Virginia Statewide Substance Use and Behavioral Health Needs Assessment

Submitted to the Virginia Department of Behavioral Health and Developmental Services

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OMNI

Virginia DBHDS
Behavioral Health Wellness:
Broadening Prevention
Virginia Prevention Works!

Virginia Statewide Substance Use and Behavioral Health Needs Assessment

For more information, please contact:

Julia Simhai, MPH

jsimhai@omni.org

303-839-9422 ext. 137

Katie Gelman, DrPH, MPH

kgelman@omni.org

303-839-9422 ext. 143

For General Inquiries/Questions

p. 303-839-9422

f. 303-839-9420

OMNI Institute

899 Logan Street, Suite 600

Denver, CO 80203

www.omni.org

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OMNI Contributors: Kait Markley, Cindy Vigil, Natalie Wheeler, Cheryl Winston

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Executive Summary

INTRODUCTION

In the spring of 2018, OMNI Institute (OMNI) collaborated with the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Behavioral Health Wellness to examine the status and needs related to behavioral health and substance use in Virginia. The report represents the synthesis of more than seventeen national and local secondary data sources, including: health surveys; morbidity and mortality data; criminal justice and law enforcement records; and population and social determinants of health statistics. In addition, OMNI collected primary data from over three dozen stakeholders through: a facilitated discussion of the data findings with the Statewide Epidemiology Outcomes Workgroup; a discussion of priority areas with DBHDS staff; and a SWOT analysis with local prevention staff.

KEY FINDINGS

This needs assessment revealed that the longstanding focus of prevention work on alcohol and tobacco remains a need in Virginia. As such, these two substances are designated priority areas along with mental health and suicide. The selection of these areas as priorities is supported by historical and current prevalence and consequence data, as well as input from DBHDS, the Virginia Statewide Epidemiology Outcomes Workgroup, and Community Service Boards (CSBs).

In recent years, DBHDS has shifted the prevention infrastructure in Virginia by emphasizing environmental prevention strategies and encouraging data-driven work. The recent completion of needs assessments and strategic planning by each CSB provided an excellent foundation for advancing work towards these goals.

Moving forward, DBHDS must balance its strategic direction and priority areas with emerging and topical public health issues that often shift attention from the longstanding prevention priorities. With this needs assessment and the ensuing strategic planning, DBHDS will be well-positioned to manage Virginia's prevention priorities and leverage its resources for significant impact and success.

PRIORITY AREAS

Priority areas are substances or issues that have high prevalence, significant consequences, and represent public or behavioral health challenges across the Commonwealth.

Alcohol

Alcohol is the most commonly used substance in Virginia with 25% of high schoolers and 56% of adults consuming alcohol in the past 30 days. In the past 10 years, **the rate of alcohol-related deaths has increased**. While Virginia has taken steps to address the ongoing issue of alcohol use, it remains a critical public health issue that affects many Virginians.

Tobacco and Nicotine

Twenty-six percent of Virginia adults and 16% of Virginia high schoolers have used some form of tobacco or nicotine in the past month. While tobacco use has decreased in recent years, **Virginia's 30 cent tax per pack of cigarettes is the second-lowest in the country**. In the past several years, e-cigarettes and vaping have increased in popularity, especially among youth (**33% of high schoolers have tried an electronic vapor product**). These products present a new challenge to the ongoing work of preventing tobacco use in Virginia.

Mental Health and Suicide

Mental health and suicide has been a longstanding issue in Virginia with approximately **20% of Virginians experiencing a mental illness** each year. More recently, Virginia has seen an **increase in symptoms of depression and thoughts of suicide** among youth, young adults, and adults. In addition to having high prevalence, the consequences of these trends are serious; **suicide is the leading cause of death for individuals with mental health and substance use disorders**.

AREAS TO WATCH

Areas to watch include substances or issues for which prevalence is relatively low, but trending upward. Although the consequences of these issues may be severe, the current prevalence does warrant assigning priority status. Future data may indicate that these issues should be elevated to priorities, and the data should be monitored accordingly.

Opioids

The opioid crisis was declared a national public health emergency in 2017. In Virginia, **opioids are the leading cause of fatal overdoses**.

Marijuana

In Virginia, marijuana is **more popular among youth than adults**. There are concerns about how cultural and social norms will impact marijuana use as more states legalize marijuana.

Cocaine and Meth

Rates of both cocaine and methamphetamine use remain low. However, their consequences, such as **arrests, drug seizures, and fatal overdoses, are trending upward.**

COMMUNITY INPUT AND ASSESSMENT

Thirty-one prevention staff members from across the Commonwealth participated in SWOT (Strengths, Weaknesses, Opportunities, Threats) discussions, in which they identified several strengths and weaknesses of the prevention workforce, funding structure, and CSB operations. In addition, participants identified external opportunities that could facilitate prevention work in the future, as well as threats that pose challenges to prevention work and may be areas to address in future years.

Strengths Strong **partnerships, coalition support,** and **passionate staff** are essential to prevention work, and CSBs are already successfully incorporating these items into their work in the priority areas.

Weaknesses Both CSBs and DBHDS highlighted **funding, staff resources**, and **workforce skills** as key internal weaknesses that hinder prevention work in the priority areas.

Opportunities DBHDS's **emphasis on environmental strategies** requires a switch from direct service to indirect, community-wide approaches. Many voiced the desire for additional **trainings, support, and resources** to shift their work in this direction.

Threats Larger trends in the **cultural and social acceptance of substance use**, and the **alignment of funding** with these priority areas, are perceived as major external threats to prevention work.

RECOMMENDATIONS

After reviewing data trends, discussing with DBHDS and the State Epidemiology Outcomes Workgroup, and receiving input from stakeholders across the Commonwealth, three key areas for potential growth and action emerged:

Fund Priorities Strategically impact priority areas by funding **strategies and outcomes** that address **appropriate risk and protective factors**.

Build Capacity Support the prevention workforce across Virginia with **training and peer learning opportunities**.

Lead Initiatives Lead efforts for **statewide messaging, advocacy, collaboration,** and **decision-making** that facilitate effective prevention work across the Commonwealth.

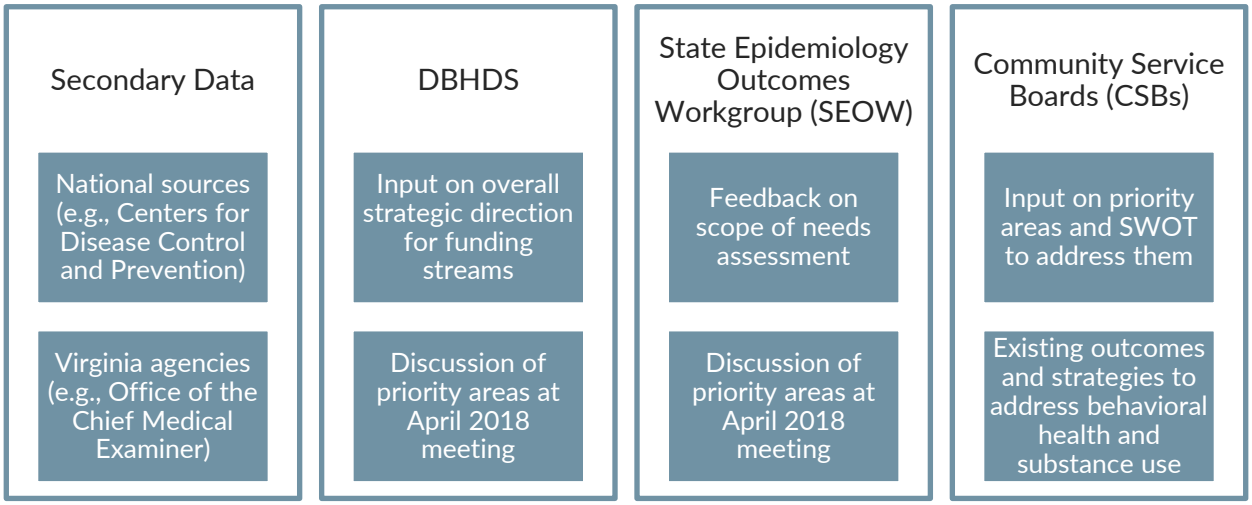
Introduction

BACKGROUND

This report was prepared by OMNI Institute (OMNI), under the direction of the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Behavioral Health Wellness, to examine the status and needs related to behavioral health and substance use in Virginia. OMNI has partnered with DBHDS since 2014 to provide evaluation and capacity building for the Substance Abuse Prevention Block Grant funding that is distributed to the 40 Community Service Boards (CSBs) across the Commonwealth. OMNI has also served as a technical assistance partner and evaluator for Virginia's Partnerships for Success grant since 2016, which funds nine communities to address prescription drug and heroin abuse.

METHODS AND DATA SOURCES

This report represents the synthesis of primary and secondary data from a variety of sources. OMNI completed data gathering and preparation of this report from February – June 2018.



Data collection began with the compilation of a comprehensive list of indicators measuring topics related to behavioral health and substance use from national sources, Virginia agencies, and the Virginia Social Indicator Dashboard[1]. OMNI shared this list of indicators with the State Epidemiology Outcomes Workgroup (SEOW) to solicit feedback on the scope of the needs assessment, and ensure that all relevant topics would be considered in the data collection process. A copy of the indicator list can be found in Appendix A. Needs Assessment Indicator Listand

[1] The Virginia Social Indicator Dashboard is an online interactive resource that houses behavioral health indicator data from agencies throughout Virginia. It can be used by stakeholders to examine trends across behavioral health areas, as well as to assess areas of strength and need for specific geographic areas. See https://vasisdashboard.omni.org/rdPage.aspx?rdReport=Home.

additional information about data sources included in the needs assessment can be found in the References section of the report.

