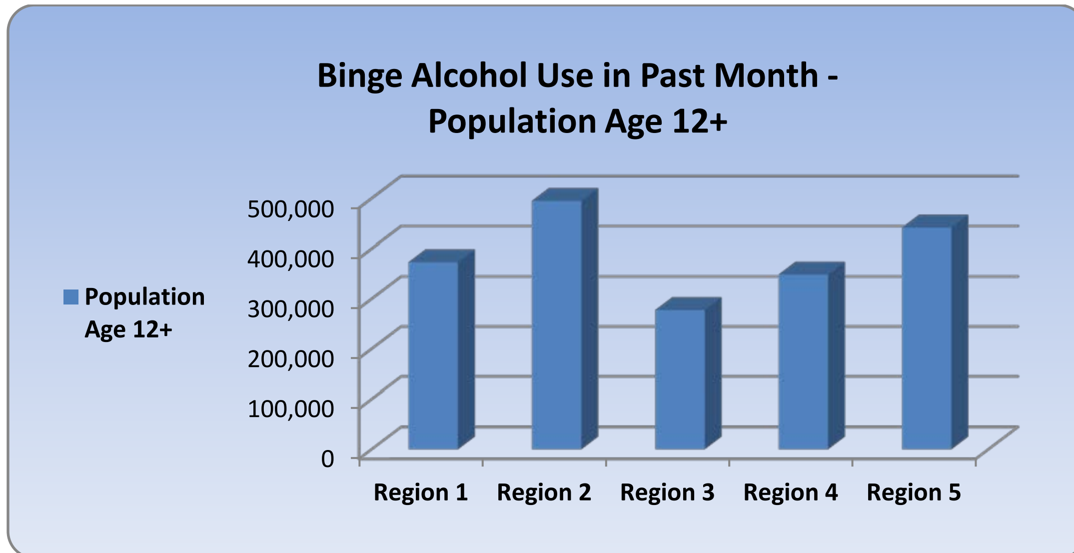
Binge Drinking - About half of those who use alcohol engaged in binge drinking (five or more drinks on one occasion) in the month prior to the survey. The national rate for binge drinking is 22.86%, and the rate in Virginia is slightly higher (23.21%), with the highest rate in Region 4 (25.10%) and the lowest rate in Region 2 (21.28%). The chart below displays the percent of the population that engaged in binge drinking.

Figure 2



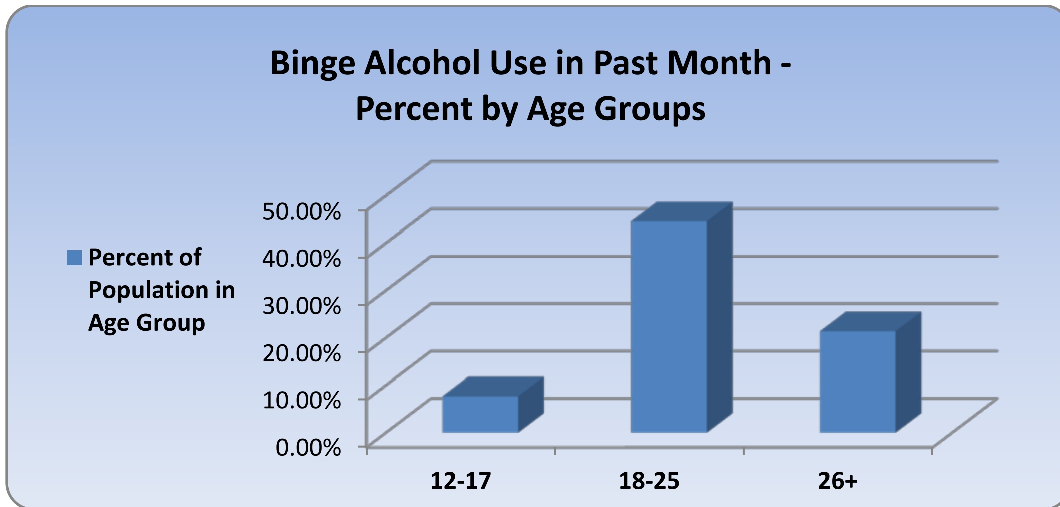
The chart below displays estimates of the actual numbers of people who engaged in binge drin king by region. Although the proportion of binge drinkers in Region 4 is the highest, the actual numbers of people who engaged in binge drinking was the highest in Region 2, followed by Region 5.

Figure 3



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	23.39%	23.72%	24.57%	21.28%	25.02%	25.10%	23.96%
Population Figure	73,424,494	1,941,689	373,279	494,952	277,543	348,654	441,434

Figure 4



	12+	12-17	18-25	26+
Percent of Population	23.21%	7.67%	44.56%	21.36%
Population Figure	1,899,941	48,715	412,531	1,151,244

The chart above displays a significant trend among Virginia youth. Although possession of alcohol is illegal for those under 21, more than eight percent of Virginia's youth engaged in binge drinking the month prior to the survey, and nearly 45% of those between 18 and 25 drank to this excess. For those who are 26 and older, more than one in five engaged in binge drinking in the month prior to the survey.

Alcohol Dependence or Abuse - In the context of the NSDUH survey, the terms "dependence" and "abuse" have specific clinical meanings. The Diagnostic and Statistical Manual, the standard reference of the American Psychiatric Association used to diagnose psychiatric disorders, sets forth distinct criteria for dependence and for abuse (see Appendix C). The chart below indicates that nationally, 7.27% of Americans met criteria for one of these disorders, while a higher proportion of Virginians (8.23%) met criteria for either abuse of or dependence on alcohol. Regions 1 and 3 had the greatest proportion while Region 2 had the lowest. In raw numbers, however, Region 2 had the greatest number of people who met one of these clinical criteria, while Region 5 had the second most.

Figure 5

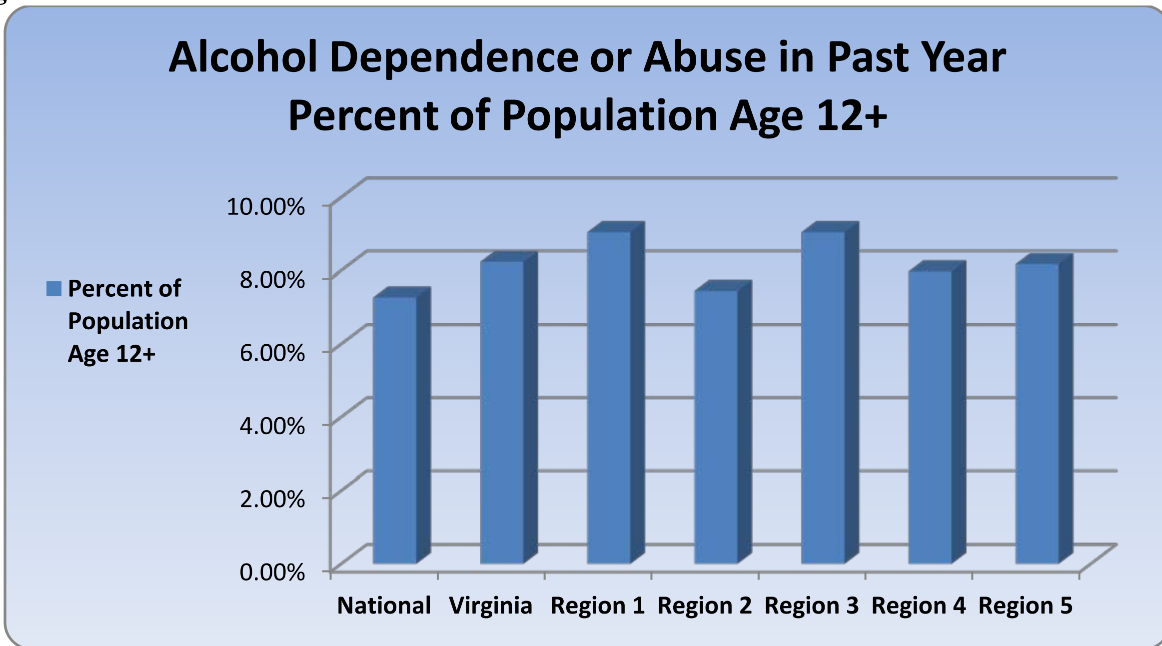
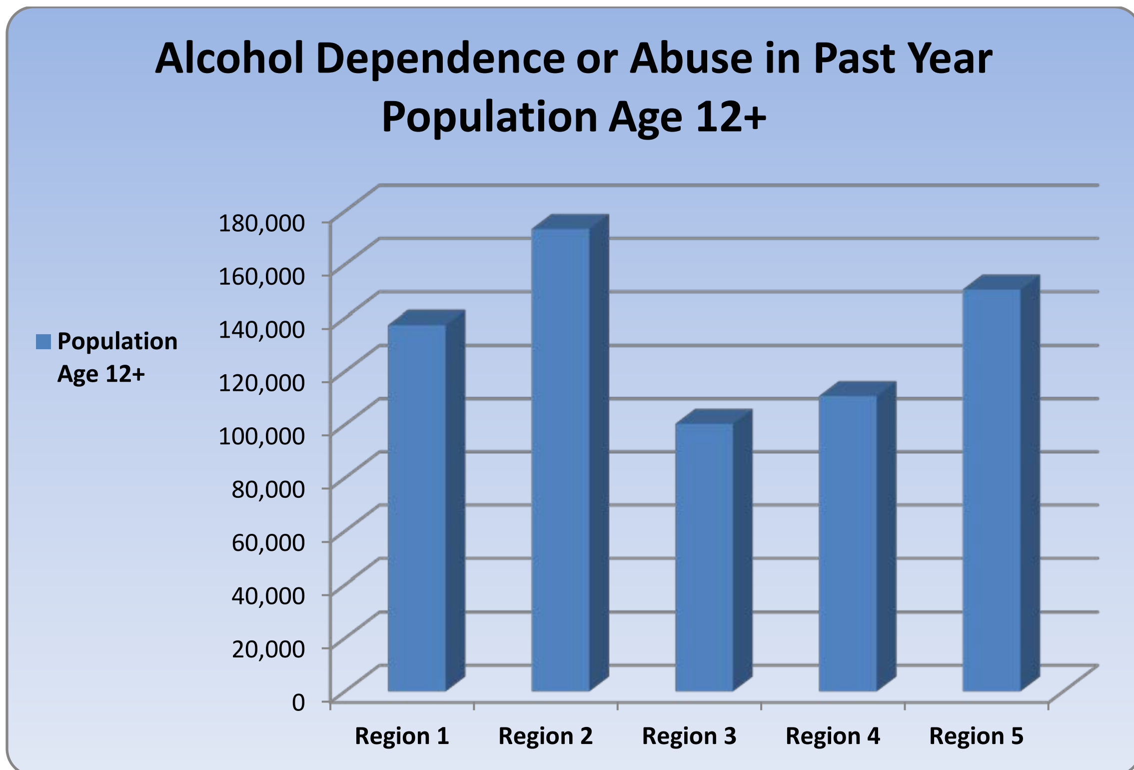
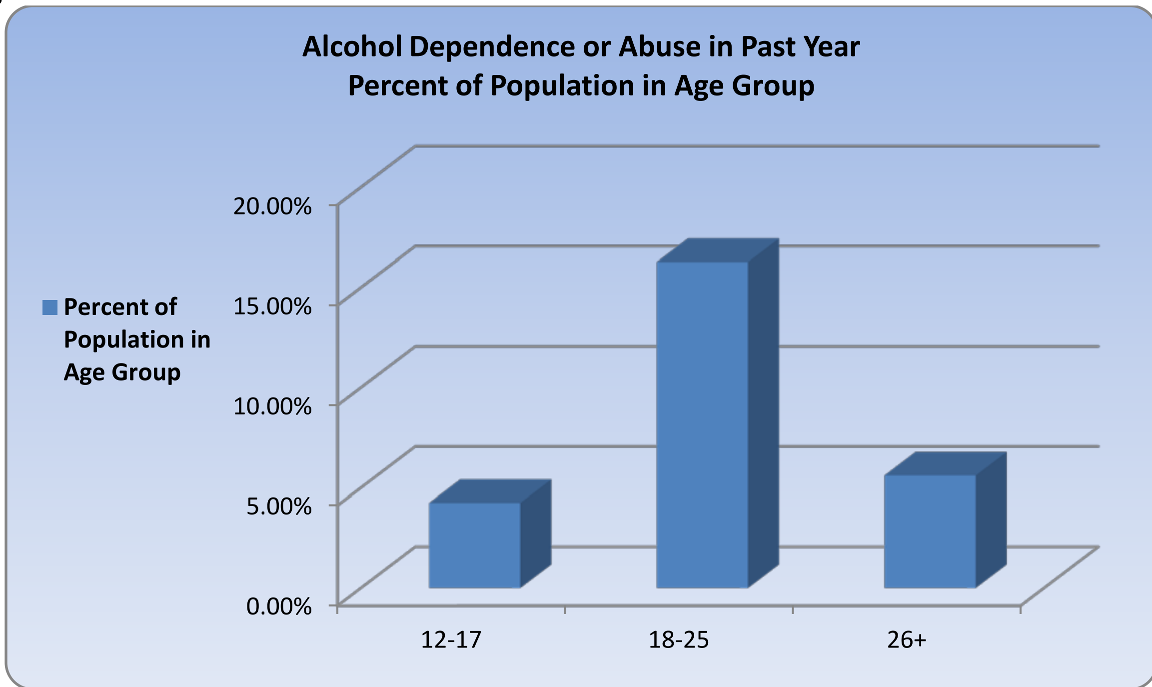


Figure 6



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	7.27%	8.23%	9.04%	7.45%	9.04%	7.97%	8.17%
Population Figure	22,821,551	673,697	137,340	173,280	100,279	110,708	150,522

Figure 7



	12+	12-17	18-25	26+
Percent of Population	6.92%	4.24%	16.27%	5.61%
Population Figure	566,462	26,930	150,626	302,363

The chart above provides a picture of the degree of the problem of alcohol dependence among youth in Virginia. Nearly five percent of children ages 12-17 suffer from alcohol dependence or abuse, and that number is higher (more than 16%) for young adults ages 18-25. All told, more than one in five Virginians ages 12-25 suffer from alcohol dependence.