OMNI gathered data based on the final indicator list, including national, state, and local indicators, as well as trends over time. After reviewing these data, OMNI identified themes and key findings to share with DBHDS and the SEOW. These findings were organized to examine the relative prevalence and trend data for seven substances (alcohol; tobacco; marijuana; prescription opioids; heroin and fentanyl; cocaine; and methamphetamines), mental health and suicide, and risk and protective factors. In April 2018, OMNI held facilitated discussions with DBHDS and the SEOW. During these meetings, the data were presented and both groups discussed what they viewed as the top behavioral health and substance use issues in the Commonwealth based on the data; what root causes were driving these issues; and what resources are needed to address these issues. A copy of the data presentation can be found on the Resources page of the Virginia Social Indicator Dashboard.[2] A copy of the discussion questions used can be found in Appendix B. The results of these discussions are included in this report and provided guidance for a second round of data collection within the identified priority areas following the April meetings.

Following the identification of priority areas, OMNI conducted an extensive SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis with CSB staff and prevention directors doing on-the-ground prevention work across Virginia. These meetings were designed to gather the perspectives of the local staff on: the internal strengths and weaknesses of CSBs; their ability to work towards the priority areas; and the external threats and opportunities surrounding their work. Eight SWOT focus groups and discussions were conducted. The focus group topics were divided by substance or behavioral health issue, allowing for two groups to focus on each of the three priority areas – alcohol; tobacco and nicotine; and mental health and suicide. An additional two discussions took place with staff from DBHDS. In total, 31 prevention staff participated in the discussions. A copy of the SWOT discussion questions can be found in Appendix C.

Finally, OMNI incorporated contextual information and data from the evaluation and technical assistance work that OMNI does with CSBs and communities across Virginia. This included aggregating information from technical assistance documents regarding strategies, resources, and outcomes in place through existing prevention funding.

[2] Direct link to the data presentation slides: https://datadashboard.omni.org/VASIS/ExportFiles/SEOW%20Needs%20Assessment%20Presentation.pdf

Substance Use and Behavioral Health in Virginia

DBHDS and the SEOW have identified priority areas to address in Virginia, along with areas to watch. Priority areas are substances or issues that have high prevalence, significant consequences, and represent public or behavioral health challenges across the Commonwealth:

- **Alcohol** is the most commonly used substance in Virginia with 25% of high schoolers and 56% of adults consuming alcohol in the past 30 days. In the past 10 years, the rate of alcohol-related deaths has increased. While Virginia has taken steps to address the ongoing issue of alcohol use, it remains a critical public health issue that affects many Virginians.
- **Tobacco and nicotine** is currently used by 26% of Virginia adults and 16% of Virginia high schoolers. While tobacco use has decreased in recent years, Virginia's 30 cent tax per pack of cigarettes is the second-lowest in the country. In the past several years, e-cigarettes and vaping have increased in popularity, especially among youth (33% of high schoolers have tried an electronic vapor product). These products present a new challenge to the ongoing work of preventing tobacco use in Virginia.
- **Mental health and suicide** has been a longstanding issue in Virginia with approximately 20% of Virginians experiencing a mental illness each year. More recently, Virginia has seen an increase in symptoms of depression and thoughts of suicide among youth, young adults, and adults. In addition to having high prevalence, the consequences of these trends are serious; suicide is the leading cause of death for individuals with mental health and substance use disorders.

Areas to watch include substances or issues for which prevalence is relatively low, but trending upward. Although the consequences of these issues may be severe, the current prevalence does warrant assigning priority status. Future data may indicate that these issues should be elevated to priorities, and the data should be monitored accordingly:

- **Opioids:** The opioid crisis was declared a national public health emergency in 2017. In Virginia, opioids are the leading cause of fatal overdoses.
- **Marijuana:** In Virginia, marijuana is more popular among youth than adults. There are concerns about how cultural and social norms will impact marijuana use as more states legalize marijuana.

- **Cocaine and Methamphetamines:** Rates of both cocaine and methamphetamine use remain low. However, their consequences, such as arrests, drug seizures, and fatal overdoses, are trending upward.

DBHDS and the SEOW recognize that these priorities do not cover the full scope of challenges in the areas of substance use and behavioral health in Virginia. However, these represent current issues of note across the Commonwealth, and offer a data-driven assessment of existing prevention priorities.

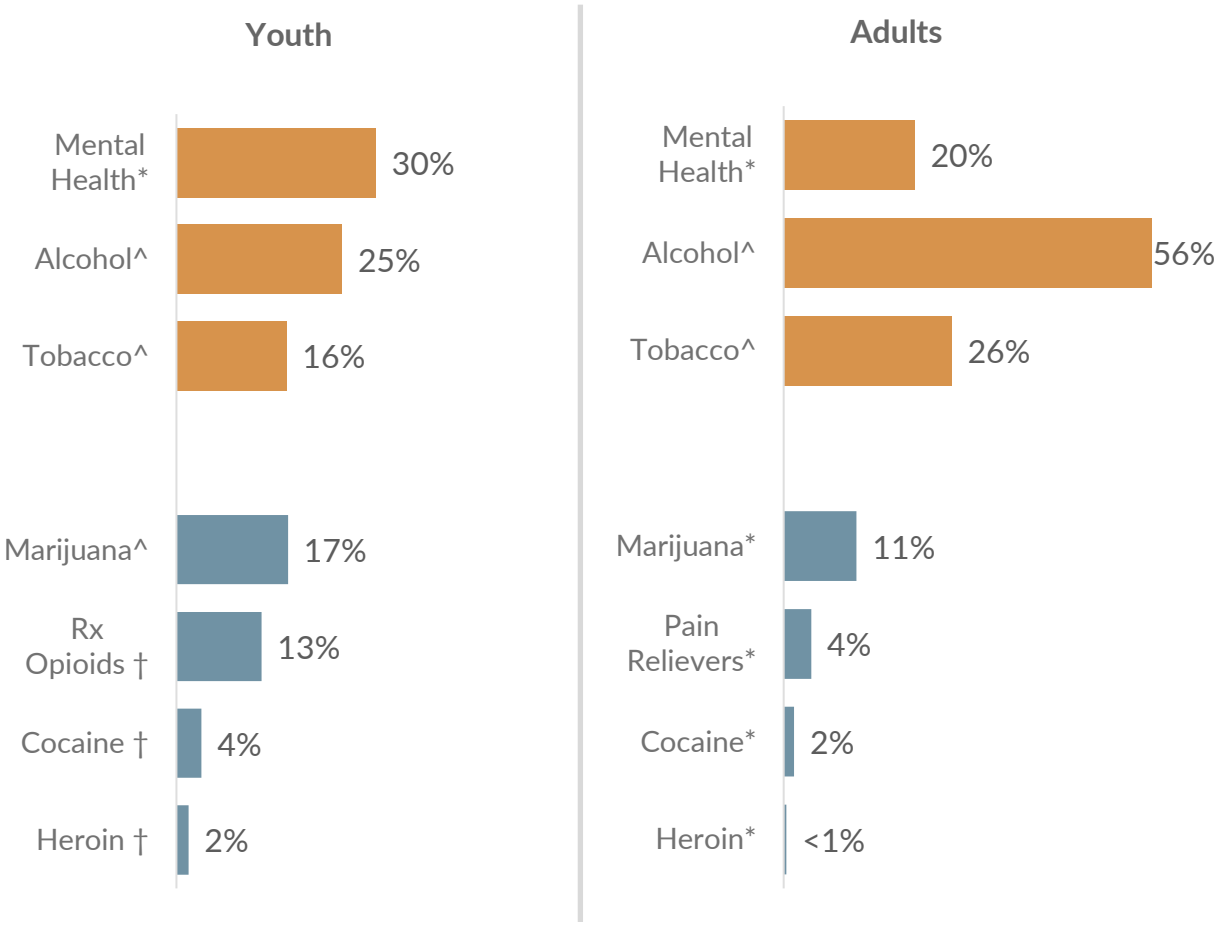
The following pages include selected data for each of the priority areas and areas to watch. These data are not comprehensive pictures of each substance or mental health issue in Virginia, but do provide insight into the prevalence, consequences, and disparities that are most pressing in each area.

Data for selected risk and protective factors are also provided. This information is integral to understanding and influencing substance use and behavioral health, and provides important context for the identified priority areas. Further, research indicates that targeting shared risk and protective factors can yield significant gains in prevention across several inter-related issue areas, including substance abuse and mental health.

Additional information about the priority areas, areas to watch, and risk and protective factors data can be found in the References section at the end of the report.

Prevalence of mental health issues and substance use are higher for **priority areas** than **areas to watch** among both youth and adults.

Across all substances, alcohol and tobacco use in the past month are most prevalent, even when compared with other substance use in the past year or in a person's lifetime.



^ Prevalence in the past month.

* Prevalence in the past year.

† Lifetime prevalence.

Youth data for high schoolers from the 2017 Virginia Youth Survey. Adult data for adults ages 18 and older from the 2015-16 National Survey on Drug Use and Health.

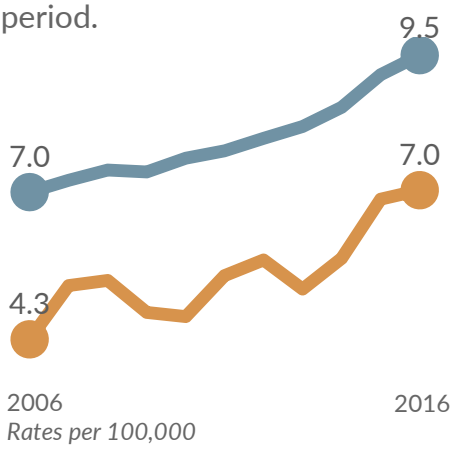
Priority Area: Alcohol

Alcohol is the most commonly used substance among youth and youth adults in Virginia. One-quarter of Virginia high schoolers (25%) report drinking alcohol in the past 30 days, which is significantly lower than the national average (30%). Since 2008, there has been a decrease in youth alcohol use, but rates remain high relative to other substances. The consequences of alcohol use, such as death and suicide, particularly affect males, 26-35 year-olds, and individuals living in Region 5 (eastern Virginia).