Needing but not receiving treatment for alcohol use - The next three charts illustrate the extent to which individuals in Virginia need but do not receive treatment for alcohol dependence. The regions with the greatest proportions of individuals needing but not receiving treatment are Regions 1 and 3, but the regions with greatest overall numbers of those individuals are Regions 2 and 5.

Figure 8

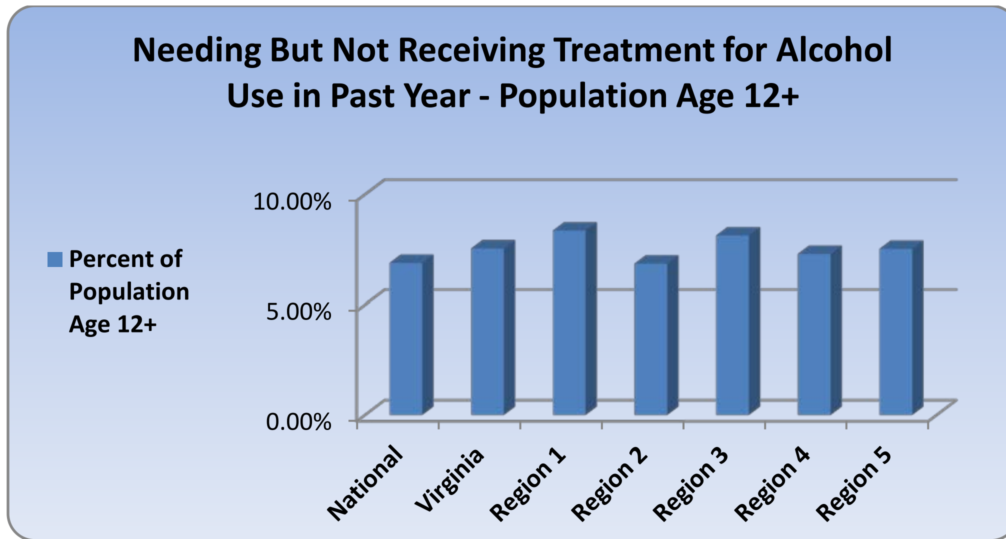
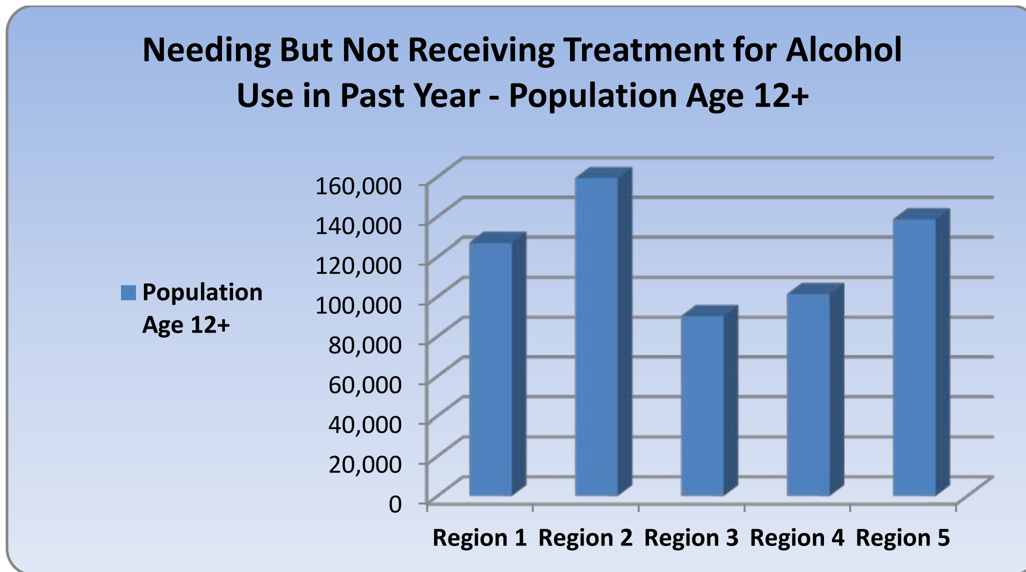


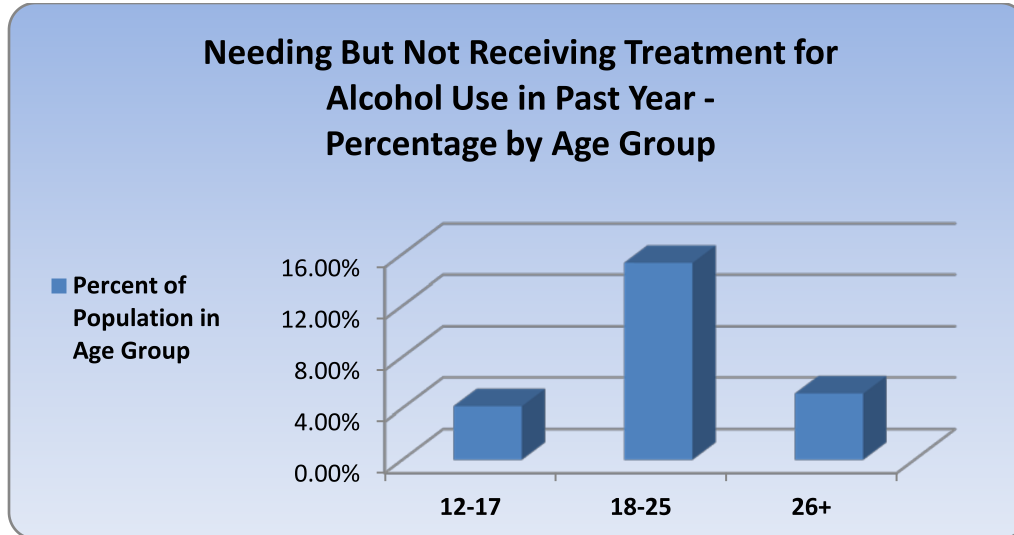
Figure 9



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	6.88%	7.54%	8.35%	6.85%	8.13%	7.29%	7.52%
Population Figure	21,597,286	617,215	126,857	159,324	90,185	101,263	138,547

As illustrated earlier, adolescents and young adults in Virginia exhibit higher rates of alcohol dependence than in the general population. Those same age groups also have higher rates of needing but not receiving treatment, as the chart below indicates.

Figure 10



	12+	12-17	18-25	26+
Percent of Population	6.42%	4.15%	15.32%	5.14%
Population Figure	525,533	26,358	141,831	277,032

Illicit drugs include legal drugs that are used illicitly as well as drugs that are illegal. Illicit drug use is on the rise in the United States. In 2010, an estimated 22.6 million (8.82%) Americans aged 12 or older were current (in the last 30 days) illicit drug users. This is an upward trend, from 8.0% in 2008 and 7.9% in 2004. Marijuana, psychotherapeutics, and cocaine lead the list of the most abused illicit drugs. In Virginia, the incidence of illicit drug use is highest in Region 5 and lowest in Region 2. However, note that in actual numbers, Region 2 is among the highest actual numbers of people using illegal drugs, with only Region 5 having more people using illegal drugs. Region 3 has the fewest overall number of individuals identified as current illicit drug users.

Figure 11

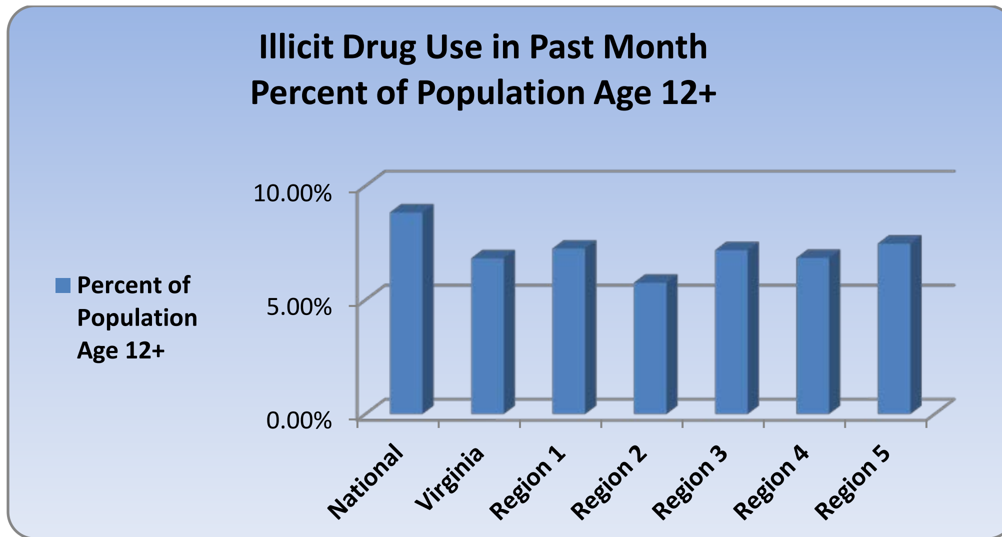
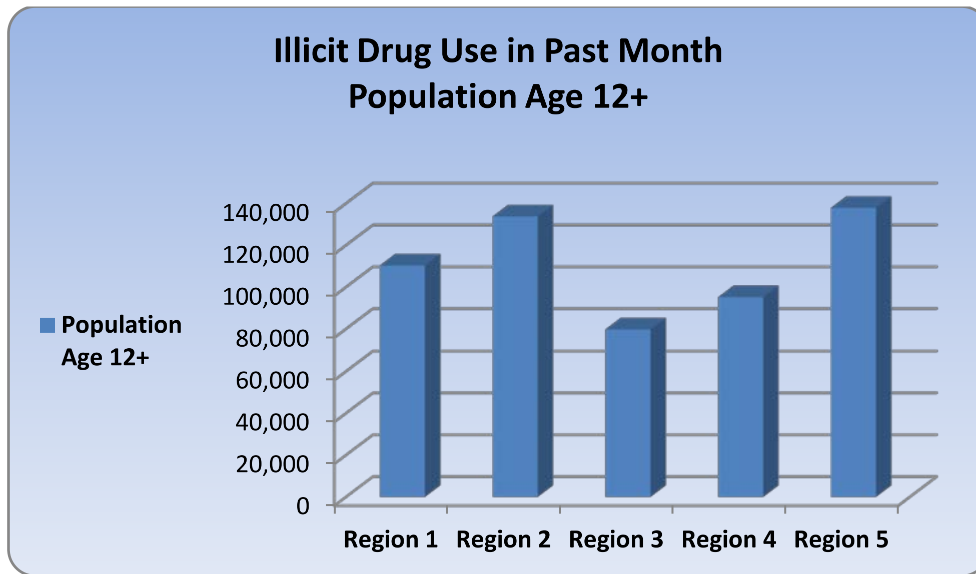


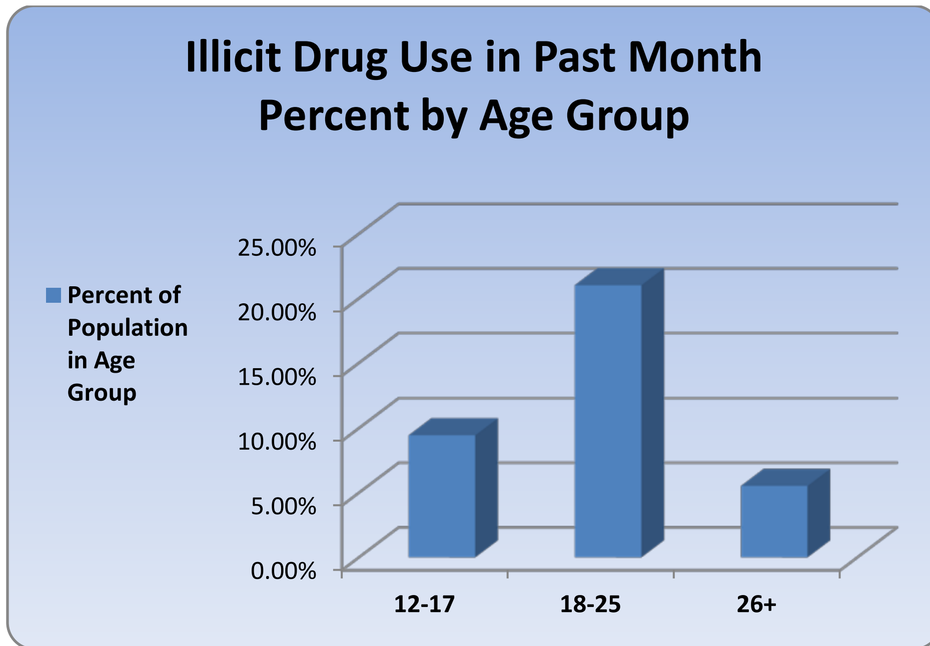
Figure 12



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	8.82%	6.83%	7.26%	5.75%	7.19%	6.85%	7.48%
Population Figure	27,687,218	559,095	110,297	133,739	79,758	95,151	137,810

When viewed by age group, the incidence of current illicit drug use is significantly higher than that of alcohol dependence in Virginia. Whereas around one-quarter of Virginians ages 12-25 are currently abusing or dependent on alcohol, more than 30% use are illicit drugs, with the majority of that higher incidence due to the 12-17 age group (5.02% for alcohol use, 9.45% for illicit drug use).

Figure 13



	12+	12-17	18-25	26+
Percent of Population	7.98%	9.45%	21.02%	5.53%
Population Figure	653,233	60,020	194,601	298,051

Marijuana use lags slightly behind national averages for proportions of the population, except for Region 5. That region has the highest proportion of the population using at nearly the same proportion as the nation. Region 4 has the second highest proportion of the population using. Region 5 also has the highest number of actual persons using marijuana in the last year and Region 2 ranks second in total number of users.

Figure 14

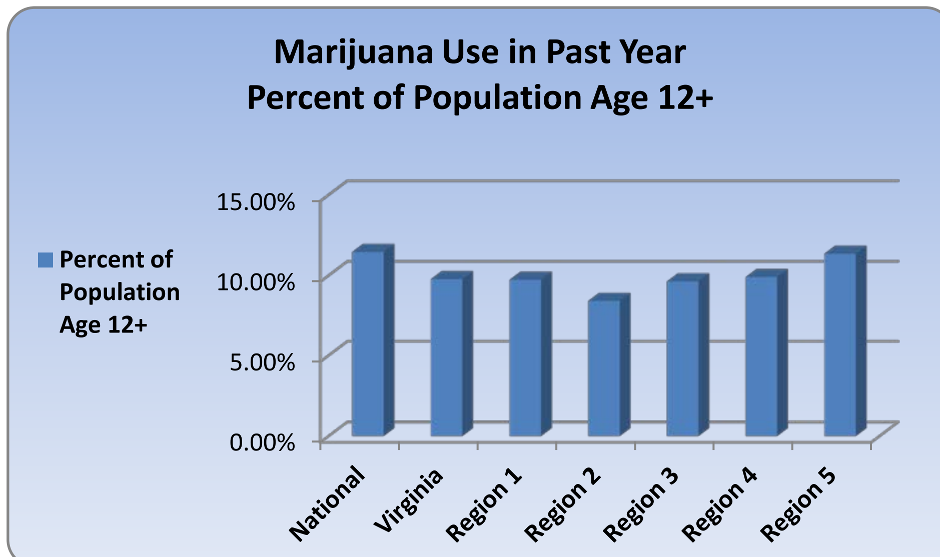
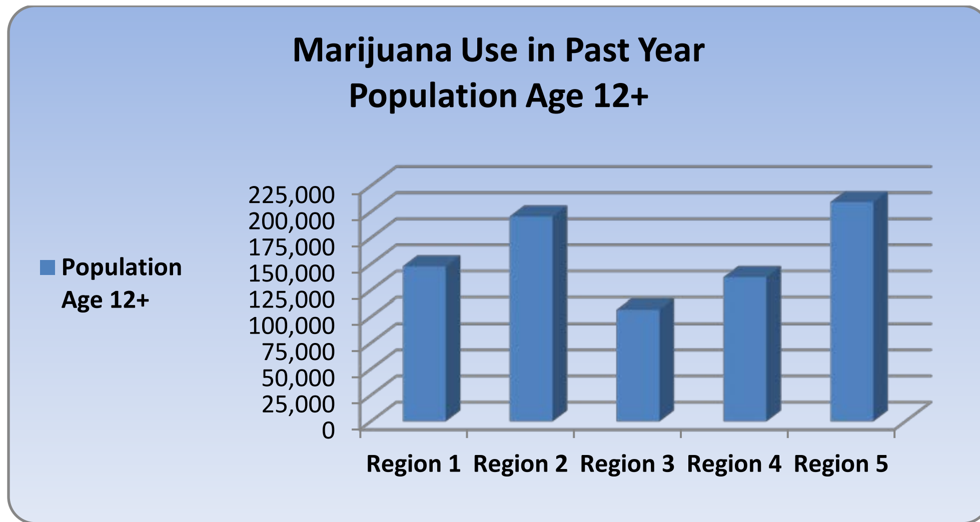


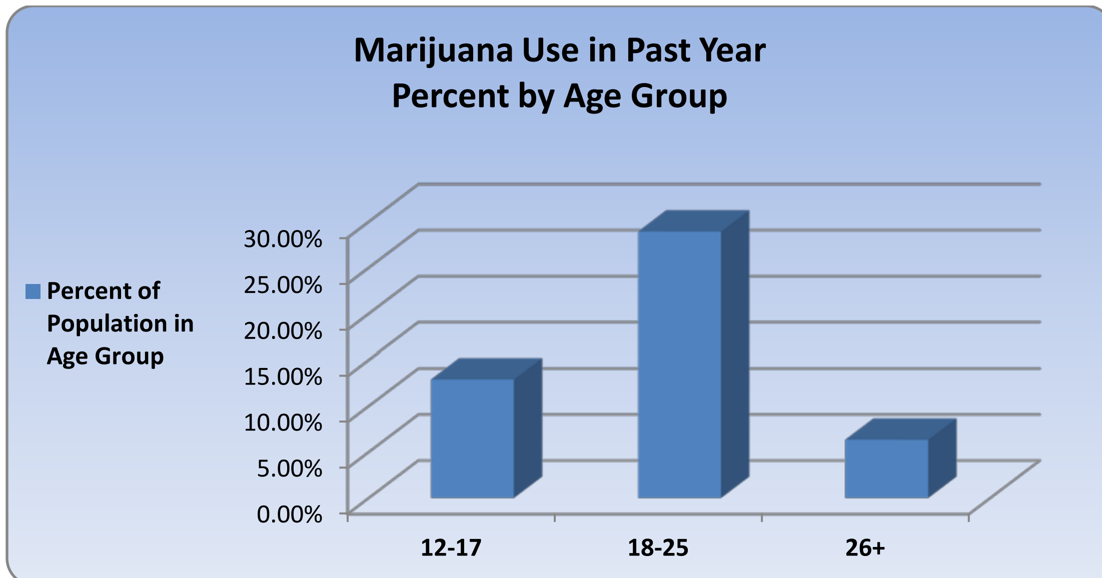
Figure 15



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	11.47%	9.77%	9.73%	8.41%	9.63%	9.90%	11.36%
Population Figure	36,005,940	799,760	147,823	195,608	106,824	137,517	209,294

Nearly 13% of those between the ages of 12-17 and nearly 30% of those between the ages of 18-25 currently use marijuana in Virginia, proportions higher than alcohol or illicit drugs as a whole. These numbers dwarf the proportion of adults age 26 and older who currently use marijuana, and provide a startling picture of the prevalence of marijuana use by Virginia's adolescents and young adults.

Figure 16



	12+	12-17	18-25	26+
Percent of Population	9.98%	12.88%	28.92%	6.33%
Population Figure	816,950	81,806	267,738	341,169

Cocaine use is not tracked for this report due to the low level of use in Virginia (1.85%), which is lower than the national average (1.80%).

Nonmedical use of pain relievers (commonly referred to as prescription drug abuse) continues to be an area of primary concern for Virginia. In the past, the southwest region of the state had been disproportionately affected by this phenomenon, as Region 3 had the highest proportion of nonmedical use of pain relievers. However, the most recent data indicate that this problem is now spreading throughout the commonwealth. While Region 3 still has the highest proportion of individuals using pain relievers for nonmedical purposes, the proportions in Regions 1 and 4 are nearly as high. A problem that was initially isolated to one part of the commonwealth is now spreading statewide.

Region 2 has the highest overall number of individuals using pain relievers for nonmedical use. The abuse of these drugs by young people presents a serious concern, as rates of abuse are nearly twice as high for adolescents between the ages of 12-17 and nearly four times as high for young adults between the ages of 18-25 than for adults ages 26 and older.

Figure 17

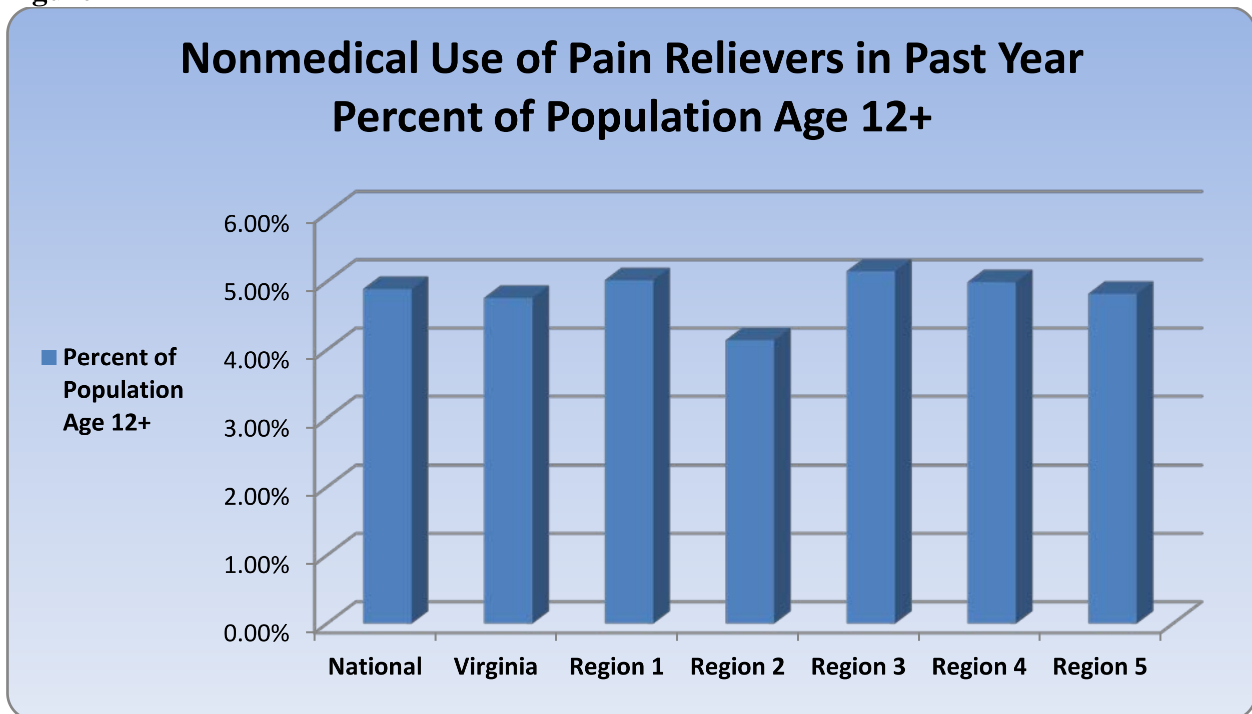
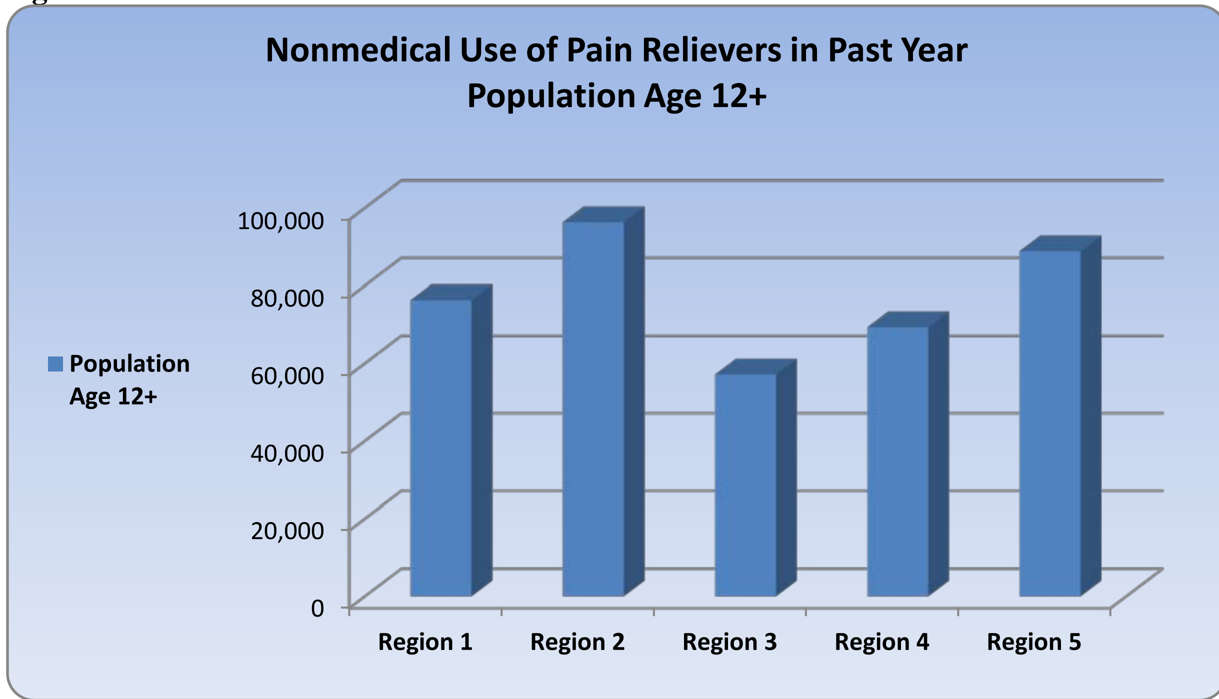
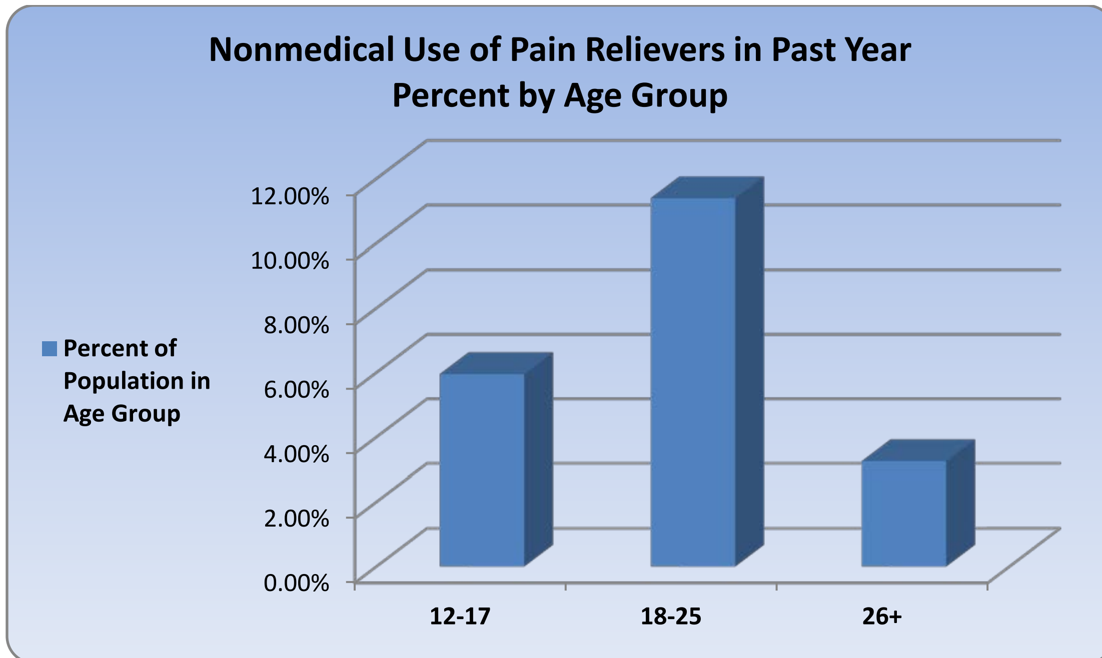


Figure 18



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	4.89%	4.76%	5.02%	4.14%	5.15%	4.99%	4.82%
Population Figure	15,350,397	389,648	76,266	96,292	57,128	69,314	88,803

Figure 19



	12+	12-17	18-25	26+
Percent of Population	4.60%	5.95%	11.39%	3.25%
Population Figure	376,550	37,791	105,447	175,166

Needing but not receiving treatment for illicit drug use – The percent of the population needing but not receiving treatment is greater in Region 5 than in any other region, followed closely by Regions 3 and 1. While the proportion is low in Region 2, it ranks second (behind Region 5) in Virginia in the actual number of individuals needing but not receiving treatment for illicit drug use.