39%

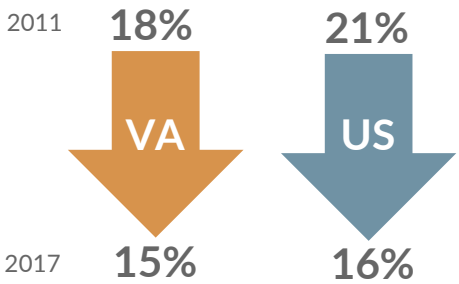
of persons who die by suicide are **intoxicated at the time of death.** [1]

From 2006 to 2016, the **rate of alcohol-induced deaths** in Virginia remained below the national rate. However, both rates increased during the period.



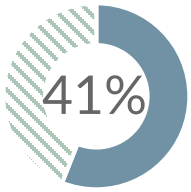
Rates per 100,000

The percentage of youth in Virginia who had their **first drink of alcohol before age 13** has followed national trends and decreased significantly since 2011.

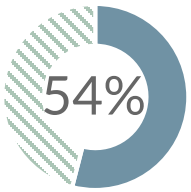


Among Virginians, in the **past 30 days:**

of underage youth had at least one drink

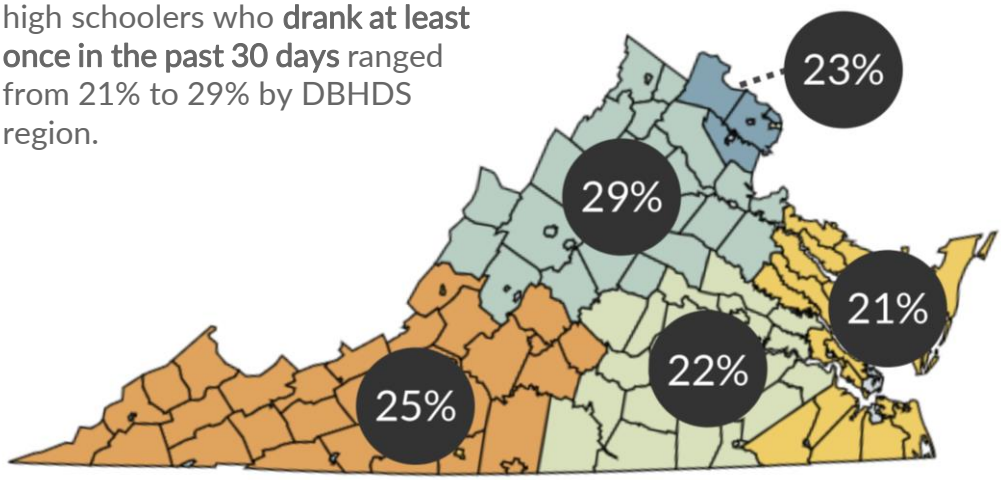


of young adults 18-25 binge drank[2] at least once



of all adults had at least one drink

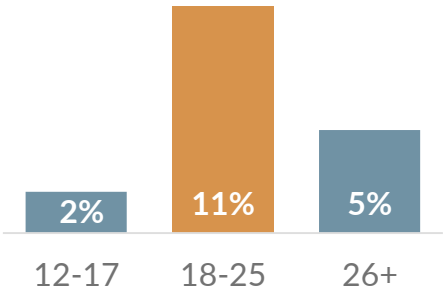
Across Virginia, the percentage of high schoolers who **drank at least once in the past 30 days** ranged from 21% to 29% by DBHDS region.



20%

of **intake cases for behavioral health** services report alcohol use, making it the most common substance of use among intake cases.

The percentage of **young adults** (ages 18-25) who **needed but did not receive treatment** for alcohol misuse in the past year is more than twice as high as adults aged 26 years and older.

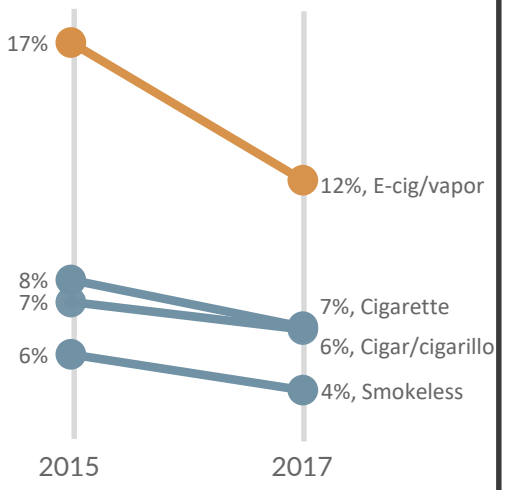


[1] Includes individuals with a Blood Alcohol Level (BAC) greater than 0%. [2] Binge drinking is defined as having four or more drinks of alcohol in a row for females or five or more drinks of alcohol in a row for males, within a couple of hours.

Priority Area: Tobacco and Nicotine

Tobacco was colonial Virginia's most successful cash crop and today Virginia is the fourth-largest producer of tobacco nationwide. Sixteen percent of Virginia high schoolers used some form of tobacco or nicotine in the past 30 days, which is significantly lower than the national average (20%). Use of all forms of tobacco and nicotine have decreased in recent years, however, e-cigarettes and vaping are especially popular among youth (33% of high schoolers have tried an electronic vapor product).

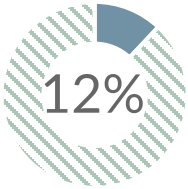
Although the percentage of youth who currently use **e-cigarettes and vapors** decreased from 2015 to 2017, it is still nearly twice as high as any **other tobacco or nicotine** product. One in six Virginia high schoolers **used some form of tobacco or nicotine in the past 30 days.**



Tax per pack of cigarettes in Virginia is the second-lowest in the country:

30¢

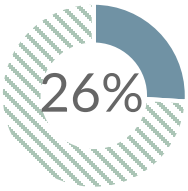
Annually, Virginia spends just



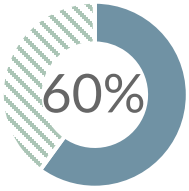
of the amount recommended by the CDC for state **tobacco control programs.**

Tobacco and nicotine use among Virginia adults:

have ever tried an e-cigarette or e-vaping product

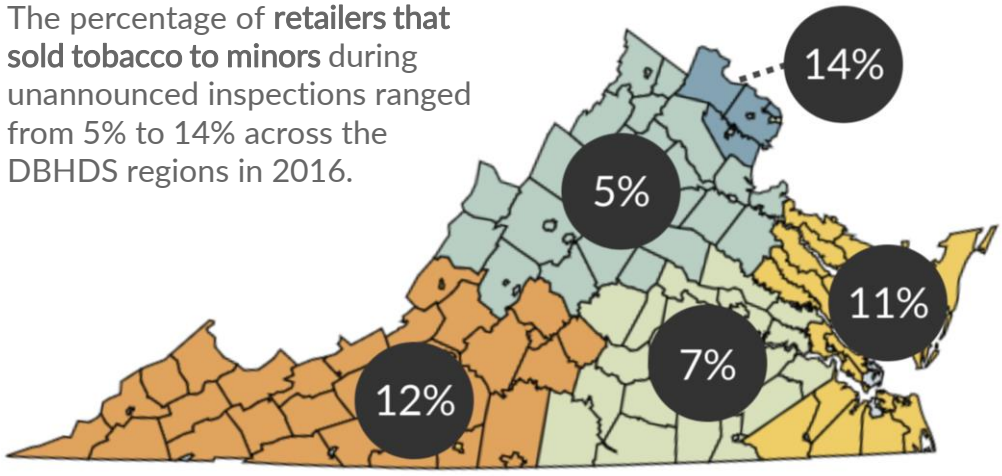


used a tobacco product in the past month

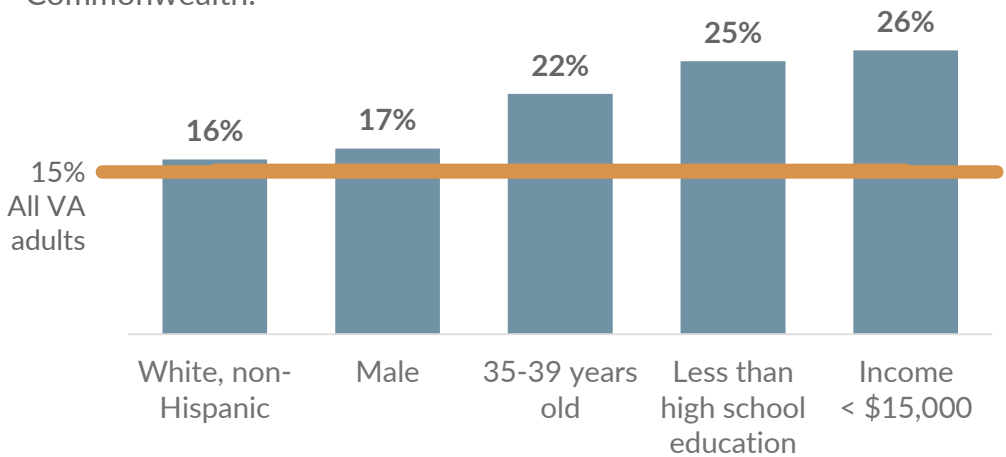


of current smokers tried to quit in the past year

The percentage of **retailers that sold tobacco to minors** during unannounced inspections ranged from 5% to 14% across the DBHDS regions in 2016.



Among **all Virginia adults**, the **current cigarette smoking rate** is 15%. However, the smoking rates among several **subpopulations** are disproportionately high compared to the average across the Commonwealth.



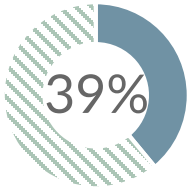
Priority Area: Mental Health and Suicide

Mental health and suicide are serious public health issues that impact individuals, families, and communities across Virginia. Suicide is the leading cause of death among individuals with substance use disorders, and individuals who have co-occurring mental illness are at an even higher risk. Across Virginia, rates of mental illness, suicidal thoughts, and intakes to mental health services have risen over recent years. Among youth, white individuals and females are more likely to report mental health concerns.

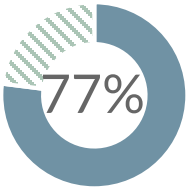
1,166

suicides were recorded in Virginia in 2016, a rate of 13 per 100,000 persons.

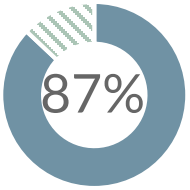
Of the **Virginians who died by suicide** from 2003-2012:



were intoxicated[1]

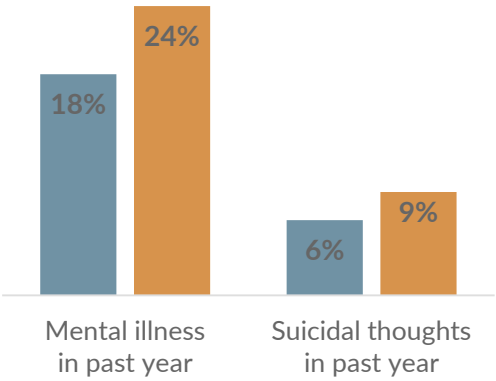


were male



were white

From 2008-09 to 2015-16, there were significant increases in the percentages of young adults (ages 18-25) who experienced **mental illness and suicidal thoughts**. These percentages are higher than those for adults 26 years and older.

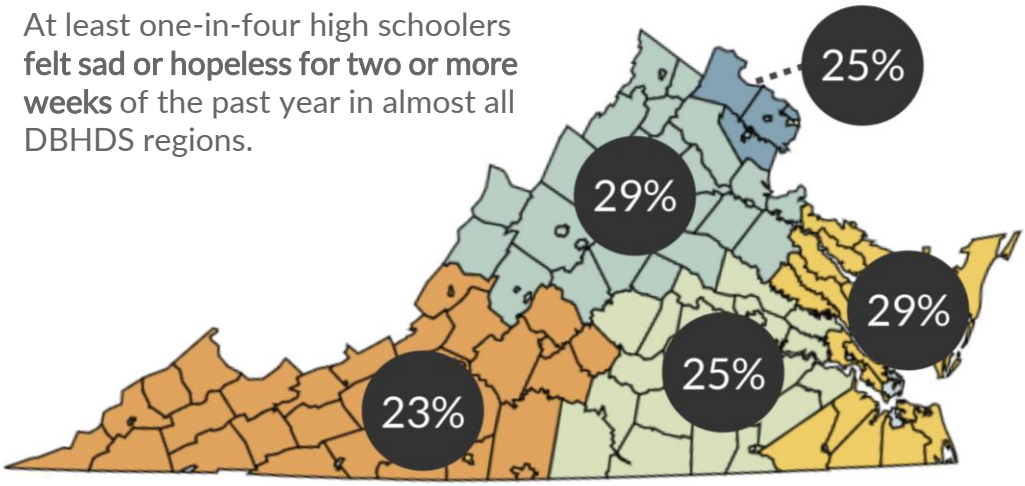


From 2008 to 2016, there was a

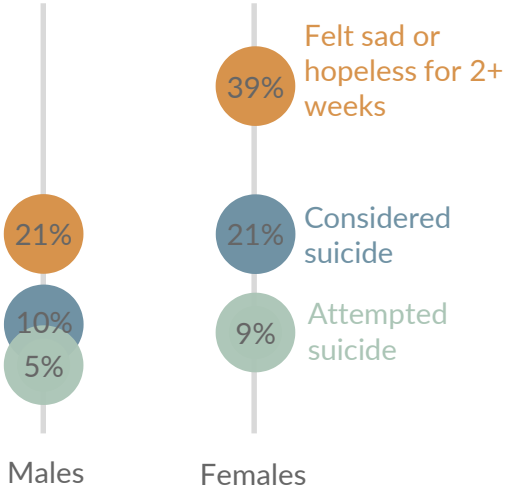
23%

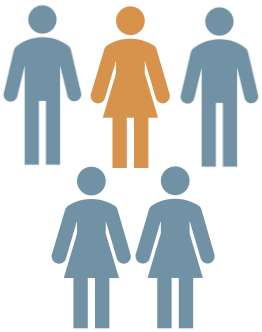
increase in the number of **intakes to mental health services** in Virginia.

At least one-in-four high schoolers **felt sad or hopeless for two or more weeks** of the past year in almost all DBHDS regions.



Among Virginia high schoolers, **mental health concerns** are significantly more prevalent in females than males.





1 in 5 adults **experienced mental illness** in the past year

[1] Includes individuals with a Blood Alcohol Level (BAC) greater than 0%.

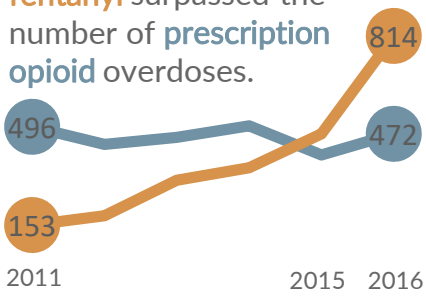
Area to Watch: Opioids

Opioids are a class of drugs that includes prescription pain relievers, heroin, and synthetic opioids such as fentanyl. Opioids have received significant attention with the federal government declaring the opioid crisis a public health emergency in 2017. In Virginia, rates of opioid use are lower compared to tobacco, alcohol, and marijuana. However, every 12 hours, a Virginian dies from an opioid overdose, and heroin/fentanyl overdoses are of particular concern due to sharply increasing trends in the past three years.

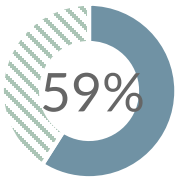
13%

of Virginia high schoolers have **misused a prescription drug.**

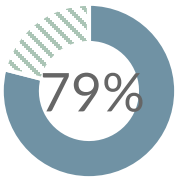
In 2015, the number of **fatal overdoses** on **heroin and/or fentanyl** surpassed the number of **prescription opioid** overdoses.



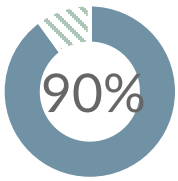
Of the **3,236 fatal prescription opioid overdose** cases from 2007-2015:



were male



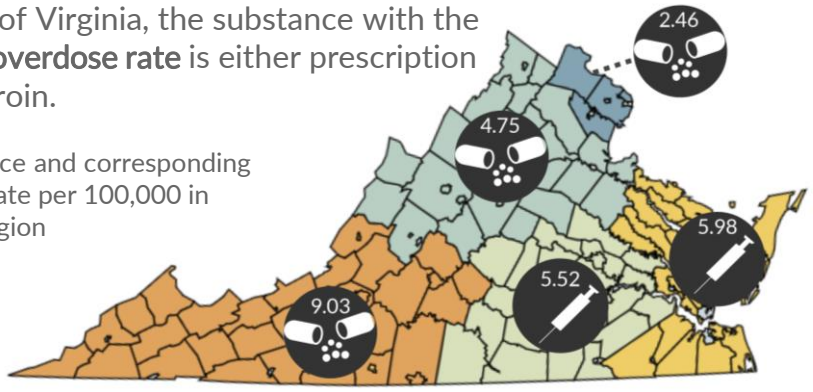
were 25-54 years old



were white

In all regions of Virginia, the substance with the **highest fatal overdose rate** is either prescription opioids or heroin.

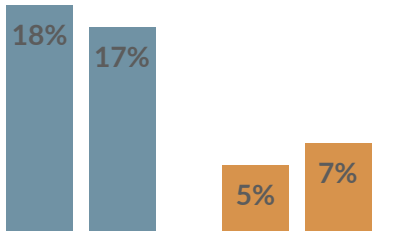
Leading substance and corresponding fatal overdose rate per 100,000 in each DBHDS region



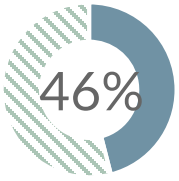
Area to Watch: Marijuana

Nine states and Washington, DC have legalized recreational marijuana use for individuals over 21. As of 201,8 recreational marijuana is not legal in Virginia, however, 17% of Virginia high schoolers had used marijuana in the past 30 days. This is significantly lower than the national rate of 20%. As has been the case for several years, youth continue to use marijuana at a higher rate than adults in Virginia.

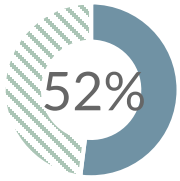
The percentage of Virginia **youth** who **used marijuana in the past 30 days** has remained steady, while **adult** use has increased a small but significant amount.



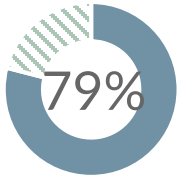
Of the **23,174 marijuana-related arrests** in Virginia in 2016:



were black



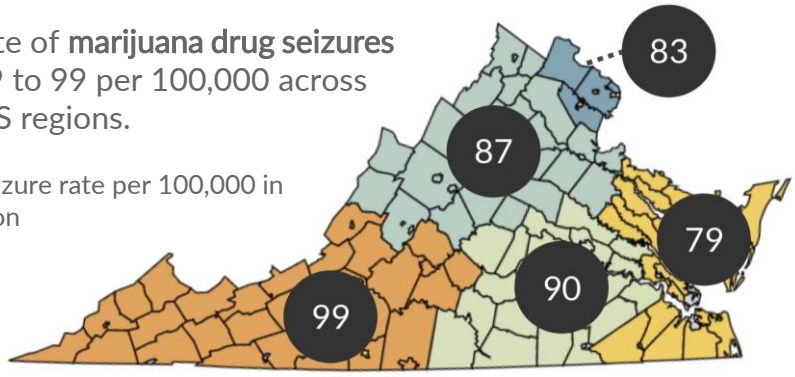
were 18-24 years old



were male

In 2016, the rate of **marijuana drug seizures** ranged from 79 to 99 per 100,000 across the five DBHDS regions.

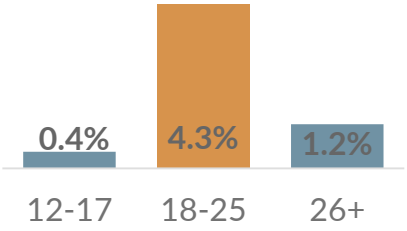
Marijuana drug seizure rate per 100,000 in each DBHDS region



Area to Watch: Cocaine

Among adults, self-reported cocaine use in the past year has remained steady since 2008, at less than 2%. A total of 3.7% of Virginia high school students have used cocaine in their lifetime which is lower than the national rate of 4.8%. More recently, the consequences of cocaine use have increased. From 2015 to 2016, arrests, drug seizures, and fatal overdoses related to cocaine began rising. These consequences disproportionately affect young adults and black individuals in Virginia.