Figure 20

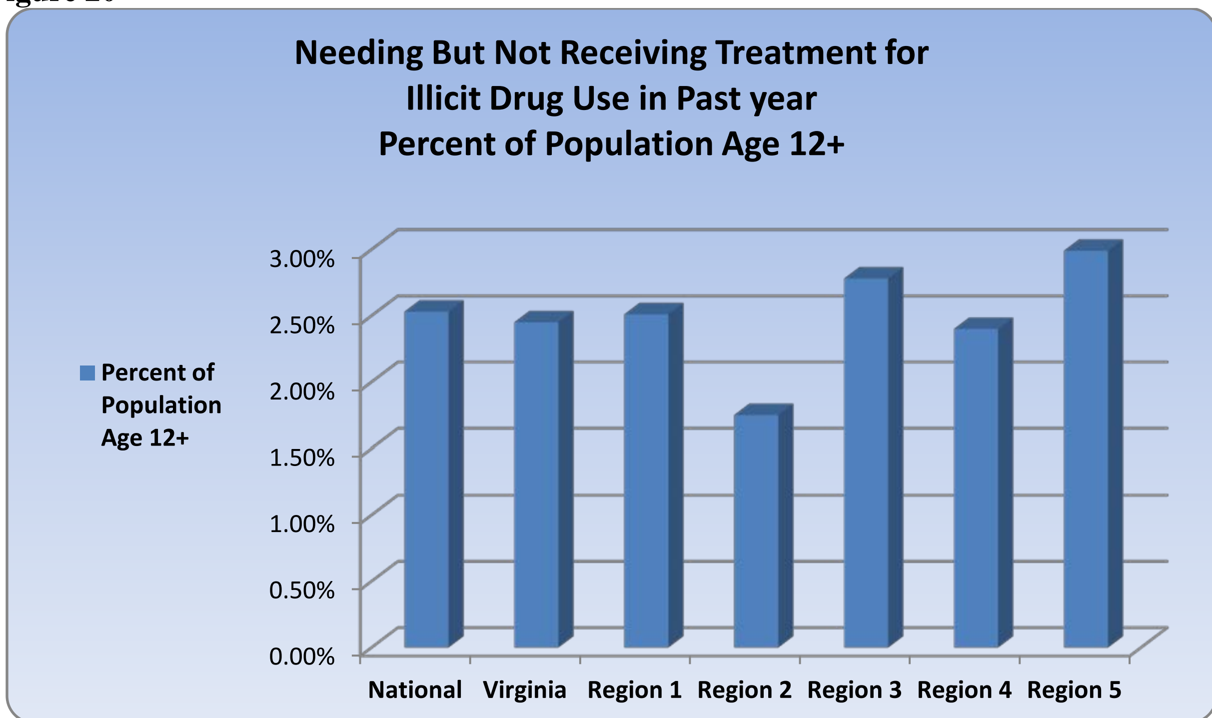
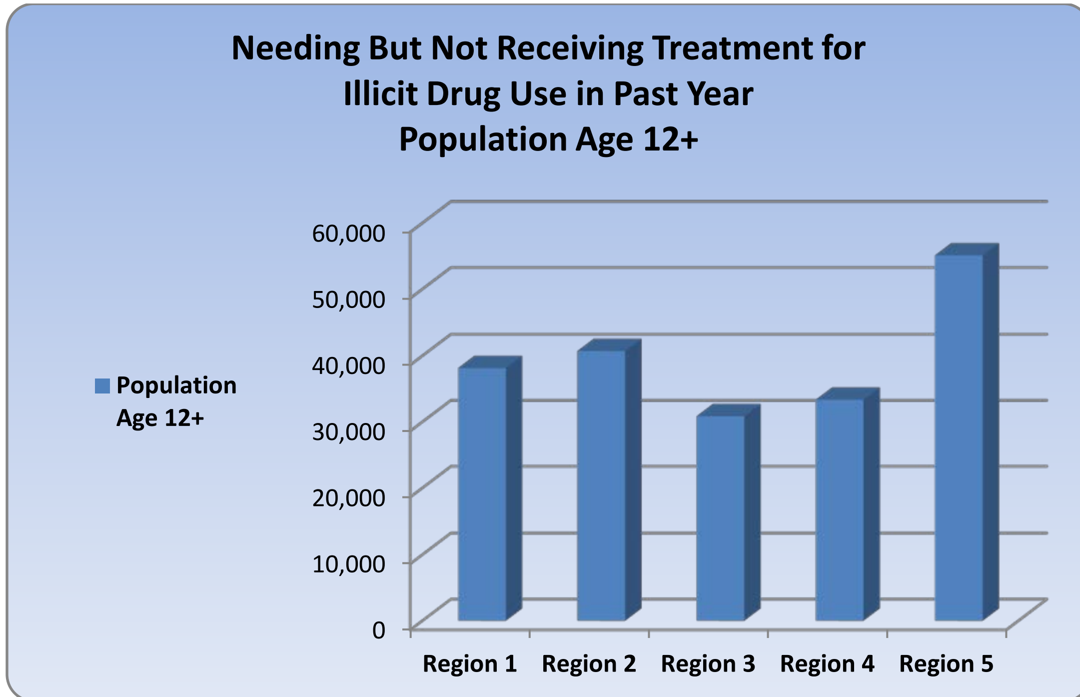


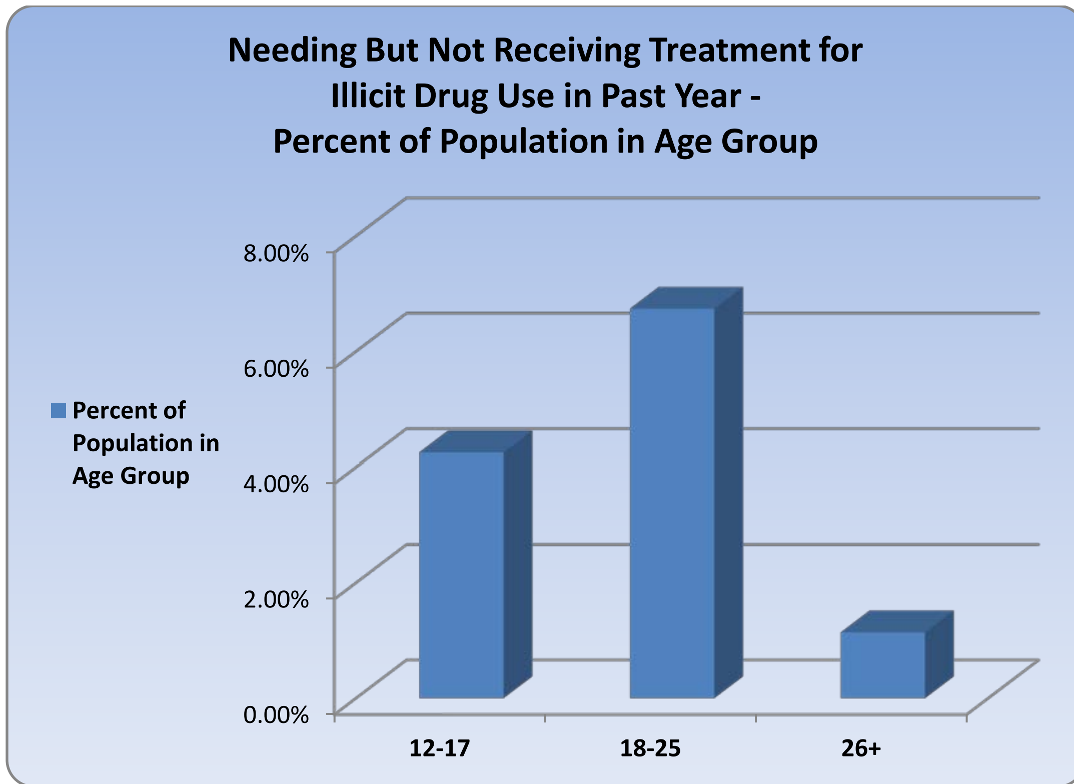
Figure 21



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	2.53%	2.45%	2.51%	1.75%	2.78%	2.40%	2.99%
Population Figure	7,942,025	200,554	38,133	40,703	30,838	33,337	55,087

In spite of the high prevalence rates for illicit drug use for the 12-17 and 18-25 age groups in Virginia, the percentages of individuals needing but not receiving treatment are low – 4.25% for ages 12-17 and 6.74% for ages 18-25. However, in actual numbers, approximately 27,000 youth between the ages of 12-17 who need treatment are not receiving it, while more than 62,000 young adults between the ages of 18-25 who need treatment are not receiving the help they need.

Figure 22

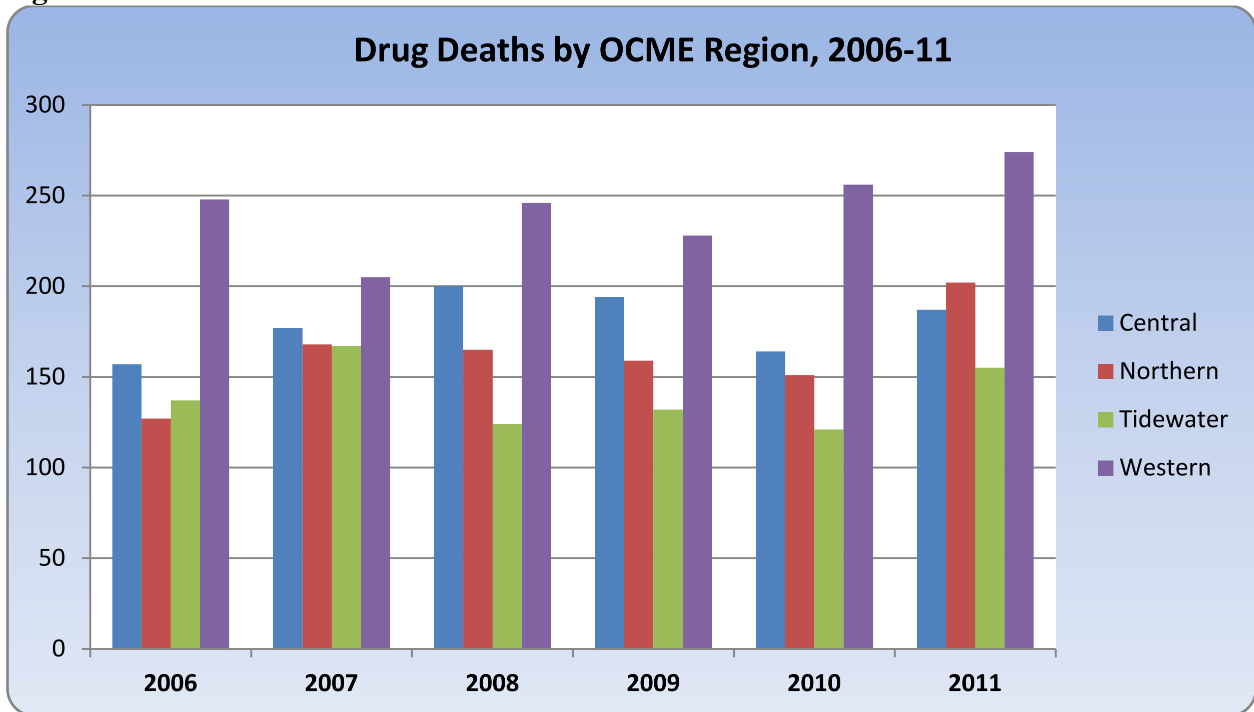


	12+	12-17	18-25	26+
Percent of Population	2.18%	4.25%	6.74%	1.14%
Population Figure	178,452	26,993	62,398	61,443

Office of the Chief Medical Examiner

The Office of the Chief Medical Examiner (OCME) produces an annual report on causes of death in the Commonwealth. The most recent report available, *The Office of the Chief Medical Examiner 2011 Annual Report,* indicates that the number of drug-caused deaths since 2010 has increased 18.2%. In 2011, 818 individuals died from this cause, with 61.74% of these deaths due to narcotics. The statewide death rate from drug caused deaths in 2011 was 9.6 per 100,000, higher than the rate of deaths by motor vehicle crashes in Virginia. Although this problem started in the far southwestern region of the state due to abuse of prescription pain medication, it has spread eastward as illustrated by the chart below. Appendix D displays a list of localities by OCME region.