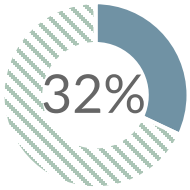
The percentage of **young adults** (ages 18-25) who **used cocaine in the past year** is more than three times as high as **youth and adults 26 years and older**.



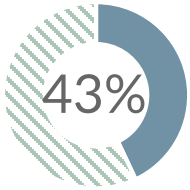
20%

of all **drug seizure cases in 2016 were cocaine-related**, making it the most commonly seized drug that year.

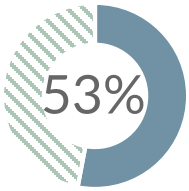
20% of Virginia's population is black, however, blacks account for:



of fatal cocaine overdoses



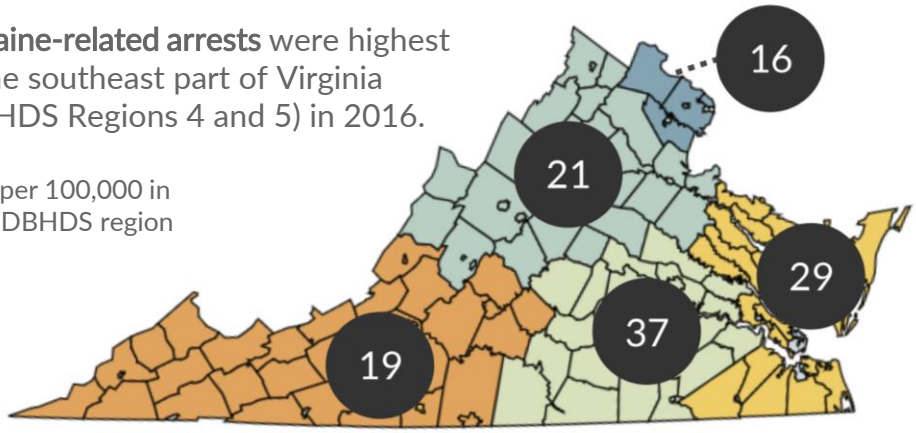
of cocaine-related behavioral health intakes



of cocaine-related arrests

Cocaine-related arrests were highest in the southeast part of Virginia (DBHDS Regions 4 and 5) in 2016.

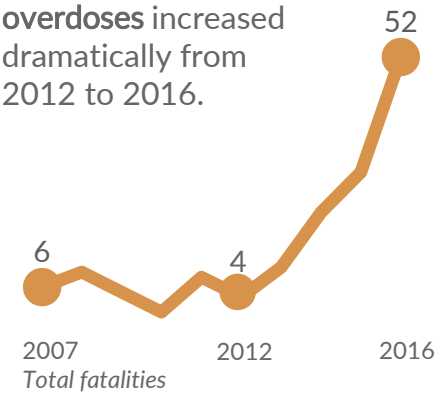
Rate per 100,000 in each DBHDS region



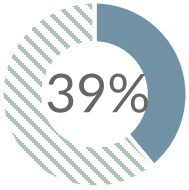
Area to Watch: Methamphetamines

Compared to other substances, the rates of methamphetamine usage are low; less than 2% of Virginia high school students used methamphetamines in the past 30 days. Similar to cocaine, the consequences of methamphetamine use have increased. The rates of fatal overdoses, arrests, and drug seizures related to methamphetamines increased between 2015 and 2016.

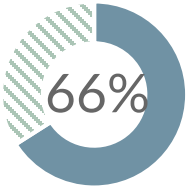
After several years without much change, the number of **fatal methamphetamine overdoses** increased dramatically from 2012 to 2016.



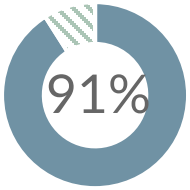
Of the **1,671 methamphetamine-related arrests** in 2016:



were 25-34 years old



were male



were white

RISK AND PROTECTIVE FACTORS

Risk factors increase the likelihood of negative outcomes, while protective factors guard against negative outcomes. Effective prevention strategies involve the use of evidence-based practices and programs designed to reduce risk factors or increase protective factors operating at multiple levels. The organization of risk and protective factors for this assessment is based on the Communities That Care (CTC) framework developed by Hawkins and Catalano, which identifies multiple domains of risk and protective factors (individual, family, school, community) that collectively determine youth risk for substance abuse, mental health issues, delinquency, and other problem behaviors.[3]

Outlined below are selected risk (—) and protective (✚) factors that are relevant to behavioral health and substance use outcomes across Virginia. Targeting these factors through prevention initiatives is an effective approach for impacting outcomes across the identified priority areas.

Individual

- — **Perceived risk of harm of substance use** among adults is lowest for smoking marijuana once per month and binge drinking 1-2 times per week.
- — Approximately 12% of 16-24 year-olds are considered **disconnected** (i.e., they are not working or in school).
- — The **teen pregnancy rate** has declined to 7.3%, however, it remains higher than the national average of 5.8%.
- ✚ **Perceived risk of harm** from substance use is highest for trying heroin, using cocaine once per month, and smoking one or more packs of cigarettes per day.

Family

- — 19.4% of Virginians **live in a household with someone who has a mental illness**. 26.9% live with someone with **substance abuse concerns**.
- — Nearly 1 in 3 Virginia youth live in **single-parent households**.
- — 55,258 children were reported as **possible victims of abuse or neglect** in 2017.
- ✚ Over two-thirds of high schoolers (71%) report **eating dinner at home with at least one parent** on four or more days in the past week.

[3] Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64-105.

School

- Nearly 1 in 6 youth report having been **offered, sold, or given illegal drugs on school property**.
- The percentage of students who **graduate within four years of entering high school** has risen steadily since 2008 to its current rate of 91%.
- Over 60% of youth report **having an adult to talk to at school**.

Community

- The proportion of **children living in poverty** has remained steady between 14% and 15% for the last 5 years.
- Virginia had 11,181 recipients of **SNAP, TANF, and/or Medicaid** in 2017, a number which has remained fairly stable since 2012.
- **Unemployment rates** are on the decline in Virginia, dropping from 7% in 2009 to 4% in 2016.

TARGET POPULATIONS TO MONITOR

In addition to identifying priority areas, DBHDS and the SEOW discussed target populations that may be particularly important to monitor within the priority areas. These populations emerged through a review of the data, as well as from the reflections of prevention experts who participated in the needs assessment discussions.[4] Resulting target populations reflect high-level focus areas that deserve attention and strategic planning. Communities may also identify additional target populations relevant to their particular locality that are important to consider when determining how best to address the identified prevention priorities.

Youth

Primary prevention with youth under 18 is an essential strategy to prevent initiation of substance use and build protective factors that support the prevention and identification of mental health issues.

- Among adult smokers in the U.S., nearly 90% report they began smoking before age 18.
- For most substances, use rates increase as adolescents get older. In Virginia, the percentage of 12th graders who report drinking alcohol in the past month (35%) is nearly three times higher than what is reported by 9th graders (12%).
- Nationally, half of all mental health problems begin by age 14.

Young Adults

Young adults (18-25 years old) tend to have higher substance use rates than most other age groups. They also pose a unique challenge to reach for prevention and services.

- Over 40% of Virginia's young adults report binge drinking in the past month, compared to 24% of adults 26 years and older.
- The percentage of Virginia's young adults who used marijuana in the past month (18%) is more than three times that of other adults. In addition, the percentage of young adults who perceive great risk of smoking marijuana (14%) is less than half that of other adults.
- The treatment gap for mental health is larger among young adults than youth or other adults. In 2015-16, 11% of Virginia's young adults reported needing but not receiving treatment, compared to 2% of youth and 5% of adults 26 years and older.

[4] A comprehensive assessment of all sub-populations was not included in the scope of the needs assessment. When possible, data is presented by different demographic and geographic sub-populations. The priorities shown here reflect the results of the discussion with DBHDS and the SEOW.

Active Military & Veterans

There is special concern for active military members and veterans because of the prevalence of tobacco and alcohol use in the military, and the impacts of military service on mental health.

- Half of Virginia's veterans are current or former smokers, compared to 37% of the non-veteran adult population.
- More than two-thirds of active military members nationwide (68%) report that the military culture is supportive of drinking alcohol, and more than 35% report drinking patterns indicative of possible alcohol use disorder.
- Mental health screenings of active military members nationwide show over 9% with probable depression and 8.5% with probable posttraumatic stress disorder (PTSD).

COMMUNITY INPUT AND ASSESSMENT

OMNI facilitated SWOT discussions to examine the environment in which prevention work is occurring in Virginia and to assess broader stakeholder agreement with identified priority areas. The SWOT (Strengths, Weaknesses, Opportunities, Threats) discussions were open to CSB representatives across the Commonwealth and the results of the eight discussions held with 31 prevention staff are outlined below. Discussion participants identified several strengths and weaknesses of the prevention workforce, funding structure, and CSB operations. In addition, participants identified external opportunities that could facilitate prevention work in the future, as well as threats that pose challenges to prevention work and may be areas to address in future years.

Overall Agreement on Virginia Prevention Priorities

Among the discussion participants, there was an **overall sense of agreement that the Commonwealth's priorities of alcohol, tobacco and nicotine, and mental health and suicide were important in the communities that CSBs served**. However, some felt that marijuana should also be a priority. It is a growing concern among prevention workers due to Virginia's recent legalization of some oil forms of medical marijuana. Prescription drugs, especially opioids, have also gained attention among prevention directors as a potential priority area. Some CSBs voiced concerns that tobacco has been treated as less of a priority given the recent media coverage around the opioid epidemic.

> **"If you are just looking at the use rates, that changes up the priorities**. If you're looking at marijuana creeping in as far as legislation and what's going on in the country, probably a state priority should have been marijuana. Not so much looking at use, but what's happening across the nation."

> "The problem with [alcohol and tobacco] is that **they are legal. And readily available. And they are socially accepted**."

Strengths

Strong partnerships, coalition support, and passionate staff are essential to prevention work, and CSBs are already successfully incorporating these items into their work in the priority areas.

Stakeholders were asked what helps to facilitate their prevention work, and what has worked well in their existing efforts. Overall, participants shared these strengths:

- Strong community partnerships and commitment of partners to prevention work, especially collaborations with schools, law enforcement, crisis centers, coalitions, court systems, advocacy groups, as well as DBHDS.

- Prevention staff who are passionate about what they do and the supportive leadership for prevention work around the Commonwealth.
- Diversified funding streams, particularly for tobacco prevention and behavioral health.
- Coordinated efforts for tobacco, such as Counter Tools, that every CSB has implemented.

Weaknesses

Both CSBs and DBHDS highlighted funding, staff resources, and workforce skills as key internal weaknesses that hinder prevention work in the priority areas.

Stakeholders were asked about the challenges or obstacles they face in their prevention work. Key themes included:

> "Other states have been more successful in their campaigns because there is a statewide message. Then there are sub-brands under that message for different populations and areas... **The lack of a statewide, coordinated campaign [in Virginia] is a weakness."**

> "There is a lot of data that we have captured [using Counter Tools] that I think could be shaped into some useful information for awareness raising, as well as helping to potentially shape policy on local levels and across the state. But **the [lack of] time and the expertise is a challenge to take the data and turn it around into telling a story."**

- Lack of skills, funding, and time to implement successful large-scale media campaigns.
- Insufficient administrative support for direct service programs (such as Mental Health First Aid) to assist with scheduling, registration, and facilitation of trainings.
- Community partner limitations, such as schools with restrictive privacy rules and policies not conducive to prevention services or evaluation.
- Lack of skills and training to shift from direct service programs to environmental approaches.
- Shortage of financial resources to carry out day-to-day prevention work alongside other CSB responsibilities.
- Limited expansion of mental health and suicide prevention activities beyond direct service programs.
- Difficulty accessing current and local epidemiological data.
- Staff training shortages due to high demand and scheduling conflicts.

Opportunities

DBHDS's emphasis on environmental strategies requires a switch from direct service to indirect, community-wide approaches. Many voiced the desire for additional trainings, support, and resources to shift their work in this direction.

CSBs were asked to reflect on what types of external factors might help their prevention work to be more successful. Overall, participants shared these factors:

- Policy prevention strategies and support to CSBs for implementation of environmental strategies.
- Opportunities for collective and collaborative learning from other CSBs about promising practices and strategies being implemented around the Commonwealth.
- Development of accessible resources and strategies for sub-demographic populations, (e.g., Latinos, LGBTQ, children, and the elderly) such as adapting program curricula and providing cultural competency training to staff.
- Statewide messaging campaigns around each of the designated priority areas.
- Effective use of Counter Tools data at the local and statewide level, as well as for regulation of tobacco retailers.

Threats

Larger trends in the cultural and social acceptance of substance use, and the alignment of funding with these priority areas, are perceived as major external threats to prevention work.

Finally, participants were asked about the outside factors that influence their prevention work. Key threats that emerged included:

- Low perceived risk of substance use – alcohol and tobacco in particular – among parents and youth.
- Cultural acceptance of alcohol and tobacco use, even in youth, as evidenced by: the historical presence of the tobacco industry in Virginia; the rise of craft breweries and wineries; and the emphasis on tobacco and alcohol as an income generator for the Commonwealth.
- Changes in political climate resulting in limited political will to invest in prevention work, especially for alcohol and tobacco.

> **"The other threat as it relates to tobacco is that we are the state of Virginia. This is the state that was founded on tobacco. It's in our backyard…** So [it's] always going to be a threat or a challenge to get tobacco-related policy laws… We are up against a lot of money that we just can't even come close to. Not to say we aren't pushing for tobacco policy changes, because we are. It's just a big hurdle compared to, you know, a state like New York that wasn't built on tobacco. That's why they have the tobacco tax that they do, and we have the second lowest in the country."

- Shifting priorities due to new funding opportunities, public interest and media coverage that draw the focus away from Virginia's longstanding prevention priorities.
- The rise of e-cigarettes and vaping, especially with a variety of flavors that appeal to youth, and a lack of regulations on these products.
- Efforts to legalize medical marijuana in Virginia, and the legalization of recreational marijuana in other states.
- Shortage of mental health providers and barriers to accessing mental health services due to location, cost and insurance coverage.
- Stigma associated with seeking mental health services in some communities.

> "It seems as though right now the opioids situation is taking front and center... **I see some of those things as threats because it just [takes] up your time."**

CURRENT PREVENTION EFFORTS

Prevention work occurs in Virginia every day, which has resulted in many achievements in building community coalitions, engaging stakeholders, and providing community prevention services.

DBHDS disseminates state and federal prevention-focused funding to CSBs and communities across Virginia to support behavioral health and substance prevention efforts. Three of these funding streams are outlined below, with a summary of the substances and outcomes they are targeting.

Substance Abuse Prevention Block Grant (Block Grant)

Block Grant is a federal funding stream provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) to each state for substance abuse prevention.

The structure of Block Grant funding does not mandate specific strategies or targets, but rather allows states to address their own prevention priorities. This flexibility means that states have variable systems for disseminating the funding and requirements for their sub-grantees. Because of the reach and broad scope of Block Grant funding, this needs assessment was conducted with a lens toward areas that could be addressed by strategic Block Grant funding decisions in the future.

In Virginia, DBHDS disseminates the Block Grant funding to all 40 CSBs across the Commonwealth. Nearly all CSBs use a portion of the Block Grant funds for CSB staff to engage in two common activities:

1. Completing Counter Tools activities related to tobacco prevention. This work has encompassed store mapping, store audits, and merchant education to all tobacco retail locations across the Commonwealth.
2. Providing Mental Health First Aid trainings to the public. These trainings help individuals "identify,

"Two years ago, our data indicated that 90% of our population did not know how to access treatment, [and] it was difficult to work on drug prevention initiatives collaboratively because many of our major partners believed that no one did drugs here... **The needs assessment revealed that drug use does happen here. We also learned how each sector could be a 'part of the puzzle'** to create a multi-level plan to raise awareness and to limit access to substances, alcohol, and to means of suicide while changing cultural attitudes about helping each other get help for mental health issues."

Goochland Powhatan Community Services

Block Grant-Funded Activities Addressing DBHDS's Priority Substances

Mental Health and Suicide

Mental Health First Aid trainings by CSBs across the Commonwealth.

Alcohol

25 CSBs have long-term outcomes related to alcohol use and its consequences.

Tobacco and Nicotine

All 40 CSBs are engaging in Counter Tools strategies to reduce tobacco use.

"Crossroads CSB was recognized at the 2018 VFHY Conference for being one of [the] state's champions who partnered with the 24/7 Campaign to successfully help get **100% tobacco-free school policies passed in two school districts this year.**"
Crossroads Community Services

"The Regional Alliance for Substance Abuse Prevention (RASAP) worked to identified youth from all four county high schools to serve on the **RASAP Youth Advisory Council. They meet monthly to look at local data related to youth substance use. They selected underage drinking as the priority substance to address**. They developed a [week-long] youth campaign … prior to prom and graduation, and presented their campaign and ways to promote the message in all four county high schools … and then met with all four county principals."

Danville-Pittsylvania Community Services

understand and respond to signs of mental illnesses and substance use disorders in [their] community."[5,6]

CSBs direct the rest of their Block Grant funds to priority areas for their catchment area. These priority areas were identified by CSBs through a needs assessment and strategic planning process completed during the 2016-17 fiscal year.

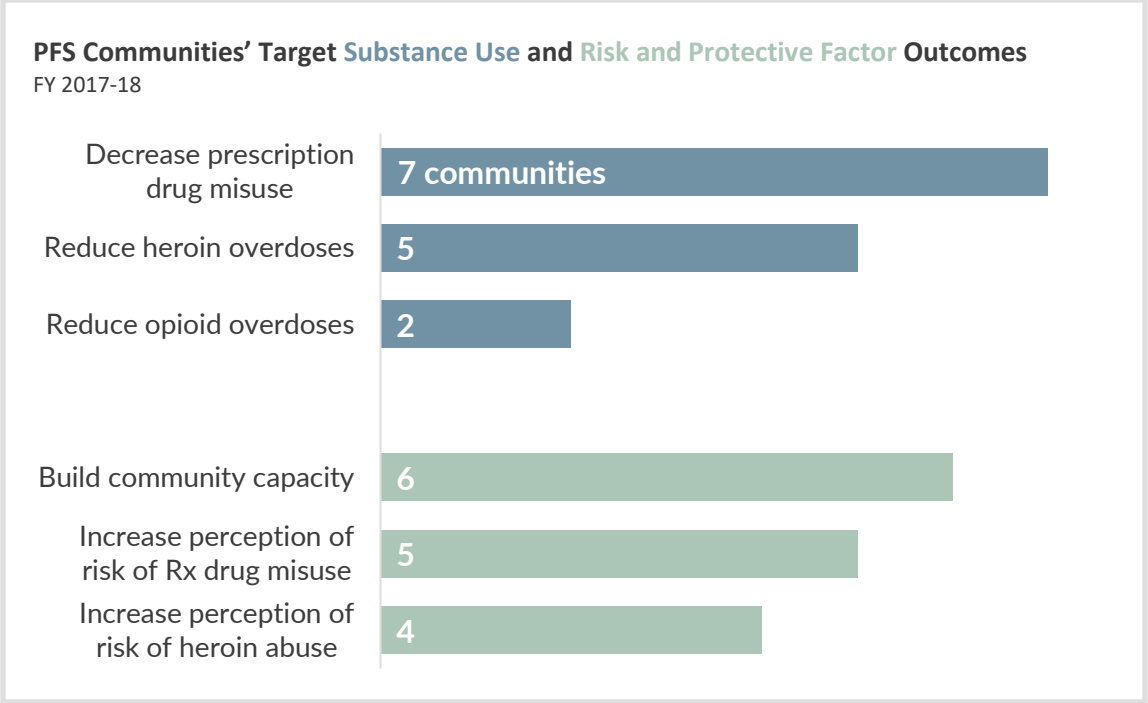
Because of the Counter Tools and Mental Health First Aid requirements, all CSBs are addressing the priority areas of tobacco and nicotine and mental health and suicide. In addition, over half are implementing alcohol prevention strategies and are targeting outcomes related to alcohol use and its consequences.

CSBs are also using Block Grant funds to target other substances that are local priorities, including marijuana (17 CSBs), prescription opioids (16), and heroin (9). None of the CSBs established target outcomes related to cocaine or methamphetamines in the 2017-18 fiscal year.

Partnerships for Success (PFS)

Virginia also receives discretionary funding from SAMHSA that is targeted to specific issue areas. Under the PFS initiative, nine community coalitions are funded to address prescription drug and heroin abuse. These communities are targeting risk and protective factors (as shown on the next page) to impact use and overdose rates of these substances. Six of nine communities have also established specific goals for building their community's capacity to address these substance use issues over the long-term.

[5] Mental Health First Aid, 2018, https://www.mentalhealthfirstaid.org/
[6] Mental Health First Aid and other mental health and suicide prevention strategies/services are funded through Virginia general fund dollars. These strategies and services intersect with Block Grant funding because prevention staff who implement these strategies are often funded through Block Grant.



Opioid Prevention, Treatment, and Recovery (OPT-R)

OPT-R funding is provided by SAMHSA to DBHDS, who distributes it to CSBs. These dollars allow CSBs to implement prevention, treatment, and recovery strategies to reduce opioid overdose deaths. The funding was first allocated in May 2017 and distributed to 35 CSBs. It was renewed for the 2018-19 fiscal year and will fund all 40 CSBs from May 2018 through April 2019. The CSBs will continue to fund and expand efforts to: build community capacity to address opioids through coalitions; heighten community awareness; and support safe storage and disposal efforts.

"Collaborating with the health department, the fire department, and the Martinsville Police Department, we visited hundreds of homes between April and October 2017 to provide information on opioids. **Volunteers and/or staff went door-to-door every Saturday to provide brochures on opioids** and took time to talk to families about the dangers and issues."

Piedmont Community Services

Recommendations

After reviewing data trends, discussing with DBHDS and the SEOW, and receiving input from stakeholders across the Commonwealth, several key areas for potential growth or action emerged. These recommendations for future focus areas and efforts are detailed below.

FUND PRIORITY AREAS

Strategically impact priority areas by funding strategies and outcomes that address appropriate risk and protective factors.

> "I think one of our shortfalls is that we don't have a lot of youth who are involved in the process of prevention. And we find out anecdotally through the youth what the new trends are... **We don't have any youth at the table really helping us identify those trends up front, and helping be creative in ways to work with their peers in an effort to reduce use.**"

- Engage in **strategic planning to identify strategies and outcomes** for each priority area, targeting specific risk and protective factors.
- Commit to addressing **risk and protective factors and root causes.** This is an essential step due to the common co-occurrence of substance use and behavioral health challenges, as well as the impact of Adverse Childhood Experiences (ACEs) on behavioral health.
- Plan **shared strategies for each priority area** that all CSBs implement. Build on the successes of Counter Tools and Mental Health First Aid to implement a shared strategy for alcohol prevention.
- Consider ways to **intentionally align Prevention Block Grant funding with identified priority areas**. Allocation thresholds may be designated to target work towards priority areas within communities, or set funding to support shared strategies for each priority area. Remaining funds could be discretionary based on community needs assessments.
- **Actively engage youth** and/or provide support for local youth coalition efforts to facilitate the success of strategies aimed at youth, and to stay current on emerging trends.
- **Allocate funding** at the state level to the identified priority areas to ensure they receive consistent resources regardless of other public health concerns.

BUILD CAPACITY

Support the prevention workforce across Virginia with training and peer learning opportunities.

- Promote **prevention workforce training** by expanding current Substance Abuse Prevention Skills Training (SAPST) and ACEs training opportunities.
- Strengthen resources and provide skill-building opportunities that enable prevention staff to successfully **transition from direct-service programming to environmental strategies**.
- **Improve capacity for policy work**, including trainings on current prevention policies, potential local-level policy changes, and the local advocacy process.
- Develop **peer learning communities** to allow CSBs to learn promising practices from each other, such as monthly showcases on the online portal or recurring conference calls.

> "I feel like we are shifting from traditional prevention programs to more of a community-based, environmental [strategies]. It's a different skill set. And we have workforce that don't have that skill set… We're aware of it… **But how do you turn a fifth-grade teacher into a community mobilizer? So that's a big challenge.**"

LEAD STATEWIDE INITIATIVES

Lead efforts for statewide messaging, advocacy, collaboration, and decision-making that facilitate effective prevention work across the Commonwealth.

- Develop large-scale **messaging campaigns** for each priority area with materials available for local dissemination across the Commonwealth. In particular, CSBs requested social norming campaigns to combat the social acceptance of alcohol and tobacco use for youth and to expand social acceptance of seeking mental health treatment.
- Utilize the Counter Tools data to **support tobacco control policies**, such as: licensing tobacco retailers; restricting vaping product flavors; and increasing the tobacco purchase age to 21.
- Continue to promote **data-driven decision making** through funding requirements and support for data collection and utilization activities, such as local survey efforts and ongoing support of the Virginia Social Indicator Dashboard. Consider expanding the Virginia Youth Survey to include additional prevention outcomes, such as perceptions of parental approval of substance use or impact of messaging campaigns.
- Implement systemic changes to encourage **effective collaboration across disciplines, departments, and agencies** at the state and local levels. This is especially important for impact on cross-cutting issues and policy work.

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PRIORITY AREA: ALCOHOL

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Appendices

APPENDIX A. NEEDS ASSESSMENT INDICATOR LIST

Provided to the State Epidemiology Outcomes Workgroup in March 2018

Scope

OMNI Institute is conducting a statewide needs assessment in Virginia in the areas of substance use and behavioral health. Below is a summary of the indicators that will be reviewed as part of the needs assessment. In addition to this data, qualitative data from Community Service Boards, DBHDS staff, and the State Epidemiological Outcomes Workgroup will be collected and serve as context to the quantitative indicators. After review of the indicators and qualitative data, priority areas and emerging trends will be identified, and relevant data will be included in the final needs assessment report. The assessment process and report aim to inform future priorities for SAPTBG and other DBHDS funding statewide.

Indicator List

All indicators below are available publicly from state and national agencies, which are listed within each section header. Where available and relevant to the data review, breakout data by age, race, ethnicity, gender, and/or region will also be reviewed. National comparisons and/or trend data will be included for context when available.

In the table below, "■" denotes that breakout or comparison data is available for that indicator in some form. Note that the available breakouts vary by data source (e.g., the race categories may be different across indicators), so there will not be direct alignment of data across all indicators and breakout groupings.

		Age	Race/ Ethnic	Gender	Region	Natl
Demographic and Socioeconomic Characteristics (CDC, Census, DSS, VDH, Voices)						
Total Population	Census demographics	■	■	■	■	■
Unemployment	Percentage of population that is unemployed	■	■	■	■	■
Educational Attainment	Percentage of adults who have attained education level (some high school; high school graduate; some college or technical; college graduate)	■	■	■		■
Household Environment	Percentage of youth in single-parent households				■	

		Age	Race/ Ethnic	Gender	Region	Natl
	Number of Child Protective Services referrals	■	■	■	■	
	Percentage of children with a parent who has ever been incarcerated					
Disconnected Youth	Percentage of youth ages 16-24 who aren't working or in school					■
Income	Median household income					■
Poverty	Percentage of population in poverty and deep poverty				■	■
	Percentage of children in poverty and deep poverty		■		■	
Child Food Insecurity	Percentage of students approved for free or reduced-price lunch status				■	
	Percentage of youth who experienced food insecurity in the past year				■	
	Percentage of youth who went hungry often or always in past 30 days	■	■	■	■	
Assistance Programs	Number of recipients of TANF, SNAP, Medicaid, and Child Care Subsidy	■	■	■	■	
Healthcare Access (CDC, HRSA, Voices)						
Health Insurance Coverage	Percentage of population with any health care coverage	■	■	■		■
	Percent of children under 19 without health insurance					
Availability of Healthcare	Ratio of population to primary care physicians					■
	Ratio of population to mental health providers					■
Births (VDH)						
Substance Use During Pregnancy	Percentage of live births in which mother used substances during pregnancy (tobacco; alcohol; other drugs)	■	■			
Teen Pregnancy	Teenage pregnancy rates per 1,000; percentage of pregnancies that were teenage pregnancies	■	■			
Education (DOE, Voices)						
Graduation and Drop-Out Rates	Percentage of students in a cohort who earned diploma within four years of entering high school; percentage of total number of students in the cohort who dropped out as their cohort moved through high school		■	■		
Chronic Absenteeism	Percentage of students who miss 10% or more of days enrolled					
Suspension	Percentage of disciplinary outcomes that are short-term suspensions (less than 10 days) associated with substance use					
Trusted Adult at School	Percentage of students who report they have trusted adult at school		■	■	■	
ATOD-Related Offenses	Percentage of disciplinary incidents that are due to ATOD-related offenses		■	■		■
Substance Use and Behaviors (CDC, NHTSA, SAMHSA, VDH)						

		Age	Race/ Ethnic	Gender	Region	Natl
Substance Use	Percentage of population reporting use in the past month (underage alcohol use; alcohol; binge drinking; tobacco; illicit drugs; marijuana). Percentage of high schoolers reporting use in the past 30 days (alcohol; cigarettes; binge drinking; marijuana)	■	■	■	■	■
	Percentage of population reporting past year use (cocaine, heroin, Rx pain reliever misuse; tobacco)	■				■
	Percentage of high schoolers reporting lifetime use (heroin; meth)		■	■	■	■
Early Onset Use	Percentage of middle schoolers reporting use before age 11 (alcohol; marijuana)		■	■	■	
	Percentage of population who first used marijuana over the past year	■				■
Perceived Risk of Substance Use	Percentage of population who perceive great risk of substance use (using marijuana once a month; cocaine use once a month; heroin use once or twice; binge drinking once or twice a week; smoking 1+ packs per day)	■				■
Past Year Substance Disorders	Percentage of adults with a substance use disorder in the past year	■				■
	Percentage of adults with an alcohol use disorder in the past year	■				■
	Percentage of adults with an Illicit drug use disorder in the past year	■				■
Impaired Driving	Percentage of driving deaths with alcohol-involvement					■
	Percentage of high schoolers who drove after drinking in the past year		■	■	■	■
Mental Health and Suicide (CDC, OCME, SAMHSA, VDH)						
Poor Mental Health Status	Percentage of adults reporting at least one day of poor mental health in the past 30 days; percentage of adults reporting frequent (at least 14 days) poor mental health in the past 30 days	■	■	■		■
	Percentage of adults ever diagnosed with a depressive disorder	■	■	■		■
	Percentage of high schoolers who felt sad or hopeless for two or more weeks of the past year		■	■	■	■
Past Year Mental Health	Percentage of adults who had serious thoughts of suicide in the past year	■				■
	Percentage of adults with any mental illness in the past year	■				■
	Percentage of adults with a serious mental illness in the past year	■				■
	Percentage of high schoolers and adults who considered suicide in the past year; percentage of middle schoolers who have ever considered suicide	■	■	■	■	■
	Percentage of high schoolers who attempted suicide in the past year; percentage of middle schoolers who have ever attempted suicide		■	■	■	■
Suicide Rate	Teen suicide rate per 100,000 (overall; by firearm; by other means)	■	■		■	■

		Age	Race/ Ethnic	Gender	Region	Natl
	Suicide rate per 100,000 by circumstance (depression, substance abuse problem, treatment for mental health, opiates, mental health problem)	■	■	■	■	
Behavioral Health Treatment and Hospitalizations (DBHDS, SAMHSA, VDH)						
Needed but Didn't Receive Treatment in Past Year	Percent of population who needed but didn't receive treatment in the past year for substance use	■				■
	Percent of population who needed but didn't receive treatment in the past year for alcohol use	■				■
	Percent of population who needed but didn't receive treatment in the past year for illicit drug use	■				■
Behavioral Health Services	Rate of substance abuse intakes and mental health intakes per 10,000 (marijuana, alcohol, crack/cocaine, heroin, other opiate/synthetic, meth)	■	■	■	■	
	Percentage of adults who received mental health services in the past year	■				■
	Rate of admissions to mental health services per 10,000 (substance use; psychotic; mood; behavioral; and anxiety disorders)	■	■	■	■	
Hospitalizations	Rate of adult substance abuse and mental health hospitalizations per 100,000	■	■	■	■	
	Rate of hospitalizations for attempt at self-harm per 100,000	■	■	■	■	
Overdoses and Deaths (CDC, OCME, VDH)						
Deaths	Accidental and undetermined fatal drug overdose rate per 100,000 (alcohol, heroin, cocaine, opiate Rx drug, benzodiazepine, meth any substance)	■	■	■	■	■
	Overdose mortality rate per 100,000 (fentanyl/heroin, Rx drugs)	■			■	
	Rate of alcohol-induced and drug-induced deaths per 100,000	■	■	■		■
Overdoses	Rate of emergency department overdose visits per 100,000 (heroin, opioids	■			■	
	Rate of Narcan administrations by EMS per 100,000	■			■	
Criminal Justice (DCJS, DFS)						
Drug Cases	Rate of Department of Forensic Science cases per 100,000 (marijuana, cocaine, Rx drug, heroin, benzodiazepine, meth)				■	■
	Uniform Crime Reports rate of all drug/narcotic violations per 100,000	■	■	■	■	■
Juvenile Justice	Rate of narcotic-related intake cases per 100,000	■	■	■	■	

Data Source Abbreviation List

Abbreviation	Data Source
CDC	Centers for Disease Control and Prevention
Census	U.S. Census Bureau
DBHDS	Virginia Department of Behavioral Health & Developmental Services
DCJS	Virginia Department of Criminal Justice Services Research Center
DFS	Virginia Department of Forensic Science
DOE	Virginia Department of Education
DSS	Virginia Department of Social Services
HRSA	Health Resources & Services Administration
NHTSA	National Highway Traffic Safety Administration
OCME	Virginia Office of the Chief Medical Examiner
SAMHSA	Substance Abuse and Mental Health Services Administration
VDH	Virginia Department of Health
Voices	Voices for Virginia's Children

APPENDIX B. DISCUSSION QUESTIONS FROM APRIL 2018 SEOW AND DBHDS MEETINGS

Virginia SEOW Data Presentation and Discussion

Before Data Presentation

1. What do you perceive to be the top two behavioral health issues for Virginia? Are these new issues? Who do you believe is being impacted most by these issues?
2. What makes these issues so important? (e.g., increase trends over time; consequences/impacts of these issues)
3. Do you have any thoughts as to what factors may be driving these issues? Why do you believe these issues are happening in Virginia (e.g., root causes; contributing factors)?

After Data Presentation

1. Now that you have reviewed the data, what do you believe to be the top two behavioral health issues for Virginia? Are these new issues? Are issues increasing or decreasing over time? Who do you believe is being impacted most by these issues (geographic region; demographic; etc.)?
2. What makes these issues so important? (i.e. increase trends over time; consequences/impacts of these issues)
3. What do you think are the contributing factors driving these issues in Virginia? Why do you believe these issues are happening in Virginia (i.e. root causes; contributing factors)?
4. Where are the gaps in resources and readiness to address these issues in Virginia?

DBHDS Follow-Up Discussion

Criteria to consider when selecting which problem(s) to address:

1. **Magnitude** – Which problem seems to be the largest? Which issue areas did the SEOW prioritize? Are there discrepancies to what you are currently addressing?

2. **Time Trend** – Is the problem getting worse over time or is it getting better over time? What is the story about this change?

3. **Severity** – What is the severity of the problem? Is it resulting in mortality? Is it costly?

4. **Comparison** – How does Virginia compare to other states?

APPENDIX C. SWOT ANALYSIS DISCUSSION GUIDE

Purpose: To gather community input in the form of a SWOT analysis on the state-level substance abuse prevention priorities that were identified by stakeholders.

Intro:

Hello everyone! Welcome to toady's discussion on a SWOT analysis (or strengths, weaknesses, opportunities, and threats) of Virginia's substance abuse prevention priorities and the role your CSBs play in _____ (*decreasing substance use* or *improving mental health and decreasing suicide*) across the state. This group will focus primarily on the topic of _____ (*Alcohol, tobacco/nicotine, or mental health/suicide*).

My name is _____ and I will be your facilitator for the focus group. My colleague _____ is also with me taking notes on our discussion today.

Before we jump in, let's take a moment to ensure that everyone is ready and familiar with the GoToMeeting control panel.

First, you should have a control panel on the right side of your screen. You may minimize this panel by clicking on the orange arrow button in the upper left corner. You may expand the panel by clicking the same orange button.

Second, in just a moment, we will unmute you on our end. We ask that you stay muted when you are not talking out of courtesy for others and to improve sound quality. When you wish to speak, please take yourself off mute, and re-mute yourself when you are finished. Please keep in mind that there may be a delay in responses due to technology. We ask that you be respectful of others and speak one at a time. There will be plenty of time to hear everyone's answers. I'm hoping everyone can hear me okay; if you are having trouble hearing me, try moving your speakers and microphone away from each other, or taking yourself off speaker phone.

We have allotted one hour for this discussion, we may or may not use all of that time; it will depend on the number of responses everyone has. This focus group will be recorded so we can refer back to it in the future for our notes.

I want to remind you that the purpose of this call is to gather your input on the state-level substance abuse prevention priorities that were identified by stakeholders. The information gathered in this session will be used in the statewide needs assessment report that we are preparing for DBHDS and is an opportunity to include your voices - from CSBs across Virginia - in the report.

Before we start, I would like everyone to introduce themselves with their name, and CSB you are representing.

Thank you for introducing yourselves! As a quick overview of the discussion, we will start off by first talking about the state's priority of (*insert topic*: Alcohol abuse, tobacco use, or suicide/mental health) prevention and *internal* strengths and weaknesses of your CSBs and their ability to work towards this priority. From there we will move onto discussing the *external* threats and opportunities that you encounter in your work. Are there any questions?

State Priorities

The state identified _____ (*insert topic*: Alcohol abuse, tobacco use, or suicide/mental health) as a top priority area of prevention for CSBs. These were agreed upon by the State Epidemiological Outcomes Workgroup (SEOW) after a preliminary review of statewide data.

1. From your perspective, do you agree that these areas are also priorities in the communities that you serve?
2. How do you set priorities for where to focus your efforts in the community you serve?

Strengths

1. What resources does your CSB use to address this priority?
    - Funding?
    - Community partnerships?
    - Coalitions?
2. How has your CSB been successful in addressing (alcohol, tobacco, mental health/suicide) in the past?

Weaknesses

1. What resources are you lacking to address the priority area of (*alcohol, tobacco, and mental health/suicide*)?
2. What challenges do you face in implementing this priority?
3. What weaknesses have people you've served voiced about how CSBs address this priority?

Now I'd like the shift the discussion to identifying external opportunities and threats.

Opportunities

1. What policies are in place that facilitate your CSB's work to address this priority?
2. What partnerships have you created that facilitate the work you're doing?
3. Talk about some funding opportunities that your CSB (DBHDS) has been successful at pursuing to address this priority.

Threats

1. In what specific areas, are there shortfalls in resources that your CSB needs in order to successfully address the priority area?
    - Staff and training?
    - Funding?
    - Other shortfalls?
2. What policy changes, if any, have made your work in this area challenging?

Wrap-Up

1. Is there anything else that we haven't discussed, but you think is important to know regarding prevention of (alcohol, tobacco, mental health/suicide)?

Thank you again for your time and for sharing your feedback today. As we mentioned, this information will be incorporated into the statewide needs assessment we are currently conducting for DBHDS. If you have any follow-up questions or concerns, please reach out to the OMNI TA team.