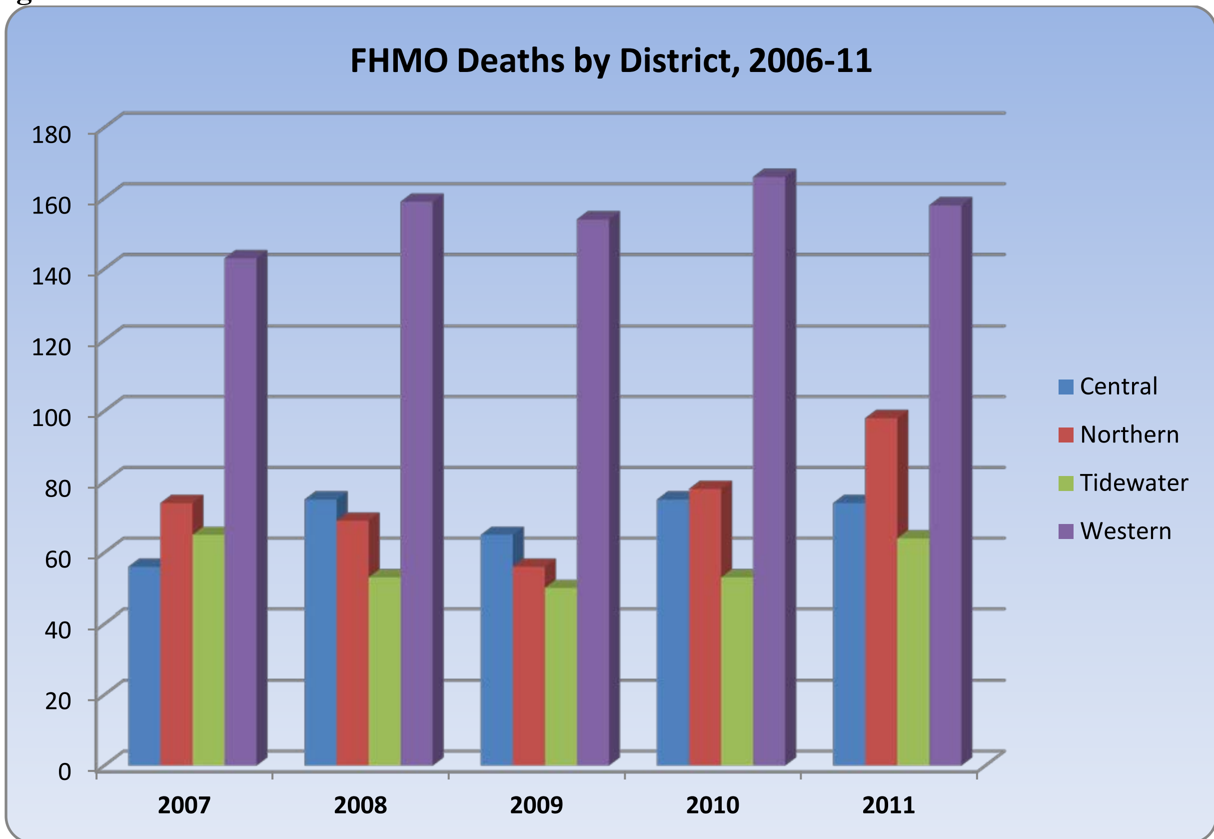
Figure 23



	2006	2007	2008	2009	2010	2011
Central	157	177	200	194	164	187
Northern	127	168	165	159	151	202
Tidewater	137	167	124	132	121	155
Western	248	205	246	228	256	274
Total	669	717	735	713	692	818

As described above, the abuse of prescription drugs continues to be an area of primary concern in Virginia. In 2007, the OCME began tracking deaths specifically contributed to fentanyl, hydrocodone, methadone, and oxycodone (FHMO). The trend in deaths related specifically to these substances continues to increase, as illustrated by the charts below. Note that while the issue persists in the Western district, usage has increased statewide.

Figure 24



	2007	2008	2009	2010	2011
Central	56	75	65	75	74
Northern	74	69	56	78	98
Tidewater	65	53	50	53	64
Western	143	159	154	166	158
Total	**338**	**356**	**325**	**372**	**394**

CHARACTERISTICS OF THE PUBLIC SERVICE SYSTEM

Public community mental health, developmental, and substance abuse services are provided in Virginia through a system of 40 community services boards (CSBs). CSBs function as single points of entry into publicly funded mental health, developmental, and substance abuse services, defined in § 37.2-100, including access to state hospital and training center services through preadmission screening, case management, services coordination, and discharge planning. CSBs also function as service providers, either directly or through contracts with other providers and as advocates for individuals who are receiving or are in need of services. The table below shows data on the services provided by CSBs in SFY 2012.

Cost of Publically Funded SA Services by Service Type - SFY 2012

Service	Total Served	Total Units	Total Cost	Unit Cost
Acute Psychiatric or SA Inpatient Services	59	362	$142,371	$393
Community-Based SA Medical Detox Inpatient Services	189	946	$452,426	$478
Outpatient Services	28,328	547,941	$45,279,427	$83
Case Management Services	10,315	79,265	$12,715,541	$160
Medication Assisted Treatment	1,779	81,070	$6,928,352	$85
Day Treatment/Partial Hospitalization	716	81,247	$3,488,097	$43
Highly Intensive Residential Services	2,582	21,785	$7,581,528	$348
Residential Crisis Stabilization Services	323	1,614	$749,856	$465
Intensive Residential Services	3,667	219,782	$26,376,715	$120
Supervised Residential Services	301	20,771	$2,419,538	$116
Supportive Residential Services	80	2,096	$387,168	$185

Note: Individuals may receive more than one service type

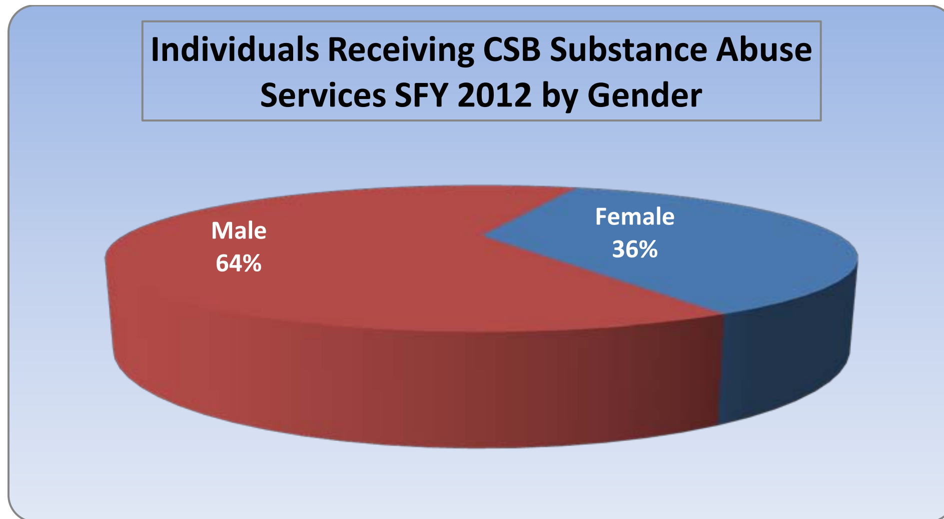
Overall in SFY 2012, CSBs provided services to 36,743 individuals at a total cost of $106,521,019. As shown above, the most commonly delivered service type was outpatient services (given to 28,328 individuals). Services range in intensity from highly intensive inpatient services ($393 - $479 per service unit) to outpatient and day treatment/partial hospitalization services ($43-$83 per service unit). For a description of each service type, see Appendix E.

The table below displays the amount of revenue by source for FY 2012.

Source of Funding	Amount
Federal	$43,956,776
State	$46,629,700
Local	$38,889,682
Fees and Third Party Payments	$13,379,713
Other	$2,875,071

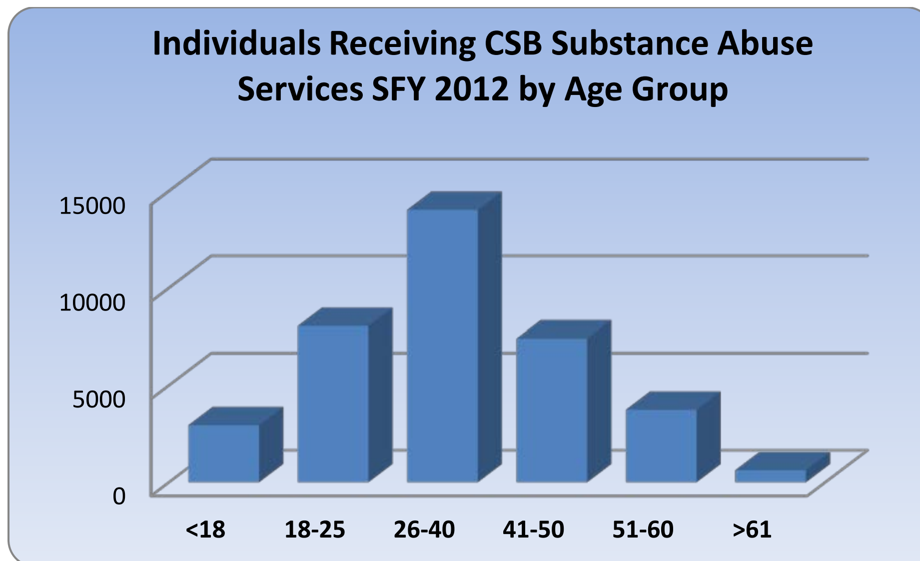
The charts below present data on the gender, age and race of the individuals served in SFY 2012.

Figure 25



Individuals served were predominately male (23,393 or 64%), with 13,279 females receiving services (36%).

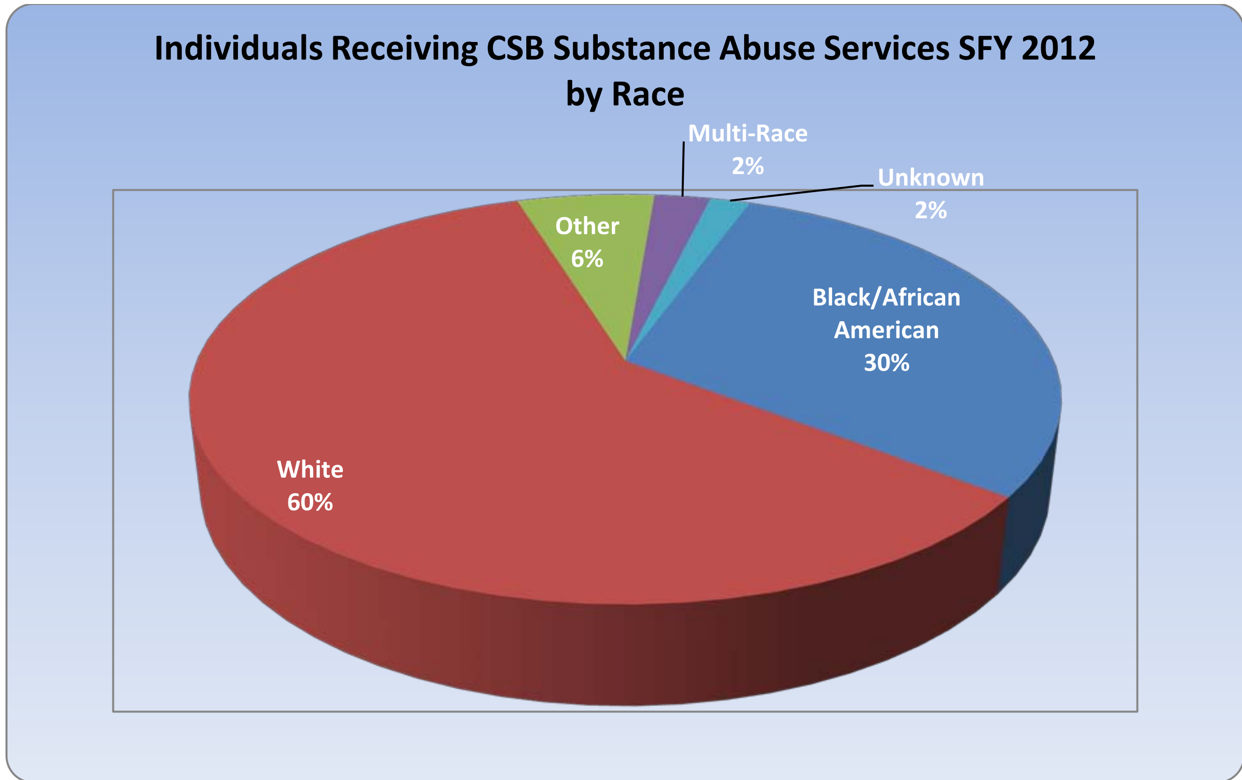
Figure 26



	<18	18-25	26-40	41-50	51-60	>61
Percent of Treatment Population	8.00%	21.87%	38.15%	20.13%	10.17%	1.68%
Treatment Population Figure	2,939	8,035	14,019	7,396	3,736	618

The average age for services recipients was 34 years of age. Thirty-eight percent of these individuals (14,019) were in the 26 to 40 age range.

Figure 27

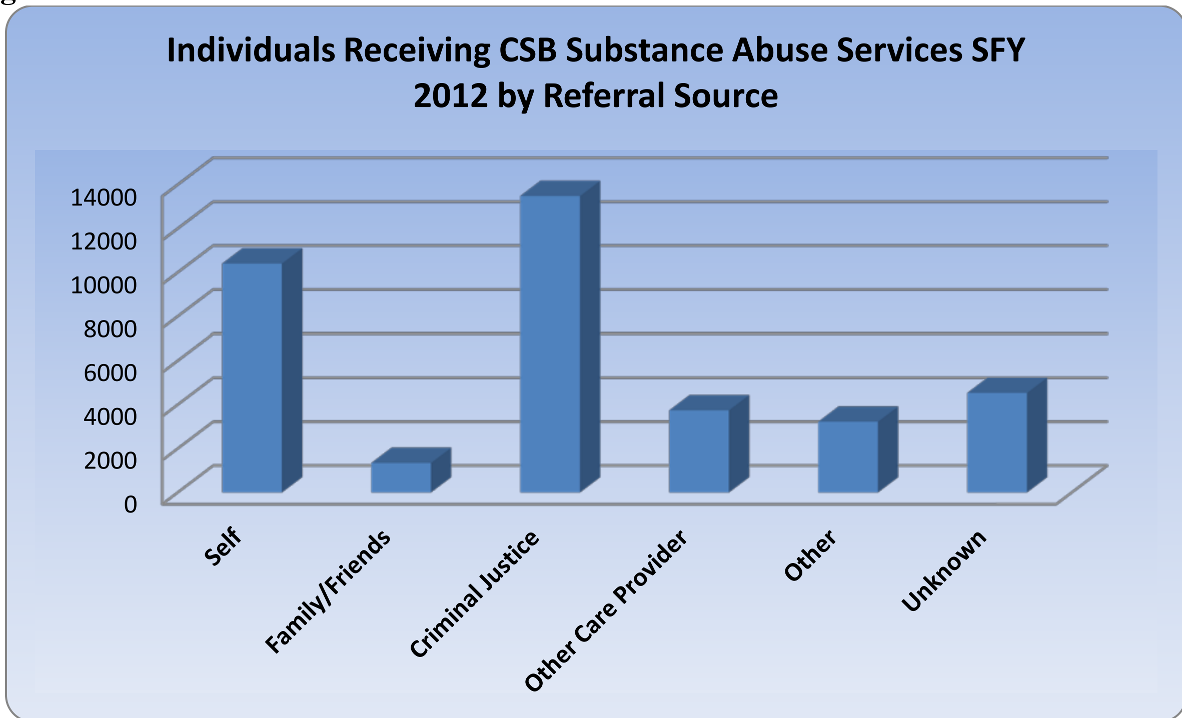


	Black/African American	White	Other	Multi-Race	Unknown
Percent of Treatment Population	29.89%	59.74%	6.10%	2.48%	1.78%
Treatment Population Figure	10,983	21,952	2,242	913	653

Most individuals served reported their race as White (21,952 or 60%) with 10,983 individuals (or 30%) reporting their race as Black/African American. Six percent (2,242) reported their race in other categories (Asian, Native American, Pacific Islander) while 2% (913) identified themselves as being Multi-Racial.

The following two charts display data on sources of referral and primary drugs of abuse for service recipients.

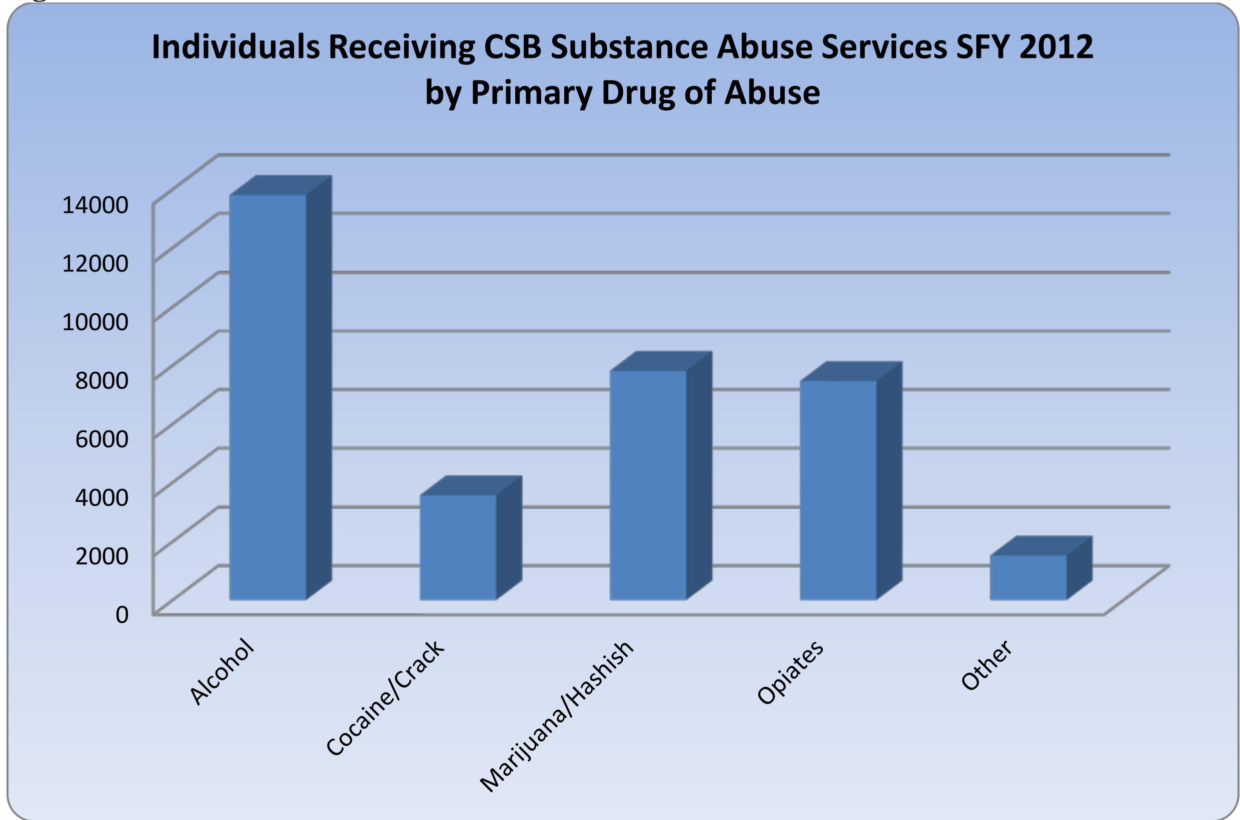
Figure 28



	Self	Family/ Friends	Criminal Justice	Other Care Provider	Other	Unknown
Percent of Treatment Population	28.32%	3.66%	36.69%	10.19%	8.78%	12.35%
Treatment Population Figure	10,406	1,346	13,482	3,745	3,226	4,538

The most common sources of referral were from components of the criminal justice system (law enforcement, probation, parole, correctional facility, etc. – 13,482 or 37%) which, along with self referrals (10,406 or 28%), accounted for over half of the individuals served.

Figure 29



	Alcohol	Cocaine/ Crack	Marijuana/ Hashish	Opiates	Other
Percent of Treatment Population	40.42%	10.41%	22.87%	21.85%	4.45%
Treatment Population Figure	13,801	3,555	7,811	7,462	1,519

Almost 14,000 service recipients (40%) reported alcohol as their primary drug of abuse. It is worth noting that the number of persons reporting Heroin/Methadone/Other Opiates as the primary drug of abuse (7,462 or 22%) is nearly equal to the number reporting Marijuana/Hashish (7,811 or 23%) as the primary drug of abuse. This is likely related to the increased incidence of abuse of prescription opioid-based pain medications. (See Figures 17, 18, 19 and 23.)

MAJOR ACTIVITIES RELATED TO SUBSTANCE ABUSE SERVICES

Treatment Services

Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development. In the spring of 2010, DBHDS began the development of an agency-wide strategic planning process which focused on critical aspects of the agency's mission. Among these was an initiative focused on substance abuse services. Numerous reports had identified weaknesses in the state's substance abuse treatment system that seriously affected its ability to provide effective services to those in need. The goal of this project was to create a strategic planning document that would provide long-term guidance for developing and strengthening the publicly-funded substance abuse treatment system in Virginia. To assure input from a wide range of stakeholders, this task was accomplished in a two-stage process. The first stage built upon the input of a workgroup that included advocates, and public and private providers. The mix included providers of services to offenders, adolescents, women and the general population served by CSBs. This group focused on improving access to the array of services necessary to support recovery, services to people with co-occurring mental illness and substance use disorders, and services needed by adults in criminal justice populations. Discussion concerning the needs other special populations (i.e., women, adolescents) was included in the overall discussion about the necessary array of services.

The second phase of this project built on this work and utilized input from state agency representatives from the Health and Human Resources secretariat (departments of Behavioral Health and Developmental Services, Health, Health Professions, Medical Assistance Services, Rehabilitative Service, Social Services) and Public Safety (departments of Corrections, Criminal Justice Services, Juvenile Justice). The intent was to get systemic input into the plan for a cohesive system across state agencies, as those in need of treatment for substance use disorders typically have complex issues that require resolution in order to support recovery.

The resulting plan document, *Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development* (http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf), was presented to the Governor in October of 2011. This plan identified a need for nearly $54 million to ensure timely access to services, address gaps in the service array, and develop other community-based supports. In addition to significant initiatives for which DBHDS is responsible, the plan included initiatives designed to be implemented by Public Safety agencies to reduce relapse associated with recidivism. This document should provide direction for the development of resources to treat substance abuse for several years.

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS). In 2012, DBHDS received a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in a federally-sponsored policy initiative, "Bringing Recovery Supports to Scale Technical Assistance Center Strategy" (BRSS-TACS). The initiative aims to advance recovery oriented systems, practices, and supports for persons with mental health and/or substance use disorders. These practices include integrating persons with lived experience of recovery into policy development, program design and delivery, improving access

to services, removing practical barriers to service, and reducing stigma. As one of only eight states selected to participate, Virginia sent a team of 12 persons including representatives of DBHDS, CSBs, state mental health facilities, peer and advocacy organizations, and DMAS to a national meeting with other state teams where they focused on developing a detailed state strategy and received technical assistance from national experts. As part of its award, Virginia received $50,000 to help implement its plan. As a result, the project sponsored a statewide Recovery Forum in Roanoke on June 9-11, 2013 to which system leaders were invited to participate. Approximately 110 persons of the state participated, representing CSBs, state mental health facilities, and substance abuse and mental health peer and advocacy services communities participated. Regional groups developed goals for furthering recovery oriented systems of care in their communities. A steering committee representing all regions and the attending stakeholders has been organized to continue work on these goals and to plan a second Recovery Forum.

National Governors Association Prescription Drug Abuse Prevention Project.
Abuse of prescription drugs continues to be a problem for the nation as well as in Virginia. The most recent information available from the Virginia Department of Health's Office of the Chief Medical Examiner (OCME) indicates that 818 people died from drug poisoning in 2011; over 60% of those deaths were related to opiate use, and most were drugs available only by prescription. In the fall of 2012, Virginia was selected, along with six other states, to participate in the first ever National Governors Association (NGA) Policy Conference focusing on the prevention of prescription drug abuse. The Department of Health Professions (DHP) was the lead agency for the Virginia team, joined by the Secretary of Public Safety and the Secretary of Health and Human Resources, DBHDS, and the Department of State Police.

After the first national meeting, where the team received information and technical assistance from national experts to help refine its strategy, the Virginia team established four workgroups: Training and Education, Enforcement, Disposal and Monitoring. Each workgroup included representatives from stakeholder organizations, including state and federal agencies and state legislators. State agencies included the departments of Health, Environmental Quality, Forensic Science, Criminal Justice Services, Aging and Rehabilitation Services, Veterans Services and the National Guard. Federal agencies represented included the U.S. Drug Enforcement Agency and the Office of U.S. Attorney – Western District. Other organizations represented include the Virginia Pharmacist Association, the Virginia Association of Commonwealth's Attorneys, the Virginia Dental Association, the Virginia Association of Chiefs of Police, the Virginia Sheriffs Association, the Medical Society of Virginia, the Virginia Association of Community Services Boards, the University of Virginia Medical School, the Virginia Association of Community Health Care, Virginia Association of Free Clinics, ConnectVirginia, OneCare of Southwest Virginia, SAFE of Chesterfield County, and the Virginia Hospital and Healthcare Association.

The workgroups each met multiple times to identify goal statements and develop objectives and strategies. In March 2013, the Virginia team hosted a day-long public meeting attended by stakeholders and interested citizens. Facilitated by staff from the NGA, each workgroup presented its draft plan and received input from members of the public who attended. At the second national meeting, the state teams received addition information and shared information about their draft strategies. The team has since finalized its plan which has been accepted by the Governor and forwarded to the NGA.

Juvenile Justice Behavioral Health Diversion Pilot. In the fall of 2012, Virginia was selected to participate in a policy academy co-sponsored by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the MacArthur Foundation, a private nonprofit organization that has targeted reform of the juvenile justice system as an ongoing concern. The policy academy focused on developing strategies to divert youth with mental health or substance use issues from engagement with the juvenile justice system. State agency partners included DBHDS, the Department of Juvenile Justice and the Office of Comprehensive Services along with community partners Horizon Behavioral Health and the 24th District Court Services Unit. Virginia's team developed a pilot project that utilized an evidence-based behavioral screening instrument administered in the court service unit to identify children who would benefit from behavioral health services whose caretakers were seeking petitions for Children in Need of Services (CHINS) or domestic violence. Based on factors identified in the screening, children were referred to the local CSB for services instead of further engaging in the juvenile justice system. Funded with $25,000, the project engaged local stakeholders in the project and trained local juvenile justice professionals in five juvenile justice service sites to administer the screening instrument. The approach to screening was unique in that the instrument was computer based and self-administered, under professional supervision. This had the effect of reducing youth resistance to being assessed and increasing the objectivity of the screening. Youth became calmer during the screening and more receptive to accepting professional assistance to address their behavior issues. During the six month pilot period, communication between the court service unit and the CSB improved. From the beginning of the pilot period until August 31, 2013, 58 screenings were conducted, resulting in 43 referrals to Horizon Behavioral Health, while only 15 petitions were filed, in contrast to 113 CHINS petitions during the same period the previous year. Anecdotal information indicated that many more families sought help from Horizon Behavioral Health as an alternative to seeking a petition simply as a result of hearing about the program.

Synar: Tobacco Law Compliance. The Synar Amendment was enacted as part of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992 (P.L. 102-321), legislation enacted the federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG), which provides a significant amount of support for community-based substance abuse treatment and prevention in Virginia. Named for its sponsor, the late Congressman Mike Synar of Oklahoma, the Synar Amendment has a number of provisions aimed at restricting youth access to tobacco products. Specifically, it requires states to: (1) enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18; (2) conduct random, unannounced inspections of tobacco outlets; and (3) report findings to the Secretary of Health Human Services annually. States are required to employ scientifically valid sampling standards to select the retail outlets that are inspected to ensure that the results are representative of retailer noncompliance statewide. States are expected to achieve a noncompliance rate of 20% or less. Failure to meet the requirements of the Synar legislation can result in a loss of as much as 40% of the SAPT Block Grant award, or, for Virginia, over $16 million. In 1997, the General Assembly specifically allocated the authority for youth tobacco law enforcement to the Department of Alcoholic Beverage Control (ABC), allowing DBHDS to enter into an agreement with ABC to conduct annual Synar inspections.

The statistically valid sample size for Virginia's retail inspection amounts to about 1,000 retail outlets which must be inspected annually. In compliance with the requirements of the Synar Amendment, ABC recruits young people aged 15 to 17 who are specially trained to assist in the inspections. Two adult ABC special agents accompany one underage buyer (UAB) during compliance checks. One special agent enters the retail establishment just prior to or just after the UAB, in a manner that ensures anonymity of the UAB as well as their safety. The UAB attempts to make the purchase and the ABC special agent witnesses the transaction. An agent always maintains close visual contact with the UAB. If a violation occurs, the UAB leaves the establishment and returns to the ABC agent waiting outside in a state vehicle and the agent returns to issue a citation. Since reporting an initial retailer violation rate of 45% in 1996, Virginia's rate improved steadily and has remained below the 20% target since 2001. In 2011 and 2012, Virginia reported rates of 13.0% and 13.5%, respectively. In addition to monitoring compliance, ABC and DBHDS periodically conduct field studies to assess the completeness of the retailer list from which the sample of inspected outlets is drawn.

In addition to inspection of tobacco outlets, DBHDS is actively involved in prevention activities focused on youth tobacco use. DBHDS works closely with the Virginia Foundation for Healthy Youth to monitor the sale and distribution of tobacco products to youth under age 18, and to promote prevention programs and messages that encourage youth not to use tobacco. Prevention personnel in the 40 CSBs conducted prevention programs designed to prevent youth from starting to use tobacco products, reaching 41,206 youth in SFY 2011 and 41,479 youth in SFY 2012. Many more youth and their parents received Synar-related material or participated in Synar-related activities.

Screening Women for Substance Use and Mental Health Disorders. DBHDS maintains information on its website regarding screening and brief intervention services for substance use and mental health. It includes screening tools as well as guidance information regarding screening and brief intervention services for pregnant women and women of childbearing age. DBHDS partnered with DMAS and the VDH to develop the Behavioral Health Risks Screening Tool for Women of Child Bearing Age, a screening tool for pregnant women and women of childbearing age that screens for substance use, mental health, and intimate partner violence. The tool is based on an instrument developed by the Institute for Behavioral Health in Boston, Massachusetts and the Institute assisted in this adaptation. Because this instrument screens for substance use (as opposed to substance abuse) as well as perinatal depression, it is especially well suited for use with pregnant women. DMAS has agreed to utilize Medicaid reimbursement for use of the tool for substance use screening and brief intervention services, and has adopted the tool for use in their Babycare Program which provides case management and other services to pregnant and postpartum women. VDH introduced use of the tool in its maternal health program and has translated it into three languages. DBHDS and VDH provided a webinar in July 2012 to train VDH staff on use of the tool.

Medication Assisted Treatment. Virginia is experiencing significant growth in Medication Assisted Treatment programs that utilize methadone. Regulated by both the federal and state government, these programs often require significant technical assistance from DBHDS staff to understand and comply with these regulations. During the reporting period, OSAS staff have

provided ongoing technical assistance to 10 potential providers in the following areas of the state: Chesapeake, Newport News, Fredericksburg, Pulaski, Williamsburg, Danville, Virginia Beach and Winchester. Since 2011, four additional programs had been licensed.

Professional Development. DBHDS sponsors a considerable amount of professional development to assure that the workforce, both public and private, is capable of providing substance abuse treatment and support services that are based on proven science. The following describes these opportunities:

Virginia Summer Institute for Addiction Studies (VSIAS). DBHDS, a founding sponsor of VSIAS, provided staff assistance and financial support using federal Substance Abuse Prevention and Treatment block grant funds, for the annual Virginia Summer Institute for Addiction Studies (VSIAS) conducted in Williamsburg, July 18-20, 2011. This event provided training and continuing education for prevention specialists and substance abuse counselors in basic and advanced skill development. DBHDS collaborated with the Virginia Association of Alcohol and Drug Abuse Counselors (VADAC), the Virginia Association of Drug and Alcohol Programs (VADAP), the Substance Abuse Certification Alliance of Virginia (SACAVA), the Substance Abuse Recovery Alliance (SAARA), the Virginia Association of Community Services Boards (VACSB), the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC), and the Virginia Drug Court Association (VDCA) to organize and coordinate VSIAS. Held annually, VSIAS connects participants with contemporary experts in the addiction treatment field through workshop sessions, featured forums, and hands-on workshops. Examples of topics addressed include: core competencies, skills training, prevention, recovery, and cultural competency. The 2011 VSIAS, "Adapting to Change," focused on: use of assessment instruments suitable for specific populations; addressing stigma; evidence-based counseling techniques; person-centered treatment planning; and, ethics. A total of 189 persons from across the state participated and the event occurred in Williamsburg. The theme of the 2012 VSIAS, also held in Williamsburg on July 16-18, 2012, was "Professional Treatment – Saving Lives, Saving Dollars." The learning objectives were to provide knowledge improvement and skill development opportunities to treatment providers, prevention staff, probation and corrections staff, school personnel, social services staff and others who work with adults and youth with substance use disorders. A total of 366 persons from across the state participated.

Services to Adolescents Who Have Experienced Trauma. Using funds from the SAPT Block Grant, DBHDS sponsored training to develop workforce skills in providing services to adolescents who have experienced trauma. Research indicates that a significant proportion of individuals with behavioral health problems have experienced serious traumatic events that have not been addressed. These events include being the victim of a violent crime or witnessing a violent assault of a loved one. The longer these events remain unaddressed, the more emotional damage occurs, often leading to substance abuse, as well as depression, poor emotional control, and other serious behavioral issues. The training focused on adolescents with co-occurring substance abuse and mental health issues and provided knowledge and skills in assessment and treatment. The 105 participants included staff from the Department of Juvenile Justice (DJJ), the Department of Social Services (DSS), CSBs, and private providers.

Informing Parents and Caregivers about Adolescent Substance Abuse. DBHDS sponsored training to help parents and caregivers understand adolescent development, signs that adolescents may be using drugs or alcohol, and how to get help. This three hour session provided information about the signs and symptoms of substance use, the treatment process, and strategies that family members can employ to take care of themselves during adolescent using episodes.

Virginia Association of Medication Assisted Recovery Programs (VAMARP). This annual conference provides current, knowledge-based training to professionals and other persons who work with individuals who are dependent on opiates. Attendees include staff providing direct clinical care, community corrections staff and local and state health department staff. DBHDS contributed staff support and funding from the federal SAPT Block Grant. The 2011 VAMARP Conference focused on improving the clinical knowledge of counselors and nurses working in opiate treatment programs about working with people with both mental illness and substance use disorder; enhancing knowledge about the connection between hepatitis and injection drug use; reducing stigma; and, improving knowledge of person-centered treatment, focusing on recovery. More than 225 attendees participated in the 2011 conference. The 2012 VAMARP conference focused on identifying and addressing specific issues that influence treatment of opioid addiction; medical and clinical issues for counselors, nurses, pharmacists and physicians; and, strategies to assist individuals with recovery support and in dealing with stigma. More than 240 attendees participated in the 2012 conference. Both the 2011 and the 2012 conferences were held in Richmond.

Prenatal Care Providers. In conjunction with the Office of Continuing Medical Education at University of Virginia, DBHDS, DMAS and VDH applied for and received a grant from the federal Office of Women's Health at the U.S. Department of Health and Human Services to support training for prenatal care providers on the importance of screening pregnant women for substance use, mental health and intimate partner violence. Approximately 89 medical and behavioral health care providers attended the training, held on August 20, 2011, in Richmond.

Clinical Supervision. Training in clinical supervision has been identified as a way to ensure best practices and to increase fidelity to treatment models and evidence-based practices by clinical staff providing services in CSBs and state facilities. In addition, the VDH Board of Counseling requires professionals who wish to supervise a candidate to become either a licensed clinical social worker (LCSW) or licensed professional counselor (LPC) to complete a specified number of hours in training about clinical supervision. To address these supervisory issues, DBHDS continued its initiative to improve their skills by providing a five-day training and skill development program at four sites statewide from July through November of 2011. The learning objective was to enhance the clinical supervision skills and knowledge of supervisors of services for clients with substance use and mental health disorders. Overall, 91 new and experienced clinical supervisors from 21 CSBs, five state facilities, and several opiate treatment programs attended. From June through September of 2012, the five-day training was again offered at two sites. Forty-nine supervisors from 12 CSBs and four state facilities attended. These events provided the training content and hours for CSB and state facility staff to meet the supervision training requirements of the Board of Counseling.

Psychiatrists and Other Medical Staff. In collaboration with UVA Medical School and VACSB, DBHDS offered training targeted to psychiatrists, doctors and other health providers in state mental health facilities and CSBs to improve their knowledge of addiction and treating people who may have co-occurring mental illness and substance use disorder. In addition, DBHDS collaborated with the Virginia Health Practitioners Monitoring Program to plan and provide training for health care providers that also included pain management for people who are recovering from addiction. This training occurred in Richmond on August 24, 2012. UVA Medical School provided CMEs. Eighty-one persons from 27 CSBs and six state mental health facilities participated.

Developing Recovery and Peer Services. DBHDS provided funding from two federal block grants (Substance Abuse Prevention and Treatment and Community Mental Health Services) and collaborated with the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA) to present the third annual conference focused on peer and recovery support services for persons with substance use disorders and mental illness. The conference, "If We Build It, They Will Come: Growing Support and Capacity for Peer and Recovery Services," took place in Charlottesville on November 9-10, 2011. This training was designed to meet DBHDS' *Creating Opportunities* goal for advancing peer and recovery services in Virginia. Specific goals were to:

- Bridge boundaries between the substance abuse and mental health peer communities;
- Improve understanding between the peer and clinical services communities;
- Gain information about peer services and how the peer community and clinical community can more effectively work together;
- Improve knowledge about how to develop and manage peer services.

Training topics included information on developing peer services, program management, supervision, ethics, career paths for peer providers, using mental health advance directives, self-directed recovery planning, and developing peer services with specific populations. Over 200 attendees, including peer providers, supervisors and clinical staff from CSBs, and state agency staff, participated in the conference.

Interagency Relationships

Commission on the Virginia Alcohol Safety Action Program. Established as a legislative agency to assure standardization of the 24 alcohol safety action programs (ASAP) serving the Commonwealth, the commission's mission is to improve highway safety by decreasing the incidence of driving under the influence of alcohol and other drugs, leading to the reduction of alcohol and drug-related fatalities and crashes. Membership in the 15 member commission is established by statute (§18.2-271.2A) and includes a representative from DBHDS, legislators, judges, a sheriff, citizens at large, appointed executive directors of local ASAPs, and a representative from the Department of Motor Vehicles. The commission meets four times a year. Commission members are actively involved in certifying that local ASAPs comply with established operational policies and procedures, and that the operations are fiscally sound. The commission also sponsors training for local ASAP staff.

Drug Treatment Courts. The State Drug Treatment Court Advisory Committee was established to: (1) evaluate and recommend standards for the planning and implementation of drug treatment courts; (2) assist in the evaluation of their effectiveness and efficiency; and (3) encourage and enhance cooperation among agencies that participate in their planning and implementation. DBHDS is represented on the Advisory Committee.

The Advisory Committee has three standing committees: the Operations Committee; the Planning and Development Committee; and the Evaluations Committee. The DBHDS representative has actively participated in the work of the Operations Committee and the Planning and Developmental Committee.

The Operations Committee is responsible for the review and initial approval of drug treatment court applications. Prior to 2012, budget language required all drug treatment courts to be approved by the General Assembly. In 2012, the budget language was amended to allow drug treatment courts funded by federal and/or local resources to be reviewed and approved by the Advisory Committee.

The Planning and Development Committee established the "Drug Courts 2020" work group. Beginning in February 2010, DBHDS actively participated in the work group. DBHDS staff participated in the development of a strategic plan for the continuation, improvement, expansion and sustainability of drug treatment courts through the year 2020. The priorities of the "Drug Courts 2020" planning effort reflected the following values: the desire for more effective and timely collection and reporting of program data; early identification and placement of eligible participants; and, provision of a comprehensive continuum of services in meeting constituents' needs. Work on this committee supports the *Creating Opportunities* substance abuse initiative to enhance access to a consistent array of substance use disorder treatment services across Virginia. This effort allowed DBHDS to expand partnerships with the judicial and criminal justice systems in addressing the challenging needs of individuals identified with substance use disorders.

Home Visiting Consortium. Virginia's Home Visiting Consortium (HVC) is a collaboration of statewide early childhood home visiting programs that serve families of children from pregnancy through age five. The HVC is committed to enhancing and improving home visiting services across the Commonwealth and also serves as the advisory committee for a federal grant for Maternal, Infant and Early Childhood Home Visiting (MIECHV). DBHDS provides technical assistance to the consortium regarding the behavioral health care needs of the clients they serve. DBHDS is a member of the HVC Training Committee and participates in the development of HVC training. In 2012, DBHDS developed a one-day training curriculum, "Substance Use: Risks and Effects in Pregnancy and Early Childhood Development," for home visitors and organized a team of trainers to present the course. James Madison University (JMU), which coordinates all training for the HVC, provided the training 13 times in 2012 to 197 home visitors. DBHDS is working with JMU to develop two additional trainings for home visitors: a web-based training regarding the importance of screening women for substance use, mental health and domestic violence, and one-day training on how to implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) model to screen women for substance use disorders, provide brief treatment, and refer for more extensive treatment when necessary.

Substance Abuse Services Council. The Substance Abuse Services Council, established by statute (§2.2-2696), is staffed by the DBHDS Office of Substance Abuse Services. Its membership consists of 29 members who are representatives of state agencies, advocacy and provider organizations, as well as gubernatorial appointees, delegates and senators. The council meets four times a year and considers issues that may have bearing on state policy. Information about the council is available via the DBHDS web site (http://www.dbhds.virginia.gov/SASC/default.htm).

Prevention Activities

Strengthening Families Initiative. The Strengthening Families Initiative began in 1999 with eight programs. These programs are used to improve resilience to substance abuse in families by increasing family cohesion. Additional immediate goals include: strengthening overall parenting skills; increasing parental involvement on multiple levels, including social networks; reducing chronic daily stress; reducing substance abuse by the child and family; reducing the chronic family conflict; and, reducing child abuse and neglect. The initiative utilizes a variety of evidence-based approaches to accomplish these goals. The programs have been conducted in both English and Spanish and encourage community partnerships with the faith and business communities, local retailers, law enforcement, medical personnel, and other entities. Graduates of the programs serve as advisory committee members and program co-facilitators. The various programs reach youth ages 4-17 depending on the needs and other services available in the community. A study conducted by Virginia Tech (VT) found positive outcomes with regards to discipline practices, communication skills, family cohesion, general nurturing and support of the parent-child relationship.

To provide technical support to the existing 16 Strengthening Families sites, DBHDS developed a learning community for the sites to share information, practices, and discuss policy issues using monthly teleconferences. The sites also receive technical assistance from experts, and learn how to improve services and address the needs of specific cultures in Virginia. Using this medium as a networking forum allows DBHDS to conserve dollars while providing an opportunity to increase the knowledge base of grantees, and address common issues pertaining to fiscal management, program integrity and staff.

Interagency Relationships
Strategic Prevention Framework-State Infrastructure Grant. To assist the states in developing strategically focused prevention initiatives, SAMHSA required and funded states to participate in an epidemiological study to target program development for a major multi-year prevention initiative. Awarded in 2008, the Commonwealth receives $2,135,724 annually through 2015. DBHDS serves as the grant administrator, but the planning and activities are conducted through the Virginia Office for Substance Abuse Prevention (VOSAP) Collaborative, a 13 member group of state agencies (formerly the Governor's Office for Substance Abuse Prevention). The Center for School and Community Collaboration at Virginia Commonwealth University (VCU) manages the grant project.

For the epidemiologic study, VOSAP selected underage use of alcohol as the target problem. Grant funds were distributed by then-named GOSAP via competitive grants to localities to

complete community-level needs assessment and strategic planning processes, implement programming to prevent underage alcohol use, and evaluate the impact of these local projects. As intended, implementation and evaluation activities continue in this multi-year project.

Prevention and Promotion Advisory Council (PPAC). The Prevention and Promotion Advisory Council (PPAC) is an advisory body to the State Board of the BHDS. The council advises the board in the formulation of policies/goals with respect to the initiation, funding and delivery of behavioral health, developmental disabilities, and substance abuse prevention and promotion services in the Commonwealth. It is comprised of members appointed by the board. Currently, there are 12 members from colleges/universities, state agencies, CSBs, and businesses as well as a liaison from the board. In August 2012, the council presented a white paper to the board describing changes in federal prevention policy that broaden the scope of DBHDS prevention efforts to encompass all of behavioral health as opposed to the singular focus on substance abuse.

Professional Development

Suicide Prevention**.** In April 2012, DBHDS provided training to 24 individuals to become as Applied Suicide Intervention Skills Training (ASIST) trainers. Of the 24 individuals, there are CSB treatment and prevention staff members, DBHDS mental health facility staff, and Virginia Department of Veterans Services staff (specifically, Wounded Warrior program). In addition, 97 individuals participated in a two- day ASIST training for suicide prevention. During SFY 2013, ASIST trainers provided ASIST training to approximately 796 individuals throughout the state. Those that received trainings were CSB personnel and local community members. Prevention services staff co-chaired a Suicide Prevention Interagency Workgroup that developed the new "Virginia Suicide Prevention, Across the Lifespan Plan." The plan draft has been completed and is under review.

Substance Abuse Prevention Specialist Training. In March 2012, DBHDS provided a five-day Substance Abuse Prevention Specialist Training to 14 CSB prevention staff. The training provides information about how to assess substance abuse-related problems in communities and form coalitions to support evidence-based prevention services that address these community issues. The training was again provided in March 2013 to 25 CSB prevention staff. An additional training event was conducted on June 2013, in Roanoke for 14 CSB prevention professionals working the southwest portion of the state. Recently, SAMHSA approved this training curriculum for distribution by its Center for Substance Abuse Prevention (CSAP).

Prevention Supervisor Mentorship Program. During SFY 2012, DBHDS sponsored five mentors who are experienced CSB prevention supervisors to support newly hired prevention supervisors at CSBs. These mentoring sessions provided 84 hours of coaching to the new prevention supervisors. During SFY 2013, three mentors combined with DBHDS prevention staff to provide 127 hours of mentoring services to newly hired prevention supervisors.

Off-Site Prevention Supervision Program**.** The Off-Site Supervision Program provides necessary supervision to prevention professionals who are seeking designation as a Internationally Certified Prevention Specialist (ICPS) and who do not have access to onsite supervision by allowing individuals with extensive field experience to document their experience, working

through the Substance Abuse Certification Alliance of Virginia (SACAVA). Credit is awarded for applicable prevention experience in lieu of the required supervised hours needed to sit for the Certified Prevention Specialist exam. This program was piloted November 2012 - April 2013 initially with one site, Rappahannock Area CSB.

Other Prevention Training. DBHDS provided scholarships for CSB prevention directors, prevention staff, and coalition members to attend training courses offered by the Virginia Foundation for Healthy Youth. These workshops were offered to increase knowledge about coalition development, enhance overall prevention knowledge, and broaden professional networks. From July 1, 2011 through June 30, 2012, DBHDS provided 360 scholarships for CSB prevention staff and community prevention coalition partners to attend these one-day training events.

APPENDICES

Code of Virginia
§ 37.2-310. Powers and duties of Department related to substance abuse.

The Department shall have the following powers and duties related to substance abuse:

1. To act as the sole state agency for the planning, coordination, and evaluation of the comprehensive interagency state plan for substance abuse services.
2. To provide staff assistance to the Substance Abuse Services Council pursuant to § 2.2-2696.
3. To (i) develop, implement, and promote, in cooperation with federal, state, local, and other publicly-funded agencies, a comprehensive interagency state plan for substance abuse services, consistent with federal guidelines and regulations, for the long-range development of adequate and coordinated programs, services, and facilities for the research, prevention, and control of substance abuse and the treatment and rehabilitation of persons with substance abuse; (ii) review the plan annually; and (iii) make revisions in the plan that are necessary or desirable.
4. To report biennially to the General Assembly on the comprehensive interagency state plan for substance abuse services and the Department's activities in administering, planning, and regulating substance abuse services and specifically on the extent to which the Department's duties as specified in this title have been performed.
5. To develop, in cooperation with the Department of Corrections, Virginia Parole Board, Department of Juvenile Justice, Department of Criminal Justice Services, Commission on the Virginia Alcohol Safety Action Program, Office of the Executive Secretary of the Supreme Court of Virginia, Department of Education, Department of Health, Department of Social Services, and other appropriate agencies, a section of the comprehensive interagency state plan for substance abuse services that addresses the need for treatment programs for persons with substance abuse who are involved with these agencies.
6. To specify uniform methods for keeping statistical information for inclusion in the comprehensive interagency state plan for substance abuse services.
7. To provide technical assistance and consultation services to state and local agencies in planning, developing, and implementing services for persons with substance abuse.
8. To review and comment on all applications for state or federal funds or services to be used in substance abuse programs in accordance with § 37.2-311 and on all requests by state agencies for appropriations from the General Assembly for use in substance abuse programs.
9. To recommend to the Governor and the General Assembly legislation necessary to implement programs, services, and facilities for the prevention and control of substance abuse and the treatment and rehabilitation of persons with substance abuse.
10. To organize and foster training programs for all persons engaged in the treatment of substance abuse.
11. To identify, coordinate, mobilize, and use the research and public service resources of institutions of higher education, all levels of government, business, industry, and the community at large in the understanding and solution of problems relating to substance abuse.
12. To inspect substance abuse treatment programs at reasonable times and in a reasonable manner.
13. To maintain a current list of substance abuse treatment programs, which shall be made available upon request.

Virginia Localities Sorted by National Survey of Drug Use and Health (NSDUH) Region

Region 1
Albemarle, Augusta, Bath, Buckingham, Buena Vista City, Caroline, Charlottesville City, Clarke, Culpeper, Fauquier, Fluvanna, Frederick, Fredericksburg City, Greene, Harrisonburg City, Highland, King George, Lexington City, Louisa, Madison, Nelson, Orange, Page, Rappahannock, Rockbridge, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton City, Warren, Waynesboro City, Winchester City

Region 2
Alexandria City, Arlington, Fairfax, Fairfax City, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William

Region 3
Alleghany, Amherst, Appomattox, Bedford, Bedford City, Bland, Botetourt, Bristol City, Buchanan, Campbell, Carroll, Clifton Forge City, Covington City, Craig, Danville City, Dickenson, Floyd, Franklin, Galax City, Giles, Grayson, Henry, Lee, Lynchburg City, Martinsville City, Montgomery, Norton City, Patrick, Pittsylvania, Pulaski, Radford City, Roanoke, Roanoke City, Russell, Salem City, Scott, Smyth, Tazewell, Washington, Wise, Wythe

Region 4
Amelia, Brunswick, Charles City, Charlotte, Chesterfield, Colonial Heights City, Cumberland, Dinwiddie, Emporia City, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell City, Lunenburg, Mecklenburg, New Kent, Nottoway, Petersburg City, Powhatan, Prince Edward, Prince George, Richmond City, Surry, Sussex

Region 5
Accomack, Chesapeake City, Essex, Franklin City, Gloucester, Hampton City, Isle of Wight, James City, King and Queen, King William, Lancaster, Mathews, Middlesex, Newport News City, Norfolk City, Northampton, Northumberland, Poquoson City, Portsmouth City, Richmond, Southampton, Suffolk City, Virginia Beach City, Westmoreland, Williamsburg City, York

Substance Use Disorders[1]

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) Tolerance, as defined by either of the following:
  a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect;
  b. Markedly diminished effect with continued use of the same amount of the substance;

(2) Withdrawal, as manifested by either of the following:
  a. The characteristic withdrawal syndrome for the substance (physiological symptoms that are specific to the substance, i.e., alcohol or other drug);
  b. The same (or a closely related) substance is taken to relive or avoid withdrawal symptoms;

(3) The substance is often taken in larger amounts or over a longer period than was intended;

(4) There is a persistent desire of unsuccessful efforts to cut down or control substance use;

(5) A great deal of time is spend in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances to obtain a supply of the substance), use the substance, or recover from its effects;

(6) Important social, occupational, or recreational activities are given up or reduced because of substance use;

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

  (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance –related absences, suspensions or expulsions from school; neglect of children or household);
  (2) Recurrent substance use in situations in which it is physically hazardous;
  (3) Recurrent substance-related legal problems;
  (4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

B. The symptoms have never met the criteria for Substance Dependence for this class of substance (e.g., a person may have had symptoms for cocaine abuse but not for alcohol abuse).

[1] Adapted from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), 2000.

List of Virginia Cities and Counties by Region
Office of the Chief Medical Examiner – Virginia Department of Health

CENTRAL *Counties of* Albemarle, Amelia, Brunswick, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Cumberland, Dinwiddie, Essex, Fluvanna, Gloucester, Goochland, Greene, Greensville, Halifax, Hanover, Henrico, James City, King and Queen, King George, King William, Lancaster, Louisa, Lunenburg, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northumberland, Nottoway, Powhatan, Prince Edward, Prince George, Spotsylvania, Stafford, Surry, Sussex, Richmond, and Westmoreland. *Cities of* Charlottesville, Colonial Heights, Emporia, Fredericksburg, Hopewell, Petersburg, Richmond, and Williamsburg.

NORTHERN *Counties of* Arlington, Clarke, Culpeper, Fairfax, Fauquier, Frederick, Loudoun, Madison, Orange, Page, Prince William, Rappahannock, Shenandoah, and Warren. *Cities of* Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, and Winchester.

TIDEWATER *Counties of* Accomack, Isle of Wight, Northampton, Southampton, and York. *Cities of* Chesapeake, Franklin, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, and Virginia Beach.

WESTERN *Counties of* Alleghany, Amherst, Appomattox, August, Bath, Bedford, Bland, Botetourt, Buchanan, Campbell, Carroll, Craig, Dickenson, Floyd, Franklin, Giles, Grayson, Henry, Highland, Lee, Montgomery, Patrick, Pittsylvania, Pulaski, Roanoke, Rockbridge, Rockingham, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe. *Cities of* Bedford, Bristol, Buena Vista, Covington, Danville, Galax, Harrisonburg, Lexington, Lynchburg, Martinsville, Norton, Radford, Roanoke, Salem, Staunton, and Waynesboro.

Services Definitions

Acute Psychiatric or Substance Abuse Inpatient Services provide intensive short-term psychiatric treatment in state hospitals or intensive shorter treatment, including services to persons with intellectual disability, or substance abuse treatment, except detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

Community-Based Substance Abuse Medical Detoxification Inpatient Services use medication under the supervision of medical personnel in local hospitals to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

Outpatient Services are generally provided to individuals on an hourly schedule on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient Services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services.

Case Management Services assist individuals and their family members to access services that are responsive to the person's individual needs. Services include: identifying and reaching out to individuals in need of services, assessing needs and planning services, and linking the individual to services and supports.

Medication Assisted Treatment combines outpatient treatment with administering or dispensing synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

Day Treatment or Partial Hospitalization is a treatment program that provides structured treatment, activities, or training, generally in clusters of two or more continuous hours per day, to groups or individuals in non-residential settings and includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with substance use, or co-occurring disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment that is not provided in Outpatient Services.

Highly Intensive Residential Services provide overnight care with intensive treatment or training services. These services include: residential services for individuals with co-occurring diagnoses, substance abuse detoxification services that provide specialized facilities with physician services available when required to systematically reduce or eliminate the effects of alcohol or other drugs in the body and return a person to a drug-free state and that normally last up to seven days.

Residential Crisis Stabilization Services provide direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention to stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

Intensive Residential Services provide overnight care with treatment that is less intense than highly intensive residential services. Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducation, consumer monitoring, case management, individual and family therapy, and discharge planning. Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services. Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility.

Supervised Residential Services offer overnight care with supervision and services. Supervised Apartments are directly-operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals in apartments and other residential settings. The expected length of stay normally exceeds 30 days. Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment.

Supportive Residential Services are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis.