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Virginia Behavioral Health System

Needs Assessment Final Report

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CANSLER COLLABORATIVE RESOURCES
Strategic Research and Consultation

Virginia Behavioral Health System Needs Assessment

FINAL REPORT
MARCH 31, 2020

SUBMITTED TO:

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Virginia Department of Behavioral Health & Developmental Services

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We, JBS International, Inc. (JBS), thank the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Behavioral Health Needs Assessment Advisory Group that is comprised of DBHDS senior staff, five Community Services Board (CSB) Executive Directors, and Ms. Gail Taylor, our Contract Officer, for their support and guidance in this process.

We especially want to voice our appreciation and respect for the distinguished professionals who work in the CSBs and are committed to community behavioral health serving many of Virginia's most vulnerable adults and children. And we thank the brave individuals with the lived experience of serious mental illness and substance use disorders (SUDs) who shared with us their unique stories of illness, treatment, recovery, and hope for a better future and a life in the community.

This final Virginia Behavioral Health System Needs Assessment report was prepared by JBS personnel in collaboration with our partners, the OMNI Institute and Cansler Collaborative Resources, LLC. This report addresses our findings regarding the need for behavioral health services provided by CSBs in Virginia, the capacity of Virginia's system to provide behavioral health services, funds used to support these services, the impact of System Transformation Excellence and Performance (STEP-VA), Medicaid expansion and Medicaid managed care, and feedback provided by behavioral health staff.

Special appreciation is extended to the Needs Assessment team listed below; their many contributions are acknowledged with gratitude.

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EXECUTIVE SUMMARY

JBS International, Inc. (JBS) was contracted by the Commonwealth of Virginia in March of 2019 to complete a needs assessment of Virginia's behavioral health system. Over the last 12 months, JBS used a mixed-method data collection approach that incorporated a variety of quantitative and qualitative data sources to best understand the capacity of the system and the unmet need. JBS used several existing data sources to describe individuals currently being served by the publicly funded community services boards (CSB) as well as several national surveys to describe the prevalence of behavioral health needs within Virginia. JBS also collected data from each CSB through a site survey, an onsite visit that included more than 600 individual interviews and 80 focus groups (560 focus group participants), and surveys from consumers and direct service providers at each CSB. In addition, prevention-specific focus groups were held, as were key informant interviews with staff from the Commonwealth of Virginia/ Department of Behavioral Health and Developmental Services (DBHDS).

This needs assessment report is framed within a window of implementation science,[1, 2, 3] as a growing body of evidence indicates systems **must** address three key components of necessary readiness when implementing new programs or practices:

(1) Motivation of key leaders and stakeholders within the organizations to adopt the new practices;

(2) General organizational capacities; and

(3) Practice or intervention-specific capacities.

The content and findings in this report are informed by the overarching framework described above, in which quantitative and qualitative findings and analysis are presented through the lens of implementation science, and actionable recommendations are framed within this same perspective. What follows in this Executive Summary are a set of findings and recommendations. Each of these findings and recommendations are described in greater detail in the body of this report.

The needs assessment focused on answering the following questions:

(1) What are the key characteristics of Virginia's publicly funded behavioral health system?

(2) What is the demand for behavioral health services in Virginia?

(3) What is the capacity of Virginia's system to provide behavioral health and prevention services?

(4) How are funds used to support provision of behavioral health services in Virginia?

(5) What has been the impact thus far of Virginia Behavioral Health System's System Transformation Excellence and Performance (STEP-VA), Medicaid expansion, and Medicaid managed care on provision of behavioral health services?

(6) What feedback has been provided by behavioral health direct service staff and consumers regarding provision and receipt of behavioral health services?

More granular level findings and recommendations are included in Section 5. Findings and Recommendations.

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[1] Meyers DC, Durlak JA, Wandersman A. The quality implementation framework: a synthesis of critical steps in the implementation process. *Am J Community Psychol.* 2012; 50(3-4):462–480.

[2] Wandersman A, Chien VH, Katz J. Toward an Evidence-Based System for Innovation Support for Implementing Innovations with Quality: Tools, Training, Technical Assistance, and Quality Assurance/Quality Improvement. *Am J Community Psychol.* 2012; 50(3-4):445–59.

[3] Greenhalgh T, Robert G, Macfarlane P, Bate O, Kyriakidou F. Diffusion of Innovations in Science: Systematic Review and Recommendations. *The Millbank Quarterly*. 2004; 82(4):581–629.

A brief synopsis of each area is below.

Key Characteristics of Virginia's Publicly Funded Behavioral Health System

Core Mental Health and Substance Use Treatment Services

The majority of CSBs reported that they currently have the capacity to provide the following core behavioral health services:[4]

- **Emergency and Ancillary Core Services:** Crisis or emergency services, assessment and evaluation, acute psychiatric or substance use disorder (SUD) inpatient services
- **Outpatient Behavioral Health Program Services:** Outpatient services
- **Mental Health Program Services for Persons with Serious Mental Illness (SMI)**: Medical/ psychiatric services, case management, psychosocial rehabilitation (PSR) services, outpatient services, Program for Assertive Community Treatment (PACT), residential crisis stabilization services, supervised residential services, supportive residential services
- **Substance Use Program Services:** Medication-assisted treatment (MAT), outpatient services, intensive outpatient services, intensive residential services

The majority of CSBs reported through the CCS3 that they currently **do not** have the capacity to provide the following core behavioral health services:[4]

- **Inpatient SUD Program Services:** SUD medical detoxification
- **Mental Health Program Services:** Day treatment and/or partial hospitalization, ambulatory crisis services, highly intensive residential services, intensive residential services
- **Substance Use Program Services:** Medical/ psychiatric (co-occurring), intensive outpatient services, day treatment and/or partial hospitalization, residential crisis stabilization services, supervised residential services, supportive residential services

It is important to note that although some CSBs reported being able to meet a baseline capacity to provide these core services, they were also repeatedly and exceedingly clear when interviewed that they do not have adequate capacity to meet the needed service volume in their communities for any of these services. Demand exceeds capacity. They identified several reasons why: Increased demand for services over time, accelerated by STEP-VA same-day access implementation; service throttling by managed care organizations (MCOs); inadequate workforce size, health information technology (HIT), and business/organizational infrastructure; difficulties recruiting and retaining available staff; and increased administrative demands that take away from direct service.

Recovery Services

CSBs provide an array of recovery support services (92.5%, n=37). In fact, 95% offer peer recovery support; 80% offer housing and residential services, such as supportive housing; 35% offer employment services; and 50% offer services to support families, such as parent training, advocacy training, and respite care.

Prevention Services

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) has identified six core prevention strategies. And all prevention activities are reported to SAMHSA under the umbrella of one of the six strategies. Best practices in prevention

[4] This has been validated through Community Consumer Submission 3 (CCS3) data.

science recommend the implementation of a mix of strategy types, such as individual-level education sessions that target a few people paired with environmental-level strategies that impact communities as a whole. In Substance Abuse Prevention and Treatment Block Grant (SABG) Fiscal Year (FY) 2019, CSBs implemented an average of four different CSAP strategy types.

Over the last few years, as Virginia has moved toward a data-driven system, there has been a push to shift from a prevention system heavily dominated by direct education strategies to more environmental strategies that reach entire populations. In SABG FY19, 36 CSBs were implementing environmental strategies, and 31 were implementing education strategies.

Use of Evidence-Based Practices

Survey and interview data collected from all CSBs demonstrate a clear commitment to using evidence-based practices (EBPs) for treatment, prevention, and recovery whenever feasible. All 40 CSBs reported using more than one EBP and/or treatment model to provide behavioral health services. More specifically, CSBs report using:

- Up to 15 (mean=6.7, SD=3.4) EBPs and/or treatment models to provide substance use and mental health treatment services;
- Up to 4 (mean=2.0, SD=1.0) to provide recovery support services; and
- Up to 8 (mean=4.0, SD=2.2) to provide prevention services.
  (Note: SD=standard deviation)

Although all CSBs demonstrated a commitment to using EBPs, there was not always an adequate grounding in the actual strategies that would support fidelity of practice for the EBP.

Need for Behavioral Health Services

Between state FY2013 and FY2019, 1,624,269 clients received services from the CSBs. Of those, 1,071,094 clients (65.9 percent) received substance use and/or mental health services from CSBs. A brief description of CSB service recipients is below:

- Slightly more males (52%) received services than females (48%),
- More persons from rural areas (52%) received services than persons from urban areas (48%)
- Most persons (48%) were 26 and older, 14% were between 12 and 17 years old, 12% were between 18 and 25, and 11% were under age 12
- 28% of persons were from Region 3; 23% were from Region 1; 21% were from Region 5; 15% were from Region 2, and 13% were from Region 4
- Most clients (60.2%) were white, 26.9% were black, 6.6% were Hispanic, 4.8% were multiracial, 4.4% were other race, 1.1% were Asian, 0.2% were American Indian, 0.1% were Native Hawaiian Other Pacific Islander, and 0% were Alaskan Native

Serious Emotional Disturbance (SED): The number of client populations at risk of or having SED has remained relatively stable over the last 7 years. Percentages of clients with SED were higher for clients served by CSBs located in primarily rural areas than in urban areas across all state FYs (2013 to 2019). Among clients ages 12–17 years, there were significant increases in the percentage of female adolescent clients with SED (FY2019 and FY2013 through FY2018, $p < 0.001$). For clients ages 12–17, results indicate that adolescent-age clients who identify as Black or African American had significant *decreases* in SED (FY2013 through FY2016 and FY2018, FY2019, $p< 0.01$). In contrast, significant increases

occurred in the percentage of clients ages 12–17 for clients from the following racial and ethnic backgrounds:

- Multiracial (identifying with two or more races; FY2019 and FY2014 through FY2017, $p<0.05$)
- Hispanic (FY2014 and FY2016 through FY2019, $p<0.01$)

SMI: There has been a gradual increase in the number of clients seeking CSB services with SMI across 7 successive FYs. A noticeably larger number of clients ages 26 and older had SMI across all FYs (2013 to 2019) compared with clients ages 18–25 years. Although there were some fluctuations across FYs, results indicate significant overall *increases* in the percentages of young adult clients (ages 18–25) who have SMI across all regions. Results also indicate significant overall *increases* in the percentages of adult clients ages 26 and older who have SMI for Regions 1,3, 4, and 5. Significant increases were identified across successive FYs in the percentage of male and female young adult (ages 18–25; $p < 0.001$) clients with SMI, as well as the successive increases in the percentage of male and female clients ages 26 and older with SMI ($p < 0.01$).

SUD: Of the 1,071,094 clients who received substance use and mental health services between FY2013 and FY2019, 46.3% of all clients (n=496,208) reported having an SUD and sought treatment at CSBs. The primary substance of abuse by clients across FYs were alcohol, marijuana/hashish, heroin and other opioids, and cocaine/crack. In addition, findings revealed significant overall *increases* ($p < 0.001$) across state FYs in the following specific primary SUD problems: Opioid use, including use of heroin and other opioids; marijuana/hashish use; and methamphetamine use. Substances of abuse changed over time. The primary substance of abuse for clients under 18 and ages 18–25 was marijuana/hashish. In addition to marijuana/hashish, more adolescent-age clients than not reported alcohol and opioids, respectively, as their primary SUD; however, for clients ages 26 and older, most clients reported alcohol as their primary SUD.

Key Findings

1. STEP-VA has been successful in increasing access to behavioral health services; however, the degree of service penetration and fidelity to models must be considered in the implementation of STEP-VA services and EBPs.

- All CSBs have taken action to implement programs and services described within STEP-VA.
- Current funding to deliver STEP-VA services and EBPs is insufficient at levels of penetration that are responsive to demand. (Service penetration is directly related to funding adequacy, available workforce, and infrastructure.)
- Provision of EBPs with acceptable fidelity requires systems to build staff competencies and changes in supervision and program infrastructure. These systems are not in place in most CSBs.
- Whereas CSBs have reported serving more persons as a result of same-day access, the increased demand frequently exceeds workforce capacity to meet the demand for clinical and case management services.
- Barriers to STEP-VA implementation include timeliness; lack of clarity and communication between DBHDS and the CSBs; availability of resources (e.g., funding, staffing) to support implementation and sustainability of services; and insufficient support, consultation, and training for implementation to build CSB staff capacity in necessary knowledge and skills.

2. Managed care has had a significant impact on service provision in Virginia and will require the CSBs to adopt new business acumen and, in some cases, new capacities and expertise to be successful.

- On January 1, 2019, Medicaid expansion took effect in Virginia, resulting in a 43% increase in enrollment into Medicaid and Children's Health Insurance Program (CHIP) from previous years.[5] As of February 2020, a total of 388,615 adults were newly enrolled and receiving services under Virginia's new Medicaid eligibility requirements. Roughly 70% of all newly enrolled adults (270,967) are below 100% of the federal poverty line (FPL) and would not have been eligible if not for Medicaid expansion. The remaining 30% of the newly enrolled adults (117,648) are between 100% and 138% FPL and are now eligible for low premium subsidies under Medicaid expansion.[6]
- In Virginia, state psychiatric hospitals are utilized at a higher rate than national averages, with a shorter length of stay, and higher-than-average 30-day readmission rate than other comparable states. The high rate of readmission indicates the need for more robust community supports and specific focus on transition of care functions for case management and expansion of services, such as PACT.
- With the emergence of Medicaid managed care in Virginia, CSBs have experienced significant barriers that have added challenges and administrative burdens on CSB infrastructure and increased administrative costs for operations and service delivery. These challenges and burdens include:
    - Significant increases in the amount of documentation for CSB clinicians, prescribers, and support staff;
    - Active recruitment and loss of clinicians to other organizations including MCOs;
    - Current Medicaid rates that do not sustain services;
    - General inconsistency and burdensome requirements from MCOs in areas such as payment and authorization requirements, level of care criteria, and network credentialing; and
    - Delays in payments and authorizations from MCOs.
- Prior to the six MCOs' involvement in Virginia Medicaid services, the CSBs had one Medicaid payer—the Department of Medical Assistance Services (DMAS). Now, with six major payers, resources must be invested in strengthening the capabilities of the CSBs' finance departments and systems to help them rise to that level of complexity. The CSB financial systems must be able to consistently and correctly bill for the same service in multiple ways, monitor billing and accounts receivables regularly, and assertively address claims delays and denials. Otherwise, CSBs are at risk of losing large sums of revenue or having significant accounts receivables that in several cases were described as in the millions of dollars. When systems can perform these more-complex procedures and have an adequate IT infrastructure and "back office" staff, there is little effect on the CSB.

[5] MACPAC 2019. Medicaid and CHIP Enrollment, Selected Months in 2013–2019. Retrieved from https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-11.-Full-Benefit-Medicaid-and-CHIP-Enrollment-Selected-Months-in-2013–2019.pdf (January 10, 2020)

[6] DMAS 2019. Virginia Department of Medical Assistance Services 2019. Retrieved from https://www.dmas.virginia.gov/#/dashboard (February 15, 2020)

- MCOs do not appear to differentiate the service needs of the principal populations with chronic conditions served by the CSBs from the behavioral health needs of the general population. Although the overarching goals for the CSB patient populations and general populations may be similar (i.e., improved functional status and quality of life), the objectives, clinical services, and strategies are different. Reduced hospitalizations, reduced emergency services, reduced police and court involvement, and stability in community living arrangements are some of the expected objectives for CSB populations. To achieve these objectives, ongoing programs, such as PACT teams, PSR, case management, and pharmacotherapies, are essential. The JBS Team knows that efforts to address some of these challenges are underway through Virginia's Behavioral Health Redesign process that is emerging. Although we fully support the priority services and ideals under Redesign, for it to be fully successful, there must be reasonable alignment with the six MCOs currently contracted with the state.
- CSBs are required to complete multiple reports to DBHDBS or DMAS, including information for the CCS-3 report, the Daily Living Activities-20 (DLA-20) multiple times a year and other reporting to capture health outcomes and performance. Currently, these data are submitted to the requesting agency but with little feedback or useable data returned to CSBs. If these data were aggregated and analyzed by the agency or agencies to which they are submitted and then made available to the CSBs that submitted them, it could inform and improve CSBs' internal quality and clinical reviews. Many CSBs were unable to clearly verbalize what outcomes they are measuring (if any) or how the results are incorporated into quality improvement activities
- Across the CSBs, challenges were identified related to the effect of managed care on CSB operations. The most salient themes included:
  - MCO decisions to restrict or deny services to patients negatively impacting care and recovery for these patients;
  - A significantly increased amount of documentation for clinicians, prescribers, and support staff;
  - Generally inconsistent or burdensome requirements;
  - Delays in payments and authorizations;
  - MCO approaches to CSBs that do not appear to reflect an understanding that patients served by CSBs have SMI and SUDs or both conditions; and
  - MCO operations and current approaches that pose a major and confounding variable to the success of STEP-VA.
- CSBs do not having adequate business infrastructure to work successfully with MCOs
  - Many CSBs lack IT, utilization management, and quality management systems that are linked to their electronic health record (EHR) to efficiently conduct business in this environment and track the delivery and quality of services.

3. Communication between CSBs and DBHDS has been identified by all parties as an area in need of improvement.

DBHDS and CSB staff identified the following areas of concern:

- Multiple changes in DBHDS executive leadership, including six DBHDS commissioners in the past 6 years;
- The absence of a defined intra- and inter-organizational communication plan;
- "Siloing" within DBHDS particularly between licensing and program staff;

- STEP-VA requirements not being communicated with sufficient time and specificity to develop CSB-specific plans, identify necessary accommodations, and train impacted staff to implement as required;
- Multiple staff with significant historic knowledge retiring or leaving and being replaced by persons with limited organizational knowledge and/or limited understanding of the CSBs and community behavioral health services; and
- The need to replace antiquated, unreliable data systems, most notably CCS3.

4. Strong leadership and collaboration between DBHDS and CSBs is a critical facilitator for STEP-VA implementation and fully maximizing the Medicaid benefit.

Necessary aspects of leadership support include:

- Improved communication;
- Strategic planning for implementation;
- Shared perspective of benefit of STEP-VA services for clients; and
- Mobilizing resources to support implementation.

5. CSBs lack sufficient workforce capacity to address challenges in workforce recruitment and retention and the delivery of EBPs with fidelity.

- All CSBs described shortages of medical and behavioral health providers. Sites described excessive lengths of time needed in recruitment, sometimes taking a year and more to recruit a psychiatrist. CSB leaders stated that salaries (particularly for prescribers) are not competitive with the private sector, and that levels of reimbursement fall significantly short of the true cost of prescribers' salaries. Numerous facilities described using locum tenens psychiatrists and contracting for telepsychiatry but viewed these as stop-gap measures, as these services are expensive. Furthermore, although these services address the immediate need for prescribing, they do not lend well to team-based care.

> For a Northern Virginia CSB, it took more than a year to recruit a licensed clinical social worker. Similarly, a rural Virginia CSB has been trying to recruit a child psychiatrist for 18 months.

- Direct services staff spend approximately **40%–60%** of their time satisfying extensive documentation requirements. Anecdotally, burdensome and redundant documentation contributes to staff burnout.
- EBP training and support is provided inconsistently throughout Virginia. Such training and support is often delivered through conference or workshop trainings with little if any follow-up. As a result, **60%** of CSB administrative staff reported that their staff do not have access to adequate training and technical assistance services to support fidelity in implementation of STEP-VA programs and services.
- Only 26% of CSBs have systems in place for appropriate EBP supervision, coaching, and monitoring for EBP fidelity.

6. Funding is not adequate for STEP-VA service implementation and delivery.

- Although CSBs clearly value the intent of STEP-VA, funding to deliver the required services is insufficient at levels of penetration that are responsive to demand. DBHDS hopes that

Medicaid will be optimized to support STEP-VA service adoption; however, low rates of Medicaid reimbursement and multiple challenges with the rollout of Medicaid managed care are confounding variables that create significant barriers to STEP-VA success.

- CSBs hired new staff to fill needed roles for STEP-VA delivery, but even with the additional staffing capacity, the service needs of their population surpass the increased staffing.
- CSBs operating multiple satellite locations do not have resources to add staff at each site with the available funding. This means that roll out of services, such as same-day access, may occur at only one place in the service area and not throughout the catchment area, which limits access to services within large geographic areas.
- Concerns felt by the JBS Team that were echoed by many CSB executives included the fact that the state and the public might be experiencing an inaccurate perception regarding STEP-VA progress. Specifically, this relates to the level of penetration of STEP-VA services into the populations of focus, as reflected in the following:
  - Many CSBs operate multiple service sites where intakes occur; however, same-day access can only be supported at a few of those sites or for limited hours each week at that CSB.
  - MAT for opioid use disorder (OUD) is "available" through most of the CSBs; however, with few exceptions, the numbers of MAT patients served is relatively small, often fewer than 50 patients per CSB. Based on certain planning/service capacity models, MAT service delivery for OUD should be exponentially greater with static systems capacity (CSBs and other providers) to serve up to 84,000 adults with OUD.
  - PACT, which is proven to reduce hospitalizations, is only available in a limited capacity within Virginia. Several of the Commonwealth's largest CSBs have one or perhaps two PACT teams. When compared with other states, comparably sized service areas operate four and up to eight teams.
  - Service penetration is directly related to funding adequacy, available workforce, and, in some cases, infrastructure.

7. Virginia's prevention system has moved to a data-driven planning model that follows current national best practices in prevention science.

- DBHDS has led several statewide efforts to both support CSBs in their prevention work and to build toward a long-term prevention infrastructure that will guide the future of Virginia's prevention system. Key initiatives include:
  - Development of a State Epidemiology and Outcomes Workgroup (SEOW) and behavioral health data dashboard. DBHDS worked to establish the Virginia SEOW, which brings together representatives from several Virginia agencies to address cross-cutting issues relevant to prevention and to provide data critical to addressing these issues. DBHDS partnered with The OMNI Institute (OMNI) to facilitate the SEOW and build the Virginia Social Indicator Dashboard (omni.org/vasis), a public online data dashboard that provides state and communities access to data related to substance use and behavioral health. This has been a critical tool for CSBs and coalitions completing needs assessments and strategic planning activities, which rely on current local data to drive decisions.

- Implementation of a prevention-focused data collection system. In 2017, DBHDS partnered with Collaborative Planning Group, Inc. to utilize their Performance-Based Prevention System, which is designed to track prevention and coalition work. This system is used to monitor and evaluate all prevention data and is especially effective because it is a system designed for the type of community prevention initiatives that CSBs engage in, rather than treatment or case management work, which is the typical structure for many data collection systems.
- Completion of a prevention-focused, statewide behavioral health needs assessment. In 2018, DBHDS and OMNI completed a statewide needs assessment with input from CSBs and the SEOW. The assessment identified priority substances for Virginia to address in prevention work over the coming years.
- Identification of strategic priorities for the next SABG 5-year cycle. Utilizing the data from the 2018 needs assessment, DBHDS engaged in a strategic planning process throughout 2019 to identify strategies that will be required as part of CSBs' SABG activities beginning in mid-2020. These strategies are designed to address the priority substances identified in the needs assessment. DBHDS is also working to specify an updated funding allocation process to better utilize data to allocate any new prevention funding within the Commonwealth.
- Each CSB conducts a periodic local needs assessment that informs the strategic plan for prevention at that CSB.
- Twenty-one CSBs' prevention programs are targeting behavioral health disorders. Suicide, adverse childhood experiences, and opioid overdoses are the most common targets.

KEY RECOMMENDATIONS

1. DBHDS is encouraged to draft a communication plan supporting the timely sharing of accurate information and decisions to all CSB leaders. This communication plan should identify opportunities to improve:

- Internal communication between divisions to better align efforts and decisions.
- Communication with CSBs to provide timely, consistent information and guidance.

2. DBHDS is encouraged to draft a plan for information technology to:

- Identify what data are necessary for the department to monitor, plan, make programmatic decisions, and allocate resources.
- Reduce redundancy in data collection.
- Improve data quality.
- Define the data and reporting timeline that are required from the CSBs.
- Reduce the burden of data collection on the CSBs.
- Define the technology needs of the department and the CSBs.

3. DBHDS is encouraged to fund a statewide contractor that operates under DBHDS' guidance to develop statewide and CSB-specific plans for systems capacity building. The contractor should be required to:

- Provide robust and ongoing training and technical assistance (TTA), coaching, and consultation with the goal of successfully supporting STEP-VA implementation and continuous quality improvement (CQI) processes, including the adoption of programs and practices with adequate fidelity and service penetration.
- Provide CSB TTA on the adoption of STEP-VA practices. EBPs should be planned and delivered within a framework of evidence-based training and should include ongoing training and consultation for clinical supervisors and staff.
- Provide capacity building TTA in critical areas, including business practices for managed care, population health, whole person care, integrated care management, quality management/CQI, data analytics, financial modeling, contract negotiations, value-based purchasing, alternative payment methodology, and service delivery within managed care.

4. DBDHS is encouraged to work collaboratively with key state and community stakeholders to establish consistent and enforceable requirements, expectations, and practices for managed care. The objectives of this collaboration would include:

- Minimizing patients being adversely impacted by managed care,
- Building systems capacity to reduce hospitalizations and rehospitalizations.
- Improving operations between MCOs and community providers.

5. CSBs, DMAS, and DBHDS should agree on one set of nationally recognized or local performance measures that indicate quality and outcomes and can be used for quality improvement.

- CSBs are not consistently using data collected from services to evaluate the quality of services delivered, leading to a lack of fidelity with evidence-based models and thus little knowledge about the quality and outcomes associated with services.
- Some CSBs lack the IT infrastructure to properly collect or track the data, and many lack the staff capacity to analyze the data they are collecting to ensure and document quality outcomes.
- High-priority technology capacity and infrastructure needs within CSBs fall into three main categories: financial information systems, an EHR, and quality management plans with a robust data analytics capacity.

6. DBHDS is encouraged to invest in CSB adoption and utilization of IT and quality management systems to conduct business and track the delivery and quality of services.

- Given the complexity arising from the presence of multiple payors with different requirements and payment structures, plus the need to share clinical or billing information in a more interoperable manner that allows for access across multiple entities, information and system technology is critical.

7. DBHDS is encouraged to support workforce development efforts to improve CSB recruitment and training of additional personnel with the needed skill sets and competencies.

- Technology and service delivery can only be successful tools if there are enough CSB personnel who possess the appropriate skills and competencies.
- CSBs are increasingly faced with the possibility of high turnover rates, and the CSBs struggle to compete with the private sector in compensation and training opportunities for staff.

8. DBHDS is encouraged to develop a workforce development committee made up of CSB representatives who make recommendations to address the unique needs of CSB staff.

- CSB staff often lack the necessary supports and resources to address the complex needs of their unique client base, causing increased stress and burnout among staff.
- CSB salaries for comparable positions are inconsistent. DBHDS may want to consider conducting a salary study across all CSBs to collect baseline information about salaries for differing levels of staff. CSBs are competing for a limited number of license-eligible/ licensed staff.

9. DBHDS, DMAS, and MCOs are encouraged to better align their respective goals and objectives.

- As STEP-VA is a signature initiative of the Virginia legislature intended to transform the Commonwealth's behavioral health system, the alignment of goals and efforts of DBHDS, DMAS, and MCOs is critical to STEP-VA's success. Furthermore, the two state agencies are encouraged to engaged in a deliberate process to better align goals and objectives and to outline new opportunities for collaboration and cooperation.

10. CSBs, in collaboration with DBHDS, should undertake a dedicated and perhaps independently facilitated process to determine true costs for essential services so that rates for services are informed by current facts.

- Interviewees described a need for additional funds to keep CSB facilities operating, implement necessary upgrades, meet state requests, and conduct daily business. Many interviewees noted that state and federal funds often only include minimal allowances for administrative needs, which limits the CSBs' ability to perform necessary upgrades. Current overhead/ indirect allowances tend to be a maximum of 10%, whereas CSBs report they need to be closer to 15%–20% to realistically cover the administrative costs.

11. DBHDS is strongly encouraged to shift or align its funding to support robust community options that can increase access to care while reducing the trauma and high costs associated with hospitalization.

12. DBHDS should encourage more use of telehealth and mid-level prescribers (e.g., nurse practitioners, physician assistants) to address the lack of psychiatrists and child psychiatrists.

13. DBHDS is encouraged to include representation from direct service providers and consumers in planning and implementation processes.

- As was amply conveyed in the focus groups conducted at the 40 CSBs, direct service providers and consumers have great appreciation for the work of the CSBs—they are the system's biggest champions. They are keenly aware of, and directly impacted by, shortcomings in the behavioral health system. These two key stakeholder groups have considerable insight and wisdom to contribute that could help ensure that reforms are workable and effective.

14. DBHDS is encouraged to increase prevention funding to deliver a broader range of prevention services as current funding is insufficient. As stated by Dr. Andrea Barthwell, "No epidemic has ever been stopped by treatment alone."

- There are no state general fund dollars for substance prevention allocated in the state budget for DBHDS to distribute to CSBs. This has been identified as a critical need for the prevention system, and advocacy is underway to encourage state legislators to recognize the value of prevention efforts and allocate prevention funds in the annual state budget.
- DBHDS is examining opportunities to shift some SABG funding from treatment to prevention because the expansion of Medicaid that went into effect in Virginia in 2019 covers a portion of treatment needs that were previously covered by DBHDS.
- CSB funding from local communities varies dramatically with urban areas contributing significantly to prevention efforts.

1. PURPOSE AND GOALS OF THE VIRGINIA NEEDS ASSESSMENT

The purpose of the Virginia Behavioral Health (BH) System Assessment is to:

- Assess the need of Virginians for publicly funded behavioral health services (BHS); and
- Assess current capacity of the Commonwealth of Virginia's BH system to meet the BH needs of Virginians across the continuum of prevention, treatment, and recovery, as well as community-based, crisis, and facility care provided throughout the Commonwealth.

The information from the assessment will be used as a base to guide system improvements and to proactively prepare for future system change with the implementation of Medicaid Expansion, Medicaid managed care, BH Redesign, and Virginia Behavioral Health System's System Transformation Excellence and Performance (STEP-VA). This assessment was also designed to include an analysis of existing Department of Behavioral Health and Developmental Services (DBHDS) funding sources and how funds are allocated, as well as DBHDS BH data sets and DBHDS' performance management infrastructure.

The assessment was funded and guided by DBHDS. For the purposes of this assessment, "publicly funded BH system" is defined as services delivered to Virginians that were predominantly funded by state, local, and federal grants and Medicaid and provided by the Commonwealth's 40 community services boards (CSBs).

Populations of Primary Interest

This assessment focused on Virginians with BH disorders. Primary client populations included:

- Adults with serious mental illness (SMI).
- Children (especially ages 0–5), youth, and young adults with serious emotional disturbance (SED).
- Adults with substance use disorders (SUDs).
- Youth under age 18 with SUDs.
- Adults experiencing co-occurring SMI and SUDs.
- Children, youth, and young adults with co-occurring SMI and SUDs.
- Adults and youth with general mental health (MH) problems.
- Adults and youth experiencing general MH problems with co-occurring SUDs.
- Populations at risk due to evidence-based risk indicators, including environmental factors, adverse childhood experiences (ACEs), and other potential indicators.

Summary of Key Questions We Are Answering

Key questions answered as a result of this assessment include the following:

- What is the prevalence of BH issues across various demographic and diagnostic groups?
- To what degree do current utilization trends compare with the BH needs of Virginians? And more specifically, what are the unmet needs of underserved Virginians?
- What factors had the greatest positive or negative impact on accessing BH care?
- What evidence-based practices (EBPs) are CSBs using for the purposes of assessment and treatment? What trauma treatment models are being used by CSBs to provide trauma-informed care?
- What steps are CSBs taking toward trauma-informed care, especially in the areas of environment, screening, assessment, intervention, and treatment?

- To what degree do CSBs possess the capacity to address and manage BH crises?
- What prevention services infrastructure exists to support the delivery and implementation of best practices in prevention?
- What recovery support services infrastructure exists to support the delivery and implementation of best practices in recovery services?
- Through the lens of BH disparities and BH equity, what are the assessment's key findings?
- Based on the data collected and analyzed throughout the STEP-VA assessment, what are the key recommendations for future policy, programming, service delivery, and evaluation enhancement?

2. INTRODUCTION AND OVERVIEW OF VIRGINIA'S PUBLIC BH SYSTEM

OVERVIEW OF THE CSBS

CSBs are by statute the single points of entry into publicly funded MH, SUD, and developmental services. Although CSBs are the focus of this overview, private providers are vital partners and major resources in serving individuals with MH or substance use disorders or developmental disabilities. DBHDS licensed 1,053 primarily private providers (including 718 new providers) that delivered a range of BH services at 9,158 locations in Fiscal Year (FY) 2017.

Types of Boards

CSBs are key operational partners with the Department and its state facilities in Virginia's public MH, developmental, and SUD services system. Although not part of the Department, the department contracts, funds, monitors licenses, regulates, and provides leadership guidance to all 40 CSBs. The Board of Directors of each CSB consist of no less than six and no more than 18 members appointed by city councils or county Boards of Supervisors. Each of the 40 CSBs are classified into four types of CSBs[7].

Administrative policy (10 CSBs): Is appointed by and accountable to the governing body of each city and county that established it to set policy for and administer the provision of MH, developmental, and SUD services, including through local government staff or contacts with other organizations and providers.

Behavioral health authority (BHA; one CSB): Is appointed by and accountable to the governing body of the city or country that established it for the provision of MH, developmental, and SUD services, including organization that provides these services through its own staff or contracts with other organizations and providers.

Policy-advisory (two CSBs): Is appointed by and accountable to the governing body of each city and county that established it to provide advice on policy matters to the local government department that provides MH, developmental, and SUD services directly or through contracts with other organizations and providers pursuant to subsection. CSB board has no operational powers or duties, it is an advisory board to a local government department.

Operating (27 CSBs): Is appointed by and accountable to the governing body of each city and country that established it for the direct provision of MH, developmental, and SUD disorder services, including the organization that provides these services through its own staff or contracts with other organizations and providers.

County Run vs Nonprofit

The public body organized in accordance with the provisions of § 37.2-500 et seq. is appointed by and accountable to the governing body of each city and county that established it for the direct provision of MH, SUD, and developmental services. "Operating CSB" denotes the Board of Directors, whose members are appointed pursuant to § 37.2-501with the powers and duties enumerated in subsection A of § 37.2-504 and § 37.2-505. The operating CSB also includes the organization that provides these services through its own staff or contracts with other organizations and providers, unless the context

[7] Virginia DBHDS 2019. "Fiscal Year Report 2019 Annual Report (Item 310.J)". https://rga.lis.virginia.gov/Published/2019/RD645/PDF

indicates otherwise. The 27 operating CSBs employ their own staff and are not city or county government departments[Error! Bookmark not defined.].

CSB Service Area Population Density–Urban and Rural CSBs

Urban CSBs have population densities of 200 people or more per square mile. Rural CSBs have population densities of less than 200 people per square mile (ref. subdivision A.6 of § 15.2-3602 of the Code). Tables 2.1 and 2.2 list the 40 CSBs sorted by population density ranking in the urban and rural sections. The number preceding the CSB's name is its population density ranking in descending order from the most densely populated to the least densely populated. The figure in parentheses after the CSB's name is its total population ranking in descending order from the largest population. Populations are the 2017 estimates from the Weldon Cooper Center for Public Service at the University of Virginia. The Center issues these official state population figures each January for the preceding calendar year[Error! Bookmark not defined.].

2018 CSB Service Area Population Density

Table 2.1. Urban CSBs (17): 200 or More People per Square Mile

Density Rank	CSB Name (Total Population Ranking)	Density per Square Mile
1	Alexandria CSB (21)	10,504
2	Arlington County CSB (14)	9,231
3	Norfolk CSB (12)	4,557
4	Richmond BHA (16)	3,708
5	Fairfax-Falls Church CSB (1)	2,926
6	Portsmouth Department of Behavioral Healthcare Services (31)	2,883
7	Hampton-Newport News CSB (8)	2,655
8	Virginia Beach CSB (3)	1,830
9	Prince William County CSB (2)	1,467
10	Chesterfield County CSB (7)	799
11	Loudoun County MH, Substance Abuse, and Developmental Services (4)	762
12	Chesapeake Integrated BH (13)	712
13	Colonial BH (20)	628
14	Henrico Area MH and Developmental Services Board (6)	560
15	Rappahannock Area CSB (5)	258
16	Hanover County CSB (28)	225
17	Blue Ridge Behavioral Healthcare (10)	218

Table 2.2. Rural CSBs (23): Less Than 200 People per Square Mile

Density Rank	CSB Name (Total Population Ranking)	Density per Square Mile
18	Harrisonburg-Rockingham CSB (25)	156
19	Northwestern CSB (15)	143
20	New River Valley Community Services (17)	126
21	Highlands CSB (35)	123
22	Horizon BH (9)	123

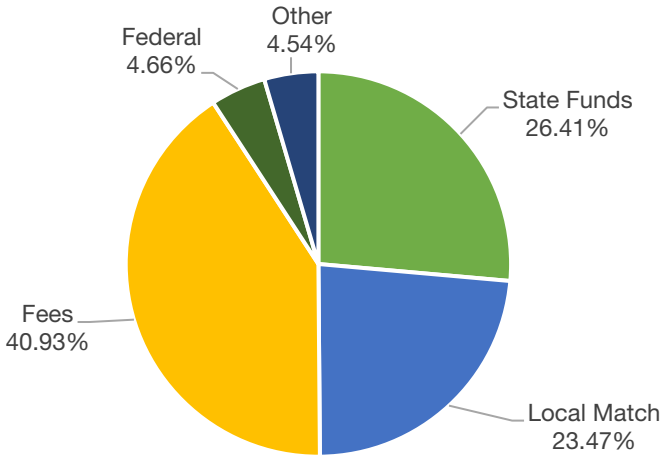
Density Rank	CSB Name (Total Population Ranking)	Density per Square Mile
23	Region Ten CSB (11)	118
24	Western Tidewater CSB (22)	118
25	Danville-Pittsylvania CSB (29)	102
26	Goochland-Powhatan CSB (36)	95
27	District 19 CSB (19)	90
28	Piedmont CSB (24)	89
29	Rappahannock-Rapidan CSB (18)	89
30	Valley CSB (26)	87
31	Middle Peninsula-Northern Neck CSB (23)	70
32	Eastern Shore CSB (37)	68
33	Planning District One BHS (33)	65
34	Cumberland Mountain CSB (32)	61
35	Mount Rogers CSB (27)	53
36	Alleghany Highlands CSB (39)	47
37	Dickenson County BHS (40)	44
38	Southside CSB (34)	41
39	Crossroads CSB (30)	37
40	Rockbridge Area CSB (38)	36

Total CSB Budget Size

The total budget of a CSB consist of state, local matching, and federal funds; fees, including Medicaid payments; and other funds, including workshop sales, retained earnings, and one-time funds. Total budget information comes from FY2017 end-of-the-FY performance contract CSB Automated Reporting System (*CARS*) reports. This is the latest year for which complete actual funding information is available. The total amount of all CSB budgets exceeded $1.2 billion. The statewide ratio of state to local matching funds was 52.95% to 47.05%. Fees included $427,489,915 of Medicaid payments, which was 35.20% of the total funds[8].

[8] Joint Legislative Audit and Review Commission (JLARC) 2019. "Implementation of STEP-VA" http://jlarc.virginia.gov/pdfs/reports/Rpt519-1.pdf

Figure 2.1. FY2017 Statewide Total CSB Funds by Source



Regions Served by CSBs

Table 2.3 lists CSBs by primary DBHDS region, including two subregions related to the catchment areas of Catawba Hospital (Subregion 3.a.) and Southern Virginia Mental Health Institute (Subregion 3.b.). The following Department divisions and offices use the primary DBHDS regions[Error! Bookmark not defined.]:

- Division of BHS;
- Division of Forensic Services;
- Division of Finance and Administration;
    - Office of Grants Management and Information Services and Technology;
    - Office of Quality Management and Development;
        - Office of Human Rights and Licensing;
        - Office of Business Analytics Center of Excellence; and
        - Office of Policy and Public Information.

Table 2.3. CSBs by Primary DBHDS Regions

Region	CSB
Region 1 Western Virginia (9 CSBs)	• Alleghany Highlands CSB • Harrisonburg-Rockingham CSB • Horizon BH • Northwestern CSB • Rappahannock Area CSB • Rappahannock-Rapidan CSB • Region Ten CSB • Rockbridge Area Community Services • Valley CSB
Region 2 Northern Virginia (5 CSBs)	• Alexandria CSB • Arlington County CSB • Fairfax-Falls Church CSB • Prince William County CSB • Loudoun County Department of MH, Substance Abuse, and Developmental Services
Region 3	• Blue Ridge Behavioral Healthcare (Subregion 3.a.)

Region	CSB
Southwestern Virginia (10 CSBs)	• Cumberland Mountain CSB • Danville-Pittsylvania CSB (Subregion 3.b) • Dickenson County BHS • Highlands CSB • Mount Rogers CSB • New River Valley Community Services • Piedmont CSB (Subregion 3.b) • Planning District One BHS • Southside CSB (Subregion 3.b)
Region 4 Central Virginia (7 CSBs)	• Chesterfield CSB • Crossroads CSB • District 19 CSB • Goochland-Powhatan Community Services • Hanover County CSB • Henrico Area MH and Developmental Services Board • Richmond BHA
Region 5 Eastern Virginia (9 CSBs)	• Chesapeake Integrated Behavioral Healthcare • Colonial BH • Eastern Shore CSB • Hampton-Newport News CSB • Middle Peninsula-Northern Neck CSB • Norfolk CSB • Portsmouth Department of Behavioral Healthcare Services • Virginia Beach CSB • Western Tidewater CSB

Figure 2.2 shows the primary DBHDS regions for CSBs.

Figure 2.2. Primary DBHDS Regions for CSBs

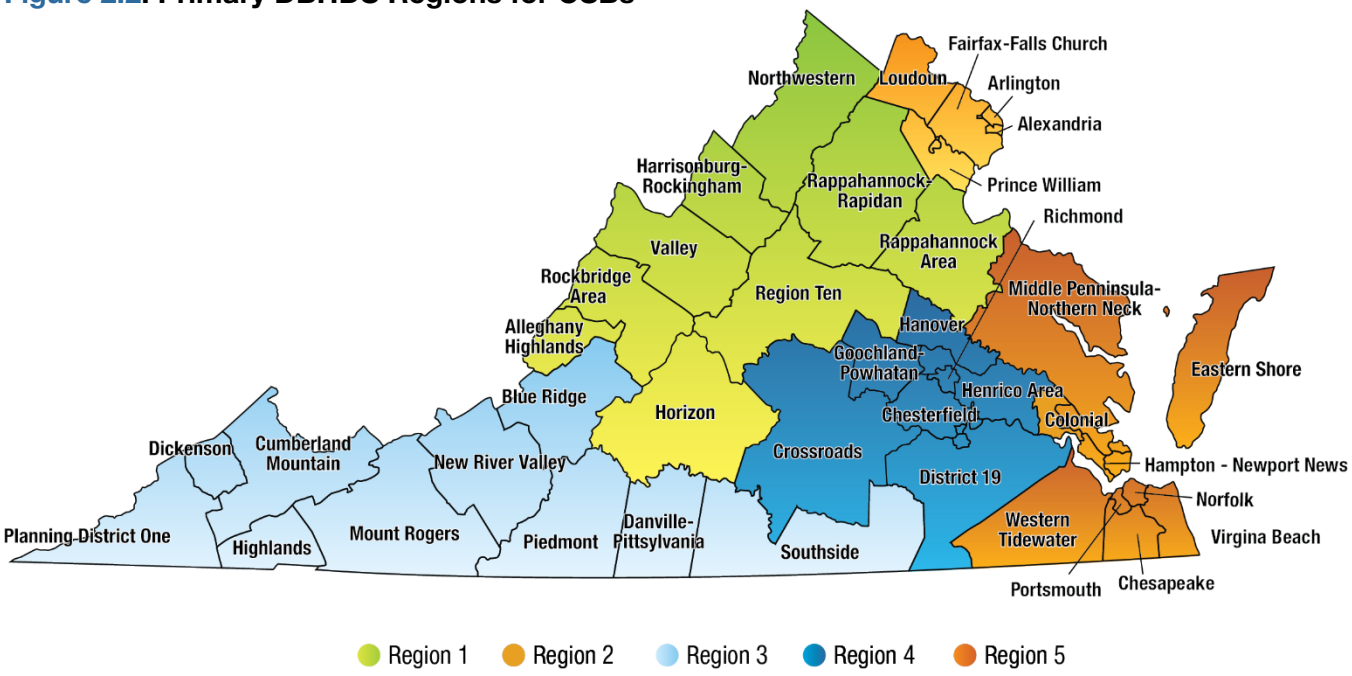
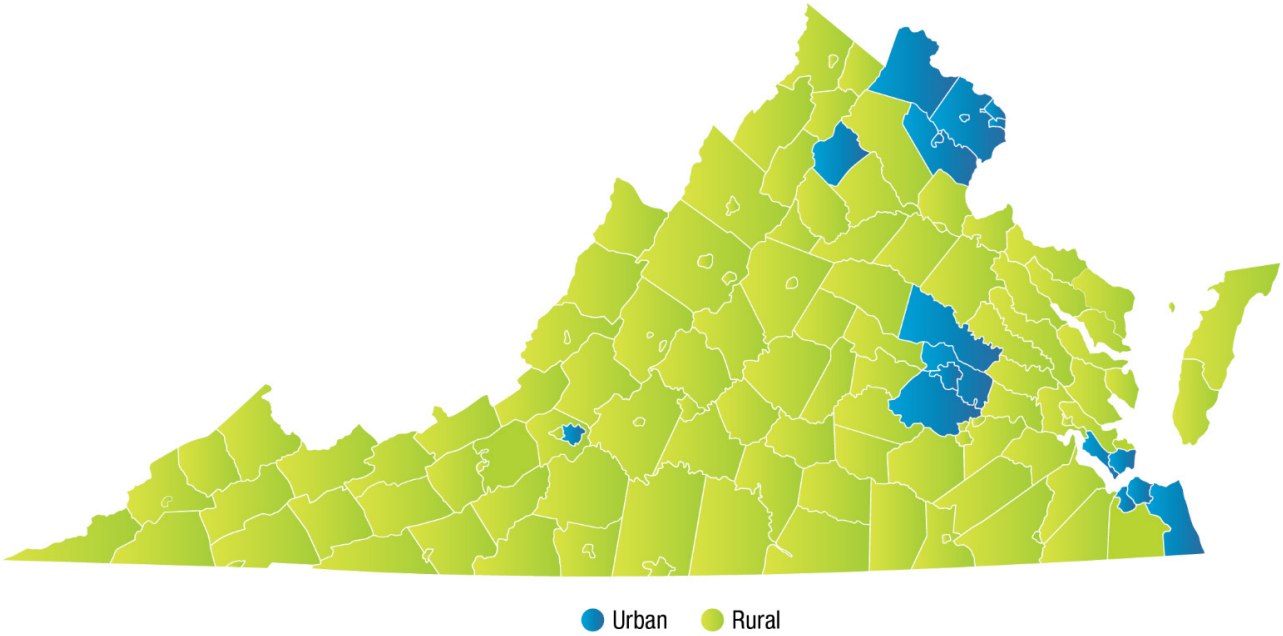


Figure 2.3. Virginia Rural and Urban Counties by CSB Regions



History of STEP-VA

The Commonwealth of Virginia made significant improvements in the quality and accountability of community services through legislative and administrative efforts. These efforts ensured that no individuals are turned away from psychiatric hospital care when needed, improved communications between courts and behavioral healthcare providers and increased administrative requirements among Virginia's local CSBs. Virginia's overall BH systems consistently were underfunded with services that were (are) not financially sustainable. To address this issue, the McAuliffe Administration, the General Assembly, stakeholders, and DBHDS worked together to transform Virginia's system in a strategic and cohesive manner[9].

What Is STEP-VA?

To reform the system, the General Assembly and DBHDS designed STEP-VA, an innovative initiative for individuals with BH disorders intended to ensure all Virginians have access to quality BHS in their communities.

Historically, CSBs offered various services directly and through contracts with private providers in delivering BH and developmental services. CSBs operate as single points of entry into public services, including access to state facility services through preadmission screening, case management, and coordination of services.

STEP-VA's goal is to expand certain existing services and implement new services to maximize impact. These services are intended to foster wellness among individuals with BH disorders to prevent crisis before they arise. STEP-VA ensures all 40 CSBs provide access to quality, community-based BHS. By providing timely access to services to Virginians, STEP-VA estimates fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with BH disorders in the criminal justice system.

[9] Virginia DBHDS. "STEP-VA". http://www.dbhds.virginia.gov/developmental-services/step-va

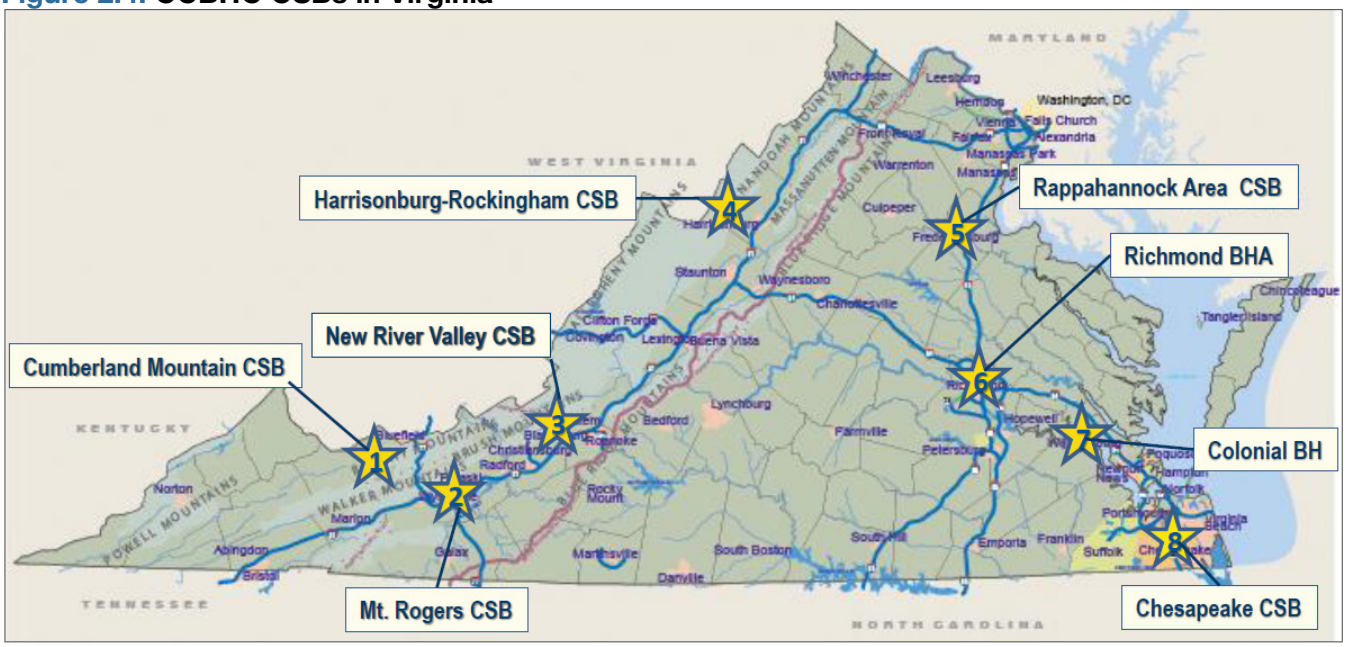
STEP-VA Components and Implementation Timelines

STEP-VA was initiated in 2017 by the General Assembly by requiring CSBs provide nine core services by July 1, 2021 (see Figure 2.4 STEP-VA Core Services). Initially, CSBs were required to only provide two core services—emergency and case management services. Each additional core service is to be implemented at all CSBs through a new phase. DBHDS leads the implementation and provides the funding of STEP-VA's phases across Virginia's CSBs. In turn, CSBs implement each phase in accordance with requirements agreed upon by DBHDS and representatives from 19 CSBs, known as STEP-VA Advisory Committee[10,11]. Part of the STEP-VA objectives and the Commonwealth of Virginia's application, eight of the 40 CSBs (Figure 2.4 CCBHC CSBs in Virginia) must be Certified Community Behavioral Health Clinics (CCBHCs). It was proposed, as part of SAMHSA'S CCBHC demonstration program, the following EBPs be adopted[12,13]:

- Cognitive–behavioral therapy (CBT) to support increasing levels of self-determination and independence through management tools among the SMI, SED, SUD, co-occurring, adults and youth population.
- Family psychoeducation to enhance consumer choice, problem solving, communication, and coping skills to decrease relapses and hospitalization among SMI and co-occurring adults and family members.
- Integrated dual disorders treatment (IDDT) to treat severe disorders to improve the likelihood of ongoing recovery among the co-occurring SMI and SUD population.
- Illness management and recovery to support consumer choice and recovery among SMI and co-occurring adults.
- Long-acting injectable psychotropic medication to prevent relapse beginning with first episode, essential for facilitating the achievement of recovery related to education, employment, relationships, and stable housing among adults with SMI.
- Medication-assisted treatment (MAT) to provide medications for SUD treatment to reduce risk of relapse and overdose in opioid users among adults with SUD.
- Motivational interviewing (MI) and motivational enhancement therapy (MET) to assist with engagement and retention within consumers seeking treatment for both behavioral and physical health among SMI, SED, SUD, co-occurring, adults, and youth.
- Recovery After Initial Schizophrenic Episode to address needs of those experiencing first symptoms to improve functioning that supports achievements of natural independence among MH late adolescence or early adulthood.
- Trauma-focused cognitive–behavioral therapy (TF-CBT) as a result of trauma being highly associated with the development of mental illness, SUD, and physical illness later in life among individuals with MH issues and trauma history.
- Wellness Recovery Action Plan (WRAP ®) to support consumer choice and recovery among SMI or co-occurring adults.

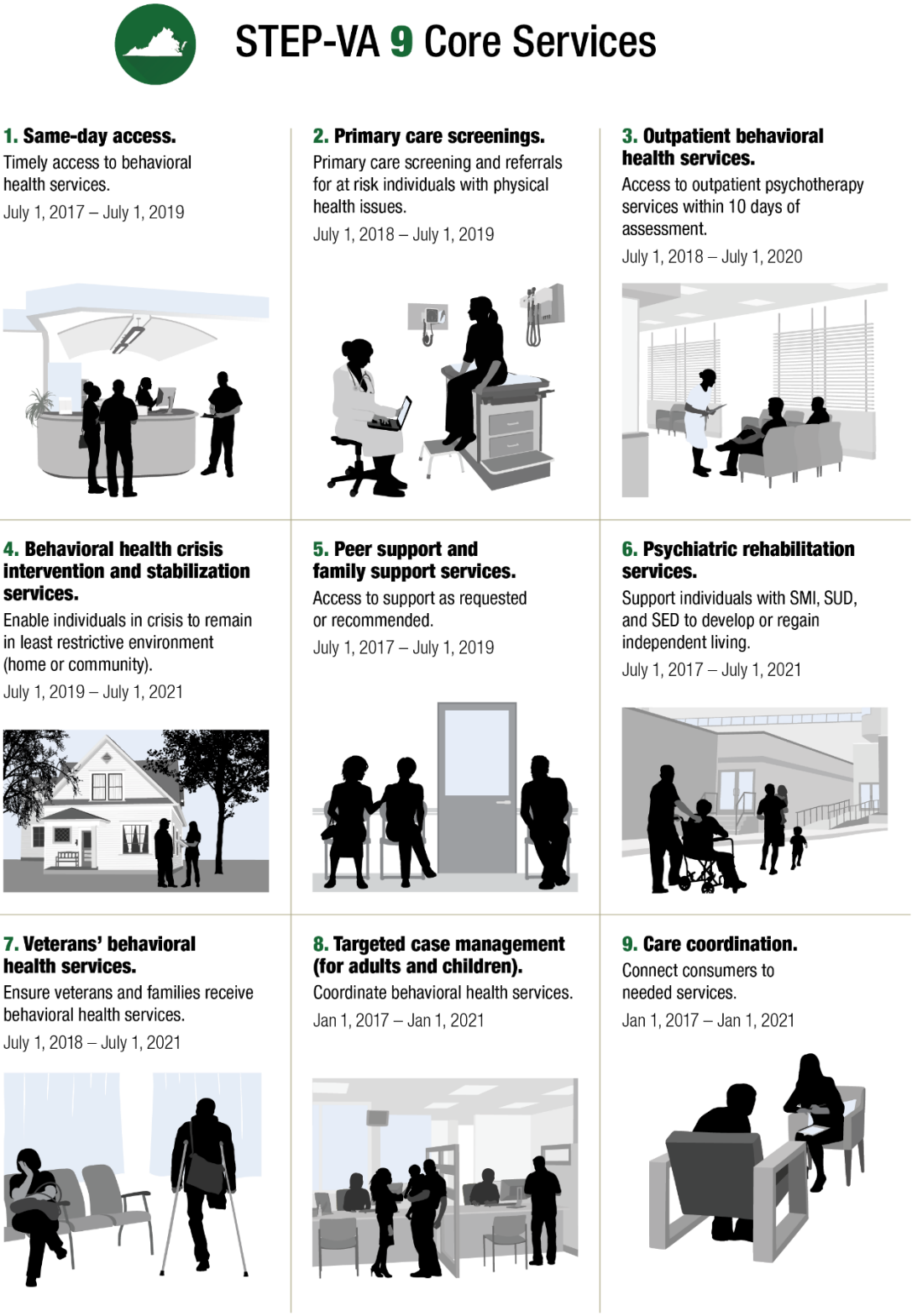
[10]JLARC 2019. "Implementation of STEP-VA" http://jlarc.virginia.gov/pdfs/reports/Rpt519-1.pdf
[11] Virginia DBHDS 2019. "Fiscal Year Report 2019 Annual Report (Item 310.J)". https://rga.lis.virginia.gov/Published/2019/RD645/PDF
[12] Daniel Herr. VDBHDS. "STEP VA: System Transformation, Excellence and Performance in Virginia".
[13] Jack Barber. VDBHDS. "DBHDS Updates and STEP VA: System Transformation, Excellence and Performance in Virginia."

Figure 2.4. CCBHC CSBs in Virginia



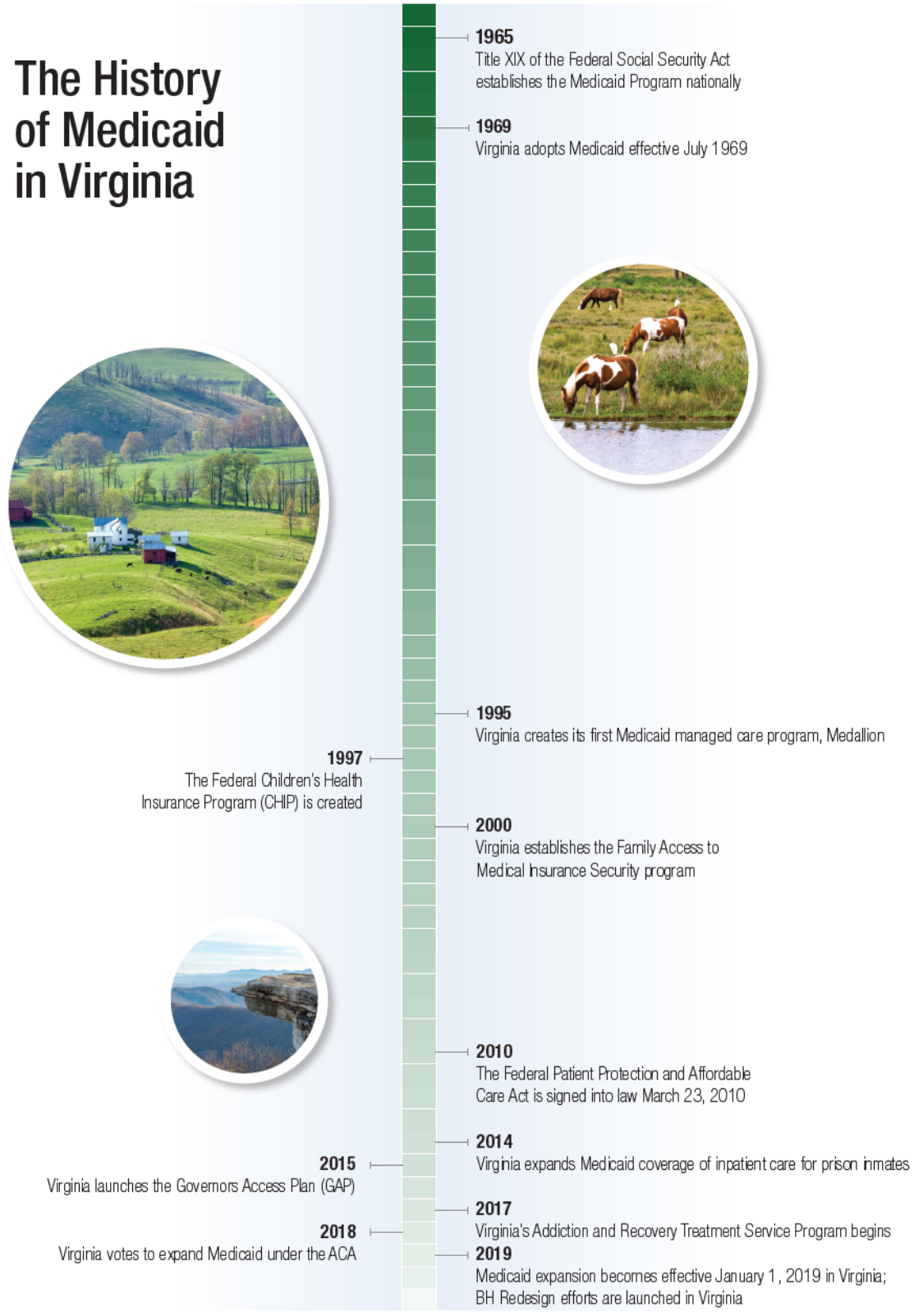
1. Cumberland Mountain CSB
2. Mt. Rogers CSB
3. New River Valley CSB
4. Harrisonburg-Rockingham CSB
5. Rappahannock Area CSB
6. Richmond Behavioral Health Authority
7. Colonial Behavioral Health
8. Chesapeake CSB

Figure 2.5. STEP-VA Core Services



MEDICAID IN VIRGINIA

Figure 2.6. Medicaid and BH in Virginia—A Timeline



Medicaid is one of the nation's largest payers for health care, providing coverage to adults, children, pregnant women, elderly adults, and people with disabilities who meet the income eligibility requirements. As of 2019, Medicaid (together with CHIP) covered approximately 72 million individuals across the nation and reported $593 million in total spending in FY2018.[14]

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 allowed states to expand coverage to low-income adults up to 138% of the federal poverty level (FPL) and receive enhanced federal matching funds for this coverage. Prior to the ACA, minimum eligibility standards for adults remained very low and, in most cases, only covered people with disabilities, low-income children and pregnant women, and extremely low-income parents, with no option to cover low-income adults without dependent children. To date, a total of 37 states, including the District of Columbia, have chosen to expand Medicaid under the ACA[15]. In the 14 states that have not expanded Medicaid under the ACA, Medicaid eligibility criteria for parents and other adults remain very limited regardless of income. Moreover, unless these states are approved for a Section 1115 waiver, premium subsidies are not available to individuals earning less than 100% FPL in states that have not expanded Medicaid under the ACA, resulting in a large Medicaid coverage gap in these states across the country.

Medicaid and BH in Virginia

As the single largest payer for BHS in the United States, including MH and SUD services, Medicaid plays a critical role in the integration of behavioral healthcare and is a major focus of the Medicaid program. At the national level, Medicaid covers roughly 21% of all adults with BH conditions, 26% of all adults with SMI, and 17% of all adults with an SUD. Medicaid accounts for $1 in $6 spent on health care in the United States and roughly 48% of all Medicaid spending. For states, BH is a state budget driver and the largest source of revenue to states across the country[16].

Enrollment in Virginia's Medicaid and CHIP was 1,397,783 in December 2019, with Medicaid alone accounting for 1.2 million enrollees.[17] In FY 2017, approximately 28 percent of Virginia's Medicaid recipients (386,305) reported having either primary or secondary behavioral health diagnoses. Of this, an estimated 53,639 or 13.9% of those who reported having a primary or secondary BH diagnosis, specifically reported having an SUD; 164,742 or 42.6% reported having an SMI; and 301,934 or 78.1% reported having a mental illness.[18]

[14] Kaiser Family Foundation 2019. "Medicaid Enrollment & Spending Growth: FY 2019 & 2020." https://www.kff.org/report-section/medicaid-enrollment-spending-growth-fy-2019-2020-appendix/ Downloaded January 15, 2020.

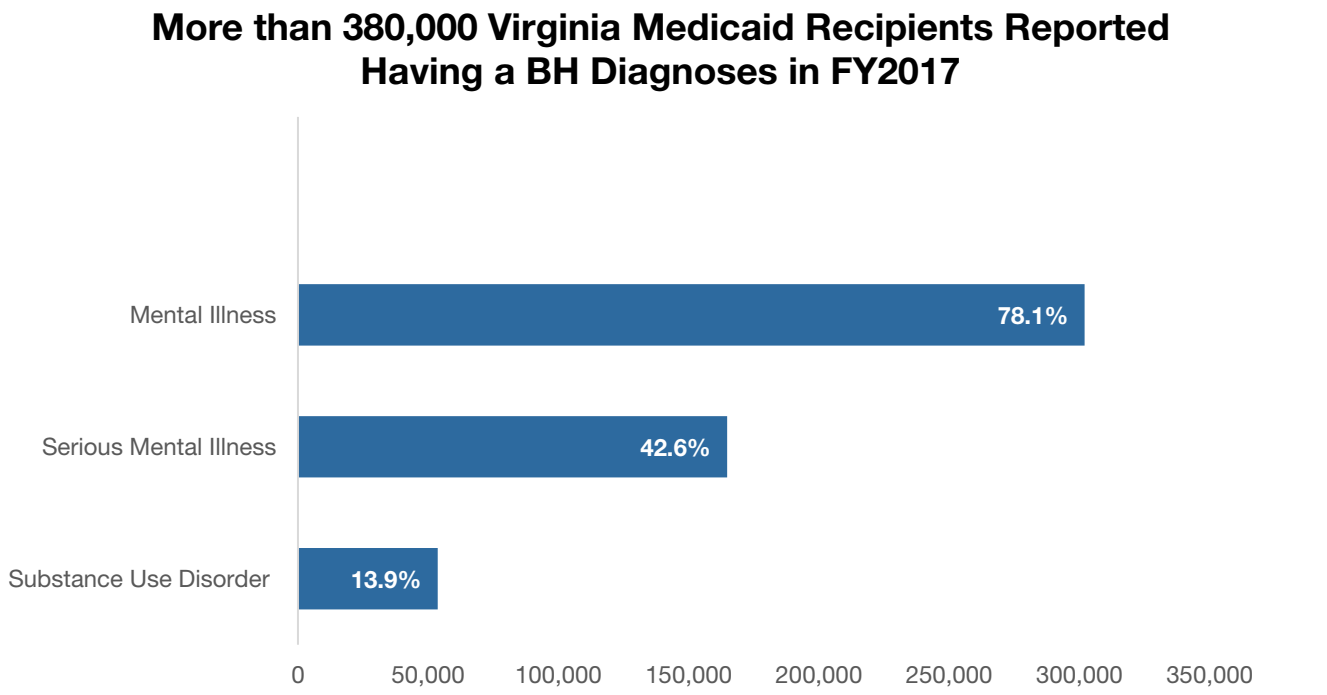
[15] Kaiser Family Foundation January 2020. "Status of State Action on the Medicaid Expansion Decision" https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D Downloaded January 15, 2020.

[16] Institute for Medicaid Innovation 2019. Behavioral Health Coverage in Medicaid Managed Care. https://www.medicaidinnovation.org/_images/content/2019-IMI-Behavioral_Health_in_Medicaid-Report.pdf Downloaded January 14, 2020.

[17] U.S. Centers for Medicare and Medicaid. December 2019. Medicaid & CHIP Enrollment Data Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html Downloaded January 15, 2020.

[18] Brou L, Gilchrist EC, Miller BF, Wong SL. Behavioral Health in Virginia: Alignment, Accountability, and Access. Farley Health Policy Center, 2018. http://farleyhealthpolicycenter.org/wp-content/uploads/2018/07/Behavioral-Health-in-Virginia-2018.pdf Downloaded January 15, 2020.

Figure 2.7. Virginia Medicaid Recipients with BH Diagnoses



Even before Medicaid expansion became effective in Virginia in 2019, several initiatives from the state had been emerging which have allowed CSBs to undertake a gradual increase in capacity for services to persons with SMI and persons experiencing an SUD. Over the years, Medicaid Section 1115 demonstration projects have provided an opportunity for the Commonwealth of Virginia to: Expand eligibility to individuals who are not otherwise Medicaid or Children's Health Insurance Program (CHIP) eligible; provide services not typically covered by Medicaid; and use innovative service delivery systems that improve care, increase efficiency, and reduce costs without increasing federal Medicaid expenditure. Federal Section 1115 law permits the secretary of the Department of Health and Human Services (HHS) to approve experimental, pilot or demonstration projects that test and evaluate state-specific policy changes in Medicaid and CHIP programs to improve care, increase efficiency, and reduce costs without increasing federal Medicaid expenditures.

The Virginia Governor's Access Plan and Addiction and Recovery Treatment Services

As part of Virginia's DMAS 1115 Demonstration waiver in 2014, Virginia adopted a new initiative called *A Health Virginia*, which included a 10-step plan to expand access to care and improve care for veterans and individuals with SMI. The first step of the plan, titled The Virginia Governor's Access Plan (GAP), was a Medicaid plan launched in 2015 to provide limited medical and behavioral healthcare coverage for low-income individuals with SMI. By December 31, 2017 there were 13,857 individuals enrolled in Virginia GAP.[19]

[19] Virginia Department of Medical Assistance. 2018. The Virginia Governor's Access Plan (GAP), Addiction, and Recovery Treatment Services (ARTS) and Former Foster Care Youth (FFCY) Delivery System Transformation: Section 1115 Annual Report: Demonstration Waiver 1115. Demonstration Year 3 – 2017. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/Governors-Access-Plan-GAP/va-gov-access-plan-annl-rpt-2017.pdf. Downloaded March 29, 2020.

In December 2016, the 1115 demonstration was expanded to include Addiction and Recovery Treatment Services (ARTS), which expanded SUD benefits for all Commonwealth of Virginia Medicaid recipients eligible under the state plan to cover the full continuum of SUD treatment. The Commonwealth of Virginia's ARTS program has been impactful in creating an enhanced SUD benefit package and resulting in an increase in integrated services, buprenorphine-waived practitioners, and treatment for SUD and opioid use disorder (OUD). ARTS can also be attributed with playing a key role in the decrease in the number of emergency department visits related to SUDs and the increase in the number of outpatient (OP) providers, including those who prescribe buprenorphine for those with OUD. In the first year of the ARTS program, nearly 25,000 Medicaid beneficiaries used addiction-related treatment services, a 57% increase from the year before. Treatment for beneficiaries with SUD increased by 64% during the first year compared with the prior year. Treatment rates were higher for beneficiaries with OUD, at 63%, compared with rates for those with alcohol use disorder, at 30%.

Although the GAP ended in March 2019, the Virginia ARTS program continues to be extended. As part of the extension period, Virginia will be required to submit a revised new evaluation design to continue to evaluate the outcomes of the ARTS program for the upcoming demonstration approval period. As of January 2019, there were 22,157 people enrolled in the ARTS program[20].

STEP-VA Services and EBPs

In addition to expanding Medicaid under the ACA, Virginia has taken bold steps legislatively to strengthen its BH system of care and increase access to evidence-based care. In 2017, the General Assembly launched STEP-VA, which provides the Commonwealth with a long-term framework for improving community BHS available to all of the Commonwealth's residents. All 40 CSBs in Virginia are statutorily required to provide all STEP-VA services by July 2021. Key features of STEP-VA include: A uniform set of required services, a recommended suite of EBPs, consistent quality measures, and improved oversight. STEP-VA is based on national best-practice models that require the development of a set of deliberately chosen services that make up a comprehensive, accessible, patient-centered system for those with serious BH disorders.

BH Redesign

In 2019, Virginia set in motion its BH Redesign efforts, a systems-transformation approach for Medicaid services that seeks to integrate and improve access to high-quality, evidence-based, trauma-informed, and cost-effective BHS. Medicaid services under the Redesign would be phased in over a 4-year period and culminate in the spring of 2022. Phase 1 is set to launch in summer 2020 and includes a plan for high-intensity services for both adults and children; services that have a short-/medium-term impact on the state psychiatric facilities census; and services with an existing framework that can be expanded in scope. Other element of the Redesign efforts are described below. Key changes proposed to the continuum of care include:

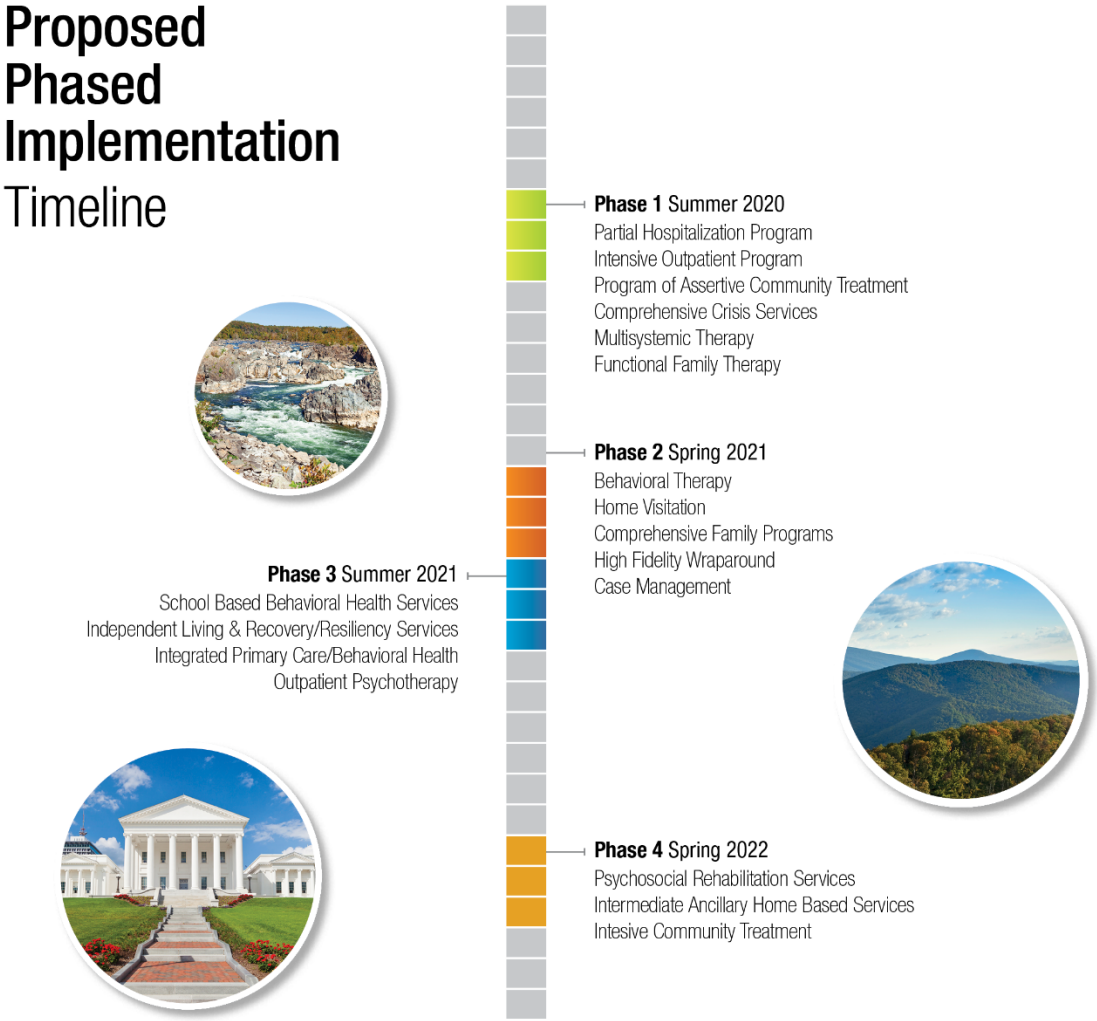
- More robust OP BHS that are integrated into schools and primary care (PC).
- Intensive community-based supports that are tiered based on the intensity of an individual's needs and include evidence-based best practices.
- Medicaid to fully fund comprehensive crisis services.
- A focus on trauma-informed care.
- Promotion of tele-mental health across levels of care[21].

[20] DMAS 2019. Virginia Department of Medical Assistance Services 2019. https://www.dmas.virginia.gov/#/accessdashboard Downloaded February 20, 2020.

[21] BH Redesign Updates May 2019. Virginia Medicaid Program. DMAS. file:///C:/Users/nslaughter/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/FDNGSBOB/redesign052219.pdf

Other initiatives addressed services and resources for new service delivery and funding opportunities for Medicaid members experiencing an SUD. These and ancillary resources provided in these initiatives have allowed CSBs to increase their capacity to provide some MH and SUD services; thus, when Medicaid expansion arrived in 2019, there had already been a limited influx of persons who would have been served under Medicaid expansion.

Figure 2.8. BH Redesign Efforts



Medicaid Expansion in Virginia

In May 2018, the Virginia General Assembly voted to expand its Medicaid State Plan under the ACA effective January 1, 2019. With this vote, Medicaid coverage became eligible to more than 400,000 low-income adults in Virginia earning up to 138% FPL (that is, $12,140 annually for a single person or $20,780 for a family of three). This historic vote extended Medicaid coverage to newly eligible adults, people with disabilities, pregnant women, and children in Virginia. It includes individuals who have not been eligible for Medicaid in the past, as well as individuals who were previously eligible for premium

subsidies and cost-sharing reductions under the ACA marketplace exchange—but now with lower out-of-pocket costs. It also qualified Virginia for a federal funding match of no less than 90% for all newly eligible adults[22]. Medicaid expansion is expected to provide an estimated $22.8 billion in additional federal funding to Virginia[23].

Workforce and Cost-Sharing Requirements

Virginia began negotiations with the Centers for Medicare & Medicaid Services (CMS) in 2018 on the Commonwealth's Section 1115 demonstration waiver application to add amendments to its Medicaid State Plan. The demonstration project, titled Virginia COMPASS: Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency, sought to implement work requirements and cost-sharing for eligible adults to enroll in Medicaid. Specifically, the demonstration waiver called for nondisabled adults to work or be enrolled in school or other community engagement activities to be eligible for Medicaid. Exemptions were included for specific populations, such as pregnant and postpartum women, children, the medically frail, and people with SMI. In December 2019, Virginia made the decision to halt its negotiation efforts with the federal government to adopt the Section 1115 waiver demonstration. With the recent change in the composition of the General Assembly, it is uncertain whether Virginia will move forward in pursuing this Section 1115 waiver demonstration for a work requirement and increased cost-sharing.

The state's waiver also incorporated new cost-sharing requirements, which have been implemented. Adults with incomes between 100% and 138% FPL would be required to pay a $5 per month premium for their Medicaid coverage or $10 per month if their income is between 126% and 138% FPL.

Increased Medicaid Enrollment

In the first year since expanding Medicaid, Virginia has seen a 47% increase in its monthly enrollment in Medicaid and CHIP from previous years[24]. As of February 15, 2020, a total of 388,615 adults were newly enrolled and receiving services under the state's new Medicaid eligibility requirements. According to Virginia's Medicaid dashboard of expansion enrollment data, roughly 70% of all newly enrolled adults (270,967) are below 100% of the FPL, indicating that a majority were ineligible for Medicaid in Virginia prior to Medicaid expansion.[25] A January 2020 report estimates that as many as 138,000 Virginians were previously in the coverage gap and ineligible for Medicaid or premium subsidies because their income was below 100% FPL and too low to qualify for Virginia Medicaid prior to expansion.[26] The remaining 30% of the newly enrolled adults (117,648) are between 100% and 138% FPL and are now eligible for low premium subsidies under Medicaid expansion.

[22] DMAS 2019. Virginia Department of Medical Assistance Services 2019. 2019 Medicaid at a Glance. https://www.dmas.virginia.gov/files/links/221/2019%20MAG%20Draft%20(01.07.2019).pdf Downloaded February 20, 2020.

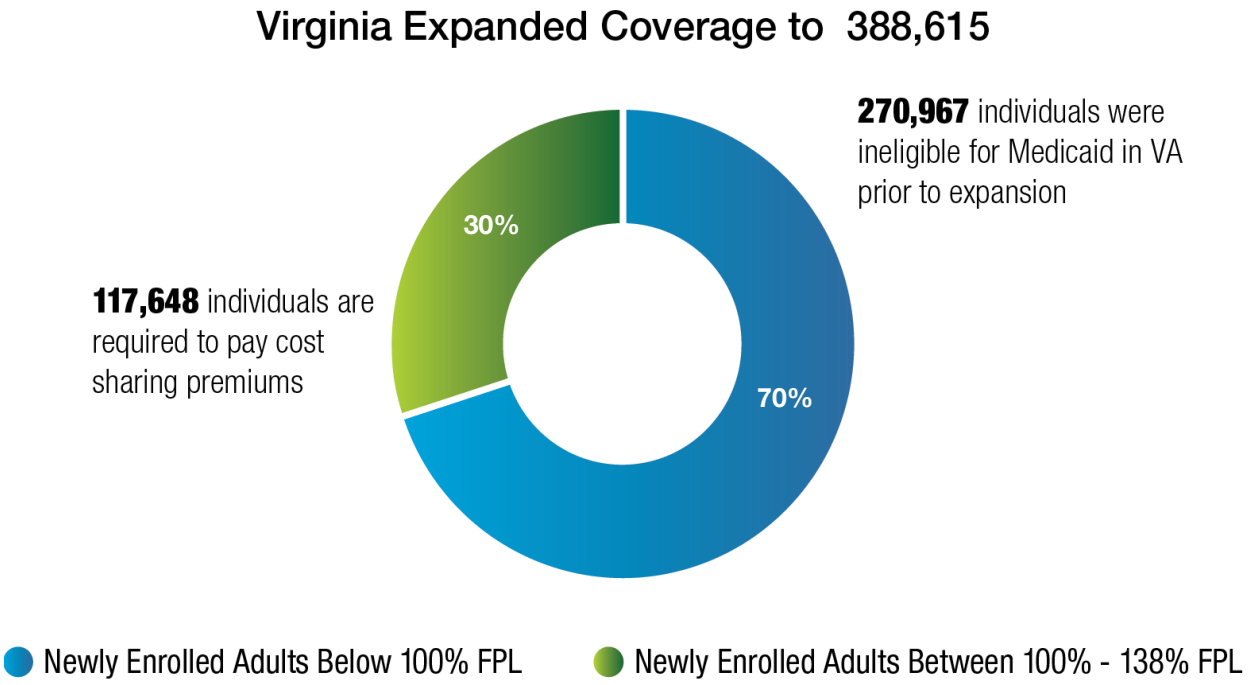
[23] Healthinsurance.org 2020. "Virginia and the ACA's Medicaid Expansion" 2020. New Health Coverage for Adults. https://www.healthinsurance.org/virginia-medicaid/ Downloaded February 20, 2020.

[24] Kaiser Family Foundation 2019. "State Health Facts: Total Monthly Medicaid and CHIP Enrollment." https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22virginia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D Downloaded January 15, 2020.

[25] Virginia Department of Medical Assistance Services. Expansion Dashboard: New Health Coverage for Adults. https://www.dmas.virginia.gov/#/dashboard. Downloaded February 20, 2020.

[26] Healthinsurance.org 2020. "Virginia and the ACA's Medicaid Expansion" 2020. New Health Coverage for Adults. https://www.healthinsurance.org/virginia-medicaid/ Downloaded February 20, 2020.

Figure 2.9. Newly Enrolled Adults in Medicaid Due to Expansion



Medicaid Expansion Financing and Spending

CMS, within HHS, is responsible for implementing Medicaid in partnership with states across the country. As a joint federal-state partnership, states must implement Medicaid in accordance with federal requirements that outline minimum benefits for states to cover through their Medicaid benefit package. States must operate within these federal standards in exchange for matching federal funds. In Virginia, DMAS administers the Medicaid program and distributes funding through six managed care organizations (MCOs) to the 40 CSBs and to private providers. DBHDS distributes federal and state allocated funds to the CSBs and performs regulatory oversight. Together, DMAS and DBHDS work collaboratively to support the CSBs in their delivery of BHS.

According to some estimates, Virginia had been missing out on as much as $142 million in federal funding every month since the start of 2014 as a result of not expanding Medicaid. This changed, however, when federal Medicaid expansion funding began to flow into the Commonwealth. For states that implemented Medicaid expansion through 2016, the ACA provided 100% federal funding to cover the costs of newly eligible enrollees. Federal funding was reduced to 93% through 2019, and starting this year, federal funding to states is reduced to 90%, where it will remain. This means that, in 2019, all participating states, including Virginia, began paying 7% of the cost through 2019. Going forward, all states, including Virginia, will be responsible for 10% of the cost of newly eligible enrollees.

Updates from the JLARC on Medicaid Enrollment and Spending

In December 2019, the JLARC of the Virginia General Assembly released findings on Virginia's Medicaid expansion enrollment and spending in FY2019. According to the report, Virginia spent $11.1 billion on Medicaid in FY2019 after projecting an estimated $11.6 billion in state Medicaid spending. The JLARC report points to two main reasons behind this reduced spending: 1) Lower than expected enrollment at the beginning of Medicaid expansion and 2) reduced general fund spending due to Medicaid expansion.

JLARC reports that in FY2019, enrollment in Medicaid expansion was 14% lower than projected during the first 6 months, accounting for roughly $140 million of the spending difference[27]. Second, Medicaid expansion reduced general fund spending by about $112 million, which was more than projected. JLARC also reported that spending growth in the base Medicaid program slowed during this time due to Medicaid expansion, but that expansion enrollment is currently keeping up with projections.

Table 2.4. Virginia Medicaid Spending in FY 2019

Medicaid Spending	Forecasted Spending	Actual Spending	Difference
Medicaid expansion	$1,094 million	$867 million	-$227 (-21%)
Base Medicaid	$10,544 million	$10,228 million	-$316 (-3%)
Total Medicaid	**$11.6 billion**	**$11.1 billion**	**-$543 (-5%)**

Medicaid Managed Care in Virginia

Federal standards outline the minimum required benefits for states to cover through their state Medicaid program. Although states must operate their program within these minimum federal requirements, states are given a great deal of latitude in how they design and operate their Medicaid benefit package. For example, states have the flexibility to expand eligibility, change benefits and impose cost-sharing requirements on enrollees.

Just as important as having the flexibility to determine the amount, duration, and scope of covered benefits, states also have the latitude to implement the type of payment and delivery structure they wish to implement to serve their Medicaid enrollees. Federal requirements allow states to choose a fee-for-service payment system, a PC case management model, or capitated managed care plans. Federal requirements do not address how states structure their delivery system; however, if a state uses a managed care payment and delivery model, it must meet certain standards related to plan choice and provide certain consumer protections.

MCOs in Virginia: An Evolving Landscape

In response to escalating healthcare costs, emergency room utilization, and physician reluctance to treat Medicaid patients, Virginia launched its first Medicaid PC case management program called Medallion in late 1991. The Medallion managed care model, which began as a pilot program in five counties, was expanded statewide in 1995. Soon after, the Options Program was established allowing Medicaid recipients the option to choose coverage from among a variety of Medicaid MCOs in select areas of the Commonwealth. This was the first time MCOs were used in the Medicaid program in Virginia. In 1996, Medallion II MCO took effect and was gradually expanded across Virginia, making it one of the first states to expand program eligibility to cover aged, blind, and disabled beneficiaries. By 2001, there were seven MCO partners in the Medallion II program and three in Medallion 3.0. The newest version, Medallion 4.0, was launched on August 1, 2018[28].

Today, Virginia has awarded contracts with six statewide MCOs to manage and oversee the payment and delivery of Medicaid-reimbursed services throughout the Commonwealth. These MCOs are Aetna Better Health, Anthem HealthKeepers Plus, Magellan Complete Care, Optima Health, United Healthcare Community Plan, and Virginia Premier.

[27] JLARC 2019. JLARC December 2019. Medicaid Enrollment and Spending FY 2019. http://jlarc.virginia.gov/pdfs/presentations/HHR_Medicaid_Enrollment_Spending.pdf Downloaded January 17, 2020.
[28] Healthinsurance.org 2020. "Virginia and the ACA's Medicaid Expansion", 2020. https://www.healthinsurance.org/virginia-medicaid/ Downloaded January 10, 2020.

Virginia Premier and Optima Health – A New MCO Partnership

Having served in Virginia as a Medicaid provider since 1995, Virginia Premier is unique in that it is the first and only nonprofit MCO in the Commonwealth. In addition to Medicare, Medicaid, and health insurance exchange plans, Virginia Premier provides third-party administrative services and operates the Virginia Premier Neighborhood Health Clinic in Roanoke. It is a wholly owned subsidiary of Virginia Commonwealth University (VCU) Health System. In September 2019, Optima Health, a wholly owned subsidiary of Sentara Healthcare, became majority owner of Virginia Premier. Going forward, VCU Health System will retain a 20% ownership stake in Virginia Premier, but the two will continue to operate as two separate companies and retain their respective names and brands in the marketplace. Together, the plans will serve an estimated 800,000 members. The transaction is expected to be finalized by the spring of 2020[29]. As this partnership materializes, it will be important to track the effectiveness and impact on Virginia's Medicaid delivery system, particularly the impact on the CSBs, Medicaid enrollees, and other service providers contracted with these MCOs in Virginia.

It is important to note that in order for Virginia's MH and SUD programs to be successful, including STEP-VA and BH Redesign efforts, there must be reasonable alignment with the six MCOs currently contracted with the state to oversee the payment and delivery of all Medicaid-reimbursed services to CSBs and other providers, particularly with regards rate setting.

"I'm not for sure how they're going to do it with Behavioral Health Redesign. I'm concerned about that because we've been trying to tell them all these services … have to line up. So, when you talk about mental health, [substance abuse] services, which are the primary services that we provide from a clinical outpatient standpoint, we must make sure we get it right. So, we have been on them saying we want to be involved." (Rural, small budget CSB)

[29] VCU 2019. VCU News. "VCU Health System and Optima Health agree on joint ownership of Virginia Premier Health Plan". September 2019. https://news.vcu.edu/article/VCU_Health_System_and_Optima_Health_agree_on_joint_ownership . Downloaded January 18, 2020.

3. METHODOLOGY

The JBS Team used a mixed-method data collection approach for the needs assessment with a variety of quantitative and qualitative data sources considered for inclusion.

3.1 Overview of Quantitative Data Collection

To guide selection of existing or secondary data sources and development and refinement of instrumentation, the JBS Team, made up of JBS International, Inc. (JBS) and our partners OMNI Institute (OMNI) and Cansler, worked in collaboration with, and incorporated feedback from DBHDS and then conducted pilot testing of instrumentation developed for the needs assessment with CSB staff members and consumers. The following sections present full descriptions of the data collection tools used for the needs assessment.

Existing or Secondary Quantitative Data Sources

Several existing data sources or secondary data were used within the needs assessment. Below is a description of the existing or secondary data sources used to support the needs assessment.

Virginia Community Consumer Submission 3 Data System

The Community Consumer Submission 3 (CCS 3) provides consumer-level data for all individuals receiving services from CSBs, including:

- Demographic data.
- Clinical service data and outcomes.
- Data on utilization of services provided, including MH, developmental, SUD, emergency, and ancillary services.

Secondary Quantitative Data Sources
American Community Survey (ACS)
National Survey of Children's Health (NSCH)
National Survey on Drug Use and Health (NSDUH)
Youth Risk Behavior Surveillance System (YRBSS)
Behavioral Risk Factor Surveillance System (BRFSS)
Uniform Reporting System (URS)

DBHDS, in partnership with CSBs, use the CCS 3 to comply with federal and state reporting requirements, including those in the federal substance abuse Treatment Episode Data Set and federal MH and Substance Abuse Prevention and Treatment Block Grants (MHBG/SABG); to submit data to state funding sources; and to produce consumer-level data about the performance of the public MH, developmental, and SUD services system. Virginia's CARS is the financial reporting system for CSBs. It provides fiscal data showing revenues by source and expenditures and costs by services provided. CARS also provides data on the individuals receiving *consumer-run services*, which include traditional clinical or treatment services provided in informal settings that are designed to support individual empowerment. CCS 3 data collected from state FY2013 and FY2019 was examined to address key areas for the needs assessment.

ACS

The ACS and U.S. Census describe the sociodemographics of the population of Virginia. The full U.S. Census is updated every 10 years and counts every person living in the 50 states, District of Columbia, and the five US territories. The ACS is updated annually and is collected from a sample of addresses. Responses from the ACS are used to generate estimates that describe the entire community population.

The JBS Team used data from the 2017 ACS for conducting analyses estimating prevalence and need and for examining population growth and the demographics of people living in Virginia.

NSCH

The NSCH is sponsored by the Health Resources and Services Administration's Maternal and Child Health Bureau. Starting in 2016, this survey has been administered annually by the U.S. Census Bureau to a sample of noninstitutionalized children in the U.S. ages 0–17 years[30]. The NSCH examines the physical and emotional health of children ages 0–17 years. Special emphasis is placed on factors related to the well-being of children. These factors include access to and quality of health care, family interactions, parental health, and neighborhood characteristics as well as school and after-school experiences. The NSCH is also designed to assess the prevalence and impact of special health care needs among children in the United States and explores the extent to which children with special health care needs have medical homes, adequate health insurance, access to needed services, and adequate care coordination. Other topics may include functional difficulties, transition services, shared decision making, and satisfaction with care. Information is collected from parents or guardians who know about the child's health. For this report, state-level data from the 2016–2017 Virginia NSCH were used to assess the prevalence of flourishing in children; the prevalence, severity, and behavioral treatment for attention-deficit disorder or attention-deficit/hyperactivity disorder; and the prevalence of ACEs. Demographic subpopulation data included gender, race/ethnicity, and age categories (depending on indicator).

NSDUH

The NSDUH is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population age 12 years or older and includes MH issues and MH service utilization for adolescents ages 12–17 and adults age 18 or older[31]. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless persons who do not live in shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. NSDUH employs a state-based design with an independent, multistage area probability sample within each state and the District of Columbia, which allows for state-level estimates. Approximately 70,000 interviews are completed each year.

The JBS Team used the NSDUH public use dataset to provide comparisons of national estimates of substance abuse and treatment need among key populations of interest (including adults experiencing SMI; youth under age 18 experiencing SED; and youth and adults reporting SUDs, co-occurring disorders, or general MH problems with co-occurring SUDs). Throughout the report, the most recent year(s) of available data were presented[32]. NSDUH data from 2009/2010 to 2016/2017 was used to assess trends in SUDs, MH, and need for BHS. Demographic subpopulation data included age groups (12–17 years, 18–25 years, and 26+ years) and five geographic regions: Northwestern Virginia (Region

[30] Prior to 2016, the survey was administered in 2003, 2007, and 2011/12 by the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC).

[31] https://nsduhweb.rti.org/respweb/homepage.cfm

[32] Most estimates represent combined years of data. The most recent year of available data varies depending on the indicator and subpopulation presented. The most recent state-level data are annual averages from 2016–17 NSDUHs. Regional data depends on the indicator, with some data available through 2014–16. See https://www.samhsa.gov/data/report/2014-2016-nsduh-overview-and-summary-substate-region-estimation-methodology for details.

1), Northern Virginia (Region 2), Southwestern Virginia (Region 3), Central Virginia (Region 4), and Eastern Virginia (Region 5).

YRBSS

The YRBSS consists of surveys administered to high school and middle school students across the United States as a part of an initiative funded by the CDC to monitor the prevalence of health and risk behaviors of students[33]. The Youth Risk Behavioral Survey (YRBS)[34] is a 53-item survey developed by the CDC to evaluate risk behaviors among school-based youth ages 11–17 across the United States who attend public and private high schools. The YRBS provides data on youth experiencing SED, including experiences of depressive symptoms, suicidal ideation, and substance use. The YRBS includes state, territorial, tribal, and local school-based surveys of high school students. In Virginia, the YRBS is also known as the *Virginia Youth Survey* and is administered every 2 years (biennially), during the spring, to a randomly selected sample of students in Virginia public schools[35], with students completing a self-administered, machine-readable questionnaire during a regular class period.

BRFSS

The BRFSS[36] is cross-sectional telephone survey conducted annually by state health departments with support from the CDC. The BRFSS survey was developed by the CDC to collect data on health and risk behaviors as well as preventative health practices about U.S. residents who are 18 years and older. Each year, states have flexibility to add optional modules that are relevant to their state priorities. Starting in 2016, the Virginia Department of Health (VDH) chose to include questions about ACEs as a part of the survey. For this report, state-level data from the 2017 Virginia BRFSS were used to report on the prevalence of ACEs among adults 18 and older. Demographic subpopulation data included gender and race/ethnicity.

URS

The URS is a state, national, and territories reporting system used to track individual state performance over time and to develop a national picture of the public MH systems of the states and territories[37]. Data are collected annually from State Mental Health Authorities, with support from SAMHSA, and include the sociodemographic characteristics of clients served by the states and territories, outcomes of care, use of selected EBPs, client assessments of care, insurance status, living situation, employment status, and readmission to state and territorial psychiatric hospitals within 30 and 180 days. The JBS Team reviewed 2018 URS output tables[38] to examine state hospital access, cost, and utilization data for the Commonwealth of Virginia in comparison to neighboring states, states who have also expanded Medicaid, and states with a similar general population to Virginia.

Data Access

ACS, NSCH, NSDUH, and URS public use data were accessed online using the guidelines and protocols set forth by each data source. YRBS and BRFSS data were provided by the VDH via data request.

[33] https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
[34] Also known in Virginia as the Virginia Youth Survey.
[35] http://www.vdh.virginia.gov/virginia-youth-survey/
[36] Also known in Virginia as the Virginia Adult Health Survey
[37] https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system
[38] https://www.samhsa.gov/data/report/2018-uniform-reporting-system-urs-output-tables

Data Quality Assurance Protocol—Prevalence Estimates

A list of BH indicators was drafted by data source and by available subpopulations (e.g., region, gender, race/ethnicity). Data shells were created for each indicator and populated with data from each of the secondary data sources described above. The resulting datasets were reviewed by a data analyst for accuracy. Where available, prevalence estimates were compared with the Virginia Social Indicator dashboard (omni.org/vasis) as a secondary data quality check. Datasets were used to describe prevalence estimates and to create tables and charts included in the prevalence section of this report.

Primary Quantitative Data Collection Tools

Although existing or secondary data were used to describe consumers served by the CSBs, service provision, and assessment of prevalence and need, the JBS Team developed instrumentation to assess perceptions from CSB staff and consumers regarding service provision and capacity, infrastructure, and funding. The following sections present tools developed to support quantitative data collection for the needs assessment.

Administrator Pre-Site Survey

The administrator pre-site survey was designed to collect quantitative information on several key aspects of the CSBs, including:

- Services,
- Practices,
- Staffing,
- Funding sources used to support service delivery,
- Progress with implementation of STEP-VA services and practices,
- Perceived service capacity and funding sufficiency, and
- Perceptions regarding the CSB's use of continuous quality improvement (CQI) and quality assurance (QA) practices.

The CSB Executive Director or other administrative staff point of contact was asked to complete the survey prior to participating in the site visit to (1) ensure that quantitative information on key content areas of interest were captured for their CSB and (2) inform key informant interviews and focus groups with CSB staff and consumers. The administrator pre-site survey was emailed to the identified administrative staff point of contact in advance of the scheduled CSB site visit. As the CSB administrative staff point of contact often needed time to obtain the requested quantitative information from other CSB staff (e.g., funding information from the Fiscal Director), the administrator survey was sent up to 2 weeks in advance of the onsite visit. The CSBs were instructed to complete the survey electronically and email it to the JBS Team prior to the scheduled site visit for review and data entry. Administrative staff from all 40 CSBs completed the pre-site survey.

Prevention Director Brief Survey

The prevention director brief survey was designed to collect quantitative information on several key aspects of the CSBs, including prevention services provided, prevention programming reach, and funding sources used to support service delivery. In addition, the prevention director survey also asked respondents to provide the names and contact information of one prevention service provider to participate in a virtual focus group for prevention staff to discuss facilitators and barriers to provision of prevention services.

The CSB Director of Prevention Services or other prevention services administrative staff was asked to complete the online survey prior to participation in the prevention director virtual focus group to (1) ensure that quantitative information on key content areas of interest were captured for their CSB, (2) inform the virtual focus group discussion with Prevention Directors, and (3) facilitate recruitment of prevention services staff for the prevention service staff virtual focus group. The prevention director survey was administered using SurveyMonkey, an online survey tool, and a URL link to complete the online survey was emailed to identified staff in advance of the scheduled virtual focus group. Thirty-nine Prevention Directors from 39 CSBs completed the prevention director survey.

Prevention Service Provider Survey

The prevention service provider brief survey was designed to collect quantitative, demographic, and background information about prevention service providers and their perspectives on several key aspects of the CSBs, including prevention services provided, prevention programming reach, access to services, delivery of prevention services, professional development and supervision, and satisfaction with the CSB. In addition, the prevention service provider survey also asked respondents to provide the names and contact information of one coalition leader or active coalition member to participate in a virtual focus group with coalition representatives to better understand (1) the role of coalitions in the Virginia prevention system and (2) facilitators and barriers to provision of prevention services.

The designated CSB prevention service provider was asked to complete the online survey prior to participation in the prevention director virtual focus group to (1) ensure that quantitative information on key content areas of interest were captured for their CSB and (2) inform the virtual focus group discussion with prevention service providers. The prevention service provider survey was administered using SurveyMonkey, and a URL link to completing the online survey was emailed to identified staff in advance of the scheduled virtual focus group. A total of 40 prevention service providers from 35 CSBs completed the survey.

Direct Service Provider Focus Group Survey

The direct service provider focus group survey is a paper-and-pencil measure that was used to collect demographic and background information about direct service providers or staff who participated in the focus groups. The survey was also designed to elicit their perspectives on access to services, service delivery, professional development and supervision, and satisfaction with the CSB. The direct service staff focus group survey was administered and collected prior to their participation in the focus group discussion.

A total of 329 providers participated in the focus groups, and 320 providers from 38 CSBs completed the survey. The JBS Team used means, counts, and aggregate frequency statistics to provide descriptive and summary information for the 320 direct service provider focus group participants who completed surveys.

Consumer Focus Group Survey

The consumer focus group survey is a paper-and-pencil measure that was used to collect demographic and background information about clients or consumers who participated in the focus groups, and their perspectives on access to services, receipt of services, relationship with their providers, and satisfaction with delivery of services from the CSB. Approximately 1.5 months into data collection activities, 12 items were removed from the original 37-item survey to facilitate completion by consumers who demonstrated challenges with completing the original survey. The client focus group survey was administered and collected prior to beginning the focus group discussion.

A total of 291 consumers participated in the focus groups, and 276 consumers from 39 CSBs completed the survey. Again, the JBS Team used means, counts, and aggregate frequency statistics to provide descriptive and summary information for 276 client focus group participants.

3.2 Overview of Qualitative Data Collection

Although the JBS Team (made up of JBS as well as our partners OMNI and Cansler) used existing or secondary data to support many of the core components of the needs assessment, existing data was not available to answer all questions of interest. To address this, the JBS Team visited 40 CSBs and conducted semistructured interviews and focus groups with key informants and consumers to address currently existing data gaps and collect qualitative data from multiple perspectives on CSB delivery systems, consumer services, infrastructure, workforce development, funding, and quality improvement and assurance.

CSB Site Visits

The JBS Team conducted site visits with all 40 CSBs between late June 2019 and October 2019. Site visits lasted for 2 days, and between two and four JBS Team members participated in each site visit. Prior to conducting site visits, the JBS Team implemented several QA procedures to ensure that interview data was collected consistently and efficiently.

Pre-Site Visit Preparation. To prepare for onsite visits to CSBs, all JBS Team members and consultants scheduled to participate in data collection activities during the onsite visits received training. The training covered project background, protocols for conducting onsite visits, and site visit activities. Prior to each site visit, a series of planning meetings took place by telephone and Zoom video conferencing. During these calls, a point of contact for each CSB was established, pre-site preparation information was shared by JBS (e.g., mock agenda, list of key interviewees, focus group planning information), and CSBs provided requested materials to JBS (e.g., organizational charts, completed agendas). In addition, these preparation calls provided a forum for any questions CSBs had prior to the site visit.

Onsite Activity. During the onsite visits, team debrief meetings were conducted at the end of the first day of each site visit to share information among team members and to aid in the understanding of information gathered from the interviews.

Post-Site Visit. Following each site visit, JBS Team members were instructed to upload all audio files to the JBS server (consultants were provided a location to upload their audio files). An assigned staff member tracked uploaded audio files in an Excel tracking sheet and sent selected audio recordings for transcription. Next, "thank you" emails were sent to each CSB primary point of contact. Lastly, individual CSB site visit reports were created following each site visit using interview notes and information synthesized during the site visit (See Appendix L for a sample site visit report).

Key Informant Interviews. During all site visits, team members collected qualitative data via semistructured key

CSB Key Informants:

1. Board President or designee
2. Executive Director
3. Medical Director
4. Clinical Director–MH Treatment Services
5. Clinical Director–Substance Abuse Treatment Services
6. Director of Prevention Services
7. Director of Recovery Program Services
8. Director of Housing Services
9. Director of Children's Services
10. Director of Women's Services
11. Director of Information Technology (IT) Services
12. Fiscal Director
13. Peer Recovery Support Staff

informant interviews with CSB leadership and administrative staff members. DBHDS requested that CSB staff with the following roles (see text box) be interviewed and/or surveyed to capture multiple perspectives on CSB delivery systems, QA, consumer services, infrastructure, workforce, and funding to support BHS.

Key Informant Interview Guides. To ensure consistency in data collection, the JBS Team used 13 separate semistructured interview guides to facilitate the interviews. Guides included core questions asked of each respondent, as well as questions specific to staffing category. All guides included a brief overview of the purpose and goals of the needs assessment, brief discussion of strategies to protect the confidentiality of interviewees, and a script for obtaining verbal consent to participate in the interview. In addition, each guide included questions that cannot be obtained through existing or secondary quantitative data sources. Interview guides addressed the following content areas: CSB involvement (e.g., staff role), capacity, workforce, funding (e.g., funding streams and allocation of funding sources), outcome information (systems for measuring and using clinical outcomes of care and recovery support), CQI, STEP-VA (e.g., readiness and capacity for delivery of required elements), Medicaid, access to services (e.g., client services are available and within a reasonable timeframe), delivery of care and recovery support, and related barriers and facilitators. The 13 guides are in Appendix G.

Client and Direct Staff Focus Groups. During each of the 40 site visits, team members also collected client and direct staff data via two separate focus groups conducted at each CSB. Client focus group participants were recruited by a designated client focus group recruiter (e.g., the CSB's Executive Director or other point of contact) who was asked to identify up to 10 clients to participate in the focus group based on service type (e.g., MH, SUD) and treatment type (e.g., inpatient, OP). Family members of clients were also invited to participate. The JBS Team provided a lunch or dinner (e.g., sandwiches, pizza) as a token of appreciation to focus group participants.

Client and Direct Service Staff Focus Group Guides. To ensure consistency in data collection, two semistructured focus group guides were utilized to facilitate the focus groups. Guides included a brief discussion of strategies to protect the confidentiality of interviewees and a script for obtaining verbal consent to participate in the interview. The purpose of the client focus groups was to obtain the perspectives of a sample of clients and their family members regarding their experience with access to services, client satisfaction, and experiences/results of recovery support services. The purpose of the direct staff focus groups was to obtain the perspectives of a sample of direct staff regarding their involvement with service delivery, accessibility of services, and their own provider experiences.

Similar to the semistructured interview guides, the client and direct service focus group guides provided an overview of the purpose and goals of the focus groups, followed by a series of questions and probes outlining the types of information to be gathered in the focus group. In addition, the JBS Team used a brief survey (Appendix B) in conjunction with the client and direct service staff focus groups guide to collect feedback, background, and demographic information about focus group participants (see Section 4.6, for more information).

Virtual Focus Groups With CSB Prevention Staff and Coalition Members

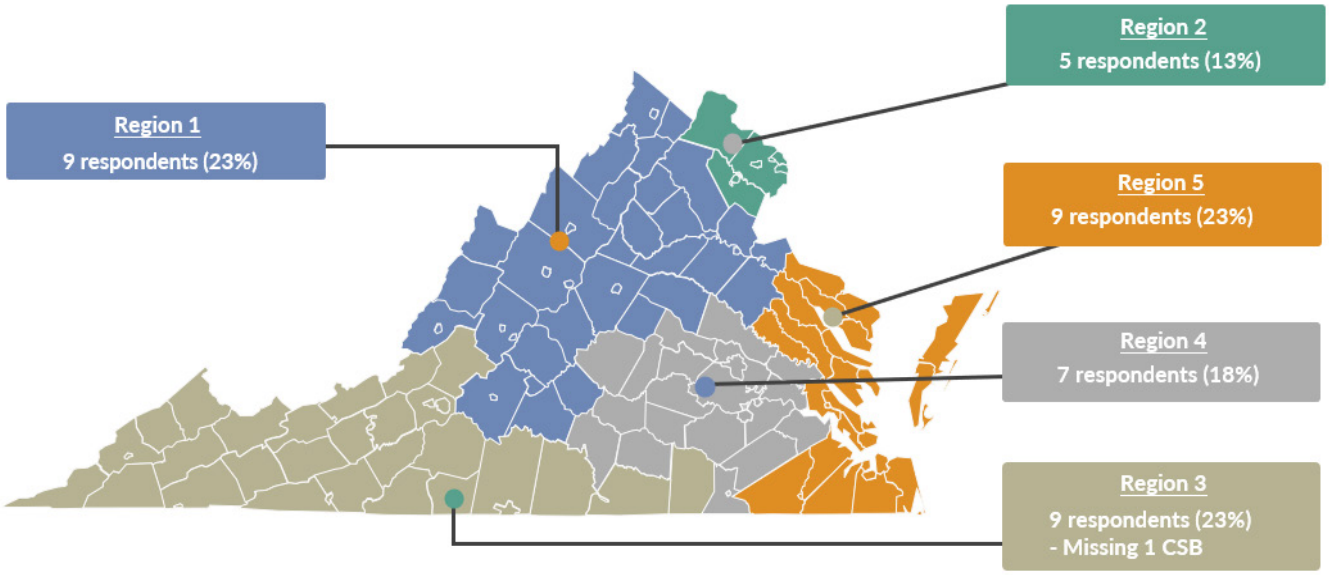
Surveys

Five virtual focus groups were conducted site visits with CSB prevention staff and coalition members between late October and early December 2019 with participants from across the five regions of Virginia. As part of the preparation for the focus groups, two surveys (the prevention service provider survey and the prevention director brief survey) were developed to assess the characteristics and

experiences of CSB Directors and staff members who engage in delivering, planning, and evaluating prevention services, including their perceptions of the effectiveness of their CSB to affect BH in Virginia. CSB Directors were first surveyed and subsequently nominated staff members from their CSB to receive the second survey using a snowball sampling approach.

CSB Directors answered a 10-question online survey using the SurveyMonkey data collection platform. The survey was sent to all 40 CSBs across the five regions in the Commonwealth of Virginia. A total of 39 of 40 CSBs (98%) were represented from all regions. Figure 3.1 shows the geographic distribution and responses to the survey among Prevention Directors.

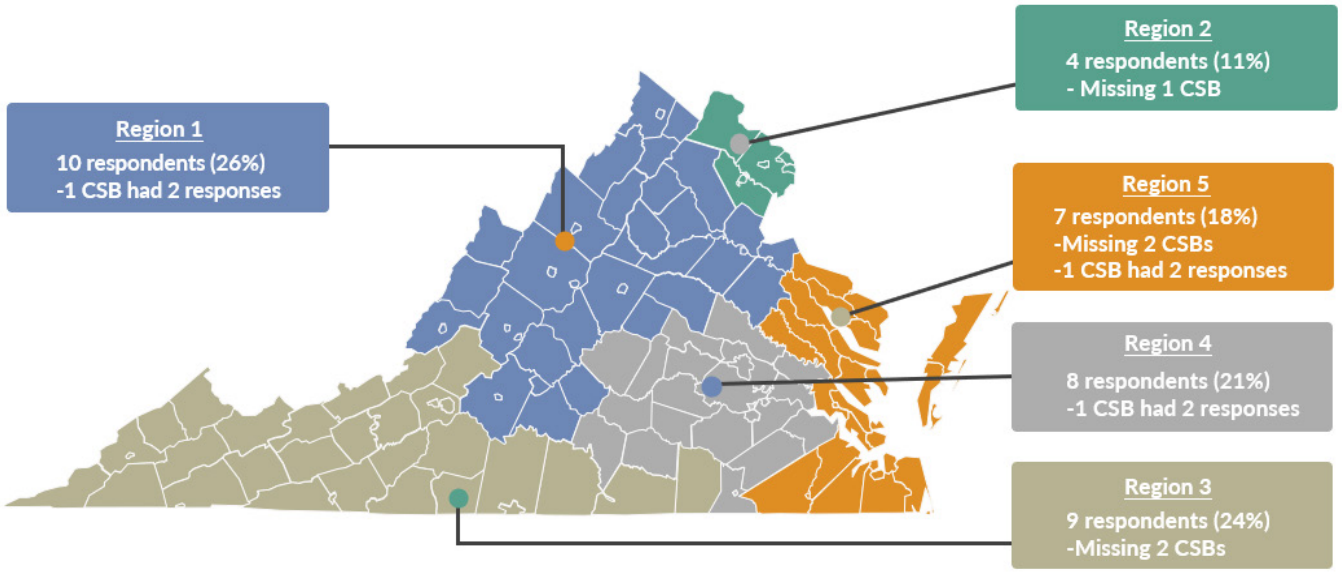
Figure 3.1. Prevention Director Survey Distribution and Response



Following the Director survey, 38 CSB prevention staff members representing 35 CSBs participated in the prevention staff survey[39]. This survey included 43 questions and was deployed online using SurveyMonkey as the data collection platform. Please see Appendix E for additional demographic information on CSB prevention staff who participated. Figure 3.2 shows the geographic distribution and responses to the survey among prevention staff.

[39] Thirty-eight total staff members responded, three CSBs were represented by two staff members, and five CSBs were not represented.

Figure 3.2. Prevention Staff Survey Distribution and Response



Survey data were cleaned and analyzed using SPSS® software. CSBs were coded as representing primarily urban or rural areas, using the 2017 CSB population estimates from the University of Virginia's Weldon Cooper Center for Public Service, which identified urban areas as having 200 or more people per square mile. Frequency level analyses were performed on all variables. Additional frequency level analyses were performed after splitting the data by urban/rural status in order to identify any key differences between CSBs serving these different types of geographic areas.

Focus Groups

CSBs. Between late October and early December 2019, five 1.5-hour long virtual focus groups were conducted. Participants (n=35) were CSB Directors, managers, and staff members from across all regions of Virginia whose role in their CSB pertained to prevention of BH disorders. Participants' roles in their CSB included prevention-related work such as planning, program implementation, community engagement, campaign or program development, supervisory positions, and others. The purpose of the focus group was to better understand the strengths, challenges, and capacity of CSB prevention staff to engage in prevention work. The focus group guide was adapted from a broad set of questions used to guide qualitative data collection at CSB site visits (See Appendix J for focus group guides).

Participants were identified through a snowball sampling technique. In a preceding needs assessment survey, CSB Directors nominated at least one participant from their CSB (some nominated themselves) to participate in a focus group. OMNI researchers then recruited participants into focus groups stratified by position level, with three groups for CSB Directors and two groups for CSB prevention staff. The focus groups were conducted virtually using Zoom teleconferencing platform (www.zoom.us/). One OMNI researcher moderated the focus group while another took notes and coordinated technical matters. Both researchers were visible via webcam in a conference-call style meeting. Participants were able to connect using either their computers or telephones and were encouraged to enable their cameras to better simulate an in-person focus group. Participants provided their verbal consent to having the focus group recorded for transcription purposes; were instructed that their participation in the focus group was voluntary and confidential; and were told that any identifying information provided in the focus group (e.g., staff and CSB names, locations) would not be included in any reports and responses would be aggregated.

Coalitions. Two additional focus groups were conducted in late November and early December 2019 using the same methodology for members from CSB-affiliated coalitions that engaged in community BH prevention work. The participants (n= 11) were similarly identified, this time from nominations from a survey of the CSB prevention staff focus group participants. Some coalition members were also CSB Directors and staff, although there was no overlap in participants across the CSB prevention staff and coalition member focus groups. The coalition focus group question prompts were generated from the CSB prevention staff focus group protocols and were similar in nature (i.e., prevention related) but tailored to assess the needs and dynamics of and services provided from coalitions affiliated with a CSB.

Analysis. Focus groups were audio recoded, transcribed, and formally coded using a qualitative analysis software (Dedoose). The coding schema was designed to capture themes and subthemes related to question areas, in addition to any emergent themes. Because of the small number of total groups, all CSB focus groups were coded together for common themes. However, analyses focused attention on various possible key differences when relevant, such as role within CSBs and coalitions, rural vs urban issues, and specific subgroup examples (e.g., the challenge of delivering prevention services when a military base is part of a CSB's locality).

Coalition focus groups were coded using a similar coding schema as CSB focus groups, as both sets of questions overlapped. Because of the similarity in themes in many cases, coalition focus group findings were integrated within the sections for themes raised by CSB focus group participants (headers and descriptive language are used to make it clear when themes were raised by CSB prevention staff and coalition members).

Interviews With DBHDS Staff

The JBS Team conducted two site visits with DBHDS in December 2019 to interview DBHDS departmental directors and staff, internal partners and external stakeholders who participate in a variety of roles to support the CSBs in implementing BHS in Virginia. Two JBS Team members and a researcher from OMNI participated in the DBHDS site visit which included two onsite visits to DBHDS on December 11–12 and December 16–17, 2019. Prior to conducting the DBHDS site visit, the JBS Team implemented quality control procedures to ensure that interview data was collected consistently and efficiently. In preparation for the onsite visit to DBHDS, the JBS Team collaborated with DBHDS to identify appropriate staff for onsite interviews. A draft agenda, list of key interviewees, and overview of interview topics were developed by the JBS Team and shared with DBHDS prior to the site visit. During the onsite visits, team debrief meetings were conducted to share information among team members and to aid in the understanding of information gathered from the interviews.

Qualitative data were collected during the onsite visits via semistructured key informant interviews with

DBHDS Key Informants:

1. Acting Deputy Commissioner of BH
2. Director, Office of Adult Community Services
3. Director, Office of Community Housing
4. Program Specialist, Office of Adult Community Services
5. Project Manager, Performance Contracts
6. Project Manager, STEP-VA
7. Senior Financial and Policy Advisor
8. Acting Deputy Commissioner of BH
9. Director, Office of BH Wellness
10. Director, Office of Recovery Services
11. Director, Office of Child and Family Services
12. Program Specialist, Office of Recovery Services
13. Program Specialist, Office of BH Wellness
14. Coordinator of Veterans Affairs
15. Substance Abuse and MH Evaluator
16. Special Projects Coordinator
17. Director of Licensing

External Stakeholders and Partners:

18. Executive Director, Mental Health America of Virginia
19. Acting Executive Director, National Alliance on Mental Illness Virginia

DBHDS departmental directors and staff, internal partners and external stakeholders. DBHDS requested that staff and stakeholders with the following roles (see text box) be interviewed to capture multiple perspectives on Virginia's BHS delivery system.

To facilitate the onsite interviews and ensure consistency in data collection, the JBS Team used a semistructured interview guide (Appendix H) with questions tailored to the roles and responsibilities of DBHDS directors, administrative staff and external partners. The guide included a brief overview of the purpose and goals of the needs assessment, brief discussion of strategies to protect the confidentiality of interviewees, and a script for obtaining verbal consent to participate in the interview. The interview guide addressed the following content areas: Capacity, workforce, resource and funding adequacy, CQI, STEP-VA (e.g., CSB readiness and capacity for delivery of required elements and DBHDS readiness and capacity to support CSBs), communication and data needs, Medicaid and Medicaid managed care, access to services, and related barriers and facilitators. Following the site visit, JBS Team members uploaded all audio recording files to the JBS server. All audio files were tracked and uploaded by an assigned JBS staff member in an Excel tracking sheet and sent for transcription.

3.3 Methods for Data Review and Analysis

Qualitative Analysis Strategies

Below, we describe the qualitative data sources and procedures for analysis of qualitative data, including the transcription, coding, and analysis.

Description of Qualitative Data Collected

Per the Qualitative Methodology section above, in-person site visits were conducted with all 40 CSBs in Virginia. Key informant interviews were conducted with selected administrative staff and direct staff members and were audio recorded with permission of the interviewee(s). A total of 473 individual interviews were conducted with 479 individual interviewees. Of the 473 interviews conducted, recordings were obtained for 422 of the interviews.

A total of 80 focus groups were conducted (i.e., 40 with direct service staff and 40 with clients). Focus groups were conducted with a total of 329 direct service staff members and 290 clients. Of the 80 focus groups conducted, 68 were audio recorded.

Qualitative Data Subject to Analysis

To support the qualitative data review, the JBS Team transcribed 272 selected recorded individual interviews. Using qualitative analysis software (MAXQDA), we selected interviews from Executive Directors and Fiscal Directors to be coded to maximize exploration of qualitative data within the brief project timeframe for data collection and analysis. The JBS Team used its notes for interviews without an audio-recording.

In addition, a JBS Team analyst coded the 40 CSB site visit reports that were created individually for each CSB, based on the findings from their site visit to obtain themes around barriers and facilitators.

With DBHDS approval, the JBS Team decided that only notes taken during focus groups with CSB direct service staff and clients, respectively, would be reviewed to provide contextual information. Audio recordings were available for notetakers for later review and confirmation of the accuracy of

notes taken. Notes from focus groups with these staff and clients were reviewed and summarized separately in order to obtain themes.

Analysis of Key Informant Interview Data

The JBS Team took several steps to analyze qualitative interview data, including data preparation, coding, and analysis.

Preparation of Interview Data for Analysis. Audio recordings of selected key informant interviews were submitted for transcription. After interviews were transcribed verbatim, the JBS Team placed each interview transcript into MAXQDA, the qualitative data software program that facilitated the systematic analysis of the Executive Director and Fiscal Director interview data. Each transcript provided raw data for qualitative analysis. An analyst then entered and coded the transcripts in MAXQDA.

Coding of Qualitative Data. The JBS Team developed a codebook for the deductive coding process that contained predefined descriptive codes and their operational definitions based on the needs assessment questions and tasks.

Codes (and subcodes) that were used as part of the analysis task for the Executive Director and Fiscal Director interviews included:

- **Funding**
  - Facilitators
  - Challenges
  - Funds used to support provision of BHS
  - Funding sufficiency
- **Medicaid**
  - Medicaid challenges
  - Medicaid MCOs
  - Medicaid expansion

Codes (and subcodes) that were used as part of the analysis task for the individual reports included:

- **Facilitators**
  - Availability of services
  - Staff characteristics and support
  - Workforce training/professional development
  - Funding facilitators
  - Partnerships and community support
  - Client satisfaction
  - STEP-VA implementation
- **Barriers**
  - Workforce inadequacy and staffing issues
  - Professional development and training challenges
  - CSB services that were inadequate to clients
  - Excessive documentation requirements
  - Electronic health records/health information technology (EHR/HIT)-related challenges
  - Funding challenges
  - Service inaccessibility
  - Lack of awareness of the CSB or CSB services
  - Lack of available community resources to support client needs
  - STEP-VA implementation challenges
  - Medicaid expansion challenges
  - Inadequate infrastructure

To prepare for coding, JBS Team members participated in a 3-day MAXQDA training conducted by an outside trainer to understand the use of the MAXQDA software program.

Descriptive, deductive, qualitative coding uses existing research and theories to develop and assign codes to qualitative data. An experienced JBS Team analyst coded the text narratives in the database using a structured protocol designed to minimize potential investigator bias. First, the data analyst

reviewed the interviews and extracted all text passages that included a discussion of one of the key topics of interest (e.g., funding barriers, Medicaid expansion). Second, the data analyst applied deductive descriptive codes to text passages in the MAXQDA database. Third, the analyst extracted the coded data, which was then assigned to two analysts who subsequently identified, summarized, and synthesized themes relating to the specific relevant key topics (e.g., funding, Medicaid). The two analysts identified, summarized, and synthesized themes relating to the relevant key topics.

Analysis Methods for Quantitative Data

Quantitative data collected for the needs assessment required different strategies for data management, preparation, and analysis. Below, we describe these activities.

Data Review

Prior to being subject to analysis, both primary and secondary data were subject to data quality review procedures, including data cleaning and validation, exploratory analysis for quality control (e.g., removal of duplicate cases, outliers and out-of-range data values). In addition, thorough review of guidance regarding sampling methodology, weights/variation estimates, and related guidance for data review and analysis was conducted for examination of existing or secondary data prior to analysis.

Content Review of Qualitative Data and Data Reduction for Quantitative Analysis

Although the JBS Team obtained quantitative data to describe most grantee processes listed above, CSB administrative and direct services provider staff also provided qualitative information to describe the EBPs and programs used to support provision of BHS. To conduct analysis on EBPs and programs reportedly used by CSBs, we reviewed content and conducted data reduction procedures to transform the qualitative information provided by the staff and providers to data that would be suitable for quantitative analysis. A description of the content review and data reduction procedures is provided below.

A team of two data analysts independently reviewed site visit reports and pre-site survey qualitative data for descriptions of the EBPs and programs used for provision of substance use and MH treatment, recovery, and prevention services. Following content review, each service description reported by grantees was coded into two categories:

- EBPs, programs and best practices used for provision of substance use and MH treatment, recovery, and prevention services and
- Other service/not an EBP.

A description was classified as an EBP based on its inclusion in DBHDS documentation regarding evidence-based programs and practices, inclusion in the CDC's Diffusion of Effective Behavioral Interventions project, or analyst's knowledge of the intervention as an EBP.

Procedures Used for Analysis of Quantitative Data

Given the complexity of the quantitative data sources and levels of analysis needed at consumer, CSB, regional, and state levels, the JBS Team used multiple methods for analyzing data to address key areas of interest for the needs assessment.

Descriptive and Multivariate Analyses. Descriptive analyses—counts, frequencies, measures of central tendency and dispersion, and percentage differences—were used to provide summary information for CSBs on BHS utilization and cost; client demographics (e.g., age, gender, race,

ethnicity); MH and substance use behaviors, population risk indicators (e.g., female pregnancy status, SED risk, employment status, military status, criminal justice involvement) of CSB clients; and CSB workforce and program characteristics. The JBS Team analyzed variance and analyses of covariance to examine differences in quality, provision, and receipt of services by consumer characteristics, region/county and other geographic characteristics (e.g., rural or urban area). Crosstabulations were used to examine differences across FYs by consumer characteristics, MH and substance use behaviors, region/county, and other geographic characteristics (e.g., rural or urban area).

Bivariate Analyses. Bivariate correlational and chi-square analyses by population subgroups, CSBs, and geographical characteristics (rural or urban area) examined the relationship between factors associated with service availability and service utilization provision at the consumer and CSB levels.

Generation of Population Estimates

To better understand how current service capacity compares with current need, crude estimates of select BH conditions and behaviors were calculated at the CSB and/or regional level. Please see Appendix K for tables of estimates.

The estimated number of people impacted by a health outcome or behavior was generated by multiplying the prevalence estimate by the estimated total number of people in a community or population. The generated estimate utilized regional prevalence estimates available from the NSDUH and state prevalence estimates from the YRBS. The sampling framework for each data source was used to select the most appropriate population-level estimate to generate the estimated number of people who may have the health behavior or outcome of interest.

YRBS

Regional population estimates[40] were generated using the prevalence estimates from the 2017 YRBS (also known as the Virginia Youth Survey). As described above, the Virginia YRBS provides prevalence estimates for health and risk behaviors of middle and high school students based on a random sample of public schools in Virginia. CSB-level estimates were not generated due to the underlying sample for the Virginia YRBS, which has unequal CSB-level representation of schools, including some CSBs which may not have any participating schools.

To calculate the regional-level estimates, the prevalence estimates and population estimates were matched by grade level and multiplied to estimate the number of students who may experience a given health behavior. Because the underlying population for the YRBS is students enrolled in Virginia public schools, the 2017 public school enrollment data, stratified by grade, was used as the population-level estimate[41]. For each grade, the following calculation was performed:

Number of Enrolled Students	**x**	**State Prevalence of Health Behavior**	**=**	**Estimated Number Impacted**
(Enrollment Data)		(YRBS)		

The generated estimates are presented separately for middle school students (grades 6–8) and high school students (grades 9–12) given that questions differed for middle and high school students (see Tables 3.1 and 3.2).

[40] Five regions included the Southwest, Northwest, Eastern, Central, and Northern Health Planning Regions used by the VDH.
[41] The school enrollment data file was used as the sample frame for the 2017 YRBS and was provided by the VDH.

Table 3.1. Middle School Prevalence Estimate Information

Health Behavior	Prevalence Year	Geographic Level
Has at least one adult they can talk to about their problems.	2017	State
Ever thought about suicide.	2017	State
Ever attempted suicide.	2017	State
Ever used marijuana.	2017	State
Ever used heroin.	2017	State
Ever misused prescription pain medication.	2017	State

Table 3.2. High School Prevalence Estimate Information

Health Behavior	Prevalence Year	Geographic Level
Has at least one adult they can talk to about their problems.	2017	State
Sad or hopeless every day for 2 weeks in a row, during the past 12 months.	2017	State
Attempted suicide at least once in the past 12 months.	2017	State
Smoked marijuana at least once in the past 30 days.	2017	State
Used heroin at least once in the past 30 days.	2017	State
Misused prescription pain medicine at least once in the past 30 days.	2017	State
Binge drank at least one day or more during the past 30 days.	2017	State

NSDUH

CSB-level population estimates were generated using prevalence estimates for various BH conditions from the Virginia NSDUH. For the CSB-level estimation, estimates were generated for the following three age groups: Ages 12–17, ages 18–25, and age 26 and older, which are the age groups for which the NSDUH publishes prevalence estimates[42]. To account for regional variability in prevalence, the most recent regional-level prevalence estimates from the NSDUH were used (2014–16). In cases where regional prevalence estimates were not available, state-level prevalence estimates from the most recent year (2016–17) were used instead.

To calculate the CSB population estimates, the prevalence estimates and population estimates were matched by age group and multiplied to estimate the number of people who may experience a given health outcome or behavior. Data from the 2017 ACS was used as the CSB-level population estimate. For each age group, the following calculation was performed:

CSB Population Size (ACS) **x** **Prevalence of Health Behavior** (NSDUH) **= Estimated Number Impacted**

Table 3.3 below describes the NSDUH indicators used to generate population-level estimates, as well as the associated year and geographic level for which the prevalence estimates were available.

[42] For some health outcomes or behaviors, prevalence estimates for people between the ages of 12–17 could not be calculated because the prevalence estimate was not available.

Table 3.3. NSDUH Prevalence Estimate Information

Health Outcome or Behavior	Prevalence Year	Geographic Level
Alcohol use disorder in the past year	2014-16	Regional
Any mental illness in the past year	2014-16	Regional
Had serious thoughts of suicide	2014-16	Regional
Major depressive episode in past year	2014-16	Regional
SMI in the past year	2014-16	Regional
Illicit drug use disorder in the past year	2016-17	State
Needing but not receiving treatment for substance use at a specialty facility in the past year	2016-17	State
SUD in the past year	2016-17	State

3.4 Limitations

Methodological Limitations–Qualitative Data

Limitations of the qualitative data included the exclusion of information from unrecorded interviews and focus groups, difficulty recruiting focus group participants, the need to control for researcher bias, and variations in the design and use of specific data collection tools. Below is a discussion of these limitations, as well as the steps that were taken to address them.

Exclusion of Information From Unrecorded Interviews and Focus Groups

To protect the privacy of interview and focus group participants, participants had the choice to opt out of the audio recording of interviews. Audio recording data from 51 of the 473 key informant interviews were not available for analysis. However, because the excluded recordings represent a small percentage of the total of 473 transcripts (10.8%), the effect on results of analyses is believed to be minimal. Audio recording data from 12 of the 80 focus groups were not available for analysis. However, because this only represented a small portion of all focus groups (15%) and because focus group recordings were not used for analysis (instead, detailed focus group notes were used), the effect on results of analyses is believed to be minimal.

Client Focus Group Participant Recruitment

For each client focus group conducted during CSB site visits, an assigned client focus group recruiter (i.e., CSB's Executive Director or other point of contact) recruited participants (i.e., clients or their family members) for the client focus groups. In some cases, however, selection bias could have occurred when participants were identified directly by the client focus group recruiter for participation and asked to participate. In addition, client focus group participants included primarily individuals who remained in services (i.e., the views of clients who dropped out of services were not represented), which may have potentially skewed the data and subsequent results and findings.

Researcher Bias

The analysis of the interview and focus group data included the identification of patterns (i.e., themes) and the construction of a narrative to report the findings. Because of the subjective nature of the qualitative analysis process, one of the challenges is that of researcher bias (Mays & Pope, 1995). To address this challenge, a senior research analyst was assigned to conduct the analysis and review

findings (see section 3.3, *Qualitative Analysis Strategies*, for a more detailed explanation of the methods employed for analysis of semistructured interview and focus group data).

Variation in Use of Data Collection Tools

The use of semistructured interviews by a variety of interviewers meant that there were slight variations in how the questions were asked across all interviewees. To create a flowing conversation, team members adapted the questions or changed the order of the questions to facilitate the interview process while still making sure to obtain answers to all interview questions.

Methodological Limitations–Quantitative Data

Although both primary and secondary data sources were used to obtain quantitative data needed to support the needs assessment, variations in the data collection methods for these different data sources accounted for several methodological limitations. Below is a discussion of these limitations, as well as methods used to address them.

Missing Data Across Primary Outcome Instruments

To allow for sufficient time for CSB administrative staff to complete the administrator pre-site survey before onsite visits with the JBS Team, surveys were sent to staff 2 weeks prior to the onsite visit. As the administrator pre-site survey contained questions about clinical service provision and fiscal and administrative aspects of the CSB, completion of all questions in this instrument likely necessitated completion from administrative staff with different roles in the CSB. For example, clinical administrative staff may have been more likely to complete those sections regarding service provision, whereas fiscal staff may have been more likely to complete those sections regarding funding. As a result, data was not always available for all questions on the administrator pre-site survey prior to the site visit. In addition, as more than one administrative staff person was likely to have completed the survey and with different administrative roles, there were occasional inconsistencies in responding across questions in the administrator pre-site survey (e.g., conflicting responses regarding the types of EBPs and/or best practices across questions from different sections of the survey). To address these concerns, the following steps were taken to maximize data quality following review of survey responses:

- Interviewers queried staff about missing and inconsistent data during site visit interviews.
- JBS Team members emailed administrative staff following the site visits to obtain missing data.
- When possible, data from the administrator pre-site survey was triangulated with qualitative data from interviews to provide the data needed.

In addition to challenges associated with data collection using the administrator pre-site survey, survey data from consumers was not obtained from one CSB. In addition, survey data from direct service providers was not obtained from two CSBs. However, because the absence of these surveys represented a small percentage of consumer survey data (5.2%) and direct service provider survey data (2.7%) unavailable for analysis, the effect on results of analyses in believed to be minimal.

Changes in Data Collection Instrumentation

After piloting of the initial survey instrumentation with a small number of CSBs, the consumer survey was altered to facilitate completion by clients who may have challenges with completing the survey independently (e.g., due to mild cognitive impairment). Prior to elimination of questions, a crosswalk was conducted to ensure that survey items were available in the revised consumer survey to address the key assessment questions of interest.

Prevalence Estimate Calculations

The calculations described above (Section 3.3, *Generation of Population Estimates*) represent a basic methodology to calculate the number of people who may experience a given health outcome of behavior at a smaller geographic level than is available directly from the data source and should not be interpreted as a precise estimate. The prevalence estimates provided by the NSDUH and YRBS have been weighted to reflect the demographics of the population in Virginia, as well as to account for the sample design and response rate of participants. These factors are not taken into account in the calculations described above. This means that the population estimates provided may over- or underrepresent the true number of people experiencing these health outcomes of behaviors in CSBs or regions that have a different demographic composition or different trends in BH prevalence than is estimated by the NSDUH or YRBS.

Use of Secondary Data

Several limitations exist with the use of secondary indicator data. First, most secondary indicator data sources have a significant temporal lag between when data is collected and when it is published. This means that decisions based on prevalence estimates often rely on data that is dated and may not reflect emergent trends in BH. This temporal lag may be exacerbated for the release of data on smaller subpopulations, such as data at the regional level.

A second limitation is the lack of data at the county or CSB level. Because many of these surveys are fielded at the state and national level, there are often not resources to support the collection of data at smaller geographic levels. This limitation may mask differences in trends at the county or locality level. Similarly, many data sources offer few subpopulation comparisons. This may mean that trends within subgroups (such as the adult population age 26+; other sociodemographic subpopulations, such as lesbian/gay/bisexual/transgender/queer/questioning [LGBTQ] or certain racial/ethnic groups) are unable to be examined. This limitation may also mask differences in trends for specific subpopulations.

Finally, each of the secondary data sources presented utilizes different methodologies for sampling, data collection, and analysis. Resulting prevalence estimates should be used to describe a broad picture of the overall trends in Virginia, but comparisons of indicators across datasets should be done with caution. For example, both the BRFSS and NSCH collect information on ACEs. However, there are significant differences in survey methodology (e.g., self-report vs report from a parent or adult), as well as the types of ACEs collected, meaning that a direct comparison of prevalence across these surveys may not be appropriate.

4. RESULTS

4.1 What Are the Key Characteristics of Virginia's Publicly Funded BH System?

4.1.1 What BHS Do CSBs Provide?

Treatment and Recovery Services

The JBS Team analyzed quantitative data from the CCS 3 and the administrator pre-site survey, as well as qualitative data from interviews with CSB staff to describe the substance use and MH services provided by CSBs.

Between state FY2015 and FY2019, CSBs reported having capacity, as indicated by having full-time equivalent staff, beds, or slots to provide an array of core BHS, as defined by the CCS 3. Table 4.1 presents an overview of the percent and number of CSBs with the capacity to provide specific services from FY2015 to FY2019. Over 90% of CSBs had the capacity to provide the following services continuously since FY2015:

- Crisis or emergency services,
- Services to assess and evaluate BH crises,
- OP services,
- Case management services, and
- Psychosocial rehabilitation (PSR) services.

CSBs also provide services in support of STEP-VA. Please see Section 4.5 for a detailed description of the services provided by CSBs directly related to STEP-VA implementation.

Over 70% of CSBs had capacity to provide the following services continuously since FY2015:

- Acute psychiatric or SUD inpatient services and
- Residential services, including:
    - Intensive residential substance use services,
    - Supervised residential MH services, and
    - Supportive residential MH services.

It's critically important to note that even though CSBs reported being able to meet a baseline capacity to provide these core services, they were also repeatedly and exceedingly clear when interviewed that they do not have adequate capacity to meet the needed service volume (demand) in their communities for any of these services. They identified several reasons why: increased demand for services over time, service reductions by MCOs, inadequate workforce size, difficulties recruiting and retaining available staff, and increased administrative demands that take away from direct service.

Findings indicate that CSBs did not have adequate service capacity to provide medical or psychiatric services (such as medication management) as part of their BH treatment programs until FY2018, with 95% of CSBs using these services to support MH programs. In addition, there was a large increase in the number of CSBs using MAT across successive FYs, from 27.5% of CSBs in FY2015 to 77.5% of CSBs in FY2019. This notable increase might be due in part due to the Medicaid 1115 waiver that established the ARTS program, increasing numbers of CSBs providing this service as part of STEP-VA and the influx of federal resources associated with the nation's opioid epidemic. Between FY2015 and FY2019,

there was a slight increase in the number of CSBs providing Programs for Assertive Community Treatment (PACT) services, with 67.5% of CSBs having the capacity to provide this service.

These increases in services reflect what CSB staff see as a greater demand for all services they provide. Staff reported they are unable to see all their clients in a timely manner due to their large caseloads. They also said clients are often given services that are readily available, such as therapeutic groups, to ensure that service can begin. This does not mean group services are always the most appropriate clinical intervention. Similar statements were made about case management services. Although these are beneficial for many clients, they were often the default placement when other services were not available right away.

"I do think really we need to dramatically expand. Most people that come to a CSB want therapy, and we don't have the capacity to give it to them unless they're sick enough." (Urban, medium budget CSB)

"What we do is, we plug folks into groups so they stay, you know, […] we want to get them into their first treatment service [and] that may be a group for us if we can't get them into a [individual] clinical appointment." (Rural, large budget CSB)

Table 4.1. Percent and Number of CSBs Providing Core BHS Between FY2015 and FY2019

CSB Core Services	FY2015		FY2016		FY2017		FY2018		FY2019	
	%	N	%	N	%	N	%	N	%	N
Emergency and Ancillary Services										
• Crisis/emergency services	100.0	40	100.0	40	100.0	40	100.0	40	100.0	40
• Assessment and evaluation services	100.0	40	100.0	40	100.0	40	97.5	39	95.0	38
Inpatient Services										
• Acute psychiatric or SUD inpatient services	80.0	32	77.5	31	77.5	31	80.0	32	80.0	32
• SUD medical detoxification (detox) services	22.5	9	22.5	9	22.5	9	17.5	7	17.5	7
MH Program Services										
• OP services	100.0	40	100.0	40	100.0	40	100.0	40	100.0	40
• Medical/psychiatric services	0.0	0	0.0	0	0.0	0	95.0	38	95.0	38
• Case management	100.0	40	100.0	40	100.0	40	100.0	40	100.0	40
• Day treatment and/or partial hospitalization services	45.0	18	47.5	19	47.5	19	50.0	20	45.0	18
• Ambulatory crisis services	40.0	16	40.0	16	40.0	16	47.5	19	42.5	17
• Rehabilitation services	97.5	39	97.5	39	95.0	38	97.5	39	100.0	40
• Residential crisis stabilization services	52.5	21	52.5	21	52.5	21	52.5	21	55.0	22
• Highly intensive residential services	22.5	9	22.5	9	5.0	2	10.0	4	5.0	2

CSB Core Services	FY2015		FY2016		FY2017		FY2018		FY2019	
	%	N	%	N	%	N	%	N	%	N
• Intensive residential services	42.5	17	45.0	18	42.5	17	37.5	15	40.0	16
• Supervised residential services	72.5	29	75.0	30	77.5	31	77.5	31	80.0	32
• Supportive residential services	100.0	40	90.0	36	85.5	34	90.0	36	85.0	34
Substance Use Program Services										
• MAT	27.5	11	30.0	12	32.5	14	57.5	23	77.5	31
• OP services	97.5	39	100.0	40	100.0	40	100.0	40	100.0	40
• Medical/psychiatric services	0.0	0	0.0	0	0.0	0	22.5	9	27.5	11
• Intensive outpatient (IOP) services	25.0	10	25.0	10	37.5	15	45.0	18	50.0	20
• PACT	55.0	22	65.0	26	67.5	27	65.0	26	67.5	27
• Case management	90.0	36	92.5	37	95.0	38	92.5	37	97.5	39
• Day treatment and/or partial hospitalization services	17.5	7	20.0	8	17.5	7	12.5	5	12.5	5
• Residential crisis stabilization services	2.5	1	5.0	2	7.5	3	5.0	2	7.5	3
• Highly intensive residential services	62.5	25	62.5	25	60.0	24	57.5	23	60.0	24
• Intensive residential services	80.0	32	75.0	30	75.0	30	75.0	30	70.0	28
• Supervised residential services	17.5	7	15.0	6	17.5	7	17.5	7	22.5	9
• Supportive residential services	10.0	4	7.5	3	12.5	5	7.5	3	5.0	2

Note: Percentages do not add to 100% because data was missing or not collected.

The amount and type of services available to clients has increasingly been determined by the authorization practices of the six MCOs, in the eyes of many CSB staff. MCOs impact services directly in two clear ways. They frequently deny services that are requested, and the administrative steps needed to request approval or challenge denials is exceedingly time consuming for CSB staff—to the point that it restricts the ability to see clients. The clinical and administrative difficulties caused by MCO oversight were cited across all CSBs and by multiple respondents, including administrators and clinical staff, including the problems caused by repeated service denials.

"We have people who are in PSR programs and mental health skill building programs … who absolutely need that level of care in order to remain stable and out of the hospital and to thrive. And since they've been there for a while, they're getting rejected [by MCOs] . […] Their authorizations are being denied. Reauthorizations are being denied. We send paperwork back to them that shows that the individuals […] meet the medical necessity criteria for the MCO, and it still gets denied. There are times we wonder if the MCO is even reading what we're saying." (Urban, small budget CSB)

"This is one of the biggest problems with the state is that we had to basically set up, like, a business office, and we had to contract with six MCOs—all

different, no consistency. It took a whole year, and now it's a nightmare. Like, they'll authorize psychiatric rehab for 2 weeks and the person has been there for 13 years and it's keeping them out of the state hospital." (Urban, large budget CSB)

"There's a lot of denials and a lot [of] authorization problems that we deal with. And that's time consuming because the clinical staff are on the phone or with the MCO trying to explain, 'Hey, this person does need this service. Yes, they've been in it for a year. But without it, they go to the hospital.' Or it's just they're denying services that individuals have had for years because they say they shouldn't need it anymore. And when you've got really seriously mentally ill people with very little support, this is what's keeping them stable. And so, we've had to educate them a lot, and we have … calls every Friday with the MCOs and CSBs to try to work some of the things out." (Rural, small budget CSB)

The most common concern about the administrative burden had to do with the different authorization processes that each CSB used.

"We were told that the MCOs, when we ended up with six of them, that there would be […] standardization, and that has been less true than more true." (Rural, medium budget CSB)

Workforce issues were also identified as a major challenge in providing an adequate service capacity as well, especially in rural areas. CSBs noted problems with having enough qualified professionals to hire and then difficulties in retaining them over time. Retention issues were typically attributed to higher pay with private providers, increases in paperwork, decreases in client contact over time, and provider burnout.

"Being in a rural area, I think one of the biggest challenges that, as a Clinical Director, I'm facing right now is a workforce development crisis […] I think it goes back to what I said about this area and poverty and lack of job opportunity. This isn't an area where people who are newly out of grad school are going to come to raise their family because there's not a lot of [professional] development and opportunity here. Unless you're […] a native of here, there's not a lot of incentive to come to a really remote and isolated area." (Rural, medium budget CSB)

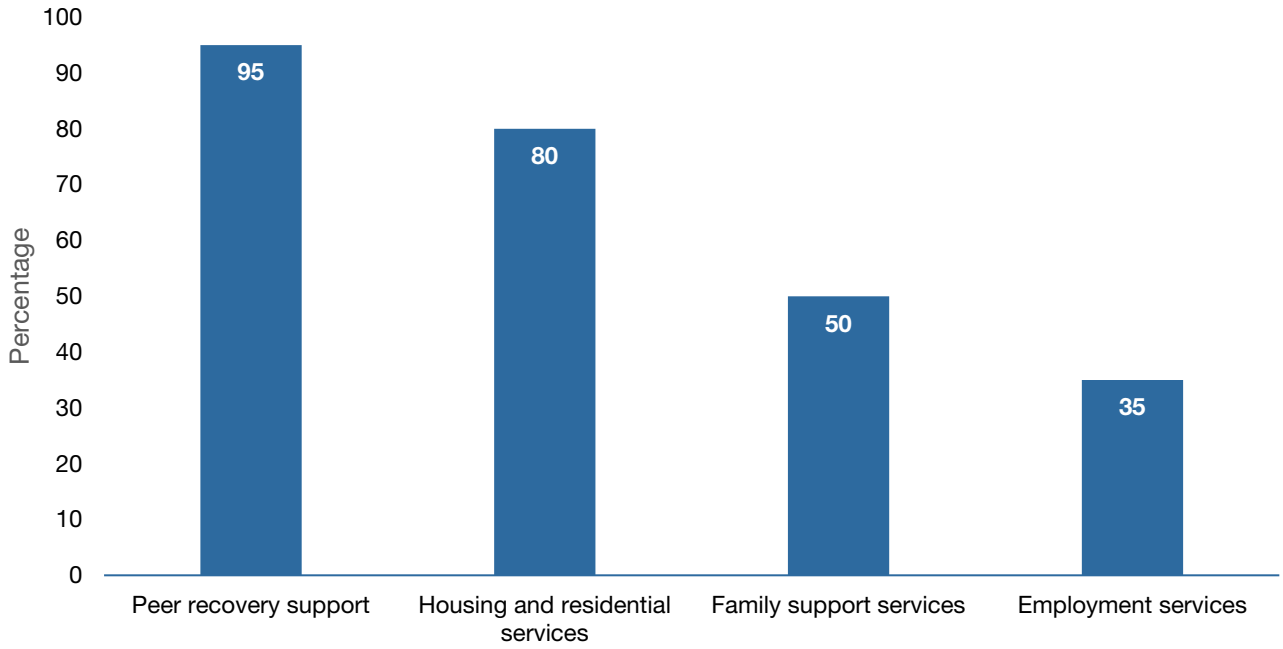
A related difficulty for staff and leadership at CSBs is the increase in the administrative burden for providers. Direct service staff at CSBs were asked the percent of time they spend on paperwork each week. The answers ranged from 33%–75%. The most common response was 50%–60%. Staff noted that spending half of their time or more greatly decreased their job satisfaction and negatively impacted client services—both because clinicians are less happy with their jobs and because there are fewer hours to see clients, despite the increase in clients needing services.

"I've been here for 18 years. The scales have turned I'd say in the last few years…It's resulted in the clinical staff having less time to work with clients and to focus on the clinical care. So, 10 years ago, I would talk with my

> **supervisors all the time about interesting new best practices and how can we start this group? And how do we get your staff trained in MRT? We're thinking clinically. Most of my conversations now are about how do we respond to this bizarre new directive we've been given from licensing that actually isn't even in the licensing regs."** (Urban, large budget CSB)

In addition to the core services listed above, most CSBs provide an array of recovery support services (92.5%, n=37), including peer recovery support; housing and residential services, such as supportive housing; employment services; and services to support families, such as parent training, advocacy training, and respite care. Figure 4.1 displays the percentage of CSBs that provide these recovery services.

Figure 4.1. Recovery Services Provided by CSBs



Findings from review of qualitative interview data build on the quantitative findings to provide information on additional services provided by CSBs, as well as perspectives regarding changes in provision of specific BHS.

Aside from the core services and recovery services listed above, most CSBs have a long history of providing MH skill building and therapeutic day treatment (TDT) services for children. Most locations have begun to phase out or have eliminated these services in the past few years. This is attributed to the low reimbursement rates and increased denials from MCOs. CSBs cited multiple examples of the direct impact on individual clients who lacked access to these services—especially in the case of MH skill building, which served as a central element to many clubhouses and day treatment programs. One example was provided by a clubhouse manager when talking about a former client who was no longer able to receive services due to managed care denials:

> **"I see this one guy walking around town like a zombie. There is nothing you can do about it. He is probably in need of a hospital."** (Rural, small budget CSB)

School-based services, TDT have seen a similar decline over time, both for services provided directly to students and to their families. This decrease has contributed to a reduction in the number of children and families seen in CSBs and has notably weakened the connection between CSBs and local schools, where these services were previously housed.

"We're providing crisis counseling for the schools. And […] we have put case managers in the schools. The problem is, as far as the schools are concerned, it's not like TDT. So, you have to understand the difficulties that schools have with structuring things. TDT is like a teacher's aide. So, you go into the classroom and you're helping kids stay on task, which is why schools, teachers, and parents love it. The outpatient counseling, if you did it at the school, it would be once a week, right? Case management, you can stop and help kids throughout the day, but you're not in the classroom keeping them on task." (Rural, medium budget CSB)

"What they're saying around TDT and MHS specifically is that those services will change over the next couple of years. … Those are two services that help keep kids and adults in the community[…]And if you're watching the news in Virginia, it's just starting to hit the news that TDT specifically is going away connected to the MCOs and the decrease in authorizations." (Rural, large budget CSB)

4.1.2 What Prevention Programs Are Provided by CSBs?

All 40 CSBs provide prevention services as part of their substance use (100%, n=40) and MH (52.5%, n=21) programs. The following section—prepared by our project partner, OMNI—describes the scope of prevention services at all CSBs.

Several characteristics can be used to describe and categorize the suite of prevention programs offered across CSBs. Table 4.2 summarizes programs provided by CSBs across several characteristics.

Center for Substance Abuse Prevention Strategy

SAMHSA's Center for Substance Abuse Prevention (CSAP) has identified six main types of prevention strategies. All prevention activities are reported to SAMHSA under the umbrella of one of the six strategies. Best practices in prevention science recommend the implementation of a mix of strategy types, such as individual-level education sessions that target a few people paired with environmental-level strategies that impact communities as a whole. In the FY2019 SABG , CSBs implemented an average of four different CSAP strategy types.

Over the last few years, as Virginia has moved toward a data-driven system, there has been a push to shift from a prevention system heavily dominated by; direct education strategies to more environmental strategies that reach entire populations. In SABG FY2019, 36 CSBs were implementing environmental strategies, and 31 were implementing education strategies.

Fifty-two percent of CSB staff felt that their agency implements environmental-level strategies are "above average" or "excellent".

Table 4.2. CSB CSAP Strategies

CSAP Strategy	Definition[43]	Example Activities	Number of CSBs Implementing (SABG FY2019)	SABG FY2019 Highlights (Performance-Based Prevention System [PBPS] data)
Community-Based Processes	Strengthen resources, such as community coalitions, to prevent substance use and misuse. Organizing, planning, and networking are included in this strategy to increase the community's ability to deliver effective prevention and treatment services.	Coalition collaboration or management, community trainings (e.g., ACEs, Applied Suicide Intervention Skills Training [ASIST], MH First Aid, naloxone training)	39	• CSBs provided 45 naloxone trainings to 525 individuals. • CSB staff engaged with over 1,300 coalition members across their communities.
Information Dissemination	Increase knowledge and change attitudes through communications. This method of learning is mainly one-way, such as classroom speakers or media campaigns.	Media campaigns, health fairs, resource directories, speaking engagements, radio and TV public service announcements	37	• 356 media campaigns reached 1.7 million Virginians. • CSB staff spoke at 237 gatherings reaching over 14,400 individuals.
Environmental Strategies	Aimed at the settings and conditions in which people live, work, and socialize. These strategies call for change in policies—to reduce risk factors and increase protective factors—for example, tighter zoning restrictions on alcohol outlets or stronger enforcement to prevent underage purchases of alcohol and tobacco products. As these changes are carried out at the community level, they can have a sweeping impact.	Counter Tools merchant education, distribution of prescription drug supply reduction materials (e.g., deactivation packets, locks), social marketing campaigns	36	• CSB staff distributed 14,973 drug deactivation packets. • 47 social marketing campaigns reached over 752,000 Virginians.
Education	A two-way approach to teaching participants important skills. These skills can include resisting pressure to use drugs, looking at the intent behind advertising, or developing other skills used in making healthy choices.	Youth education programs (e.g., Al's Pals, Life Skills, Too Good for Drugs); parenting and family management programs (e.g., Active Parenting, Children of Divorce Intervention Program)	31	• Over 300 small group substance use prevention and MH programs reached 12,425 youth. • Over 1,300 individuals participated in parenting and family management classes.
Alternative Activities	Provide fun, challenging, and structured activities with supervision so people have constructive and healthy ways to enjoy free time and learn skills. These alcohol- and drug-free activities help people—particularly young people— stay away from situations that encourage use of alcohol, tobacco, or illegal drugs.	Drug-free recreation activities, parties, and dances	14	• 7,252 youth participated in recreation activities instead of using substances.
Problem Identification and Referral to Services	This process includes determining when the behavior of people who are at high risk or who are using alcohol, tobacco, and other drugs requires education or other intensive interventions.	Student assistance programs	1	• 2,172 students were provided with resources and referrals to services.

Source: PBPS evaluation data system

[43] SAMHSA, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: CSAP, SAMHSA, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

EBPs, Programs, and Policies

Across Virginia, CSBs use needs assessment data and the strategic planning process to select evidence-based prevention strategies that fit the substances, populations, and risk and protective factors they are targeting.

Seventy-five percent of CSB staff felt that their agency implements EBPs that are "above average" or "excellent".

Research and evaluation have shown that evidence-based strategies produce the intended results. Using evidence-based strategies maximizes the chances that a prevention initiative will be effective. Although an evidence-based strategy might be proven to impact an issue a community wants to target, that does not mean it will work perfectly in that community. All EBPs may require adaptation to meet local needs and context[44].

Historically, evidence-based strategies typically only included programs, but prevention science now supports the use of EBPs and policies in addition to programs. CSBs are implementing a mix of evidence-based programs, practices, and policies.

Types of Evidence-Based Strategies	Example CSB Strategies
Program A program is a set of predetermined, structured, and coordinated activities. A program should have specified goals, objectives, and structured components (e.g., a defined curriculum, an explicit number of hours) to ensure the program is implemented with fidelity to its model[45].	Active Parenting; Al's Pals; All Stars; Children of Divorce Intervention Program; Life Skills; Second Step; Too Good for Drugs; ACEs Trainings; ASIST; Mental Health First Aid
Practice A practice is a type of approach, technique, or strategy[45].	Using the Strategic Prevention Framework through prevention programming; facilitating active coalitions to address community issues; implementing environmental strategies such as merchant education to support enforcement of tobacco laws
Policy A law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions (e.g., tobacco control policies and school nutrition policies for healthier meals in schools)[46].	Hosting legislative roundtables for local legislators and community members to meet and discuss policy options to address substance use issues

Continuum of Prevention

All CSB Prevention Directors reported their CSB implements universal prevention programs. Over 70% implement selective prevention programs. Harm reduction activities are also becoming more common prevention initiatives.

In general, prevention programs aim to reach individuals before substance use has begun. The continuum of prevention classifies prevention programs according to the audiences for which they are suited based on risks for substance use[47]:

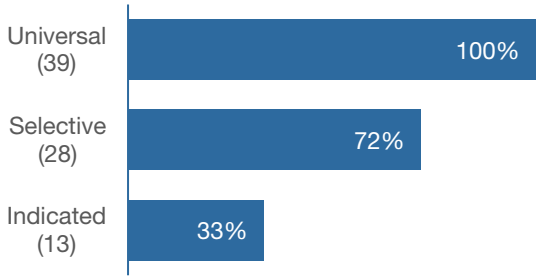
[44] SAMHSA, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: CSAP, SAMHSA, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

[45] SAMHSA. (September 2018). *Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners*. Retrieved from https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

[46] CDC. (September 26, 2017). *State, tribal, local & territorial public health professionals gateway*. Retrieved from https://www.cdc.gov/stltpublichealth/policy/

[47] SAMHSA, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: CSAP, SAMHSA, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

- Universal programs reach the general population, such as all students in a school or all parents in a community. These are the most common type of prevention programs implemented in Virginia, and all CSBs implement at least some programs that are considered universal.
- Selective programs target groups, such as children of substance users or those who display problems at school and have an above-average risk of developing substance use issues. Over 70% of CSBs implement at least some selective programs.
- Indicated programs are for those whose actions—for example, antisocial or other risky behaviors, such as truancy, academic failure, or hanging out with peers who misuse substances—put them at high risk for substance use issues. One-third of CSBs implement these types of programs.



In addition to the continuum above, a fourth type of activity has gained traction in the prevention field in recent years: Harm reduction. Harm reduction activities are designed to mitigate the negative impacts of substance use after it has begun. A common example of a harm reduction activity is syringe exchanges that provide sterile needles to individuals who are injection drug users. Although this strategy does not necessarily reduce the prevalence of injection drug use, it is a form of prevention against the potential negative impacts of using unsterile needles, such as transmission of hepatitis C and human immunodeficiency virus (HIV). Harm reduction activities have increased, particularly because of opioid epidemic and its associated consequences. Two-thirds of CSB prevention directors reported their CSB is implementing harm reduction strategies (26 CSBs; 67%).

4.1.3 To What Extent Do CSBs Provide Services to Meet the Cultural and Linguistic Needs of the Populations They Serve?

The JBS Team used quantitative data from several surveys—the administrator pre-site survey, the direct service provider survey, and the consumer survey—and data from the CCS 3 to provide multiple perspectives on strategies used by CSBs to provide services to meet the cultural and linguistic needs of the populations they serve. We also incorporated qualitative data from on-site interviews to provide additional context.

Preferred Languages Used by Clients

Table 4.3 lists the preferred languages used by consumers receiving services at CSBs, including those CSBs that serve primarily urban and rural areas, respectively. Findings indicate that the vast majority of consumers receiving services (91.2%) identified their preferred language as English. Among languages other than English, some consumers identified Spanish as their preferred language (1.3%), followed by Russian (1.0%), and another unidentified language (0.2%). Similar findings were demonstrated regarding English language preferences for consumers receiving services at CSBs that serve primarily urban and rural areas. However, fewer consumers receiving services at CSBs that serve primarily rural areas identified preferred languages other than English.

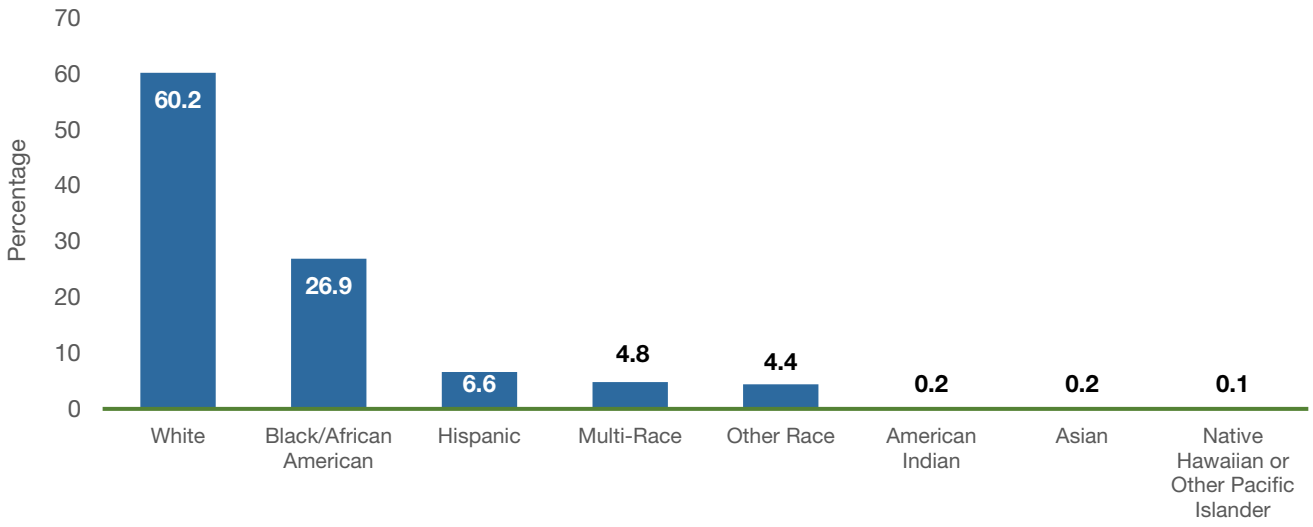
Table 4.3. Preferred Languages Used by Consumers (N=158,914)

Preferred Language	Percentage and Number of Consumers Using Preferred Language at CSBs					
	All CSBs		Urban		Rural	
	%	n	%	n	%	n
American Sign Language	0.1	159	0.1	82	0.1	77
Amharic	0.1	84	0.1	77	0.0	7
Arabic	0.1	112	0.1	80	0.0	32
Chinese	0.0	62	0.1	52	0.0	10
English	91.2	144,984	90.4	69,536	92.0	75,448
Farsi/Persian/Dari	0.0	74	0.1	40	0.0	34
Hindi	0.0	10	0.0	6	0.0	4
Japanese	0.0	28	0.0	28	0.0	0
Korean	0.0	24	0.0	18	0.0	6
Nonverbal	0.0	69	0.1	40	0.0	29
Russian	1.0	546	0.7	542	0.0	4
Spanish	1.3	2,021	1.9	1,481	0.7	540
Tagalog	0.0	23	0.0	22	0.0	1
Urdu	0.0	49	0.1	47	0.0	2
Vietnamese	0.0	68	0.1	66	0.0	2
Other language	0.2	345	0.4	317	0.0	28

Note: Data were obtained from the CCS 3 for FY2019. Percentages do not add to 100% because data were missing or not collected for 10,256 consumers.

Of the 158,914 consumers for whom data on preferred languages was obtained, the majority of consumers —60.2%—identified as White, 26.9% identified as Black or African American, and 6.6% identified as being of Hispanic origin. Figure 4.2 displays the racial and ethnic background of these consumers.

Figure 4.2. Racial and Ethnic Background of Consumers Reporting Their Preferred Languages



Note: Data were obtained from the CCS3 for FY2019. Percentages do not add to 100% because data were missing or not collected for 10,256 consumers.

The notably homogenous nature of the client population at many CSBs, particularly those in rural areas, appeared to shape their response to providing culturally competent services. However, some CSBs were aware of this and viewed it as an opportunity to improve on in the future. The more homogenous locations still identified cultural subgroups that had their own unique needs, particularly when a pervasive culture of poverty was present.

"There is definitely a more Caucasian mix. But we do have a wide variety of different people. As far as to help them with language, so all of our services and doors are in English. Within the CSB, there is translation services, and there is a Spanish speaking group. So, if they were only Spanish speaking, they could go to that group." (Urban, medium budget CSB)

"We do face a challenge of linguistic and cultural competence for the populations that we serve because we do have a lot of Spanish, Amharic, and Tigrinya speakers, and we do not have a corresponding staff…So, the people we serve, that may be their first language or their only language, and we certainly have access to language lens and interpretive services. But in terms of staff who represent and reflect the diverse community, that is a challenge." (Urban, large budget CSB)

"Our community is fairly homogenous. But I also think that that helps us get more lackadaisical in thinking about cultural competency. And that is, I think, something we need to nudge out a little bit stronger." (Urban, small budget CSB)

"I think we have worked hard to get staff trained in trauma informed because we see a lot of that in our area. You know, trauma's hidden so often. And so, we've worked really hard to—and I think that (trauma) is a culture itself, too. You have people who are traumatized. We don't have a lot of cultural diversity. When you talk about pure culture as in, we're mostly White-Anglo Saxon. I think we counted; we have five Spanish-speaking people." (Rural, small budget CSB)

"We actually have a cultural committee at our CSB. So, they are constantly evaluating sort of the changing culture of our city. Our city has 55 different languages spoken in it." (Rural, small budget CSB)

By serving such a significant percentage of White, English-speaking clients, there were often limited resources for providing translation or interpretation services, for example. Nearly all CSBs had access to phone-based translation services, and some were in contact with local community members who could serve as translators. This was often not available on demand. Staff identified the importance of reaching all segments of their area as reflected in the statements below.

"We are not a very diverse community…" (Rural, small budget CSB)

"I think in terms of linguistic, we do have some bilingual folks, front desk, therapists. Staff know how to access interpreters and to invoice that and get people onsite if we need to, those kinds of things." (Urban, large budget CSB)

Strategies Used by CSBs to Address Cultural and Linguistic Needs of Consumers

Administrative staff reported their CSB used several strategies to match service providers with consumers to help engage consumers in service provision. Table 4.4 lists these CSB strategies. Administrative staff from almost all CSBs reported that providers are assigned based on availability, rather than using specific strategies to match consumers. Some 55% of administrative staff reported using shared experience with SUD and/or MH disorders as a strategy for matching consumers to service providers.

More than 52% of respondents reported their CSB provides services in the consumer's preferred language and matched service providers based on the gender of the consumer; however, strategies to match providers based on other cultural needs, such as racial and/or ethnic background and sexual orientation, were reportedly used by fewer CSBs.

Table 4.4. Administrative Staff Reports of Strategies Used to Match Service Providers with Consumers

Strategies Used by CSBs to Match Service Providers With Consumers	Percentage and Number of Strategies Used by CSBs	
	%	n
Providers assigned based on availability	97.5	39
Shared experience with SUDs and/or MH disorders	55.0	22
Language and/or linguistic match (e.g., providing services in consumer's preferred language)	52.5	21
Gender match	52.5	21
Racial and/or ethnic background match	22.5	9
Sexual orientation (e.g., LBGTQ) match	20.0	8
Other–Provider knowledge and expertise	27.5	11
Other–Consumer requested preference	25.0	10
Other–Insurance billing ability	15.0	6
Other–Consumer presenting concern	10.0	4

Note: Data were obtained from the CSB administrator pre-site survey.

Review of staff responses on the direct service provider survey revealed that, similar to administrative staff, most direct service providers—65.9% (n=211)—reported that services are available in the preferred language of CSB consumers. However, some direct service providers did note that, for some consumers who may speak languages other than English, such as those who identify as Asian, the opportunities to receive services in their preferred language(s) may be limited.

"We can't keep up with [the different languages]. I mean, it's interesting. Sometimes we walk in and it will be a new language. It's spoken in just a certain region, a certain country, and it's different. And then it might be something, well, it sounds a lot like this. So, then we have an interpreter that can make out three-fourths of the conversation, but it's not exact. But sometimes it's a challenge for us. But by and large, our largest, it's English speaking, then Spanish speaking. Then after that we have a fairly large Korean and Vietnamese population." (Urban, large budget CSB)

The most common means to increase staff cultural competency was through mandatory trainings. Nearly all CSBs reported conducting annual trainings, with some additional support for new staff. Many CSBs reported that these trainings are provided in Relias, an online training software.

"We have an annual training in cultural competency, and everybody gets that when they're hired, as well as once a year." (Rural, medium budget CSB)

"I don't get to spend a lot of resources on cultural competence, but it is a mandated training for all of our staff." (Rural, small budget CSB)

"I think they need to be better…We have regular e-learnings and those kinds of trainings. We just had a staff go to the side by side training on LGBTQ+s and try to increase competency [with] that population." (Urban, large budget CSB)

These annual trainings were typically described as providing general knowledge about how to work with culturally diverse populations. Staff did not note that these required trainings were geared towards populations who were known to represent a large portion of their community, such as trainings in working with Spanish-speaking clients in areas with larger Latin populations. Many CSBs expressed that their client population mirrored their community demographics. However, this is not borne out in demographic breakdowns of local communities in many cases. There was little identified outreach by CSBs to underserved populations, and often a very limited understanding of what underserved populations can be found in their communities. This belief is summarized by the Executive Director of one rural CSB as reflected in the statements below.

"The people [staff] that we have here are from here. We understand our own culture here."

"We're a very impoverished group. So, a lot of our people live below that poverty level. And we all grew up in that culture. So, I guess we don't think about that as a culture, but it is." (Rural, small budget CSB)

Several interviewees discussed the need for more cultural competence training for staff who work with veterans. Administrative staff recognize that military members have different needs, and with the future implementation of a component of STEP-VA that will be geared towards veterans, there is a desire to improve in this area. The quotes below, from a variety of interviewees, sum up their views:

"I do want to make sure that our staff are more culturally informed on the culture of the military because it is different. I mean, I interned and worked at a VA. So, I got a little taste of the different culture there. And people don't get it that it's different with that, I think. So, educating my staff on that would need to be better." (Urban, large budget CSB)

"We're working also on that trends service members and family members and how we can educate our workforce to have military cultural competency and understand the resources of the systems. Because we have a lot of military [installations] around here." (Urban, large budget CSB)

"We have some military cultural competency trainings that we're looking to increase. So, I would say it's fair to say it's an awareness that we're continuing to work on." (Urban, large budget CSB)

Consumer Perspectives on CSBs' Efforts to Address Cultural and Linguistic Needs

The vast majority of consumers—94.9% (n=262)—who participated in the consumer focus group agreed or strongly agreed they were able to obtain services from their CSB in their preferred language. As the preferred language for most consumers was English, this finding may not be surprising. Some clients in the focus group noted their CSB does not have any interpreters. Another client noted their CSB has a sign asking the language spoken by their clients, and that the CSB will find an interpreter if the client needs services in a language other than English.

Consumers were less universal in their agreement about CSB sensitivity, with 80.4% (n=222) agreeing or strongly agreeing that the services and care received by their CSB is sensitive to their cultural background. Table 4.5 displays ratings of agreement by consumers' race and ethnic background.

Table 4.5. Consumer Agreement on CSBs' Efforts to Address Cultural and Linguistic Needs

Consumer Racial and Ethnic Background	Percentage and Number of Consumers Who Agree or Strongly Agree (N=276)			
	Able to Obtain Services in My Preferred Language		Services and Care Received Sensitive to My Cultural Background	
	%	n	%	n
Alaskan Native	100.0	8	75.0	6
American Indian	100.0	8	87.5	7
Asian	75.0	6	50.0	4
Black/African American	91.6	76	75.9	63
Hispanic	100.0	19	89.5	17
Native Hawaiian or Other Pacific Islander	0.0	0	0.0	0
White	97.9	184	83.5	157
Other race	80.0	4	80.0	4

Note: Data were obtained from the CSB consumer focus group survey.

It was apparent that all CSBs understood the importance of providing culturally sensitive services to clients. It was equally apparent that their dedication to doing so was defined by the demographic breakdown of the clients that walked through their doors; however, there may be a need for CSBs to use additional strategies beyond service provision in languages other than English to help consumers feel that the CSB is sensitive to their cultural background. Establishment of partnerships with local community agencies that serve culturally and linguistically diverse populations to review current policies and practices for service provision may help enhance CSBs engagement with the array of consumers they serve. Other strategies, as listed in the National Standards for Culturally and Linguistically Appropriate Services[48], may be considered as well.

Due to the limited sustained strategies and capacity for outreach to underserved communities, the CSBs may exacerbate service disparities for cultural and racial minorities. In the face of multiple, competing, high-priority demands on staff time with limited resources, this is understandable. But not prioritizing and providing high-quality services to all sectors of their communities leaves CSBs in a position of not adequately addressing health inequities rather than reducing them, which may underscore the need for additional resources, outreach and targeted professional development for some CSB staff. One Housing Director said,

> **"I ...wonder, too, about our language barriers and translations and translators and having people, enough staff that speak primarily Spanish."** (Urban, large budget CSB)

[48] https://thinkculturalhealth.hhs.gov/clas/standards

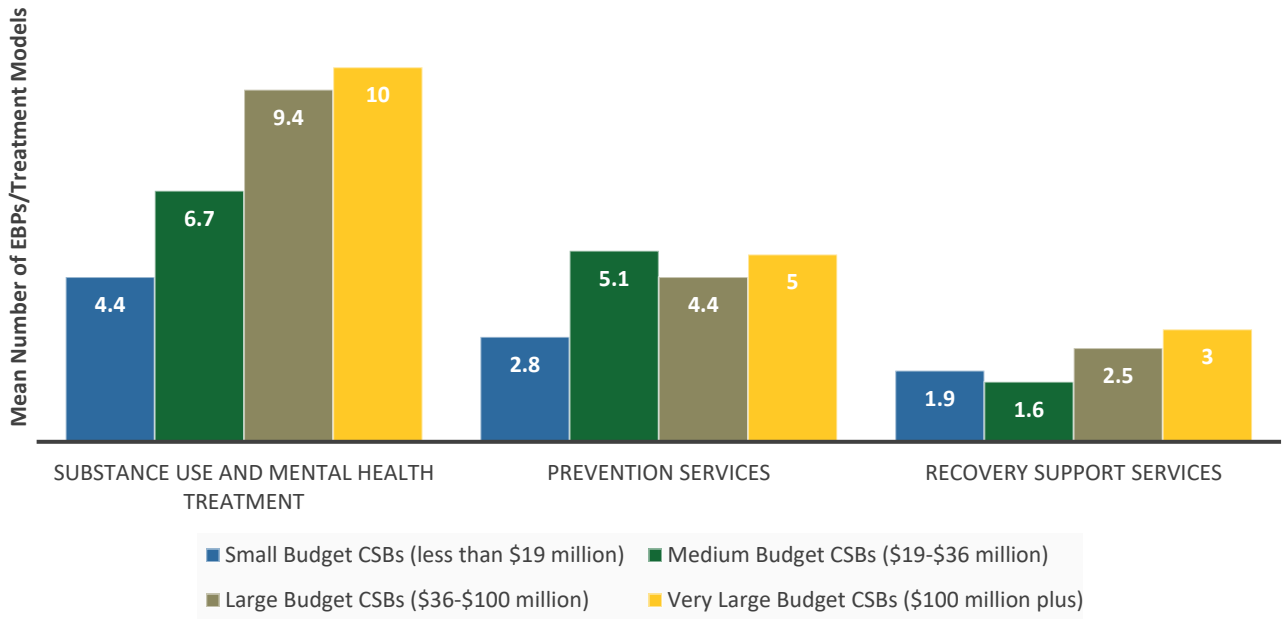
4.1.4 Which Treatment Models and EBPs Do CSBs Use?

Survey and interview data collected from all CSBs demonstrate a clear commitment to using EBPs for treatment, prevention, and recovery whenever feasible. All 40 CSBs reported using more than one EBP and/or treatment model to provide BHS. More specifically, CSBs report using:

- Up to 15 (mean=6.7, SD=3.4) EBPs and/or treatment models to provide substance use and MH treatment services;
- Up to 4 (mean=2.0, SD=1.0) EBPs to provide recovery support services; and
- Up to 8 (mean=4.0, SD=2.2) EBPs to provide prevention services.

The number of EBPs and treatment models used by CSBs varied significantly by the overall budget size of the CSB ($p < 0.001$), with CSBs that have larger overall budgets reporting use of more EBPs and treatment models to provide BHS (Figure 4.3).

Figure 4.3. Mean Number of EBPs and Treatment Models Used by CSBs



Mean number of EBPs and treatment models used by CSBs to support delivery of substance use and MH treatment, prevention services, and recovery services across CSBs with small, medium, large, and very large overall budgets (as of state FY2017).

Treatment Services

Most CSBs reported using EBPs required by the Commonwealth of Virginia to become CCBHCs and support implementation of STEP-VA (Table 4.6), such as CBT, MI) TF-CBT, MAT, MET, and IDDT. In some cases, CSBs reported a long history of using specific EBPs, such as CBT and MI.

Table 4.6. Virginia CCBHC-Required EBPs

EBP	Justification	Target Population
CBT	Supports increasing self-efficacy and independence through coping skills and symptom management tools	SMI, SED, SUD, co-occurring; adults and youth

EBP	Justification	Target Population
Family psychoeducation	Enhances consumer choice, problem-solving, communication, and coping skills, leading to fewer relapses and hospitalizations and improved knowledge for families	SMI and co-occurring; adults and family members
IDDT	Treating severe MH/SUD disorders together improves the likelihood of ongoing recovery	Co-occurring SMI and SUD
Illness management and recovery	Supports consumer choice and recovery	SMI and co-occurring; adults
Long-acting injectable psychotropic medication	Prevention of relapse beginning with first episode is an essential foundation for facilitating the achievement of recovery goals related to education, employment, relationships, and stable housing	Adults with SMI
MAT	Medications for SUD treatment support neurological stability and reduce risk of relapse and overdose in opioid users	Adults with SUD
MI MET	Assists with engagement and motivation within consumers seeking treatment for both behavioral and physical health.	SMI, SED, SUD, co-occurring; adults and youth
Recovery After Initial Schizophrenic Episode	Focused system of service delivery addressing needs of those experiencing first symptoms, improving functioning that supports achievement of natural independence	MH; late adolescence or early adulthood
TF-CBT	Trauma is highly associated with the development of mental illness/addiction/physical illness later in life	Individuals with MH issues/trauma history
WRAP®	Supports consumer choice and recovery	SMI/co-occurring; adults

Source: STEP-VA: System Transformation, Excellence and Performance in Virginia. Virginia's pathway to excellence in behavioral healthcare. Available at http://dls.virginia.gov/groups/mhs/Step_VA.pdf

CSBs reported using a variety of EBPs and treatment models to address the complex clinical issues facing clients seeking treatment for substance use and/or MH disorders (Table 4.7). For example, CSBs reported using EBPs and treatment approaches that address trauma and substance use, such as Seeking Safety, TF-CBT, and Helping Women Recover. CSBs also noted use of transdisciplinary team approaches to support treatment of substance use and MH treatment, such as MAT, PACT, and the Clubhouse model. In addition, CSBs reported using different approaches to help strengthen child and family systems (e.g., play therapy and other family systems treatment approaches) impacted by substance use and MH disorders.

There was a demonstrated willingness to try new evidence-based models when the opportunities arose. New opportunities often stemmed from dedicated funding, but some CSBs reported offering new EBPs due to staff interest and population need. The best example of this was data collected from staff interviews at two different CSBs that began using eye movement desensitization and reprocessing (EMDR) because direct service staff felt it would help clients with anxiety, depression, and trauma.

Several CSBs reported using EBPs and treatment models typically associated with provision of recovery services, such as Self-Management and Recovery Training (SMART Recovery) and WRAP® to support delivery of treatment services.

Over 40% of CSBs reported using the following EBPs and treatment models to support service delivery: CBT, TF-CBT, MAT, EMDR, and dialectical behavior therapy (DBT).

CBT was reported as being used by 80% of CSBs for MH treatment. This is equivalent to 32 out of 40 CSBs and is the highest number reported out of all types of MH treatment. MI was reported as being used by 78% of CSBs, and TF-CBT was reported as being used by 55% of CSBs. Overall, 27 EBP treatment services were named by CSBs.

"The state…has been supporting us with a couple of the trainings, the TF CBT, which some of our therapists have just been trained in, and PCIC. But the DBT, that's a huge need. And many of the EBPs, it's very costly to maintain if you're going to maintain fidelity. We don't have funding and support for that. So, there is a need to use them. We want to use EBPs. But we have to choose EBPs that aren't as costly. So, we have been trained in motivational interviewing and CBT because they […] can be broadly used." (Urban, large budget CSB)

Table 4.7. EBPs, Best Practices, and Treatment Models Used to Support Delivery of Substance Use and MH Treatment

EBPs, Best Practices, and Treatment Models	Percentage and Number of CSBs Reporting Use of EBPs, Best Practices, and Treatment Models for Service Delivery	
	%	n
Substance Use and MH Treatment		
• †CBT	80.0	32
• †MI	77.5	31
• *†TF-CBT	55.0	22
• **†MAT	55.0	22
• EMDR	40.0	16
• DBT	40.0	16
• Matrix Model	35.0	14
• ***†Family-strengthening approaches ○ Behavioral activation for children and adolescents (n=1) ○ Ecosystemic structural family therapy (n=1) ○ Filial therapy (n=1) ○ Functional family therapy (n=2) ○ Healthy families (n=1) ○ Multisystemic family therapy (n=1) ○ Nurturing parenting program (n=2) ○ Play therapy (n=5)	35.0	14
• *Seeking Safety	32.5	13
• **PACT	30.0	12
• †MET	25.0	10
• **†Clubhouse	25.0	10
• Moral reconation therapy	20.0	8
• Solution focused brief therapy	20.0	8
• Acceptance and commitment therapy	20.0	8
• **†IDDT	20.0	8
• Housing first	12.5	5

EBPs, Best Practices, and Treatment Models	Percentage and Number of CSBs Reporting Use of EBPs, Best Practices, and Treatment Models for Service Delivery	
	%	n
• MH skill building	12.5	5
• Living in Balance	10.0	4
• *Helping Women Recover	7.5	3

*Trauma-focused approaches
**Transdisciplinary team approaches
***Youth and family approaches
†EBP, best practice, and/or treatment model to support STEP-VA implementation

It should be noted that even though the use of EBPs is ubiquitous, there were many cases where CSBs said they were using non-EBPs as well. There was also a lack of clarity in some situations among CSB staff as to whether a particular practice or program was evidence based.

Recovery Services

CSBs identified considerably fewer recovery EBPs as being commonly in use. There was a strong commitment to the most well-established practices, and CSBs expressed a consistent desire to increase EBPs for recovery. Over 40% of CSBs reported using the following EBPs and treatment models to support delivery of recovery services: WRAP®, peer certification, and Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other self-help programs. 12-Step programs were run by CSB staff in some cases and by outside organizations but housed in the CSB in others. It should also be noted that it was not uncommon for staff to identify treatment EBPs as being used in recovery, (e.g., MI and TDT to support delivery of recovery services). In some cases that seems appropriate, but it also may be due to confusion about the differences between the services.

WRAP® was reported as being used by 73% of CSBs in the recovery service category. This is equivalent to 29 out of 40 CSBs and is the highest number reported out of all types of recovery services. Certified recovery specialists were reported as being used by 63% of CSBs and providing AA groups was reported as being used by 50%. Overall, seven types of recovery services were named (Table 4.8).

Table 4.8. EBPs, Best Practices, and Treatment Models Used to Support Delivery of Recovery Services

EBPs, Best Practices, and Treatment Models	Percentage and Number of CSBs Reporting Use of EBPs, Best Practices, and Treatment Models for Service Delivery	
	%	n
Recovery Services		
†WRAP®	72.5	29
Peer certification	62.5	25
AA, NA, and other self-help programs	50.0	20
SMART Recovery	17.5	7
Hi-Fidelity Wraparound	15.0	6
Relapse prevention	7.5	3
Warmline	7.5	3

†EBP, best practice, and/or treatment model to support STEP-VA implementation

Prevention Services

Over 40% of CSBs reported using the following practices to support service delivery: MH First Aid, Lock and Talk, lock boxes, Counter Tools, and REVIVE!. MH First Aid was reported as being used by 73% of CSBs in the prevention service category. This is equivalent to 29 out of 40 CSBs and is the highest number reported out of all types of prevention services. Lock (e.g., Lock and Talk, lock boxes) was reported as being used by 48% of CSBs, and Counter Tools was reported as being used by 45%. Overall, seven types of prevention services were at or above 30%, and 15 types of prevention services were named in total (Table 4.9).

Table 4.9. EBPs, Best Practices, and Prevention Models Used to Support Delivery of Prevention Services

EBPs, Best Practices, and Treatment Models	Percentage and Number of CSBs Reporting Use of EBPs, Best Practices, and Treatment Models for Service Delivery	
	%	n
Prevention Services		
MH First Aid	72.5	29
Lock and Talk, lock boxes, etc.	47.5	19
Counter Tools	45.0	18
REVIVE!	40.0	16
*ACE Interface	37.5	15
Drug take-back programs	30.0	12
Too Good for Drugs	30.0	12
ASIST	27.5	11
Botvin Life Skills Training	27.5	11
***Strengthening Families	17.5	7
Too Good for Violence	10.0	4
Signs of Suicide	10.0	4
Safe Talk	7.5	3
Al's Pals	7.5	3
Synar Program	7.5	3

*Trauma-focused approaches
***Youth and family approaches

As mentioned in Section 3 Methodology, the JBS Team analyzed results from surveys completed by CSB Prevention Directors and conducted virtual focus groups with prevention focused staff and CSB-related coalition members to determine the extent to which EBPs fit into the prevention work in Virginia. It should be noted that there were discrepancies between the EBPs that CSBs reported using in their survey responses and what was said in staff individual interviews and focus groups. The following four paragraphs summarize these findings. See Appendix J for additional results from these focus groups and surveys.

CSB prevention staff shared that their prevention efforts are grounded in evidence-based strategies and programs. Most mentioned evidence-based strategies and programs in the education realm, including after school programming in partnership with social workers and counselors, as well as

specific programs, such as "Too Good for Drugs," "Teen Intervene," "Safe Dates," and other ongoing education curricula. Participants also shared that efforts are shifting more toward environmental strategies and community-level interventions, such as merchant education and media campaigns. Some CSBs receive smaller grants from the Virginia Foundation for Healthy Youth to implement evidence-based programming related to tobacco, substance use prevention, and childhood obesity.

Participants also stressed the importance of implementing evidence-based programming that has been evaluated to show change and replicated in various communities. This has become a criterion for the selection of their prevention strategies as well as ensuring risk and protective factors are considered: "The science-based approach has empowered my ability to say yes, there's poverty. Yes, there's drug addiction, but yes there's [also] protective factors." Identifying risk and protective factors in their community, implementing evidence-based strategies, and assessing outcomes have contributed to CSB ownership of the work and the larger belief in its value: "…and I think that's where prevention will become a value to the continuum of care rather than just some free thing that feels good." Participants emphasized that it is rewarding to identify positive outcomes and have evidence that can lead to additional funding opportunities. Further, 80% of CSBs felt confident that they implement prevention programming with fidelity.

EBPs are less a focus for coalitions than for CSBs. Generally, coalitions make themselves aware of EBPs and resources by attending conferences such as the Community Anti-Drug Coalitions of America and consulting national registries of evidence-based programming websites. Coalition members said they implement programs that are "well-known." At the same time, some participants seemed unsure when it comes to evidence-based work at their coalition, and a few mentioned this aspect was addressed by employing a coordinator or consultant to review their grant applications or otherwise ensure their work was evidence based.

Coalitions may experience tensions between funding that requires use of EBPs, and what they believe works best in their communities. EBPs are commonly becoming a requirement for receiving funding for coalitions. However, difficulty in employing evidence-based prevention practices in coalition work lies in shifting from established practices with long-time histories of implementation in communities to newer, evidence-based ones that may not be as familiar to the coalition or their community partners. Also, participants explained that what works in other localities doesn't necessarily work for their locality, and coalitions decide to implement what best serves local needs rather than what has been established as a best or promising practice.

Conclusions on the Use of Prevention and Treatment Models and EBPs

An important caveat to all these data collected on the use of EBPs is that the term was sometimes misused or used inconsistently by CSB staff. A number of services were identified as being used as EBPs that are not truly evidence based. In some cases, staff were not able to cite the evidence behind the practices they chose, often substituting what was a common practice as being an EBP. Examples of this include references to PSR and community engagement as being treatment and prevention strategies that are evidence based. Although there are PSR and community engagement models that are evidence based, there was no clear correlation to when a CSB cited these as evidence based and when they used the specific supported models. This was true in other areas as well. The clear takeaway is the commitment to EBPs that all CSBs demonstrated does not always include adequate grounding in the actual supporting evidence in a way that would support model fidelity. Whenever possible, this report excluded practices identified as EBPs by the CSBs that are not broadly identified as such in the professional literature.

4.1.5 To What Extent Do CSBs Support CQI and QA?

In a survey conducted prior to their site visit, CSBs were asked to indicate how much they agree with several statements regarding strategies used to support QA and CQI. Results of these analyses are displayed in Table 4.10. Survey findings indicate that the majority of CSBs agree or strongly agree that they use data to identify service priorities for treatment, prevention, and recovery services, respectively, with the highest levels of agreement for using data to identify priorities for prevention services (87.5%).

Table 4.10. QA and CQI Strategies Used by CSBs

QA and CQI Strategies	Number and Percent of Agreement by CSBs on Use of QA and CQI Strategies					
	Substance Use and MH Treatment		Prevention Services		Recovery Services	
	n	%	n	%	n	%
Data are used to identify service priorities	28	70.0	35	87.5	25	62.5
There is sufficient infrastructure to support data collection and data entry requirements for service provision	20	50.0	28	70.0	17	42.5
Our performance management systems are sufficient for tracking delivery of services	26	65.0	29	72.5	16	40.0
Data collected from our performance management systems are used to evaluate the quality of services delivered	21	52.5	27	67.5	11	30.0

Note: Percentages may not add to 100% because of missing data.

On average, about half of CSBs reported they agree or strongly agree that the infrastructure and performance management systems are sufficient for data collection and entry requirements and tracking service delivery, with the highest levels of agreement for infrastructure and systems that support data collection and entry requirements and tracking for prevention services (70% and 72.5%, respectively). The OMNI report incorporated into this document provides details on factors contributing to this. CSBs reported the lowest levels of agreement for recovery services, suggesting that the infrastructure and performance management systems may not be sufficient for data collection, data entry, and tracking delivery of this service.

Comparatively fewer CSBs reported that they agree or strongly agree that they use data from performance management systems to evaluate the quality of services delivered, with the smallest number of CSBs (30%) reporting that using such systems to evaluate delivery of recovery services. These findings are consistent with interview data from administrative and direct staff, who generally noted challenges with using data to evaluate and inform clinical service delivery.

There were discrepancies between this survey data and what was reported during site visit interviews. A wide range of staff were interviewed at each CSB. They were generally not as clear about the presence of strong CQI/QA systems within their organization. There were differing levels of commitment and success with each of the areas noted above, as expressed by staff, with different drivers and supports for the use of data collection.

"I don't think they realize that the data that goes into [the EHR] can come out too." (Rural, large budget CSB)

"I'm pretty sure that [the EHR] has the ability to pull out lots and lots of really relevant and helpful information, but we haven't gotten there yet to the extent that I want to." (Urban, large budget CSB)

When asked about data being used to identify service priorities, there were some references to periodic reporting of service utilization, which was reviewed by CSB leadership or supervisory staff. When possible, this was shared with direct service staff in some CSBs as part of the supervision process. These reports were compiled by IT or CQI staff depending on the CSB. In some cases, they were canned reports provided by the EHR, but it was more common that they were customized reports created internally at each CSB. Reports used to show utilization trends across service types, patterns in service provision by individual providers, and, in some cases, as part of a larger system of staff productivity measurement. It was not regularly noted that these data were used to drive changes in service provision patterns within the organization.

"We have a lot of good data to show what the needs are, but we need to do a much more integrated approach, I believe." (Urban, large budget CSB)

Service drivers were typically viewed as being funding or population driven, with these data being indicators of community need rather than tools for clinical decision making. It was also stated that the resources necessary to support data-driven decision making are not always available.

"Administratively, I would like to have, if I could, a data management person, someone who could really look into all of that and we could have productivity goals and objectives." (Rural, small budget CSB)

One of the challenges made evident in moving towards consistent data-driven decision making is the lack of infrastructure and QA/CQI systems in place at many of the CSBs, as indicated by staff. Nearly all of the CSBs said they had some of the pieces necessary to develop a reliable infrastructure; adequate IT, compliance, or CQI staff; an EHR that can generate trustworthy reports; policies and procedures to spell out operational expectations (although rarely for CQI efforts); and leadership commitment to CQI. The amount of each of these, and the manner in which they were utilized within the CSB, varied greatly, leading to very few examples of rigorous infrastructures used to inform service provision.

"We struggle in data management here." (Rural, small budget CSB)

"It's hard to pull the data." (Rural, small budget CSB)

It was regularly stated by CSB staff that CQI and QA work was very important, and many executive-level staff said they either wished they could commit more resources to this or that they intended to in the future. Most commonly, staff cited limited time and money as the largest barriers to making this commitment, particularly with other demands being viewed as more pressing.

"I would like to do that [CQI] very much. For me, I don't have anything measurable currently in place, but not to say that we couldn't create that." (Rural, small budget CSB)

Despite the difficulties using data to identify service priorities and developing a reliable QA/CQI infrastructure, CSBs regularly noted the ability to sufficiently track delivery of services. This appears to be a standard function of most EHRs and one on which CSBs rely. This drives the development of the service utilization reports that are shared with leadership and supervisors in some locations. It is also driven by external reporting demands. Many CSBs spoke about the importance of sending reliable data to DBHDS. One CSB noted the importance beyond being just a simple reporting requirement. When asked about the resources they use for CQI practices, it was noted, "CCS (sic) is pretty much the mechanism we use for that." This requirement—along with other expectations from the state, federal, grant funders, and local stakeholders—put the CSBs in the position of doing extensive external reporting. The frequency that this happens, and the fact that much of the external reporting relies on the same data reported in different formats, was a source of frustration at a number of CSBs. Multiple locations said that uniformity across reporting requirements would save them considerable time and money. As noted above, it is not clear how consistently or diligently these data are used internally at the CSBs.

Using data to measure the quality of services provided was not regularly reported by CSB staff. There were several locations that referred to standardized instruments like the Daily Living Activities-20 (DLA-20) instrument that were used to indicate clinical progress. There was also considerable credence given to the value of service quality being determined at the individual client level between clinician and supervisor. The difficulty in relying on anecdotal measures was highlighted by on CSB OP Coordinator:

"Yeah. I mean, I don't get clients calling me enraged, I don't feel like I'm getting my needs met. But evidence is nice. Show it to me in black and white. Are they doing better? Do they feel like their symptoms are reduced?" (Urban, medium budget CSB)

The majority of approaches to service quality measurement appear to be done at the client or small-group level, with few indicators of systems designed to support this CSB wide. Indicators of clinical progress given by CSB staff included length of stay, no-show frequency, readmission or recidivism, and use of crisis services, among others. Many anecdotal examples were provided of service quality.

"So, every month we have what's called critical indicators…every team has their own critical indicators. So, for some teams, like PACT, it's keeping clients out of the hospital. That's one of the examples. For us, we're monitoring for the IOP services. How many clients that start IOP make it through at least a month in the service, which means they've gotten a good chunk of it versus ones that drop out or that we lose for various reasons. And then we're also monitoring the contact with peer services." (Rural, large budget CSB)

"I look at recidivism…So, we have those outcomes. And then, of course, satisfaction and things like that. In emergency services, I take a look at response time." (Urban, medium budget CSB)

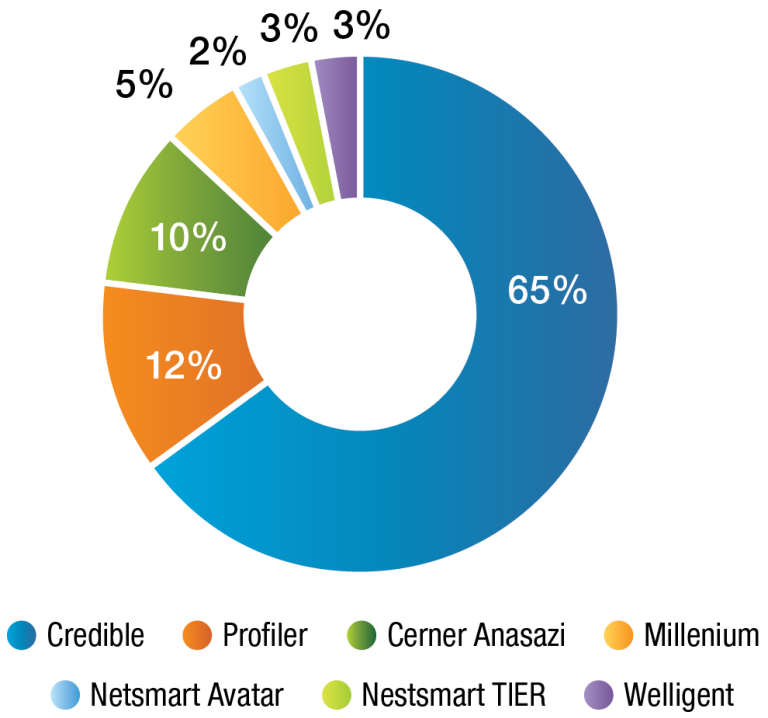
> **"And we get a lot of good feedback from our individual psychotherapy, too, with our younger generation as well. So that's a positive."** (Rural, small budget CSB)

This inconsistent use of data collection, QA/CQI, and data-driven decision making appeared to look starkly different with prevention services at many CSBs. Prevention services were reported as regularly collecting and using data to drive both community-level campaigns and to engage community stakeholders. Data is said to be used internally to understand the amount and type of prevention services being provided year-to-year. Examples of the kind of data collection that takes places in prevention services include coalition member satisfaction surveys conducted annually and point-in-time surveys for event participants to complete. Numerous prevention services directors attributed this data-driven approach to the long-standing requirements from external funders, which have required performance measurement or evaluation of services as a condition for funding for a long time. It was noted at several CSBs that prevention services can serve as a model for organization-wide QA/CQI efforts.

Performance Management Systems Used to Track Service Delivery

Figure 4.4 lists the EHR systems used by CSBs. Most CSBs—65% (n=26)—reported using Credible as their EHR. Other EHR systems used by multiple CSBs included Profiler (12.5%, n=5) and Cerner Anasazi (10.0%, n=4).

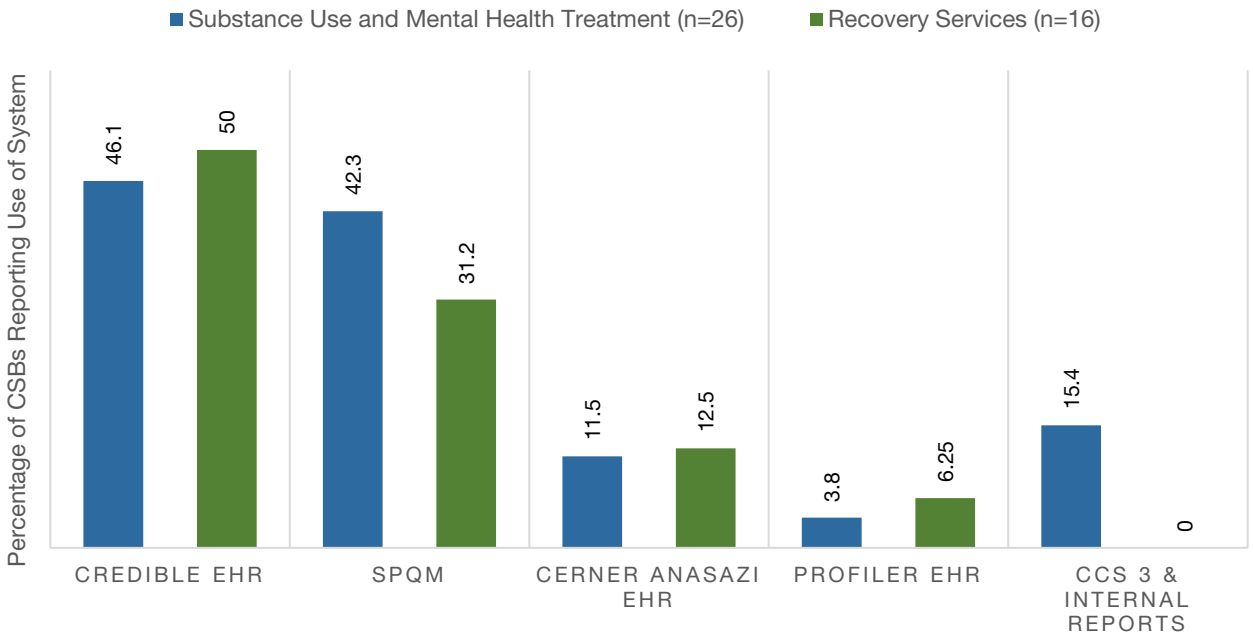
Figure 4.4. EHR Systems Used by CSBs



Approximately half of all CSBs specified the performance management systems they use to track service delivery, and some of those CSBs reported using their EHR system to track service delivery. Results indicated that performance management systems used by CSBs to track service delivery varied by the type of service. In addition, some CSBs reported using more than one system to track delivery of services.

Twenty-four CSBs specified the performance management systems they use to track delivery of substance use and MH treatment services, and 16 CSBs specified the systems they use to track delivery of recovery services. The performance management systems reported by CSBs to track delivery of substance use and MH treatment services, and recovery services, respectively, is displayed in Figure 4.5.

Figure 4.5. Performance Management Systems Used by CSBs to Track Delivery of Treatment and Recovery Services



Those CSBs that responded reported using similar performance management systems to track delivery of treatment and recovery services, respectively. Most CSBs reported using the Credible EHR system and the Service Performance Quality Management (SPQM) system, respectively, to track delivery of treatment and recovery services.

Twenty-five CSBs specified the performance management systems they use to track delivery of prevention services. Of those 25 CSBs, 76% (n=19) of CSBs reported using the PBPS system, and 16% (n=4) reported working with OMNI to support tracking of delivery of prevention services. In addition, 2 CSBs (8%) cited the Collaborative Planning Group, which supports online systems to support tracking service delivery, including PBPS and the Coalition Management System, which is used for administering and evaluating coalitions.

When looking at the survey and site visit data that were collected, a picture of a CSB system that is very much in the nascent stages of embracing CQI/QA practices to improve the work they do emerges. There is a verbal commitment to embracing performance improvement from nearly all CSBs, and there is evidence of staff resources dedicated to data requirements. The staff available to manage this work varies widely across locations, as does the models and systems they use, the prioritization of CQI efforts in comparison to other work, and the training and expertise of the staff assigned to these tasks. The most common message received was that CQI/QA was very important in principle, but resources could not be taken away from client services to support it. Section 4.3.3, Barriers to the Provision of BHS, describes challenges CSBs experienced related to the use of EHR systems.

4.1.6 To What Extent Do CSBs Use Telehealth Services?

To expand the strategies by which consumers can access care, many CSBs reported using telehealth to support remote behavioral healthcare. Telehealth includes the use of telecommunication technologies, including videoconferencing, the internet, wireless communication, mobile devices (e.g., tablets, smartphones), and streaming media, to:

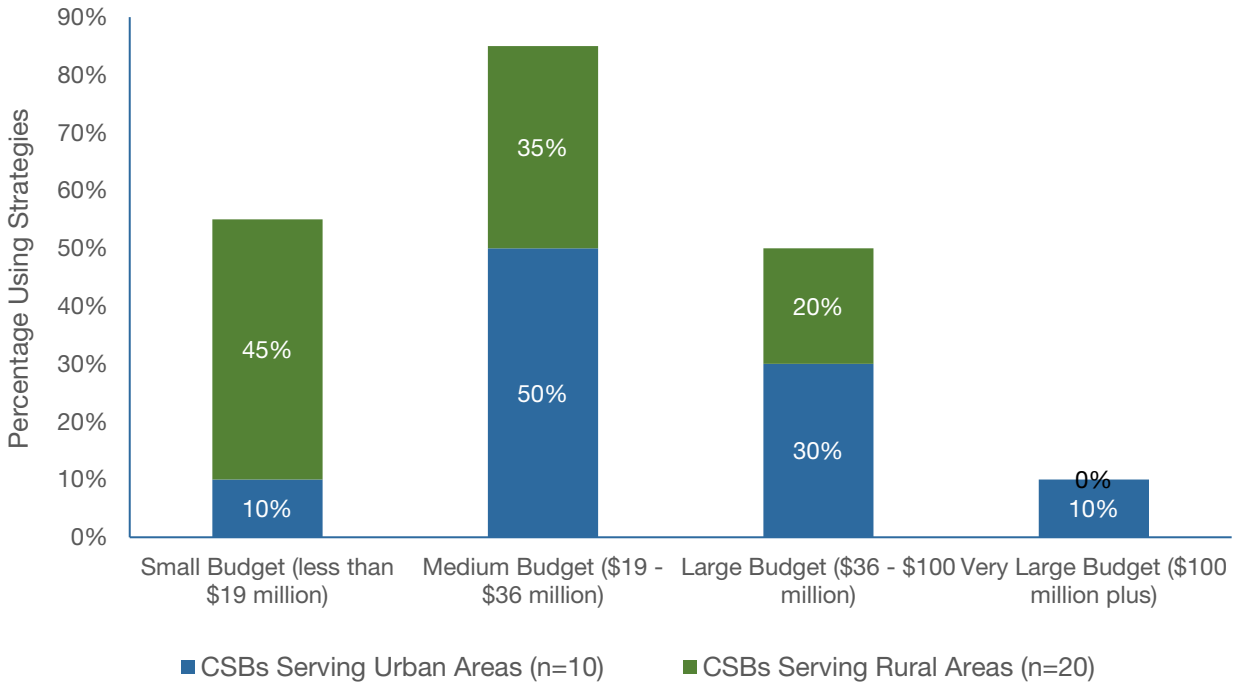
- Connect consumers to providers to provide virtual care services.
- Provide nonclinical services, such as interactive health communications with clinicians, to provide trainings, clinical consultation, and continuing education.
- Allow clients to remotely access BH resources and information to support their care and recovery.

The amount and type of telehealth services provided by CSBs across Virginia varies considerably. Analysis of pre-site survey questions regarding provision of telehealth services by CSBs indicated that 75% (n=30) of all CSBs reported using a range of telehealth services to support provision of substance use and MH prevention, treatment, and/or recovery services. Of the 30 CSBs that reported using telehealth services, 10 (33.3%) serve primarily urban geographic areas and 20 (66.7%) serve primarily rural geographic areas. As rural CSBs are likely to have clinic locations that are geographically distant, and have greater limitations in hiring psychiatrists, it may not be surprising that the majority (87%) of the 23 CSBs serving primarily rural areas (vs 58.8% of the 17 CSBs serving primarily urban areas) reported using telehealth, virtual care technologies, or mobile services. That said, the broad adoption of telehealth supports the notion that it serves as a valuable service extender for both rural and smaller CSBs regardless of location.

"We've partnered with [a specific corporation], which is a [….] national pharmacy. But they have a component of their organization that's telepsychiatry. And so, for instance, we've contracted with them, with one of the providers that we have in our [city name] location to do telepsychiatry out there. And it's worked out really well. Obviously, they want to expand their market here in Virginia. So very affordable compared to psychiatry nowadays an M.D. is going for $250,000. We worked out somewhere in the area if we analyzed it $180,000. So quite a cost savings with contracting with [corporation], with outsourcing it, rather than hiring someone. So that's not the total solution because everyone's not comfortable with telepsychiatry, but we're trying different things to help with this issue." (Rural, large budget CSB)

Figure 4.6 shows the percentage of CSBs using telehealth services by geographic areas served and overall CSB budget size. Among CSBs serving primarily rural areas, those with smaller overall budgets appeared to be more likely to use telehealth and virtual care strategies than those CSBs serving primarily urban areas. However, as the overall budgets for CSBs increased, a greater percentage of CSBs from urban areas reported using telehealth services.

Figure 4.6. Percentage of CSBs Using Telehealth and Virtual Care Strategies by Type of Geographic Areas Served and Overall Budget Size



Although the majority of CSBs serving rural areas report using telehealth services, the extent to which CSBs use these services may not reflected in the quantitative data. In addition, the amount of time spent providing telehealth services differs at each CSB. Interview data show that, in some locations, telehealth services constitute a significant percentage of psychiatric services that are provided, particularly for children. In other locations, there are relatively few hours of telehealth provided, and it is seen as a minor supplement to onsite services. In a few locations, all of the children's psychiatric services are provided remotely. A number of CSBs rely on the University of Virginia for these psychiatric telehealth services. Several other CSBs connect eligible patients to the Veteran's Administration for telehealth psychiatric services, and a few use telehealth as part of their crisis stabilization work. Along with direct service, more than one CSB noted that they are using remote access to get rural providers into trainings and to consult directly with other providers.

"Like outpatient. There's always been deficits with psychiatry. Psychiatry's running up to 250 bucks an hour, depending on who you're contracting with. We use Locums. …. I do a lot of telemedicine here in the rural community because I can't get an onsite doc." (Rural, small budget CSB)

"Our psychiatry is very limited. We have one psychiatrist right now full time. Psychiatrists are expensive, and they're in high demand. So, they too can often work from home and make a lot more money because of the telemedicine. And so, a challenge for us for hiring, for any position is that we have nine localities. And if you're one doctor and you don't want to travel to multiple clinics, which we do the webcam for the others, but there's still some time involved." (Rural, small budget CSB)

"We actually are pretty robust in doctors and board-certified child doctors. A lot of it's with telepsych, I mean, with the doctor sitting at home somewhere completely out of our area. But that seems to work just fine." (Urban, medium budget CSB)

"Outpatient, we implemented same-day access before it was mandated and chose to do it in two sites and have the ability to do telehealth. So, if somebody is somewhere else to be able to come in." (Urban, medium budget CSB)

"It is definitely my hope to try and expand telemedicine. I've heard some good things about groups that have been able to use psychiatrists through telemedicine consistently. And that has been a challenge for us. Many psychiatrists, it takes a little bit of getting used to the clients that we work with. And we also have been working with them. They [psychiatrists] have had a 46% no-show rate." (Urban, medium budget CSB)

Table 4.11 lists the type of telehealth and virtual care strategies used by the 30 CSBs that reported using telehealth for provision of BHS. The majority of CSBs that use telehealth services reported using telemedicine platforms, with approximately 27% (n=8) of CSBs that serve primarily urban areas and approximately 63% of CSBs that serve primarily rural areas using such platforms for service provision.

Table 4.11. Type of Telehealth and Virtual Care Strategies Used by CSBs

Telehealth and Virtual Care Strategies	Urban CSBs (n=10)		Rural CSB (n=20)		All CSBs Using Telehealth and Virtual Care Strategies (N=30)	
	n	%	n	%	n	%
Mobile health (mHealth) applications (e.g., smartphone applications [apps] for clients to access health resources and information via the internet)	1	3.3	2	6.7	3	10.0
mHealth Wearables (e.g., mobile phones and wearable devices used to monitor vital signs in real time, medication adherence)	0	0.0	1	3.3	1	3.3
Telemedicine platforms (e.g., Zoom, Skype)	8	26.7	19	63.3	27	90.0
Digital messaging platforms (e.g., use of platforms such as Google or Facebook to deliver health messaging)	1	3.3	1	3.3	2	6.7
Mobile health units (e.g., mobile health clinics use to provide BHS to remote areas)	0	0.0	1	3.3	1	3.3
Other telehealth and virtual care strategies (e.g., use of EHR patient portals, such as Polycom RealPresence, for health literacy)	1	3.3	3	10.0	4	13.3

Note: Percentages may not add to 100% because of missing data.

Analysis of the consumer focus group survey indicated that approximately 58% (n=129) of respondents reported that their CSB provides mobile and/or electronic health services to access care needed. Half of consumer focus group participants whose CSB serves primarily urban areas (n=106) and approximately 64% of consumers whose CSB serves primarily rural areas (n=118) reported that their CSB provides such services.

When asked about low adoption and use of telehealth services, CSB staff provided a few common justifications during interviews.

Insufficient Funding/Cost of Implementation. It was noted that CSBs were not able to contract for telehealth services due to budget limitations, limited availability of telehealth providers, or because of limited interest by their staff or client population.

"…as a matter of fact, we just had an ethical consult on even telephone therapy. And I know the staff feel very uncomfortable with that because they're missing the cues that they think they need in just doing the psychotherapy. So, that paired with the fact that it's not—we're not inaccessible. There's not a lot of pressure to go in that direction." (Urban, large budget CSB)

"But probably my biggest issue is with our psychiatric staff. We have half of our psychiatric staff are face-to-face psychiatrists or nurse practitioners. The other half are through telepsych. And that was kind of a good and a bad thing for me, the telepsych. We've expanded that over the years. But psychiatrists are prima donnas in a lot of ways. They require so much money." (Rural, small budget CSB**)**

"We don't get reimbursed near what we end up paying out. You figure our telepsych costs us $186 an hour. We can't see enough people in an hour to make up for to get that back." (Rural, small budget CSB**)**

Client Resistance/Lack of Trust. In some CSBs where telemedicine services were being used, there were reports of client resistance. This was attributed, at times, to discomfort talking to a stranger remotely, which led more than one CSB to dedicate staff to supporting these sessions.

"Telepsychiatry is easier on the psychiatrists to do because you're behind on a screen, and our people hate it. They hate it... the other thing is you don't have a person in front of you. So, some of the nuances of seeing someone with serious mental illness, you can't smell. You can't see the feet, the hands, anything else. So, you're missing some visual cues, I think. And smell is important with my people. The other thing is that we have emergency services 24 hours a day, 7 days a week, and sometimes our emergency services people talk to our psychiatrists in the middle of the night. So, your telepsychiatry is not available unless they're on. So, we just contracted with telepsychiatry because we had to get somebody in here because we don't have enough people. But nobody's happy. Nobody." (Rural, small budget CSB)

Adequate IT Infrastructure. In some cases, especially in rural parts of the state, there was not adequate, reliable internet access to consistently use telehealth. For CSBs with very small IT departments this was compounded by not having IT resources to support the service. There was more than one instance where non-IT staff were responsible for managing and maintaining telehealth hardware and services. This left them with limited, unsustainable options when there were technical issues that staff were not equipped to troubleshoot.

"Medicare's changing their rules around telehealth for 2020. So that will offer some opportunities for us where we've seen some barriers to see people in their homes because home will be a place of service. We'll be limited by the internet… whether or not you even have internet capability…so, that will be what our barrier is for those kinds of things." (Rural, small budget CSB)

CSBs that have been using telehealth services noted the benefit of continuing to provide the services since the convenience will outweigh clients' lack of familiarity with providers.

"It's starting to be well received." (Rural, large budget CSB)

Recommendations

- **Training.** The annual cultural competence training provided at CSBs does not allow any kind of uniformity of approach or knowledge, and it is not intended to cover subpopulations that are particularly relevant for each community. Promulgating an evidence-based cultural competency training for all CSBs to use will address this. Providing annual demographic data by community will also help CSBs understand where more in-depth knowledge is needed.
- **Outreach.** One barrier to effectively providing services to diverse populations is the limited outreach to those groups, aimed at reducing barriers to service engagement. The prevention model used by many CSBs is a good example of inclusive community engagement. Using prevention coalitions to reach underserved populations can increase participation in treatment.
- **Institutional Standards.** Because services at CSBs are stretched so thin, CSBs focus on providing services to those that most easily access treatment. This frequently does not include underserved and unique populations. Statewide standards on translation, interpretation, and culturally sensitive engagement practices as part of same-day access (SDA) can help to decrease stigma around starting services at CSBs.
- **In-House Resources.** CSBs typically made efforts to match clients to service providers based on common background and/or experience. State-funded cultural brokers operating in each of the CSBs would make this much easier and would allow for much more effective outreach and engagement to underserved populations. This would be akin to what is done in recovery services, using peers to match to client need from the first contact on.
- **Translation/Interpretation.** CSBs reported wide variety in their ability to access, and likelihood to use, translation and interpretation services. They are responsible for arranging these services on their own, so the perceived lack of need by staff affects this access. A state-funding service available to all CSBs, with clear guidance on how and when to access it, would decrease this barrier significantly.

4.2 What is the Need for BHS in Virginia?

4.2.1 What Are the Demographic and Clinical Characteristics of Clients Seeking BHS?

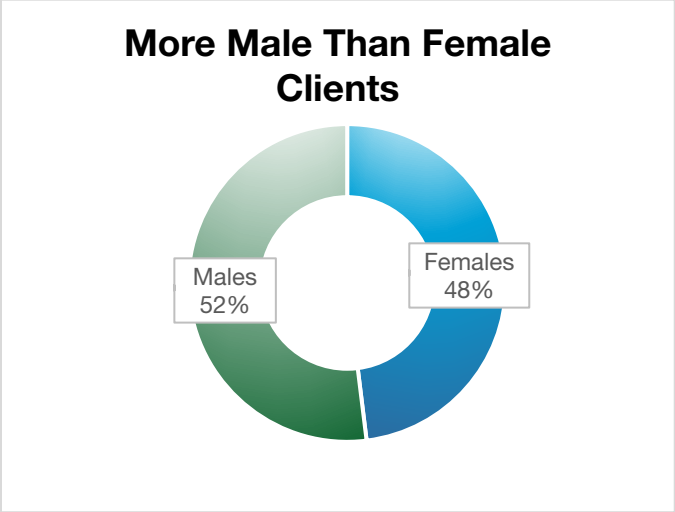
The JBS Team analyzed quantitative data from the CCS 3 to better understand the demographic, geographic, and clinical characteristics of clients who sought BHS at the CSBs. Between state FY2013 and FY2019, 1,071,094[49] clients received substance use and/or MH services from CSBs.

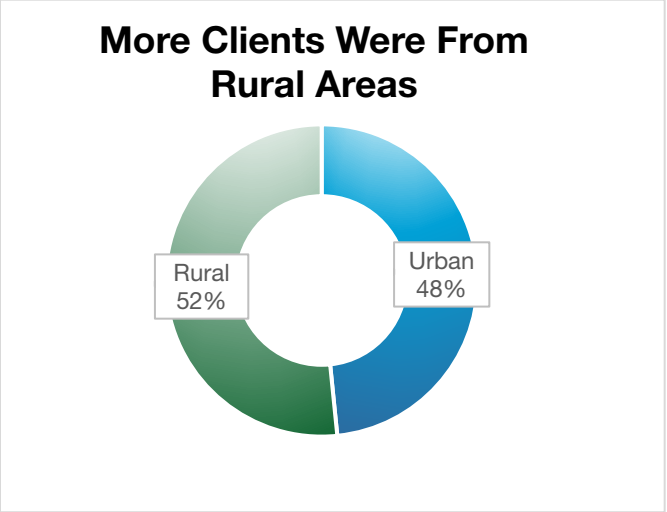
Demographic and Geographic Characteristics of Clients Receiving BHS

Table 4.12 presents a breakdown of the demographics of the clients who received BHS between FY2013 and FY2019. Across FYs, there were significant increases in the total number of:

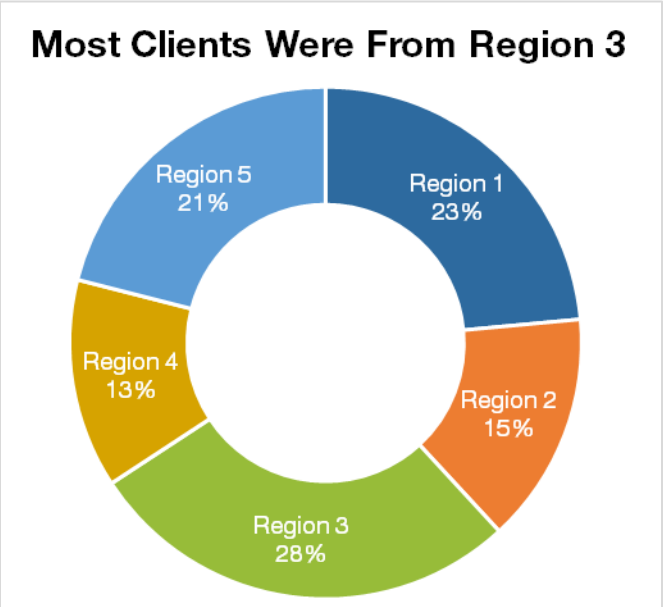
- Female clients ($p < 0.01$).
- Adolescent clients (ages 12–17 years; $p < 0.001$).
- Adult clients age 26 years and older ($p < 0.05$).
- Clients who identify as Alaskan Native ($p < 0.05$).
- Clients who identify as American Indian ($p < 0.05$).
- Clients who identify as Black or African American ($p < 0.05$).
- Clients who identify as Hispanic ($p < 0.01$).
- Clients who identify as White ($p < 0.01$).
- Clients who identify with two or more races ($p < 0.01$).

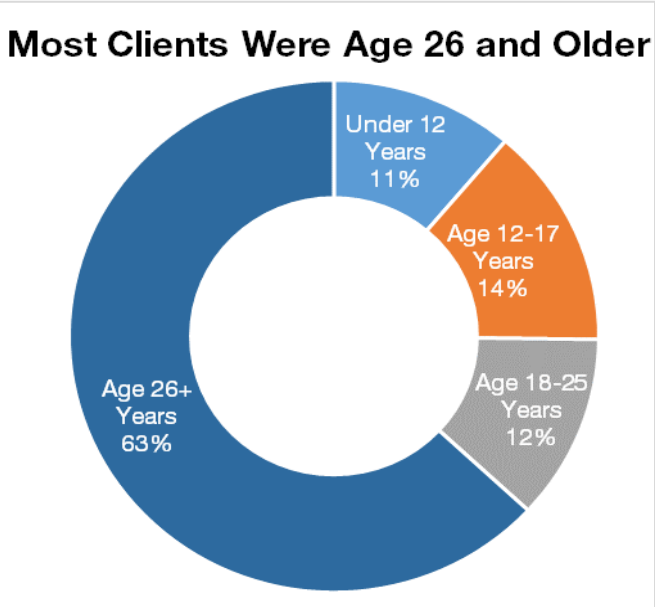
Demographic characteristics of clients who received BHS in FY2019 (N=158,914) can be described as follows:





[49] Between FY2013 and FY2019, the 40 CSBs provides BHS to 1,624,269 clients. Of those 1,624,269 clients, 1,071,094 (65.9%) received substance use and MH services. Services provided to the remaining 34.1% (n=553,175) clients include, but may not be limited to, emergency and ancillary services, developmental services, and Part C early intervention services. As the needs assessment was tasked with focusing on those clients who received substance use and MH services, all analyses in this section were based on the 1,071,094 clients who received substance use and MH services.


Most Clients Were From Region 3
Region 1
23%
Region 2
15%
Region 3
28%
Region 4
13%
Region 5
21%


Most Clients Were Age 26 and Older
Under 12
Years
11%
Age 12-17
Years
14%
Age 18-25
Years
12%
Age 26+
Years
63%

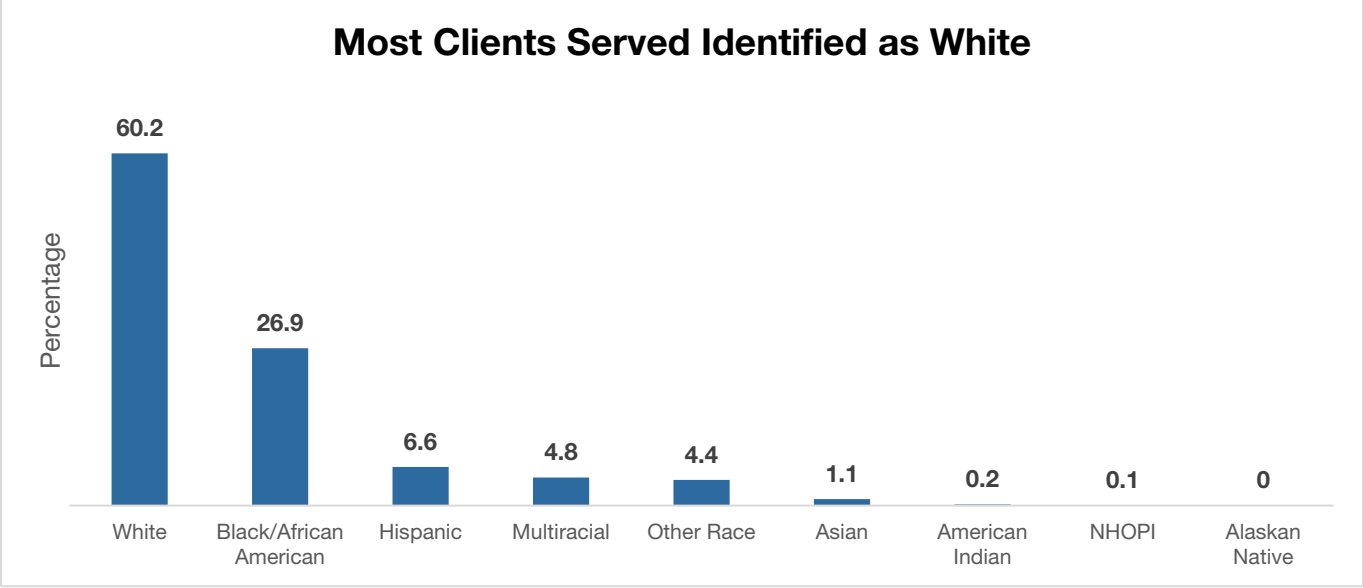

Most Clients Served Identified as White
Percentage
60.2
26.9
6.6
4.8
4.4
1.1
0.2
0.1
0
White
Black/African American
Hispanic
Multiracial
Other Race
Asian
American Indian
NHOPI
Alaskan Native

Table 4.12. Demographic Characteristics of Clients Who Received BHS Between FY2013 and FY2019

Client Demographic Characteristics	FY2013 (N=146,211)		FY2014 (N=148,487)		FY2015 (N=151,883)		FY2016 (N=151,309)		FY2017 (N=157,394)		FY2018 (N=156,896)		FY2019 (N=158,914)	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Gender														
• Female	46.9%	68,515	47.2%	70,012	47.2%	71,648	47.8%	72,376	48.3%	75,944	48.1%	75,399	48.0%	76,302
• Male	53.1%	77,641	52.8%	78,435	52.8%	80,190	52.1%	78,900	51.7%	81,399	51.9%	81,415	51.9%	82,506
Age														
• Under 12 years	11.0%	16,104	11.2%	16,605	11.1%	16,886	11.2%	17,017	11.4%	17,977	11.2%	17,501	11.2%	17,792
• 12–17 years	13.2%	19,364	13.5%	20,009	14.0%	21,202	13.9%	21,105	14.0%	21,970	13.8%	21,591	14.0%	22,245
• 18–25 years	13.2%	19,327	12.9%	19,158	12.6%	19,174	12.2%	18,468	12.0%	18,886	11.9%	18,663	11.7%	18,570
• 26+ years	62.5%	91,416	62.4%	92,715	62.3%	94,621	62.6%	94,719	62.6%	98,561	63.2%	99,141	63.1%	100,307
Ethnicity														
• Not Hispanic	94.4%	138,032	94.2%	139,818	94.0%	142,810	94.1%	142,361	94.0%	147,981	93.7%	146,971	93.4%	148,395
• Hispanic	5.6%	8,179	5.8%	8,669	6.0%	9,073	5.9%	8,948	6.0%	9,413	6.3%	9,925	6.6%	10,519
Race														
• Alaskan Native	0.0%	44	0.0%	39	0.0%	31	0.0%	34	0.0%	24	0.1%	137	0.0%	69
• American Indian	0.2%	316	0.2%	288	0.2%	290	0.2%	272	0.2%	281	0.3%	434	0.2%	338
• Asian	1.0%	1,430	1.0%	1,464	1.0%	1,517	1.0%	1,465	1.0%	1,561	1.0%	1,622	1.1%	1,746
• Black/African American	27.4%	40,129	27.6%	41,021	27.8%	42,151	27.9%	42,198	28.0%	44,015	26.9%	42,191	26.9%	42,746
• Native Hawaiian or Other Pacific Islander	0.1%	123	0.1%	104	0.1%	121	0.1%	117	0.1%	122	0.1%	129	0.1%	146
• White	61.0%	89,227	60.8%	90,274	60.8%	92,395	60.7%	91,873	59.8%	94,144	60.6%	95,004	60.2%	95,693
• Multiracial	3.6%	5,286	3.7%	5,536	3.9%	5,916	4.2%	6,365	4.3%	6,846	4.6%	7,159	4.8%	7,651
• Other race	4.0%	5,871	4.2%	6,280	4.4%	6,654	4.1%	6,255	4.1%	6,508	4.2%	6,571	4.4%	7,039

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

At-Risk Client Populations

CSBs provided BHS to several populations at risk of developing substance use and MH disorders, including the following:

- Pregnant women with SUDs;
- Clients who were not currently employed;
- Individuals involved with the criminal justice system, including:
  - Clients who were court ordered to receive treatment and
  - Juveniles involved in the criminal justice system; and
- Clients involved in the military, including:
  - Armed forces on active duty,
  - Family members of those who served, and
  - Veterans.

Table 4.13 presents the number and percentage of clients in these at-risk populations who received BHS between FY2013 and FY2019.

Pregnant Women With SUDs. After some fluctuations in the percentage of pregnant females with SUDs across FYs, the percentage of pregnant females with SUDs was highest in FY2019 compared with FY2013 ($p < 0.001$), FY2015 ($p < 0.001$), FY2016 ($p < 0.001$), and FY2018 ($p < 0.001$), indicating an overall significant increase in the percentage of this client population across FYs.

Clients Who Were Not Currently Employed. The percentage of clients who are unemployed was highest in FY2013 ($p < 0.001$) and has declined significantly in successive FYs.

Justice-Involved Clients. There was a significant decline across FYs in the number of clients who were court ordered to treatment, including those court ordered to treatment as a diversion from the criminal justice system ($p < 0.001$). In addition, there were significant declines in (1) the percentage of juveniles involuntarily admitted for court-ordered treatment ($p < 0.001$), and (2) the percentage of incarcerated clients transferred to a state hospital for treatment ($p < 0.01$). However, there was increase in the number of justice-involved individuals, including incarcerated persons, involuntarily admitted to treatment between FY2013 and FY2018 ($p < 0.01$).

Clients Involved with the Military. Although the percentage of clients on active duty has remained generally consistent over time, the number of clients on active duty has declined since FY2013 ($p < 0.05$). However, there has been a significant increase across FYs in the number of family members dependent on someone in the military, with the highest percentage of these clients in FY2019 ($p < 0.001$).

Table 4.13. At-Risk Clinical Characteristics for Clients Who Received Substance Use and MH Services Between FY2013 and FY2019

Insurance Types	FY2013 (N=146,211)		FY2014 (N=148,487)		FY2015 (N=151,883)		FY2016 (N=151,309)		FY2017 (N=157,394)		FY2018 (N=156,896)		FY2019 (N=158,914)	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Females with SUDs who are pregnant	0.9%	1,290	1.3%	1,874	0.7%	1,076	1.0%	1,560	1.3%	1,976	1.0%	1,579	1.3%	2,022
Unemployed clients	20.4%	29,836	19.6%	29,105	18.9%	28,759	18.5%	27,977	18.2%	28,630	18.4%	28,912	18.3%	29,044
Military status														
• Veterans	2.1%	3,122	2.1%	3,064	2.0%	3,020	2.0%	2,960	1.9%	3,025	1.9%	3,057	2.0%	3,176
• Dependent family members	0.5%	701	0.4%	659	0.4%	591	0.4%	608	0.4%	672	0.6%	880	0.7%	1,085
• Armed Forces Reserve or National Guard	0.2%	287	0.2%	286	0.2%	283	0.2%	298	0.2%	294	0.2%	320	0.2%	311
• Active Duty	0.2%	293	0.2%	274	0.2%	254	0.2%	241	0.1%	225	0.1%	218	0.2%	241
Justice-involved individuals														
• Individuals court ordered to treatment	8.6%	12,519	8.6%	12,818	8.6%	13,087	7.6%	11,567	7.5%	11,754	7.5%	11,717	6.8%	10,741
• Juveniles involuntary admitted for court-ordered treatment or evaluation	1.6%	2,277	1.7%	2,503	1.7%	2,572	1.4%	2,157	1.2%	1881	1.0%	1,613	0.9%	1,405
• Incarcerated individuals transferred to state hospital for treatment	0.1%	149	0.1%	115	0.1%	96	0.1%	113	0.1%	116	0.1%	101	0.1%	134
• Other justice-involved individuals involuntary admitted for treatment	1.6%	2,324	1.7%	2,522	1.7%	2,512	1.7%	2,501	1.7%	2,636	1.8%	2,824	1.7%	2,715

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Key Findings–Client Demographics and Clinical Characteristics

- Most clients who receive substance use and MH services from CSBs are located in rural areas, are adults, and identify as White.
- There were significant increases across FYs in the percentage of clients from the following demographic groups:
  - Females,
  - Adolescents (ages 12–17 years),
  - Adults (age 26 years and older), and
  - White/nonminority clients and racial and ethnic minority clients, including clients who identify as Hispanic and clients who identify with two or more races.
- There were significant increases across FYs in the percentage of clients from the following at-risk clinical populations:
  - Pregnant females with SUDs,
  - Justice-involved individuals involuntarily admitted to treatment, including incarcerated persons, and
  - Family members dependent on someone in the military.

Recommendations

- Given the increasing percentage of Hispanic clients, clients dependent on a family member in the military, and clients from rural areas seeking BHS, CSBs may want to use strategies (e.g., translators, Spanish-language direct service providers, transportation, telehealth) and build partnerships (e.g., military family resource organizations) to facilitate greater access to services for these client populations.

4.2.2 How Do Substance Use and MH Needs Differ Across CSB Client Populations?

SED

SAMHSA defines people with SED as those who, "from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), Third Edition, Revised (American Psychiatric Association, 1987) that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities" (SAMHSA, 1993, p. 29425)[50].

The JBS Team analyzed quantitative data from the CCS 3 to describe the demographic and geographic characteristics of the clinical population of clients who had SED or were at risk for SED from FY2013 through FY2019. Although no definition of "at risk of SED" was provided, based on the definition of SED, we believe that young clients at risk for SED may demonstrate some functional impairment in their family, community, and scholastic relationships. In addition, young clients at risk for SED may

[50] SAMHSA, Center for Mental Health Services. (1993). Defining serious emotional disturbance in children: Final notice. Federal Register, 58(96), 29422-29425. Accessed on March 1, 2020, at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf

demonstrate some aspects of mental, behavioral, or emotional disorders but not meet the diagnostic criteria specified within the DSM.

Table 4.14 displays the number of clients under age 12 who had SED or were at risk for SED, relative to the total client population. Across all FYs, a total of 119,882 clients under age 12 (11.2% of the total client population of 1,071,094) received substance use and MH services, indicating that children constitute a smaller percentage of the total client population. Of those 119,882 clients, 21.5% (n=25,779) were at risk for SED, and 58.8% (n=70,478) had SED. Among those at risk for SED, there was a gradual decrease in the number of child-age clients across FYs. However, there was a gradual increase across FYs in the number of child-age clients with SED.

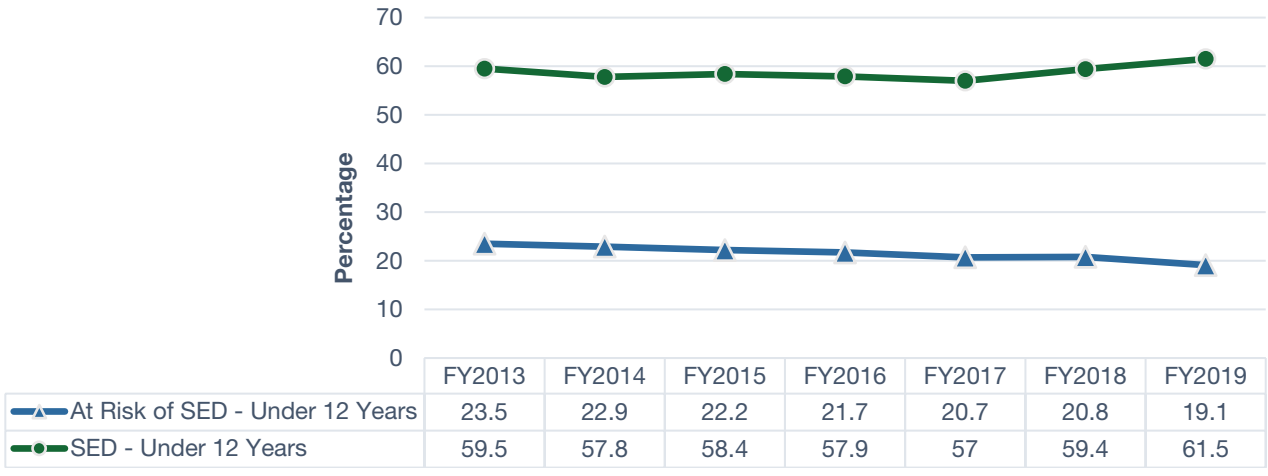
Table 4.14. Number and Percent of Clients Under Age 12 Having SED or at Risk for SED, Relative to Total Client Population

Client Age Groups	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
At Risk of SED							
Under 12 years	3,783 (2.6%)	3,809 (2.6%)	3,743 (2.5%)	3,690 (2.4%)	3,720 (2.4%)	3,637 (2.3%)	3,397 (2.1%)
SED							
Under 12 years	9,586 (6.6%)	9,599 (6.5%)	9,855 (6.5%)	9,847 (6.5%)	10,241 (6.5%)	10,404 (6.6%)	10,946 (6.9%)
Total N—Clients Under Age 12	16,104 (11.0%)	16,605 (11.2%)	16,886 (11.1%)	17,017 (11.2%)	17,977 (11.4%)	17,501 (11.2%)	17,792 (11.2%)
Total N—Clients Under Age 18	35,468 (24.3%)	36,614 (24.7%)	38,088 (25.1%)	38,122 (25.2%)	39,947 (25.4%)	39,092 (24.9%)	40,037 (25.2%)
Total N—All Clients	146,211	148,487	151,883	151,309	157,394	156,896	158,914

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.7 displays the percentage of clients under age 12 who had SED or were at risk for SED by FY. Results indicate that the percentage of clients under age 12 at risk for SED in FY2019 was significantly lower that all previous FYs ($p < 0.01$), indicating a *decrease* in the percentage of children with SED over time. In contrast, the percentage of clients with SED under age 12 in FY2019 was significantly higher than FYs 2014 through FY2017 ($p < 0.01$), indicating a significant increase in the number of child-age clients with SED.

Figure 4.7. Percentage of Clients Under Age 12 With SED or at Risk for SED



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
At Risk of SED - Under 12 Years	23.5	22.9	22.2	21.7	20.7	20.8	19.1
SED - Under 12 Years	59.5	57.8	58.4	57.9	57	59.4	61.5

Note: Percentages do not add to 100% because data was missing, not applicable, or not collected.

Table 4.15 displays the number of clients ages 12–17 who had SED or were at risk for SED, relative to the total client population. Across all FYs, a total of 147,486 clients ages 12–17 (13.8% of the total client population of 1,071,094) received substance use and MH services, indicating that adolescents constitute a smaller percentage of the total client population. Of those 147,486 clients, 0.9% (n=1,412) were at risk for SED, and 70.3% (n= 103,768) had SED. Among those at risk for SED, there was a gradual decrease in the number of clients ages 12–17 across FYs. However, there was a gradual increase across FYs in the number of adolescent-age clients with SED.

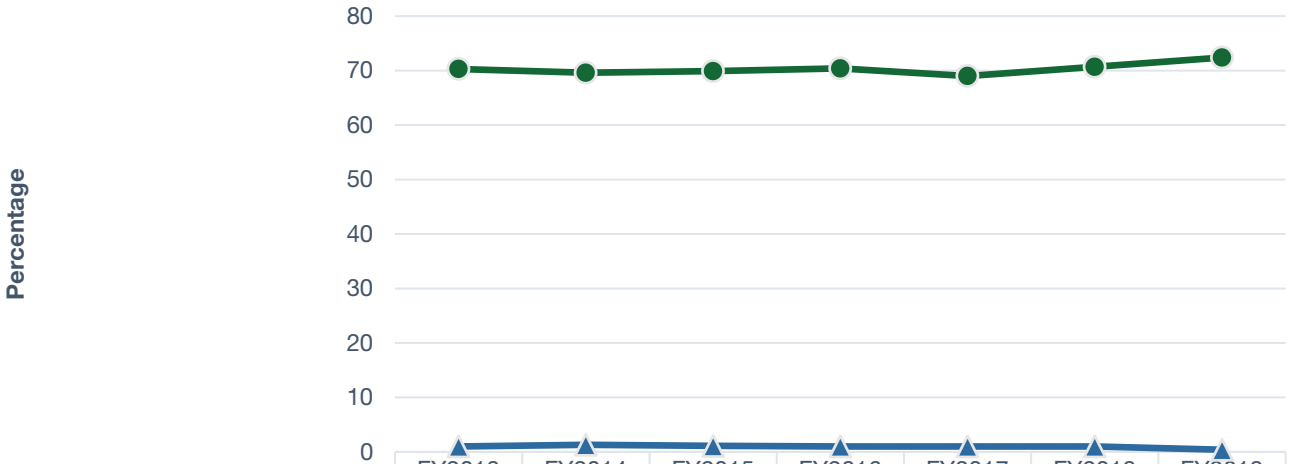
Table 4.15. Number and Percent of Clients Ages 12–17 Years Having SED or at Risk for SED, Relative to Total Client Population

Client Age Groups	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
At Risk of SED							
12–17 years	200 (0.1%)	268 (0.2%)	227 (0.1%)	203 (0.1%)	211 (0.1%)	210 (0.1%)	93 (0.0%)
SED							
12–17 years	13,622 (9.3%)	13,934 (9.4%)	14,816 (9.8%)	14,865 (9.8%)	15,164 (9.6%)	15,255 (9.7%)	16,112 (10.1%)
Total N—Clients Age 12–17	19,364 (13.2%)	20,009 (13.5%)	21,202 (14.0%)	21,105 (13.9%)	21,970 (14.0%)	21,591 (13.8%)	22,245 (14.0%)
Total N—Clients Under Age 18	35,468 (24.3%)	36,614 (24.7%)	38,088 (25.1%)	38,122 (25.2%)	39,947 (25.4%)	39,092 (24.9%)	40,037 (25.2%)
Total N—All Clients	**146,211**	**148,487**	**151,883**	**151,309**	**157,394**	**156,896**	**158,914**

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.8 displays the percentage of clients ages 12–17 who had SED or were at risk for SED by FY. The percentage of clients ages 12–17 years at risk for SED appeared to be consistent across FYs. In contrast, the percentage of SED for clients ages 12–17 years in FY2019 was significantly higher than all previous FYs ($p < 0.01$), indicating a gradual increase in the number of adolescent clients with SED over time, despite some fluctuations across FYs.

Figure 4.8. Percentage of Clients Ages 12–17 With SED or at Risk for SED



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
At Risk of SED - 12-17 Years	1	1.3	1.1	1	1	1	0.4
SED - 12-17 Years	70.3	69.6	69.9	70.4	69	70.7	72.4

Note: Percentages do not add to 100% because data was missing, not applicable, or not collected.

Overall, findings indicate that CSBs are continuing to serve increasing numbers of child- and adolescent-age clients with and at risk for developing SED. CSB administrative staff noted the need for CSBs to continue providing BHS to children and their families.

"Our outpatient services are for all people that are serious mental illness, except for the kids. Now, the kids, the definition is a bit different. It's serious mental illness or at risk. And the world is a little bit different in kids that we hardly turn away any kids. So, with the adults, it's around 50% we're turning away. With the kids, it's a very small percentage." (Urban, large budget CSB)

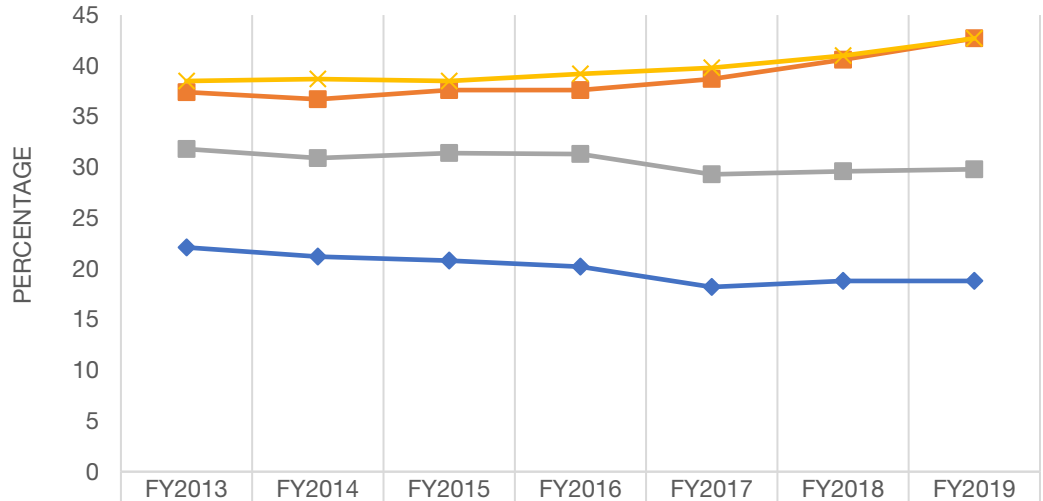
"So, and that changed because the available dollars were sucked up by the smaller group of individuals, a lot of what fell by the wayside on the adult side with those folks that needed traditional counseling. We still tried to serve youngsters. But in terms of the adults, they were put to the side. Now with STEP-Virginia, we're seeing a resurgence back to some OP as an important area that now we want to prioritize. But, of course, we still have to support people that are SMI and SED." (Rural, medium budget CSB)

Geographic Differences in SED–Urban and Rural Areas

Figure 4.9 displays the percentage of clients with SED for two age groups—those under 12 years of age and those ages 12–17 years—who were served by CSBs in primarily urban or rural areas, respectively. Results indicate that, for both age groups, rural CSBs serve a higher percentage of SED clients than urban CSBs.

Among clients served by CSBs in primarily urban areas, percentages of SED were highest in FY2016 for clients across both age groups. For clients under age 12, percentages of SED for FY2017 through FY2019 were significantly lower ($p < 0.01$) than those of prior FYs, indicating a decline in the number of children with SED after FY2016. In contrast, among clients served by CSBs in primarily rural areas, percentages of SED were highest for both age groups in FY2019 ($p < 0.01$). In summary, since 2016, the number of SED clients in urban areas has gradually decreased and the number of SED clients in rural areas has increased.

Figure 4.9. Percentage of Clients With SED Across Urban and Rural Areas



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Urban - Under 12 Years	22.1	21.2	20.8	20.2	18.2	18.8	18.8
Rural - Under 12 Years	37.4	36.7	37.6	37.6	38.7	40.6	42.7
Urban - 12-17 Years	31.8	30.9	31.4	31.3	29.3	29.6	29.8
Rural - 12-17 Years	38.5	38.7	38.5	39.2	39.8	41	42.7

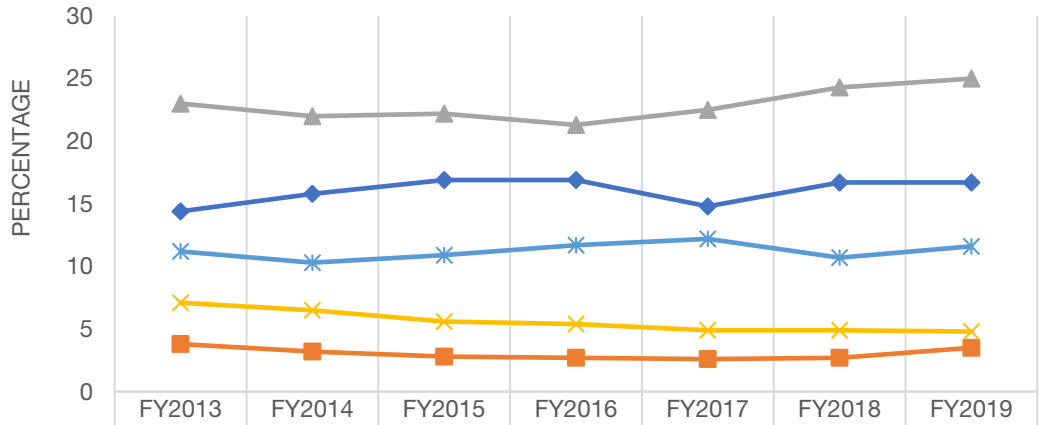
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Geographic Differences in SED–Regions

Figure 4.10 presents findings for clients under age 12 across regions served by CSBs. Although some fluctuations occurred across FYs, results indicate significant overall *declines* in the percentages of child-age clients who have SED for Region 4 (FY2013 and FY2015 through FY2019, $p < 0.05$) and overall *increases* across FYs for Region 1 (FY2013 and FY2014 through FY2016, FY2018, FY2019, $p < 0.001$).

For Region 2, Region 3, and Region 5, respectively, the percentage of child-age clients with SED appears to follow a nonlinear trend, with fluctuations across FYs and with the highest percentage of child-age clients in FY2019 for Region 3 ($p < 0 .001$) and Region 5 ($p < 0 .05$), respectively.

Figure 4.10. Percentages of SED for Clients Under Age 12 Across Regions



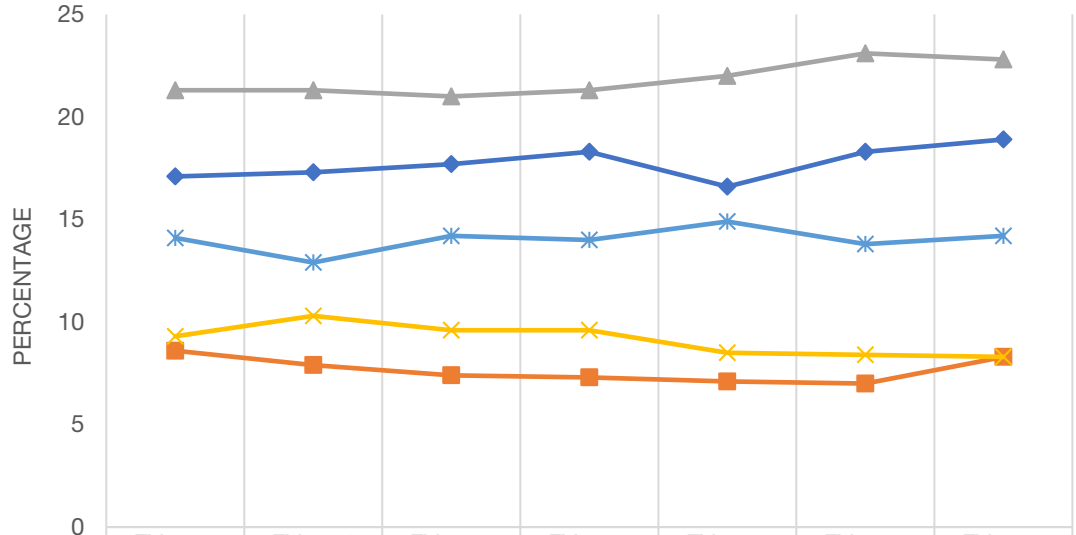
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - Under 12 Years	14.4	15.8	16.9	16.9	14.8	16.7	16.7
Region 2 - Under 12 Years	3.8	3.2	2.8	2.7	2.6	2.7	3.5
Region 3 - Under 12 Years	23	22	22.2	21.3	22.5	24.3	25
Region 4 - Under 12 Years	7.1	6.5	5.6	5.4	4.9	4.9	4.8
Region 5 - Under 12 Years	11.2	10.3	10.9	11.7	12.2	10.7	11.6

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.11 presents findings for clients ages 12–17 with SED across regions served by CSBs. Although fluctuations occurred across FYs, results indicate significant overall *declines* in the percentages of child-age clients who have SED for Region 4 (FY2014 and FY2015 through FY2019, $p < 0.05$) and overall *increases* across FYs for Region 1 (FY2013 and FY2014 through FY2016, FY2018, FY2019, $p < 0.001$).

For Region 2, Region 3, and Region 5, respectively, the percentage of adolescent-age clients with SED appears to follow a nonlinear trend, with fluctuations across FYs.

Figure 4.11. Percentages of SED for Clients Ages 12–17 Across Regions



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - 12-17 Years	17.1	17.3	17.7	18.3	16.6	18.3	18.9
Region 2 - 12-17 Years	8.6	7.9	7.4	7.3	7.1	7	8.3
Region 3 - 12-17 Years	21.3	21.3	21	21.3	22	23.1	22.8
Region 4 - 12-17 Years	9.3	10.3	9.6	9.6	8.5	8.4	8.3
Region 5 - 12-17 Years	14.1	12.9	14.2	14	14.9	13.8	14.2

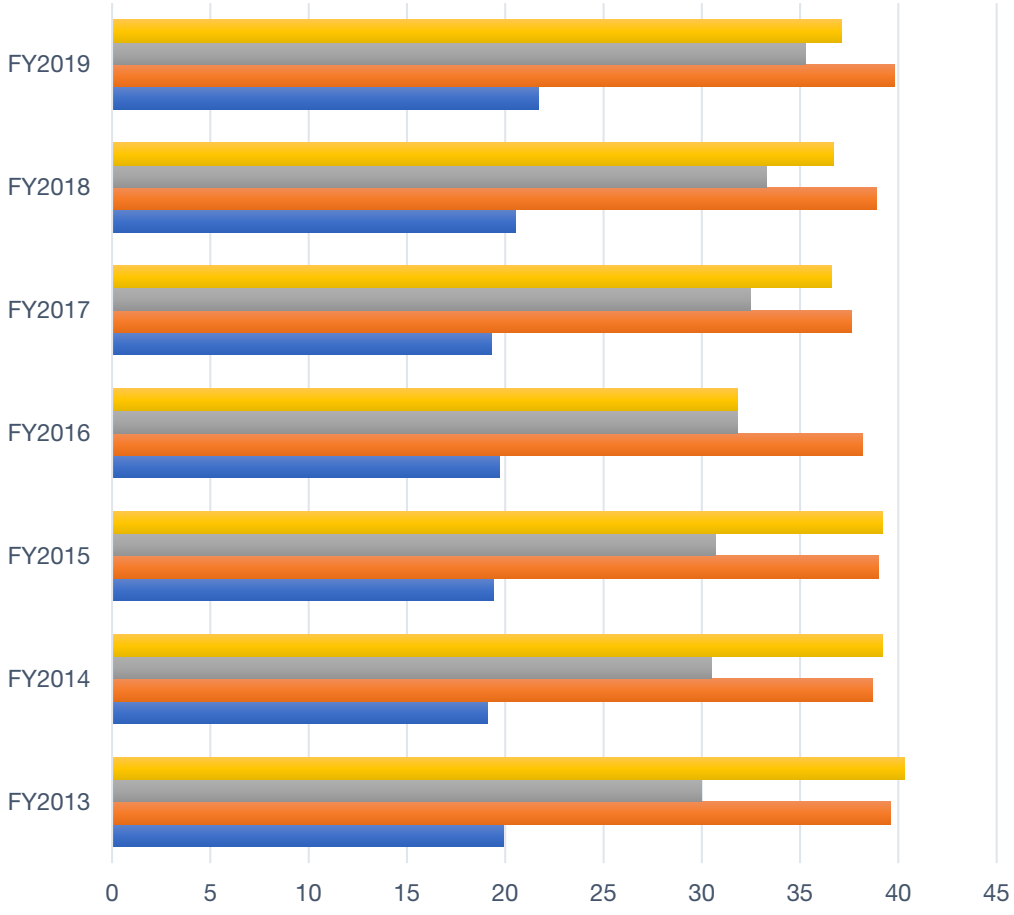
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Demographic Characteristics of Clients With SED

Figure 4.12 displays the percentage of male and female clients under age 18 who had SED across state FYs. The percentage of male and female children, respectively, with SED was highest in FY2019 ($p < 0.05$).

Among clients ages 12–17 years, there were significant increases in the percentage of female adolescent clients with SED (FY2019 and FY2013 through FY2018, $p < 0.001$). However, the percentage of males appears to follow a nonlinear trend, with decreases from FY2013 through FY2017 ($p < 0.05$) followed by increases in subsequent FYs.

Figure 4.12. Percentage of Male and Female Clients Under Age 18 With SED



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Males with SED - 12-17 Years	40.3	39.2	39.2	31.8	36.6	36.7	37.1
Females with SED - 12-17 Years	30	30.5	30.7	31.8	32.5	33.3	35.3
Males with SED - Under 12 Years	39.6	38.7	39	38.2	37.6	38.9	39.8
Females with SED - Under 12 Years	19.9	19.1	19.4	19.7	19.3	20.5	21.7

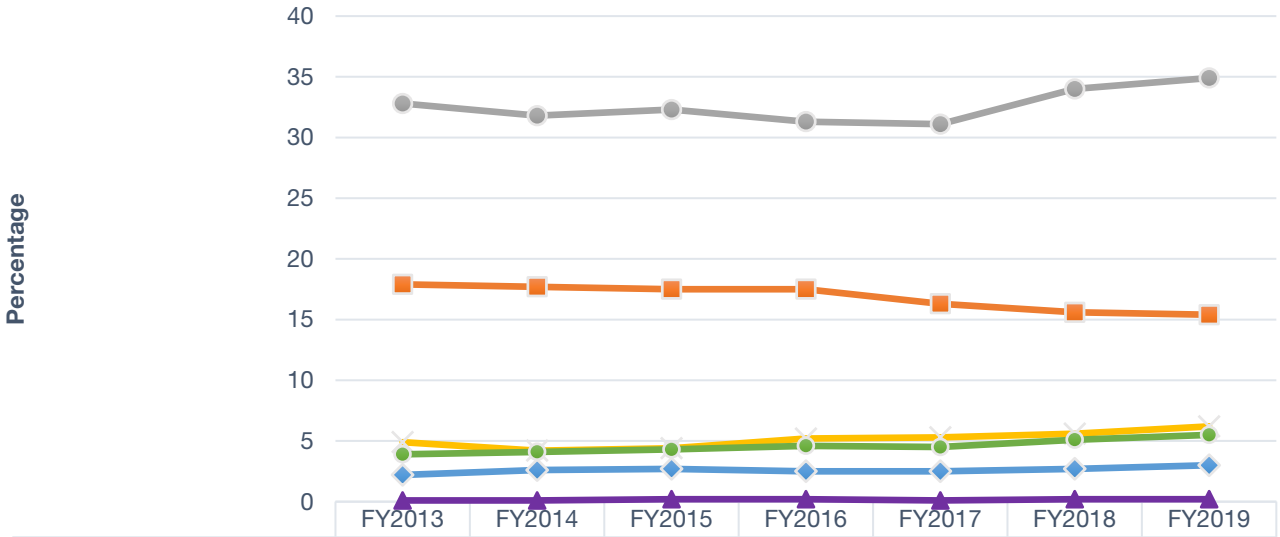
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.13 and Figure 4.14 present findings for clients by race and ethnic background for child and adolescent clients with SED, respectively. Results indicate significant *increases* in the percentage of child-age clients with SED for clients from the following racial and ethnic backgrounds:

- Multiracial (identifying with two or more races; FY2019 and FY2014 through FY2017, $p < 0.05$) and
- Hispanic (FY2013 and FY2015 through FY2019, $p < 0.01$).

Results indicate that child-age clients who identify as Black or African American had significant *decreases* in SED (FY2013 through FY2016 and FY2018, FY2019, $p < 0.01$).

Figure 4.13. Percentage of Clients Under Age 12 With SED by Race and Ethnic Background



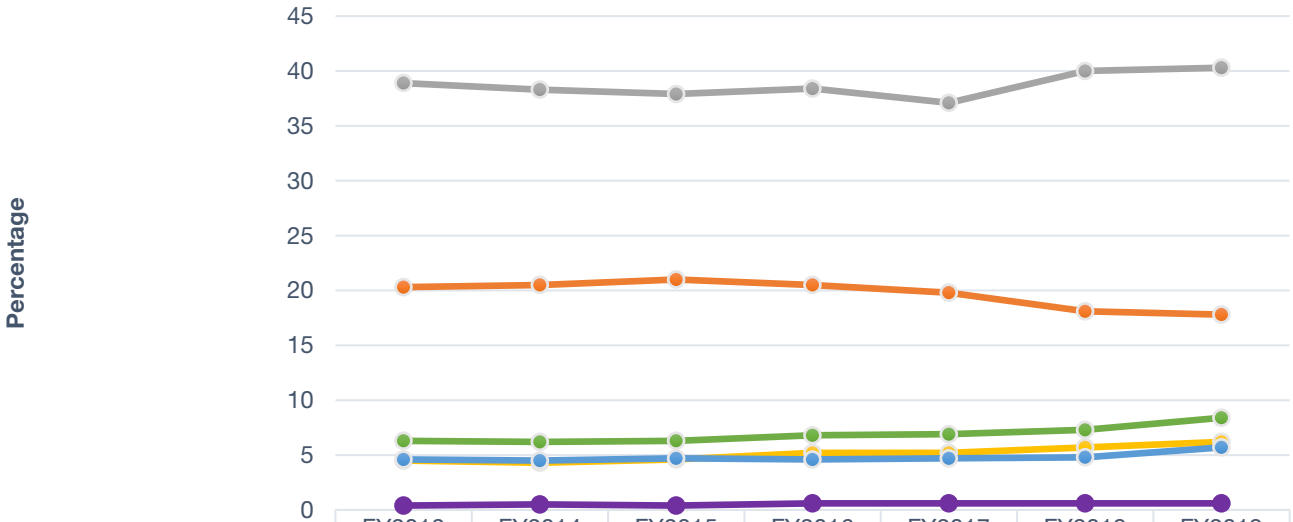
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Asian	0.1	0.1	0.2	0.2	0.1	0.2	0.2
Black/African American	17.9	17.7	17.5	17.5	16.3	15.6	15.4
White	32.8	31.8	32.3	31.3	31.1	34	34.9
Multiracial	4.9	4.2	4.4	5.2	5.3	5.6	6.2
Other Race	2.2	2.6	2.7	2.5	2.5	2.7	3
Hispanic	3.9	4.1	4.3	4.6	4.5	5.1	5.5

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

For clients ages 12–17, results indicate that adolescent-age clients who identify as Black or African American had significant *decreases* in SED (FY2013 through FY2016 and FY2018, FY2019, $p < 0.01$). In contrast, significant increases occurred in the percentage of clients ages 12–17 for clients from the following racial and ethnic backgrounds:

- Multiracial (identifying with two or more races; FY2019 and FY2014 through FY2017, $p < 0.05$) and
- Hispanic (FY2014 and FY2016 through FY2019, $p < 0.01$)

Figure 4.14. Percentage of Clients Ages 12–17 With SED by Race and Ethnic Background



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Asian	0.4	0.5	0.4	0.6	0.6	0.6	0.6
Black/African American	20.3	20.5	21	20.5	19.8	18.1	17.8
White	38.9	38.3	37.9	38.4	37.1	40	40.3
Multiracial	4.5	4.3	4.6	5.2	5.2	5.7	6.2
Other Race	4.6	4.5	4.7	4.6	4.7	4.8	5.7
Hispanic	6.3	6.2	6.3	6.8	6.9	7.3	8.4

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

SMI

A person with SMI is defined as someone over the age of 18 years who currently has, or has had in the past, a mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[51]. Schizophrenia, bipolar illness, and major depressive disorder are the most common diagnoses associated with SMI, but people with one or more other disorders may also fit the definition of SMI if those disorders result in functional impairment. The burden of mental illness is particularly concentrated among those who experience disability due to SMI.

The JBS Team analyzed quantitative data from the CCS 3 to describe the demographic and geographic characteristics of the clinical population of clients who had SMI across FY2013 and FY2019. Exhibit Table 4.16 displays the number and percentage of clients among the total client population who had SMI. Across all FYs, a total of 132,246 clients ages 18–25 (12.3% of the total client population of 1,071,094) received substance use and MH services, indicating that young adults constitute a smaller percentage of the total client population. Of those 132,246 clients ages 18–25, 42.5% (n=56,207) had SMI.

[51] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Among clients age 26 or older, a total of 671,480 clients (62.7% of the total client population of 1,071,094) received substance use and MH services across all FYs, indicating that adults constitute most of the total client population. Of those 671,480 clients age 26 and over, 57.7% (n=387,313) had SMI.

Findings indicated a gradual increase in the number of clients with SMI across successive FYs. A noticeably larger percent of clients age 26 and older had SMI across all FYs compared with clients ages 18–25 years.

Table 4.16. Number and Percent of Total Client Population With SMI

Client Age Groups	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
18–25 years	6,920 (4.7%)	7,183 (4.8%)	7,631 (5.0%)	7,871 (5.2%)	8,191 (5.2%)	8,769 (5.6%)	9,642 (6.1%)
26 years and older	48,512 (33.2%)	50,102 (33.7%)	53,027 (34.9%)	54,964 (36.3%)	57,922 (36.8%)	60,458 (38.5%)	62,328 (39.2%)
Total N—Clients Ages 18–25 Years	19,327 (13.2%)	19,158 (12.9%)	19,174 (12.6%)	18,468 (12.2%)	18,886 (12.0%)	18,663 (11.9%)	18,570 (11.7%)
Total N—Clients Over Age 26	91,416 (62.5%)	92,715 (62.4%)	94,621 (62.3%)	94,719 (62.6%)	98,561 (62.6%)	99,141 (63.2%)	100,307 (63.1%)
Total N—All Clients	146,211	148,487	151,883	151,309	157,394	156,896	158,914

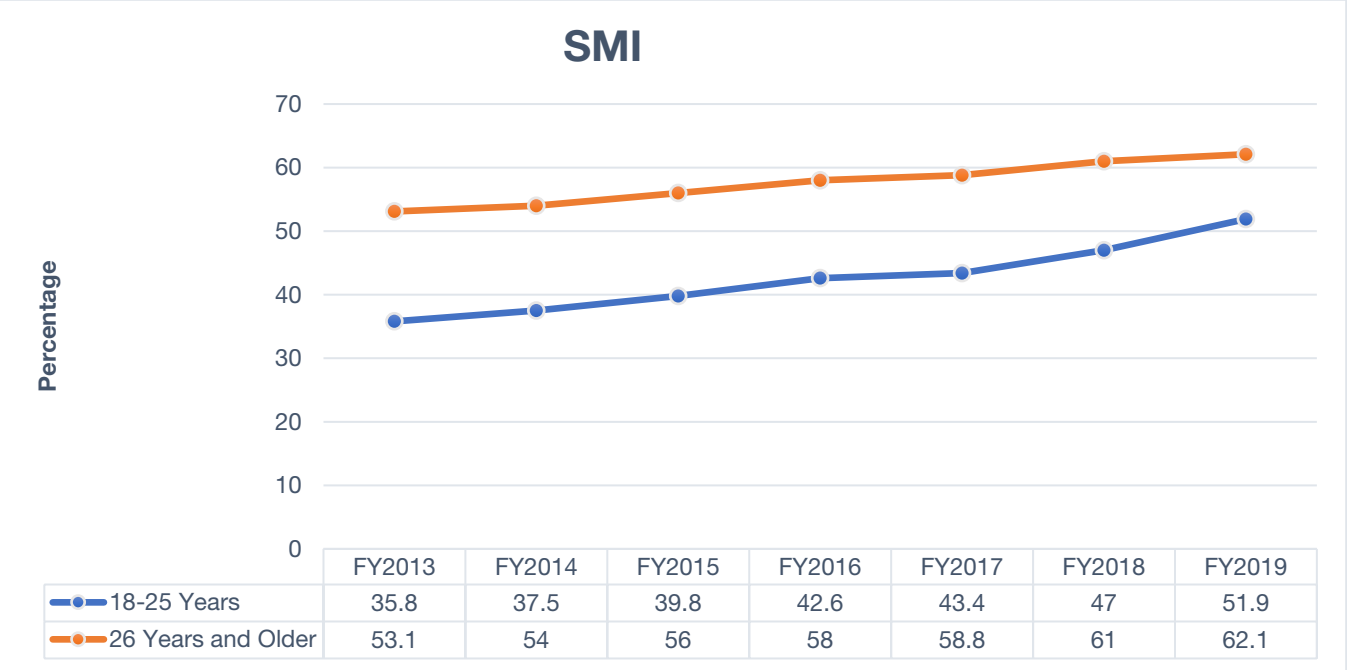
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.15 displays the percentage of clients age 18 and older who have a SMI. Among the population of clients who are age 18 and older, results indicate that the percentage of clients ages 18–25 with SMI in FY2018 and FY2019, respectively, was significantly higher than those of previous FYs ($p < 0.05$), indicating a significant *increase* in the number of young adult clients with SMI over time. Findings were similar for clients age 26 and older with SMI, with significant *increases* in the percentage of adults with SMI each successive FY ($p < 0.01$). As seeing SMI populations is a priority for CSBs, it appears that they are continuing to reach increasing numbers of this client population.

"As far as serving, I think we serve the adult SMI population very well. That is what we're here for. That's what we've done forever. And I do think that that is something we're not afraid of—psychosis. I've got clinicians that are very comfortable with that." (Rural, small budget CSB)

"I think with the SMI, it's just the CSBs are kind of known as the provider. And like I said, there's not a bunch of private providers out there waiting to serve that population. And just with the type of services we have as far as psychosocial day club and case management and medical and therapy all in one place, really that's the best place for—and our PACT team—the best place for people with serious mental illness to get kind of all their services in one place. And I think that's kind of the CSB's general niche throughout Virginia." (Urban, large budget CSB)

Figure 4.15. Percentage of Clients Age 18 and Older With SMI



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
18-25 Years	35.8	37.5	39.8	42.6	43.4	47	51.9
26 Years and Older	53.1	54	56	58	58.8	61	62.1

Note: Percentages do not add to 100% because data was missing, not applicable, or not collected.

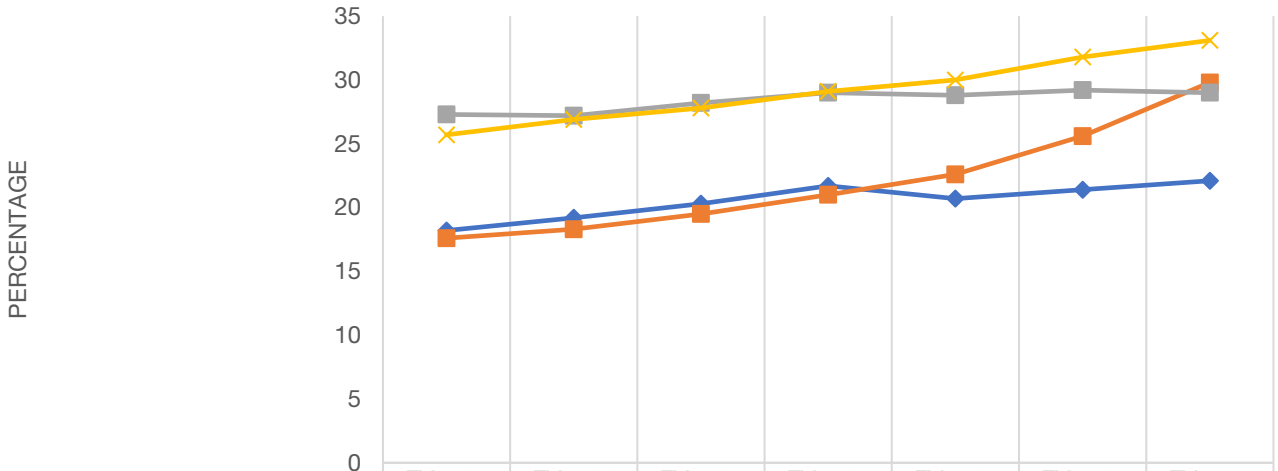
Geographic Differences in SMI–Urban and Rural Areas

Figure 4.16 displays the percentage of clients with SMI for two age groups—those ages 18–25 years and those age 26 years and older—served by CSBs located in primarily urban or rural areas.

Percentages of clients ages 18–25 with SMI were lowest in FY2013 with overall increases in subsequent FYs for clients receiving services in both urban and rural areas ($p < 0.001$).

Among clients age 26 and older, we observed an increase in the percentages of clients with SMI across FYs for clients receiving services in primarily urban (FY2015 and FY2019, $p < 0.05$) and rural (FY2014 and FY2016 through FY2019, $p < 0.01$) areas.

Figure 4.16. Percentage of Clients With SMI Across Urban and Rural Areas



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Urban - 18-25 Years	18.2	19.2	20.3	21.7	20.7	21.4	22.1
Rural - 18-25 Years	17.6	18.3	19.5	21	22.6	25.6	29.8
Urban - 26 Years and Older	27.3	27.2	28.2	29	28.8	29.2	29
Rural - 26 Years and Older	25.7	26.9	27.8	29.1	30	31.8	33.1

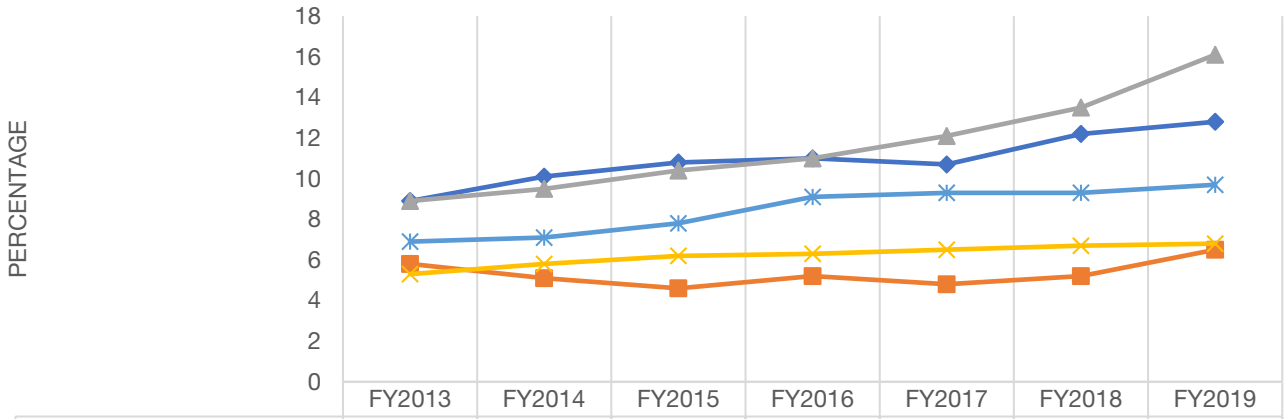
Note: Percentages do not add to 100% because data was missing, not applicable, or not collected.

Geographic Differences in SMI–Regions

Figure 4.17 presents findings for clients ages 18–25 with SMI across regions served by CSBs. Although there were some fluctuations across FYs, results indicate significant overall *increases* in the percentages of young adult clients who have SMI across all regions:

- Region 1 (FY2013 and FY2014 through FY2019, $p < 0.001$),
- Region 2 (FY2015 and FY2016 through FY2019, $p < 0.01$),
- Region 3 (FY2013 and FY2014 through FY2019, $p < 0.001$),
- Region 4 (FY2013 and FY2014 through FY2019, $p < 0.001$), and
- Region 5 (FY2013 and FY2015 through FY2019, $p < 0.01$).

Figure 4.17. Percentages of SMI for Clients Ages 18–25 Across Regions



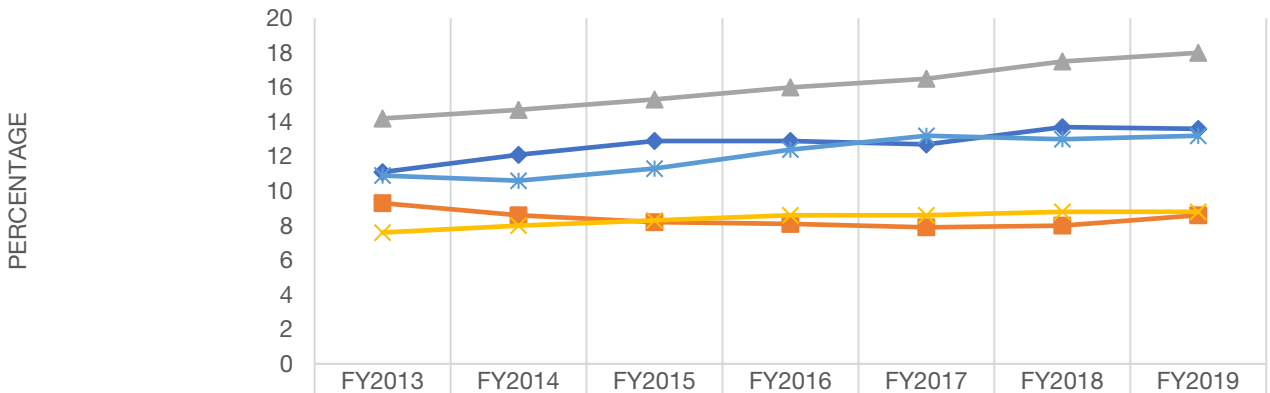
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - 18-25 Years	8.9	10.1	10.8	11	10.7	12.2	12.8
Region 2 - 18-25 Years	5.8	5.1	4.6	5.2	4.8	5.2	6.5
Region 3 - 18-25 Years	8.9	9.5	10.4	11	12.1	13.5	16.1
Region 4 - 18-25 Years	5.3	5.8	6.2	6.3	6.5	6.7	6.8
Region 5 - 18-25 Years	6.9	7.1	7.8	9.1	9.3	9.3	9.7

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.18 shows findings for clients age 26 and older with SMI across regions served by CSBs. Although there were some fluctuations across FYs, results indicate significant overall *increases* in the percentages of adult clients who have SMI for the following regions:

- Region 1 (FY2013 and FY2015 through FY2019, $p < 0.001$),
- Region 3 (FY2013 and FY2015 through FY2019, $p < 0.001$),
- Region 4 (FY2013 and FY2015 through FY2019, $p < 0.01$), and
- Region 5 (FY2014 and FY2015 through FY2019, $p < 0.001$).

Figure 4.18. SMI Percentages for Clients Age 26 and Older Across Regions



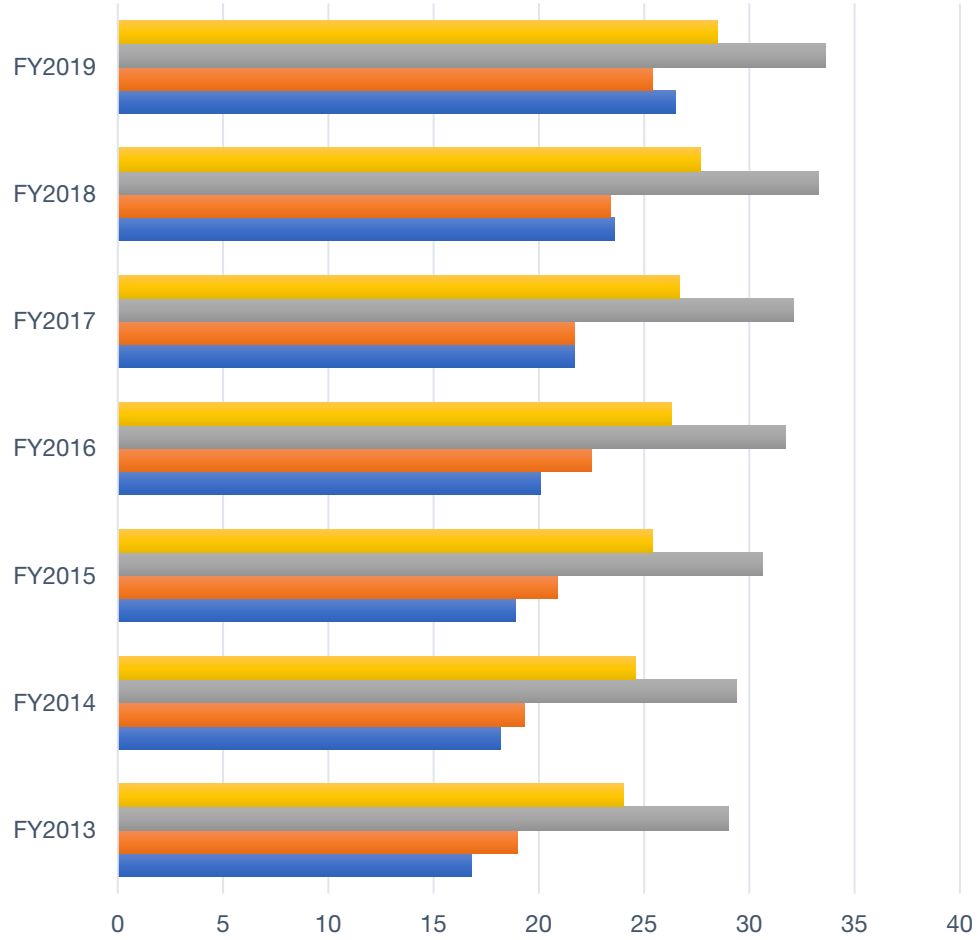
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - 26+ Years	11.1	12.1	12.9	12.9	12.7	13.7	13.6
Region 2 - 26+ Years	9.3	8.6	8.2	8.1	7.9	8	8.6
Region 3 - 26+ Years	14.2	14.7	15.3	16	16.5	17.5	18
Region 4 - 26+ Years	7.6	8	8.3	8.6	8.6	8.8	8.8
Region 5 - 26+ Years	10.9	10.6	11.3	12.4	13.2	13	13.2

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Demographic Characteristics of Clients With SMI

Figure 4.19 displays the percentage of male and female clients age 18 and older with SMI across state FYs. Results indicated significant increases across successive FYs in the percentage of male and female young adult (ages 18–25; $p < 0.001$) clients with SMI as well as the successive increases in the percentage of male and female clients age 26 and older with SMI ($p < 0.01$).

Figure 4.19. Percentage of Male and Female Clients Age 18 Years and Older With SMI



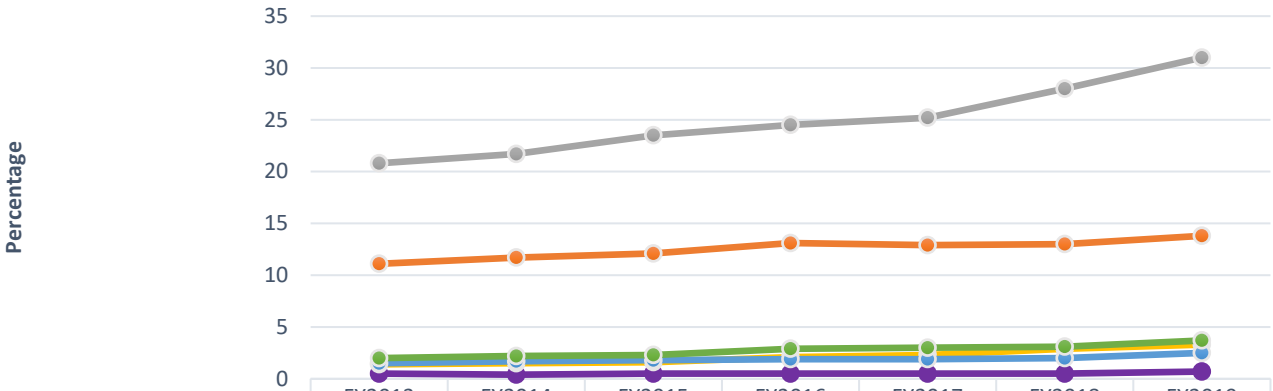
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Males with SMI - 26 Years and Older	24	24.6	25.4	26.3	26.7	27.7	28.5
Females with SMI - 26 Years and Older	29	29.4	30.6	31.7	32.1	33.3	33.6
Males with SMI - 18-25 Years	19	19.3	20.9	22.5	21.7	23.4	25.4
Females with SMI - 18-25 Years	16.8	18.2	18.9	20.1	21.7	23.6	26.5

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.20 presents findings for clients ages 18–25 with SMI by race and ethnic background. Although some fluctuation in percentages across fiscal years occurred, results indicate significant *increases* in the percentage of young adult clients with SMI for clients from all racial and ethnic backgrounds:

- Asian (FY2014 and FY2019, $p < 0.05$),
- Black or African American (FY2013 and FY2016 through FY2019, $p < 0.001$),
- White (FY2013 and FY2014 through FY2019, $p < 0.01$),
- Multiracial (identifying with two or more races; FY2013 through FY2015 and FY2016 through FY2019, $p < 0.001$),
- Other racial background (FY2013 through FY2015 and FY2016 through FY2019, $p < 0.001$), and
- Hispanic (FY2013 through FY2015 and FY2016 through FY2019, $p < 0.001$).

Figure 4.20. Percentage of Clients Ages 18–25 With SMI by Race and Ethnic Background



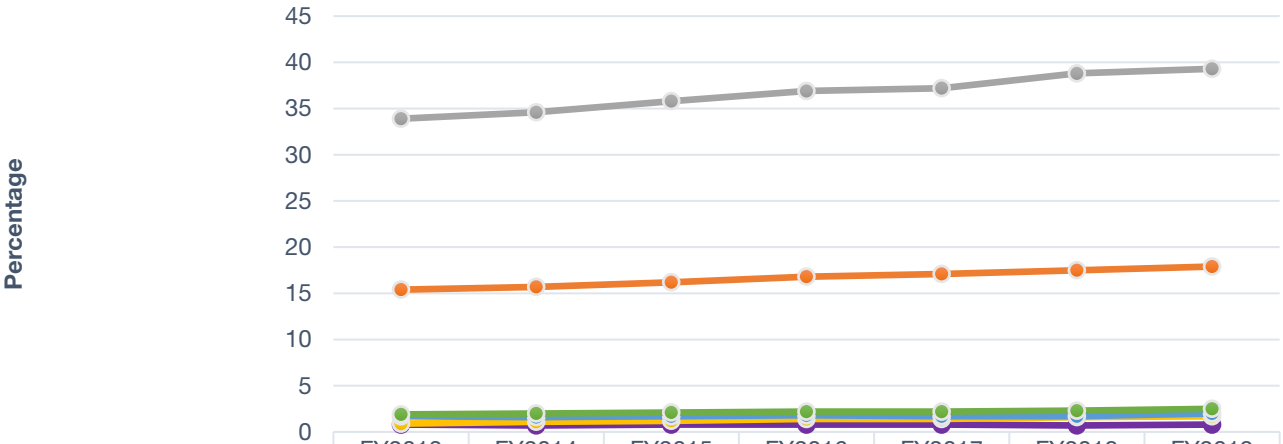
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Asian	0.5	0.4	0.5	0.5	0.5	0.5	0.7
Black/African American	11.1	11.7	12.1	13.1	12.9	13	13.8
White	20.8	21.7	23.5	24.5	25.2	28	31
Multiracial	1.4	1.5	1.6	2.1	2.3	2.9	3.3
Other Race	1.5	1.7	1.8	1.9	1.9	2	2.5
Hispanic	2	2.2	2.3	2.9	3	3.1	3.7

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.21 presents findings for clients age 26 and older by race and ethnic background. Although there was some fluctuation in percentages across FYs, results indicate significant *increases* in the percentage of young adult clients with SMI for clients from the following racial and ethnic backgrounds:

- Black or African American (FY2013 and FY2015 through FY2019, $p < 0.001$),
- White (FY2013 and FY2014 through FY2019, $p < 0.01$),
- Multiracial (identifying with two or more races; FY2013 through FY2014 and FY2016 through FY2019, $p < 0.001$), and
- Hispanic (FY2013 through FY2015 and FY2016 through FY2019, $p < 0.001$).

Figure 4.21. Percentage of Clients Age 26 and Older With SMI by Race and Ethnic Background



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Asian	0.8	0.7	0.8	0.8	0.8	0.7	0.8
Black/African American	15.4	15.7	16.2	16.8	17.1	17.5	17.9
White	33.9	34.6	35.8	36.9	37.2	38.8	39.3
Multiracial	0.9	1.1	1.2	1.4	1.4	1.6	1.7
Other Race	1.7	1.6	1.7	1.8	1.7	1.7	2
Hispanic	1.9	2	2.1	2.2	2.2	2.3	2.5

Note: Percentages do not add to 100% because data was missing, not applicable, or not collected.

Key Findings–SED

- Across FYs, there were significant decreases in the percentage of clients under age 18 at risk of SED; however, there were significant increases in the percentage of clients under age 18 with SED.
- Most clients with SED were:
  - Ages 12–17 years (adolescents).
  - More likely to be male and White.
  - More likely to reside in rural areas.
- There were significant increases in the percentage of clients with SED who identified as Hispanic and identify with two or more races.

Key Findings–SMI

- Across FYs, there were significant increases across multiple regions in the percentage of clients over age 18 with SMI.
- Most clients with SMI were:
  - Age 26 and older (adults).
  - More likely to be male and White.
  - More likely to reside in rural areas.
- There were significant increases in the percentage of clients with SMI who identified as Black or African American, identified as Hispanic, and identified with two or more races.

Recommendations

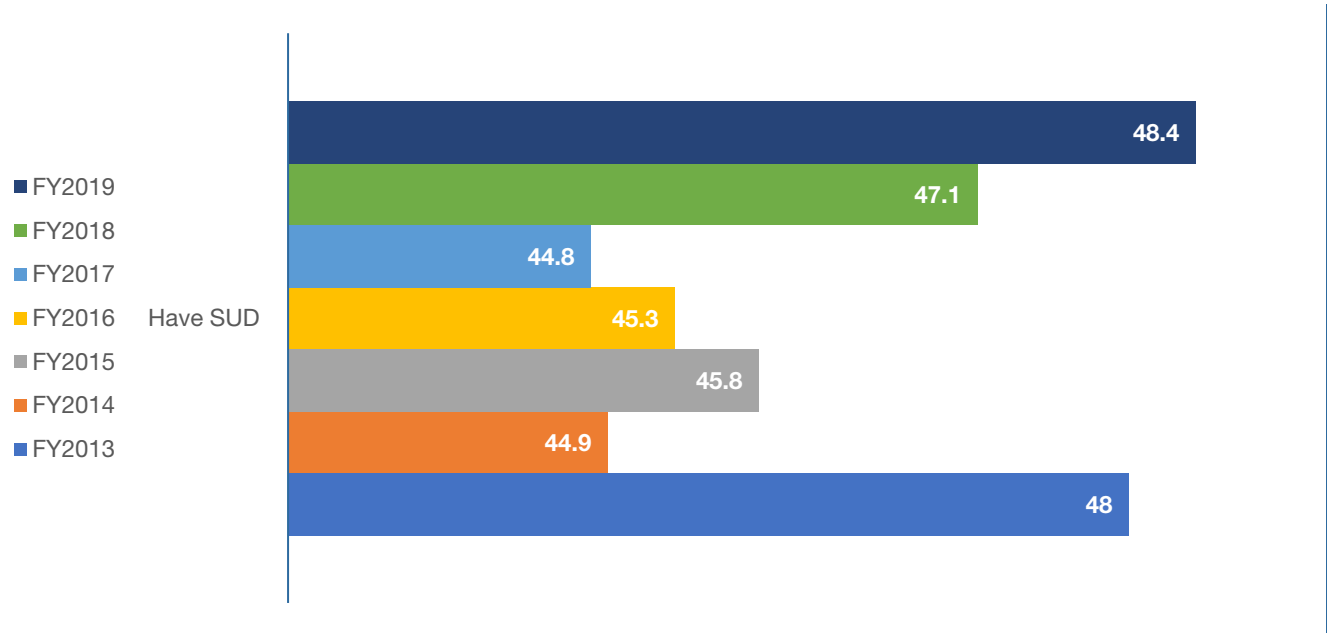
- CSBs should continue to build on their success in reaching the SED, SMI, and risk for SED client populations, and they should continue to work in collaboration with state hospitals, schools and related institutions to access and provide services to this growing client population. Although both administrative and direct service staff noted declines in the provision of TDT and other school-based services, these findings warrant continuing to provide such services in school settings to help school-age children at risk for SED and those having SED.
- Given the increasing percentage of SED and SMI client populations, respectively, who identify as Hispanic, identify as member of racial minority groups, and live in rural areas, CSBs may want to use strategies that facilitate greater access to services for these populations.

SUD

As noted by SAMHSA, SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home[52]. A key goal of the CSBs is to provide treatment and recovery services to youth and adults in Virginia who are impacted by substance use.

The JBS Team analyzed quantitative data from the CCS 3 to describe the demographic and geographic characteristics of the clinical population of clients who had SUDs among the population of clients seen between FY2013 and FY2019. Of the 1,071,094 clients who received substance use and MH services between FY2013 and FY2019, 46.3% of all clients (n=496,208) reported having an SUD and sought treatment at CSBs. Figure 4.22 displays the percentage of clients reporting any SUD. Although the percentage of clients with any SUD declined significantly ($p < 0.001$) between FY2013 and FY2017, a significant increase ($p < 0.001$) occurred in the percentage of clients reporting any primary SUD between FY2017 and FY2019.

Figure 4.22. Percentage of Clients Reporting Any SUD Each FY



[52] https://www.samhsa.gov/find-help/disorders

Table 4.17 displays the specific primary SUD for all clients receiving substance use and MH services from CSBs. Results revealed that use of alcohol, marijuana/hashish, heroin and other opiates, and cocaine/crack were among the primary SUD problems reported by clients across FYs.

Findings also revealed significant overall *decreases* ($p < 0.001$) across state FYs in alcohol use and cocaine/crack use. In addition, findings revealed significant overall *increases* ($p < 0.001$) across state FYs in the following specific primary SUD problems:

- Opioid use, including use of heroin and other opioids,
- Marijuana/hashish use, and
- Methamphetamine use.

"The opioid use disorder monies have been being pushed out left and right. We've been happy to respond to that. But methamphetamines are growing in our community. And still we have more people with alcohol disorders, and we know that more people die of alcohol related disorders still than opioid use disorders. But you can't say that in today's environment because it's all about opioids." (Urban, medium budget CSB)

"The [opioid] addiction hit us earlier than any of the state, Southwest Virginia. We started dealing way back in 2006, 2007 with [opioids] because the coal miners being disabled and being injured and getting those. I mean, men who had worked in the coal mines for 20 years were becoming addicted. It wasn't your young kids becoming addicted. It was older folks. But then it spread because it's so good. But now doctors that we've spent a lot of time educating doctors, a lot of publicity, so [to] speak. And so, we've done a good job—and not just Cumberland, I mean the community—a good job of kind of keeping a lid on opioid addiction, but we're seeing more methamphetamine now." (Rural, medium budget CSB)

CSB administrative staff were consistent in noting increases in the amount of federal and state funds received to target the opioid epidemic because of its impact on the Commonwealth of Virginia. These findings indicate that, although efforts to address the opioid epidemic are clearly warranted, funds to support efforts to address increases in marijuana and methamphetamine SUD, respectively, are also needed. In addition, despite the decreases in alcohol and cocaine/crack SUDs, the number of clients continuing to report these substances as their primary SUD indicates that continued funds and efforts to target use of these substances are warranted.

"We see a huge co-occurring population for us. We have some trouble with opioids here, but meth is our big, big driver here. And alcohol will always be number one, because it's legal, with mental health, absolutely. And I will say that detox and residential services for SUD is a huge gap in our area. It's very, very expensive, and it's hard to deliver. And so, there's just not very many people that do it." (Rural, small budget CSB)

Table 4.17. Primary SUD of Clients Who Received BHS Between FY2013 and FY2019

Primary SUD	FY2013 (N=146,211)		FY2014 (N=148,487)		FY2015 (N=151,883)		FY2016 (N=151,309)		FY2017 (N=157,394)		FY2018 (N=156,896)		FY2019 (N=158,914)	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Alcohol	21.9%	32,073	20.0%	29,741	19.3%	29,312	18.1%	27,379	17.3%	27,155	17.5%	27,469	17.4%	27,704
Amphetamines														
• Methamphetamine	0.5%	799	0.6%	863	0.8%	1,175	1.1%	1,589	1.4%	2,181	2.1%	3,360	2.9%	4,652
• Other amphetamines	0.2%	232	0.2%	249	0.1%	196	0.1%	206	0.1%	200	0.1%	234	0.2%	240
Cocaine/crack	4.4%	6,393	3.9%	5,819	3.8%	5,721	3.8%	5,728	4.0%	6,232	4.1%	6,466	4.1%	6,554
Hallucinogens														
• Phencyclidine	0.2%	221	0.1%	204	0.1%	193	0.2%	245	0.1%	220	0.1%	224	0.1%	236
• Other hallucinogens	0.1%	117	0.1%	129	0.1%	142	0.1%	164	0.1%	160	0.1%	154	0.1%	152
Inhalants	0.1%	88	0.1%	89	0.1%	87	0.1%	102	0.1%	83	0.1%	82	0.1%	86
Marijuana/hashish	11.6%	16,966	11.0%	16,370	11.5%	17,395	11.3%	17,112	11.2%	17,582	11.9%	18,708	12.6%	19,995
Opioid analgesics														
• Heroin	3.1%	4,525	3.4%	5,107	3.9%	5,991	4.4%	6,622	4.6%	7,256	5.0%	7,908	5.1%	8,179
• Nonprescription methadone	0.1%	178	0.1%	131	0.1%	144	0.1%	127	0.1%	98	0.1%	93	0.1%	85
• Other opiates	4.0%	5,914	3.5%	5,230	3.9%	5,936	4.0%	5,986	3.8%	6,045	4.0%	6,306	3.8%	6,105
Over-the-counter drugs	0.1%	142	0.1%	128	0.1%	141	0.1%	127	0.1%	158	0.1%	119	0.1%	113
Sedatives/hypnotics														
• Barbiturates	0.0%	31	0.0%	42	0.0%	39	0.0%	37	0.0%	40	0.0%	28	0.0%	32
• Benzodiazepines	0.5%	784	0.5%	750	0.5%	808	0.5%	810	0.5%	809	0.5%	758	0.4%	700
• Other sedatives/ hypnotics	0.1%	120	0.1%	120	0.1%	129	0.1%	133	0.1%	140	0.1%	108	0.1%	107
• Other tranquilizers	0.0%	23	0.0%	19	0.0%	17	0.0%	13	0.0%	9	0.0%	10	0.0%	13
Other stimulants	0.2%	280	0.2%	303	0.2%	262	0.2%	233	0.2%	275	0.2%	278	0.2%	287
Other drugs	0.9%	1,315	0.9%	1,375	1.2%	1,813	1.2%	1,869	1.2%	1,910	1.0%	1,579	1.1%	1678
No drug use	36.2%	52,909	30.8%	45,680	31.2%	47,430	32.9%	49,806	37.0%	58,163	35.4%	55,529	33.2%	52,832

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

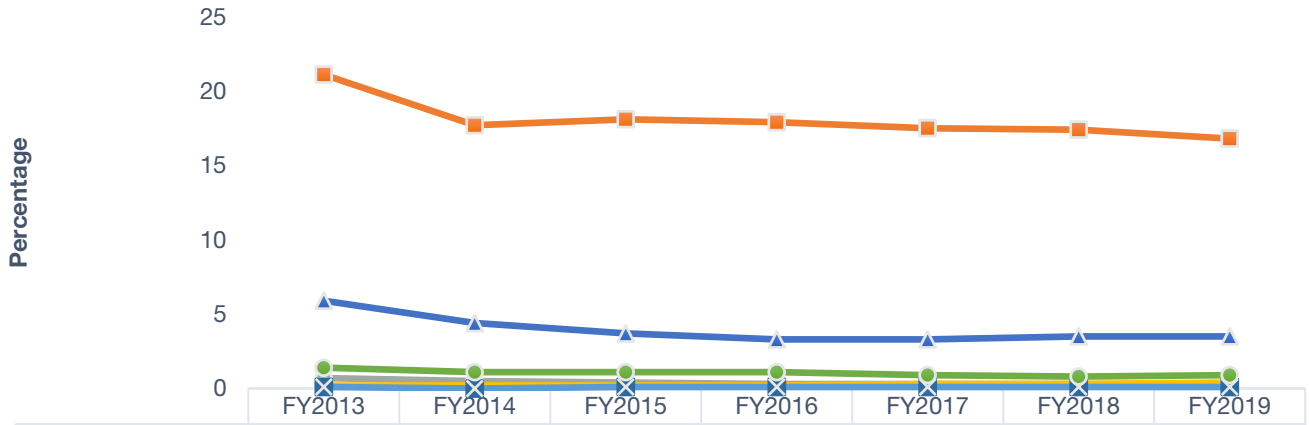
The types of substances used tend to vary with age, with first use often occurring in adolescence[53]; however, changes in the types of substances used as persons progress through adulthood often change[54]. The JBS Team analyzed primary SUDs among clients across three age groups—ages 12–17 (adolescence), ages 18–25 (young adulthood), and age 26 and older (adulthood)—to examine variations in SUDs across age groups. Figures 4.23, 4.24, and 4.25 display percentages of clients across these age groups reporting specific primary SUDs between FY2013 and FY2019.

Findings indicate that, across state FYs, the primary SUD for most clients under age 18 and clients ages 18–25 is marijuana/hashish. In addition to marijuana/hashish, more adolescent-age clients than not reported alcohol and opioids, respectively, as their primary SUD; however, for clients age 26 and older, most clients reported alcohol as their primary SUD.

For adolescent-age clients, results revealed a significant overall *increase* in amphetamine SUDs (FY2013 and FY2014 through FY2019; $p < 0.05$), and significant overall *decreases* across FYs in the following primary SUDs:

- Alcohol (FY2013 through FY2014 and FY2019; $p < 0.001$),
- Marijuana/hashish (FY2013 and FY2014 through FY2019; $p < 0.001$),
- Opioids (FY2013 and FY2014 through FY2019; $p < 0.001$), and
- Other drug use (FY2013 and FY2015 through FY2019; $p < 0.001$).

Figure 4.23. Primary SUDs for Clients Under Age 18



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Alcohol	5.9	4.4	3.7	3.3	3.3	3.5	3.5
Marijuana	21.1	17.7	18.1	17.9	17.5	17.4	16.8
Opioids	0.7	0.5	0.4	0.3	0.3	0.3	0.3
Amphetamines	0.2	0.2	0.2	0.2	0.3	0.3	0.4
Cocaine/Crack	0.1	0	0.1	0.1	0.1	0.1	0.1
Other Drugs	1.4	1.1	1.1	1.1	0.9	0.8	0.9

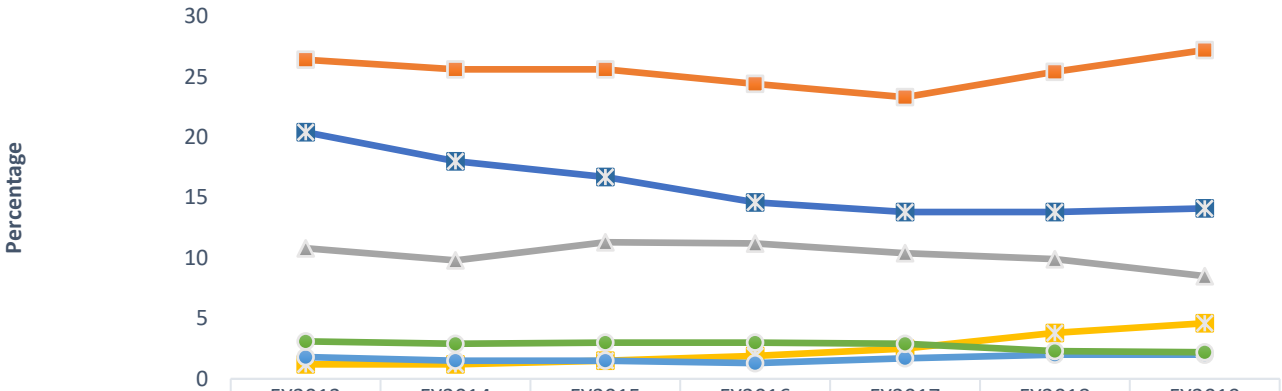
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

[53] https://www.drugabuse.gov/publications/drugfacts/nationwide-trends
[54] https://www.drugabuse.gov/national-survey-drug-use-health

For clients ages 18–25, results revealed significant overall *increases* in amphetamine SUDs (FY2013 and FY2019; $p < 0.05$) and marijuana/hashish SUDs (FY2013 and FY2019; $p < 0.05$). In addition, there were significant overall *decreases* across FYs in the following primary SUDs:

- Alcohol (FY2013 through FY2015 and FY2016 through FY2019; $p < 0.001$) and
- Opioids (FY2015 and FY2017 through FY2019; $p < 0.001$).

Figure 4.24. Primary SUDs for Clients Ages 18–25 Years



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Alcohol	20.4	18	16.7	14.6	13.8	13.8	14.1
Marijuana	26.4	25.6	25.6	24.4	23.3	25.4	27.2
Opioids	10.8	9.8	11.3	11.2	10.4	9.9	8.5
Amphetamines	1.2	1.2	1.5	1.9	2.5	3.8	4.6
Cocaine/Crack	1.8	1.5	1.5	1.3	1.7	2	2
Other Drugs	3.1	2.9	3	3	2.9	2.3	2.2

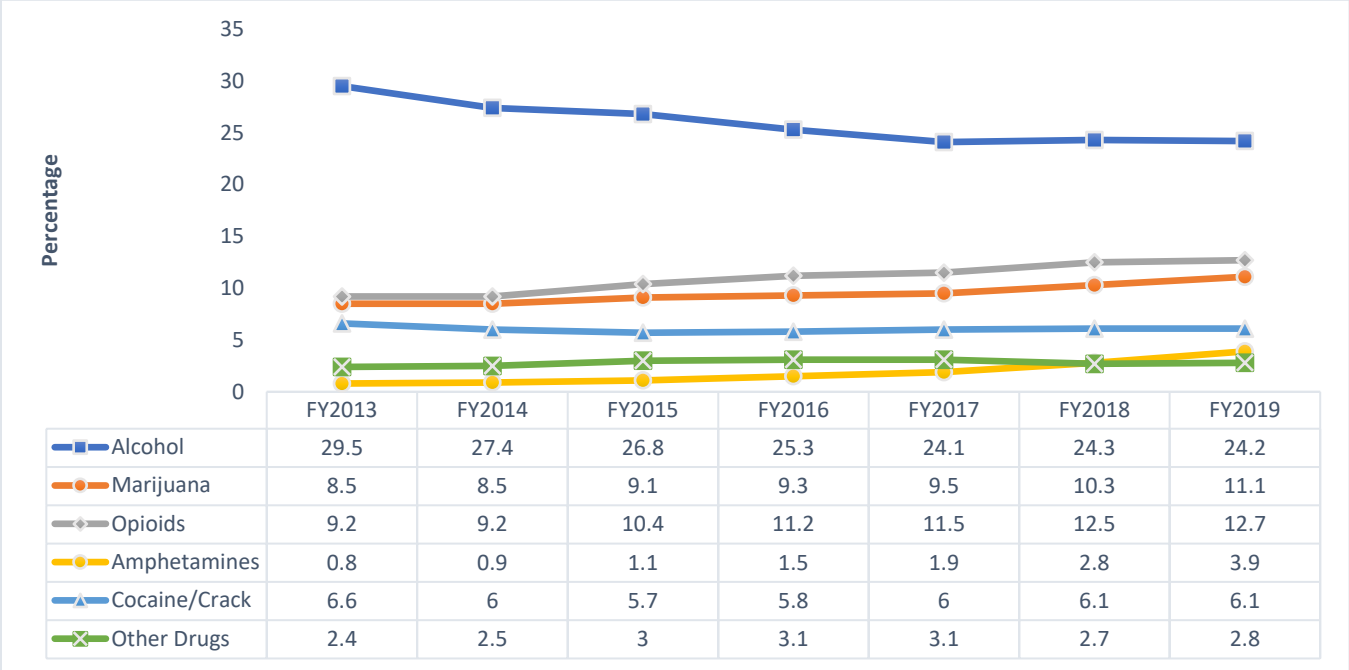
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

For clients age 26 and older, results revealed significant overall *increases* in the following primary SUDs:

- Amphetamines (FY2013 through FY2014 and FY2017 through FY2019; $p < 0.001$),
- Marijuana/hashish (FY2014 through FY2015 and FY2019; $p < 0.001$), and
- Opioids (FY2013 through FY2014 and FY2019; $p < 0.01$).

In addition, significant overall *decreases* in alcohol SUDs (FY2013 through FY2014 and FY2019; $p < 0.001$) occurred among adult-age clients across FYs.

Figure 4.25. Primary SUDs for Clients Over Age 26



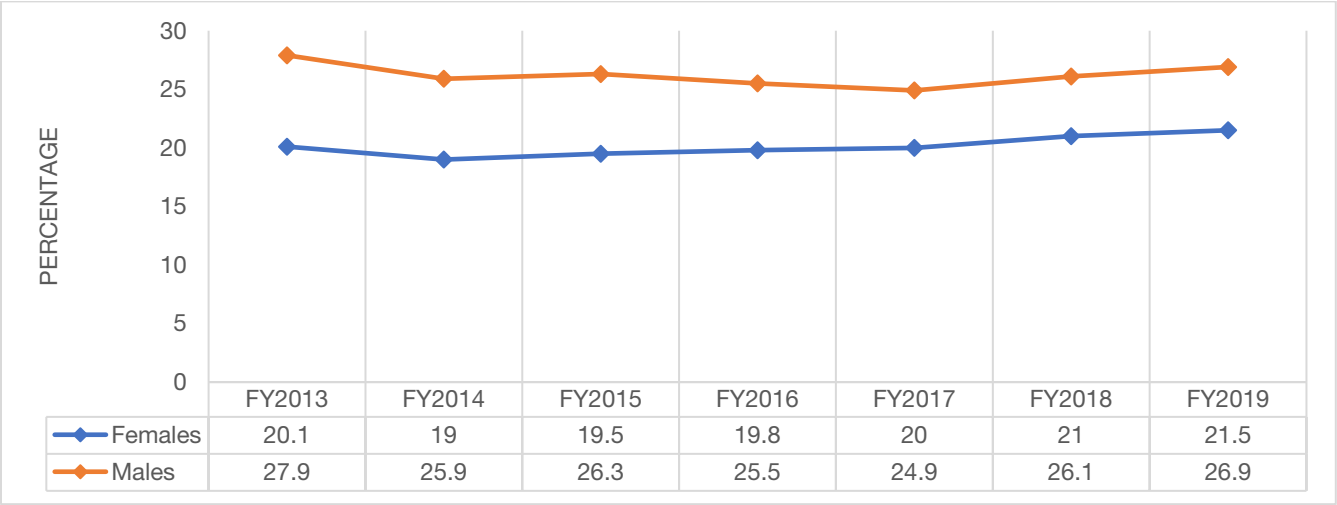
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Alcohol	29.5	27.4	26.8	25.3	24.1	24.3	24.2
Marijuana	8.5	8.5	9.1	9.3	9.5	10.3	11.1
Opioids	9.2	9.2	10.4	11.2	11.5	12.5	12.7
Amphetamines	0.8	0.9	1.1	1.5	1.9	2.8	3.9
Cocaine/Crack	6.6	6	5.7	5.8	6	6.1	6.1
Other Drugs	2.4	2.5	3	3.1	3.1	2.7	2.8

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Demographic Characteristics of Clients with Any SUD

Figure 4.26 presents findings for male and female clients with any SUD. Results indicated that more male (N=280,656) and female (N=215,461) clients reported having an SUD across FYs than not. Percentages of male and female clients, respectively, with any SUD fluctuated somewhat across FYs. FY2013 had the highest percentage of male clients with any SUD (FY2013 and FY2014 through FY2017; $p < 0.01$); however, the highest percentage of female clients with any SUD was in FY2019 (FY2019 and FY2014 through FY2016; $p < 0.01$).

Figure 4.26. Percentage of Male and Female Clients With Any SUD



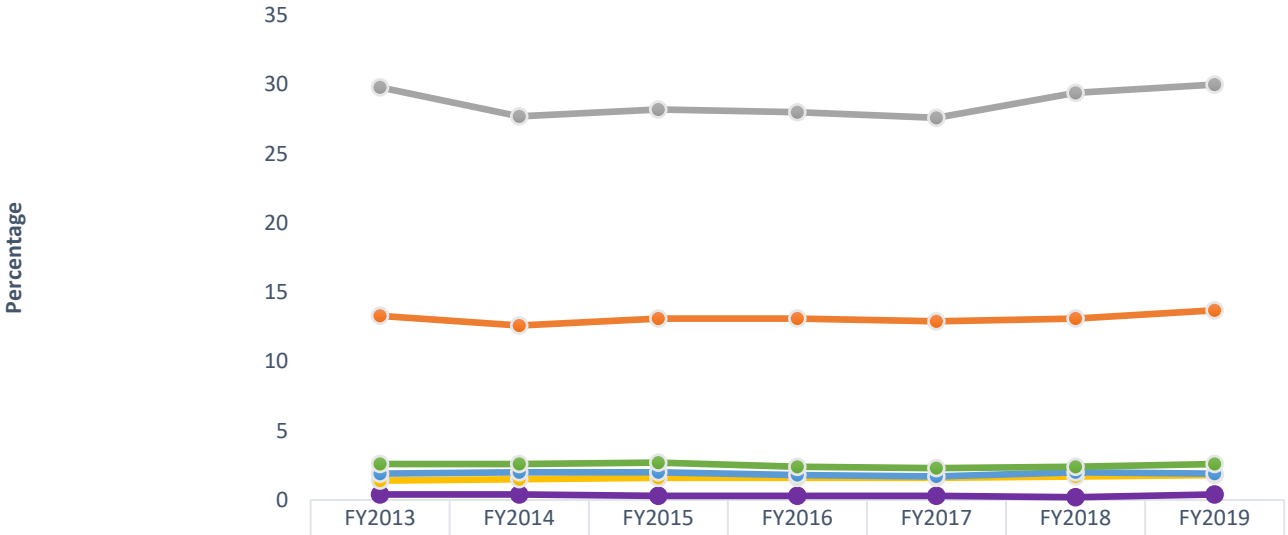
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Females	20.1	19	19.5	19.8	20	21	21.5
Males	27.9	25.9	26.3	25.5	24.9	26.1	26.9

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.27 presents findings for clients with any SUD by race and ethnic background. Results indicate that clients who identify as Black/African American or White had the highest percentage of reporting any SUD across all FYs. Percentages of all clients with any SUD fluctuated somewhat across FYs, regardless of racial and ethnic background. FY2019 had the highest percentage of clients with any SUD for clients from the following racial and ethnic backgrounds:

- Black or African American (FY2019 and FY2015 through FY2017, $p < 0.01$),
- White (*ns*), and
- Multiracial (identifying with two or more races; N=17,162; FY2019 and FY2013 through FY2014, $p < 0.05$).

Figure 4.27. Percentage of Clients With Any SUD by Race and Ethnic Background



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Asian	0.4	0.4	0.3	0.3	0.3	0.2	0.4
Black/African American	13.3	12.6	13.1	13.1	12.9	13.1	13.7
White	29.8	27.7	28.2	28	27.6	29.4	30
Multiracial	1.4	1.5	1.6	1.6	1.6	1.7	1.8
Other Race	1.9	2	2	1.8	1.7	2	1.9
Hispanic	2.6	2.6	2.7	2.4	2.3	2.4	2.6

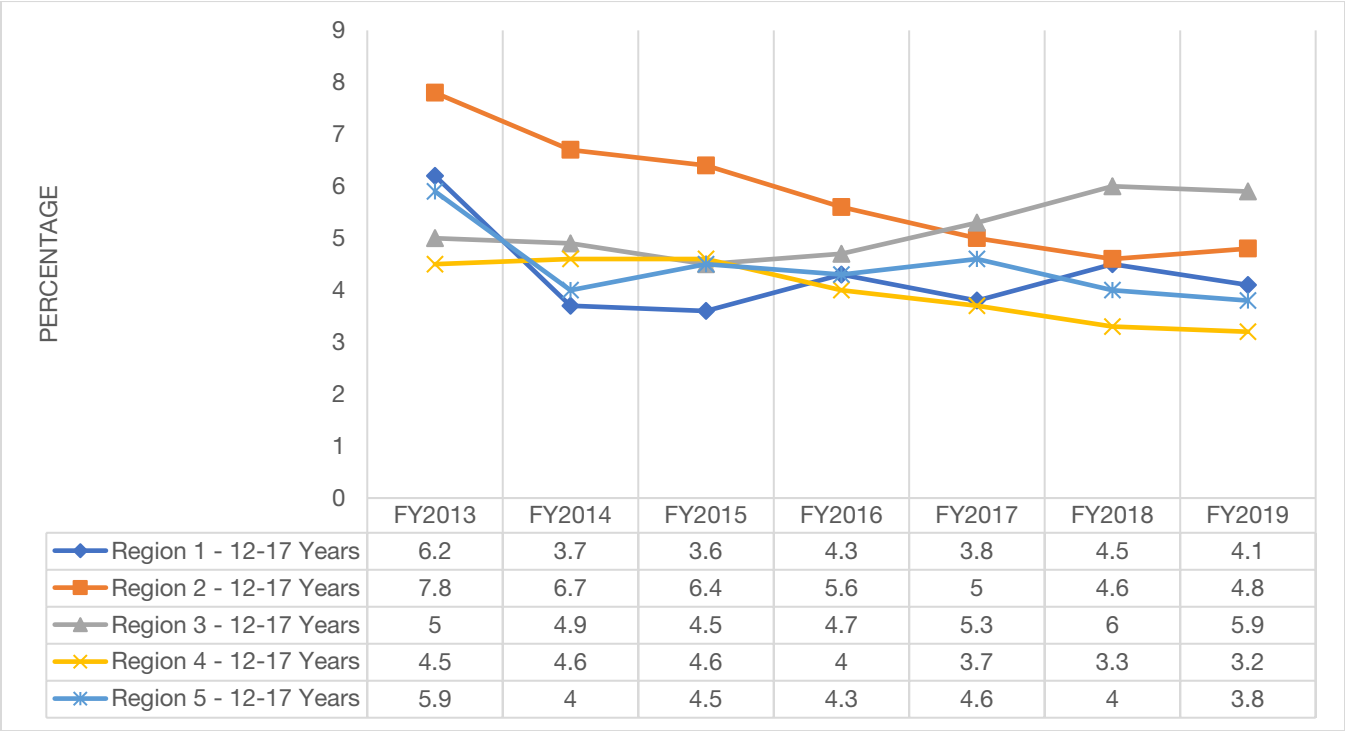
Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Geographic Differences in SUD–Regions

Figure 4.28 presents findings for clients ages 12–17 with any SUD across regions served by CSBs. Although some fluctuations occurred across FYs, results indicate significant overall *declines* in the percentages of adolescent-age clients who have any SUD for the following regions:

- Region 1 (FY2013 and FY2014 through FY2019, $p < 0.001$),
- Region 2 (FY2013 and FY2014 through FY2019, $p < 0.001$),
- Region 4 (FY2013 through FY2015 and FY2019, $p < 0.05$), and
- Region 5 (FY2013 and FY2014, FY2018, FY2019, $p < 0.01$).

Figure 4.28. Percentages of Any SUD for Clients Ages 12–17 Across Regions



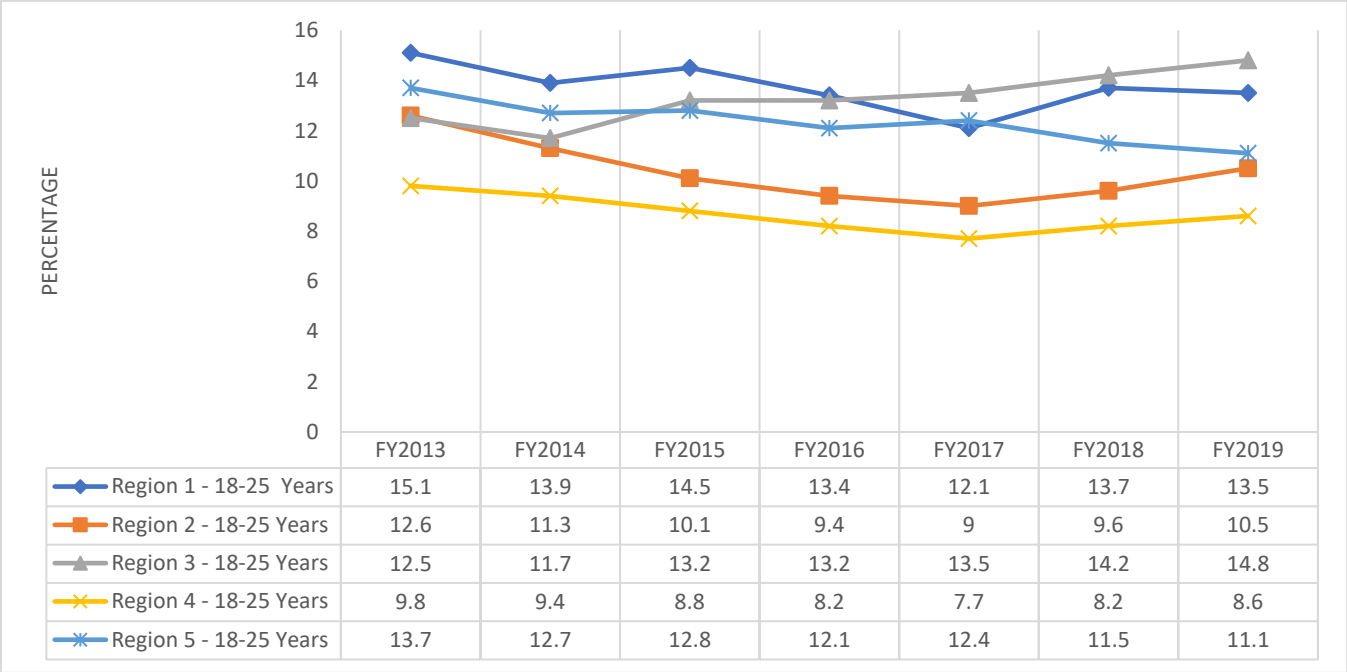
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - 12-17 Years	6.2	3.7	3.6	4.3	3.8	4.5	4.1
Region 2 - 12-17 Years	7.8	6.7	6.4	5.6	5	4.6	4.8
Region 3 - 12-17 Years	5	4.9	4.5	4.7	5.3	6	5.9
Region 4 - 12-17 Years	4.5	4.6	4.6	4	3.7	3.3	3.2
Region 5 - 12-17 Years	5.9	4	4.5	4.3	4.6	4	3.8

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.29 presents findings for clients ages 18–25 with any SUD across regions served by CSBs. Although some fluctuations occurred across FYs, results indicate significant overall *decreases* in the percentages of young adult clients who have any SUD for Region 5 (FY2013 and FY2014, FY2018, FY2019, $p < 0.01$). In contrast, Region 3 reported significant overall *increases* after FY2014 in the percentages of clients ages 18–25 with any SUD ($p < 0.05$).

For Region 1, Region 2, and Region 4, respectively, changes in the percentage of clients ages 18–25 appear to follow a nonlinear trend, with overall declines from FY2013 through FY2017 ($p < 0.01$), followed by increases in subsequent FYs.

Figure 4.29. Percentages of Any SUD for Clients Ages 18–25 Across Regions



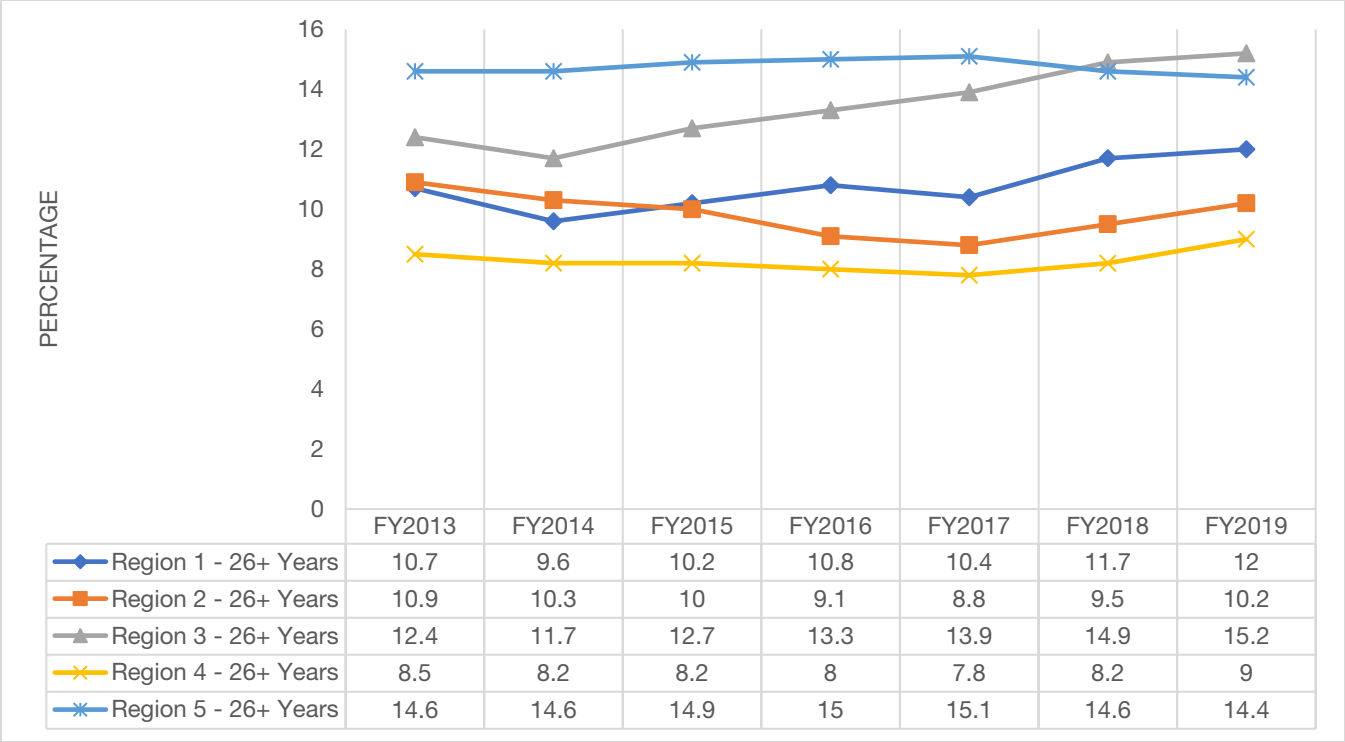
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - 18-25 Years	15.1	13.9	14.5	13.4	12.1	13.7	13.5
Region 2 - 18-25 Years	12.6	11.3	10.1	9.4	9	9.6	10.5
Region 3 - 18-25 Years	12.5	11.7	13.2	13.2	13.5	14.2	14.8
Region 4 - 18-25 Years	9.8	9.4	8.8	8.2	7.7	8.2	8.6
Region 5 - 18-25 Years	13.7	12.7	12.8	12.1	12.4	11.5	11.1

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Figure 4.30 presents findings for clients age 26 and older with any SUD across regions served by CSBs. Although some fluctuations occurred across FYs, results indicate significant overall *increases* after FY2014 in the percentages of clients age 26 and older with any SUD ($p < 0.001$) for Region 1 and Region 3, respectively.

For Region 2, and Region 4, respectively, changes in the percentage of adult clients appear to follow a nonlinear trend, with overall declines from FY2013 through FY2017 ($p < 0.01$), followed by increases in subsequent FYs.

Figure 4.30. Percentages of Any SUD for Clients Age 26 and Older Across Regions



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Region 1 - 26+ Years	10.7	9.6	10.2	10.8	10.4	11.7	12
Region 2 - 26+ Years	10.9	10.3	10	9.1	8.8	9.5	10.2
Region 3 - 26+ Years	12.4	11.7	12.7	13.3	13.9	14.9	15.2
Region 4 - 26+ Years	8.5	8.2	8.2	8	7.8	8.2	9
Region 5 - 26+ Years	14.6	14.6	14.9	15	15.1	14.6	14.4

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Geographic Differences in SUD–Urban and Rural Areas

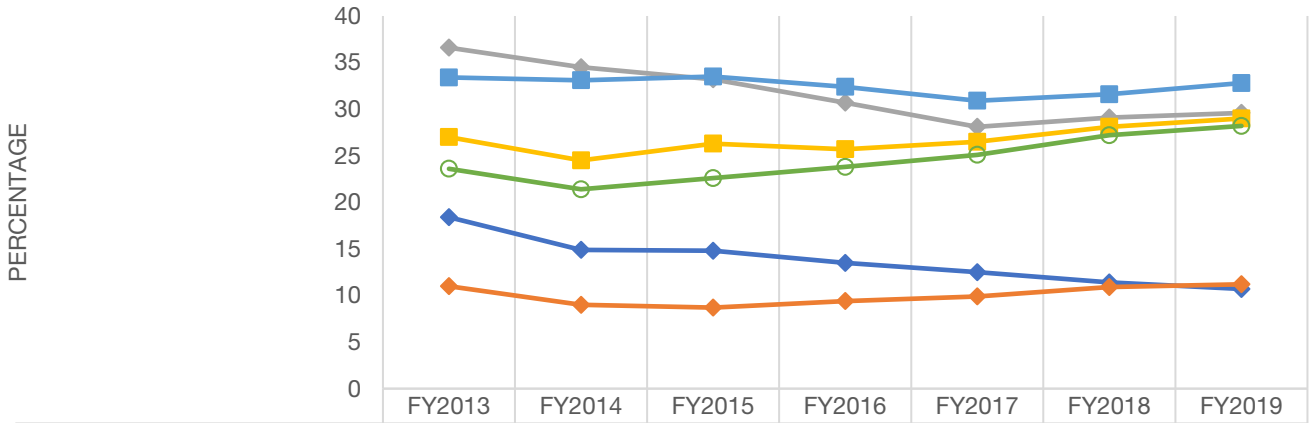
Figure 4.31 presents findings for clients with any SUD across all age groups (ages 12–17, ages 18–25, and age 26 and older) located in primarily rural and urban areas served by CSBs.

For CSBs that serve primarily urban areas, results showed a significant *decrease* in the percentage of adolescent-age clients with any SUD across FYs (FY2013 and FY2014 through FY2019, $p < 0.001$); however, CSBs that serve primarily rural areas reported a significant *increase* in the number of clients ages 12–17 after FY2015, for each successive FY ($p < 0.001$).

Results indicated a significant overall *decrease* in the percentage of young adult clients with any SUD across FYs (FY2013 through FY2014 and FY2017 through FY2019, $p < 0.01$) for CSBs that serve primarily urban areas; however, CSBs that serve primarily rural areas reported a significant *increase* in the number of clients ages 18–25 after FY2016, for each successive FY ($p < 0.01$).

The percentage of clients age 26 and older with any SUD fluctuated across FYs for CSBs that serve primarily urban areas. CSBs that serve primarily rural areas reported a significant *increase* in the number of adult-age clients after FY2014, for each successive FY ($p < 0.001$).

Figure 4.31. Percentage of All Clients With SUD Across Urban and Rural Areas



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Urban - 12-17 Years	18.4	14.9	14.8	13.5	12.5	11.4	10.7
Rural - 12-17 Years	11	9	8.7	9.4	9.9	10.9	11.2
Urban - 18-25 Years	36.6	34.5	33.2	30.7	28.1	29.1	29.6
Rural - 18-25 Years	27	24.5	26.3	25.7	26.5	28.1	29
Urban - 26 Years and Older	33.4	33.1	33.5	32.4	30.9	31.6	32.8
Rural - 26 Years and Older	23.6	21.4	22.6	23.8	25.1	27.2	28.2

Note: Percentages do not add to 100% because data were missing, not applicable, or not collected.

Key Findings–SUD

- Despite significant decreases in the percentage of clients having alcohol and cocaine/crack as their primary SUD, alcohol, marijuana/hashish, heroin and other opioids, and cocaine/crack were the primary SUD problems reported across FYs.
- There were significant increases across FYs in clients having the following primary SUDs:
  - Marijuana/hashish,
  - Opioids, and
  - Methamphetamine use.
- Types of specific SUD were significantly different across the following age groups: Clients age 12 and under (children), ages 12–17 (adolescents), and age 26 and older (adults).
  - Clients across *all* age groups reported significant increases across FYs in the percentage of clients with amphetamine SUDs and decreases in alcohol SUDs.
  - For adolescents and young adults:
    - The primary SUD was for marijuana/hashish, followed by alcohol.
    - There were significant decreases the percentage of clients with opioid SUDs.
  - For adults:
    - The primary SUD was for alcohol.

    - There were significant increases in the percentage of clients with marijuana/hashish and opioid SUDs.

- Although most clients with any SUD identify as White, increasing numbers of Black/African Americans and persons who identify with two or more races have SUDs.
- Across *all* age groups, there were significant increases in the percentage of clients with any SUD located in rural areas served by CSBs.

Recommendations

- Although increases in federal and state funding and other efforts to target the opioid epidemic in the Commonwealth of Virginia are clearly warranted, funding and other efforts are needed to address increases in methamphetamine use.
- Despite decreases across FYs in the number of clients with alcohol and cocaine/crack SUDs, respectively, the number of clients continuing to report these substances as their primary SUD indicates that funds and other efforts to target continued use of these substances is warranted.
- Based on the percentage of clients across FYs who had any SUD (46.3%) and were at risk of SED, had SED or SMI (60.2%), respectively, CSBs are continuing to see clients who have co-occurring disorders[55]. It is recommended that CSBs continue to provide services to address clients with serious MH issues and who also use substances.

[55] Data regarding the number of unduplicated clients who received substance use and/or MH services from CSBs and had co-occurring disorders was only available through FY2015. As such, analyses to examine characteristics of clients with co-occurring disorders could not be conducted on this client population.

4.3 What is the Capacity of Virginia's System to Provide BH and Prevention Services?

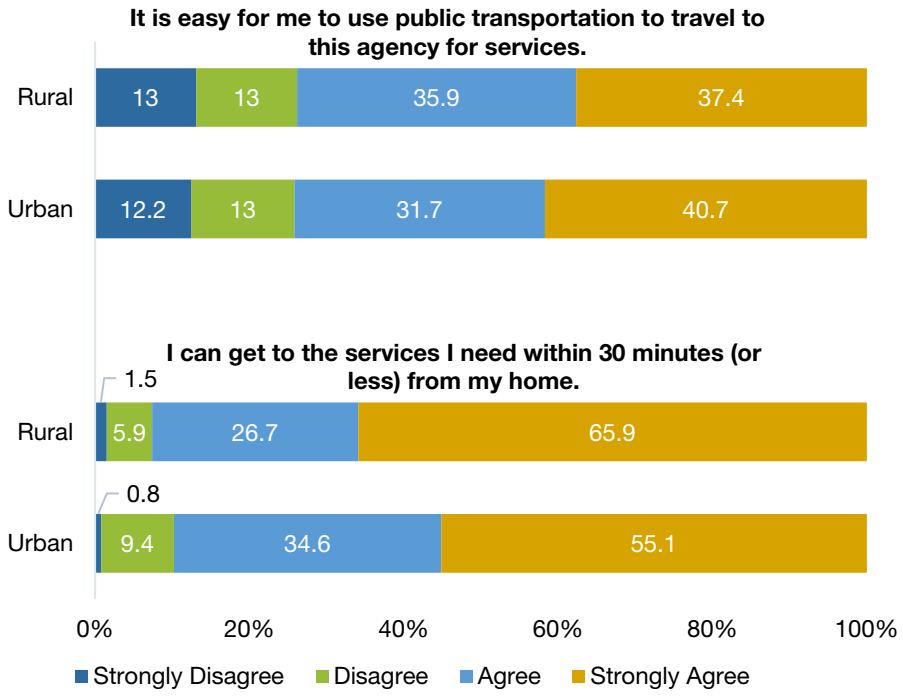
4.3.1 To What Extent Are Clients Able to Receive Services Where and When They Need Them?

Quantitative data from the consumer focus group surveys (n=291), direct service staff focus group surveys (n=329), and the administrator pre-site survey (n=40) was examined to obtain perspectives from consumers, direct service providers, and administrative staff regarding the extent to which clients are able to receive services from their CSB.

Geographic Availability of Services

Approximately 82% (n=239) of clients agreed or strongly agreed that they can get to the services they need within 30 minutes (or less) from their home; however, fewer clients agreed that it was easy for them to use public transportation to travel to their CSB for services (6%7, n=185). The subsection Community-Level Challenges, Client Challenges to Accessing Services (under Section 4.3.3 Barriers to the Provision of BHS) explains in detail additional barriers to accessing services. Interestingly, we found no differences between clients who receive services at CSBs located in primarily rural and urban settings regarding ratings on the ease of using public transportation to access services. Figure 4.32 displays these findings.

Figure 4.32. Consumer Reports of Geographic Availability of Services



Note: Percentages may not add to 100% because of missing data.

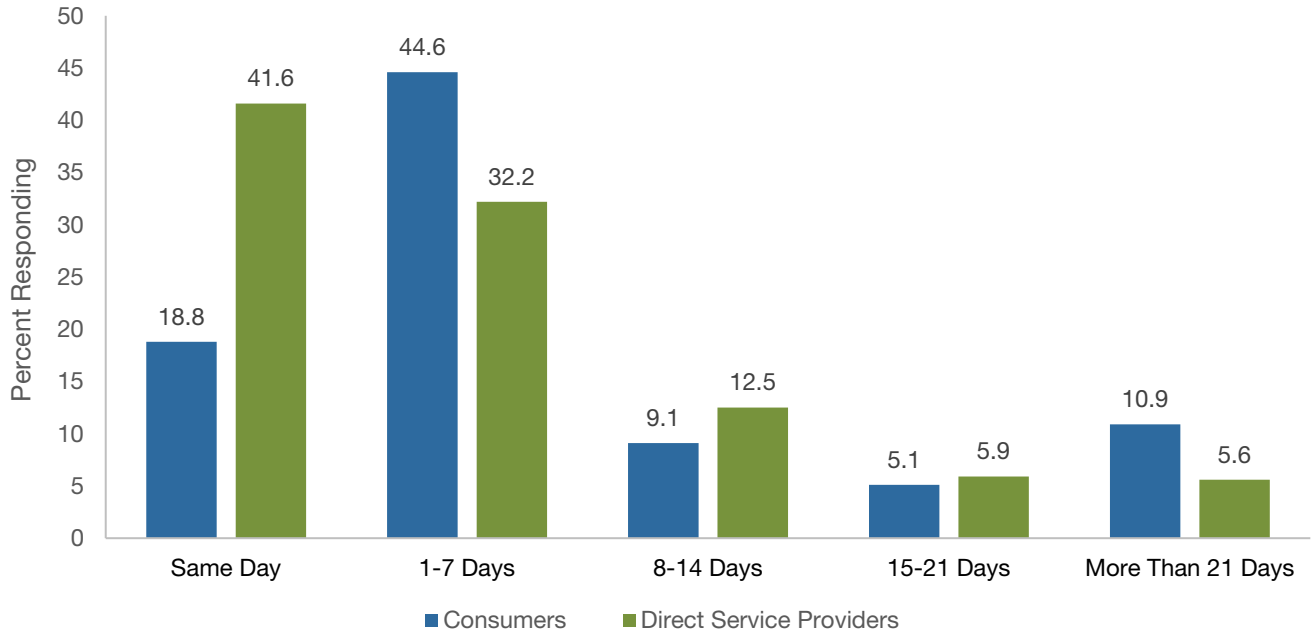
Approximately 70% (n=213) of direct service providers agreed or strongly agreed that their CSB had resources such as nearby public transportation, shuttle service, travel vouchers, free parking, and/or extended hours to help clients access services. Providers who work for CSBs located in primarily urban areas were significantly more likely to agree that their CSB has resources to help their clients access

services (78.6%, n=117) compared with those who work for CSBs located in primarily urban areas (63.5%, n=106; $p < 0.05$).

Time Needed to Access Services

Clients, direct service providers, and administrative staff reported on the average amount of time it takes for a client to receive services once they have requested services. Most clients (44.6%, n=123) reported that it takes about 1–7 days from requesting services to receive services. In contrast, most providers reported that clients typically can access services on the same day they request them (41.6%, n=133). Approximately 32% (n=103) of providers reported that clients can access services within 1–7 days. Figure 4.33 displays these findings.

Figure 4.33. Consumer and Direct Service Provider Reports of Time Needed to Access Services



Note: Percentages may not add to 100% because of missing data.

Administrative staff reported on the average time it takes clients to receive specific BHS. These findings are displayed in Table 4.18. Most administrative staff—95%—reported that clients generally can access crisis or emergency services on the same day. In addition, most administrative staff reported clients can access inpatient and residential MH treatment services on the same day. Administrative staff reported that clients can generally access the following services within 1–7 days:

- Substance use inpatient and residential treatment services,
- Substance use OP and IOP treatment services,
- Recovery support services, and
- Substance use prevention services and MH promotion services.

Table 4.18. Administrative Staff Reports of Average Time to Access BHS

BHS Type	Same day		1–7 days		8–14 days		15–21 days		22–30 days	
	%	n	%	n	%	n	%	n	%	n
Crisis/emergency services	95.0	38	2.5	1	0.0	0	0.0	0	0.0	0
Substance use treatment—inpatient and residential services	12.5	5	30.0	12	12.5	5	2.5	1	0.0	0
Substance use treatment—OP and IOP services	20.0	8	50.0	20	20.0	8	0.0	0	0.0	0
Substance use prevention services	10.0	4	27.5	11	10.0	4	2.5	1	2.5	1
MH treatment—inpatient and residential services	37.5	15	22.5	9	5.0	2	1	2.5	0.0	0
MH treatment—OP and IOP services	25.0	10	35.0	14	30.0	12	5.0	2	5.0	2
MH promotion services	7.5	3	12.5	5	10.0	4	2.5	1	5.0	2
Recovery support services	20.0	8	47.5	19	15.0	6	12.5	5	0.0	0

Note: Percentages may not add to 100% because of missing data.

Direct Service Provider Feedback on Client Access to Services

Approximately 65% (n=209) of direct service providers reported they were satisfied or very satisfied with the time clients spend on waitlists, and more providers—approximately 81% (n=259)—reported they were satisfied or very satisfied with the ease of the process for scheduling clients.

Ease of Contacting Their CSB

Approximately 87% (n=241) of clients agreed or strongly agreed that they are able to contact their provider(s) outside of their scheduled appointments, and approximately 92% (n=255) of clients agreed or strongly agreed that their CSB is open during hours that are convenient for them. Clients who receive services from CSBs located in primarily rural areas were significantly more likely to agree that they are able to contact their provider(s) outside of their scheduled appointments (93.6%, n=130) compared with those receiving services from CSBs located primarily in urban areas (86.8%, n=111; $p < 0.05$).

4.3.2 What Is the System's Capacity to Manage BH Crises?

The JBS Team examined quantitative data from the direct service provider survey and the administrator pre-site survey to obtain perspectives from direct service providers and administrative staff, respectively, regarding the capacity of CSBs to manage provision of BHS.

Administrative Staff Reports of Staffing Capacity

Administrative staff reported on the current staffing capacity of their CSB to provide a range of BHS. The findings are displayed in Table 4.19. Administrative staff from 45% or more of CSBs reported that their agency does not provide the following services:

- Substance use inpatient and residential treatment services and
- MH inpatient and residential treatment services.

Administrative staff from 50% or more of CSBs reported that their agency is currently challenged with having the staffing capacity needed to provide the following services:

- Crisis/emergency services,
- Substance use OP and IOP treatment services,
- MH OP and IOP treatment services, and
- Recovery support services.

Increased workloads, increased documentation requirements, low salaries, and clinical staff shortages are factors that contribute to a decrease in capacity to provide recovery support, substance use and MH OP and IOP services. Staff at many CSBs reported that the risk for burnout is high among staff who provide these services. Administrative staff also noted difficulties in competing with private providers, as these providers were more likely to offer higher salaries. In addition, shortages of clinical staff to fill these roles resulted in increased competition between CSBs for qualified staff.

"We do have people [particularly outpatient clinicians] leaving in terms of the clinic clinical work because they said that they're burning out. The requirements, in our exit interviews that we conduct, the paperwork. That's a factor. And the piece that we are upping the ante with the productivity." (Urban, medium budget CSB)

"So, my workforce issues, the private sector is my competition. And quite frankly, I can almost compete with them when we look at the money; and our benefits definitely blows them out of the water. My benefits cost me 50%. So, when I have to cost out staff, it's very expensive. But I can't compete with the documentation regulatory requirements and when we've lost good clinicians that really wanted to go into private practice, they said, 'Look, I got into social work to serve people, not to document serving people.' I mean, it's hurting us." (Urban, large budget CSB)

Similarly, challenges recruiting and retaining crisis and emergency services staff may relate to both the nature of the work and wages incommensurate with responsibilities of the position. Staff reported that turnover rates in the crisis/emergency services departments was higher than in other departments.

"The only constant thing is a struggle to recruit, hire, and retain a lot of our professional staff and specifically in the acute or emergency services. And, I think, again, from outside perspective, and this has come up, I think that staff, there's a lot of pressure put on them. They're on call during hours that we don't normally think of as busy hours. And we still need, or we desperately need those people to be on the other end to answer that phone. But from a pay perspective, they're not necessarily compensated for the additional risk and strain that they take on. And so, a concern that I have is our turnover rate when it comes to the acute services is higher. And so that's probably the biggest concern. And that's both the mental health and substance abuse and that emergency intake." (Urban, large budget CSB)

"Emergency services, we've had a high turnover. They [the staff] have so much liability. The bed search has gotten to be so cumbersome where the acute hospitals are not taking our individuals. So, they're having to call for prescreening to 10 hospitals." (Rural, small budget CSB)

Administrative staff from 50% or more of CSBs reported that their agency is currently at capacity for providing the following services:

- Substance use prevention services and
- MH promotion services.

Table 4.19. Administrative Staff Reports of Current Staffing Capacity for BHS

BHS Type	Not Applicable (CSB does not provide this service)		Demand Exceeds Capacity/Service Overutilized		At Capacity		Excess Capacity/ Service Underutilized	
	%	n	%	n	%	n	%	n
Crisis/emergency services	0.0	0	50.0	20	45.0	18	2.5	1
Substance use inpatient and residential treatment services	62.5	25	20.0	8	10.0	4	0.0	0
Substance use OP and IOP treatment services	0.0	0	60.0	24	32.5	13	5.0	2
Substance use prevention services	2.5	1	35.0	14	62.5	25	0.0	0
MH inpatient and residential treatment services	47.5	19	22.5	9	15.0	6	10.0	4
MH OP and IOP treatment services	0.0	0	72.5	29	22.5	9	2.5	1
MH promotion services	15.0	6	32.5	13	50.0	20	2.5	1
Recovery support services	5.0	2	55.0	22	32.5	13	5.0	2

Note: Percentages may not add to 100% because of missing data.

Direct Service Provider Feedback on Service Capacity

Almost half of direct service providers—approximately 47% (n=148)—reported there were *not* adequate staff available to provide services to clients at their CSB, regardless of whether providers worked at CSBs located primarily in urban (50%, n=75) or rural (44.5%, n=73) areas.

Approximately 68% (n=217) of direct service providers reported they were satisfied or very satisfied with the capacity management systems used to manage waitlists, prioritize specific populations, and/or provide interim services. Providers that work for CSBs located in primarily rural areas were significantly more satisfied with the capacity management systems used by their CSB (80%, n=128), compared with those who work for CSBs located in primarily urban areas (63.6%, n=89; $p < 0.01$).

4.3.3 Barriers to the Provision of BHS

Administrative staff, direct service providers, and clients from the 40 CSBs described a range of factors that impeded the delivery of BHS. The analysis on barriers to CSBs providing services was guided by an adapted socioecological framework[56] (Figure 4.34) focused on policy, community, and organizational factors that hinder the provision of BHS. Analysis of qualitative data from the interviews and focus groups showed that sources of barriers were primarily found at three levels—organizational, community, and policy. Each of these categories jointly influence the provision of BHS; thus, it is important to understand how they relate to one another. The organizational-level challenges category refers to rules, regulations, agency services and characteristics within the

Figure 4.34. Adapted Socioecological Model

[56] McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, *15*(4), 351-377.

organization that can impact the provision of services. The community-level category includes the availability and location of resources and relationships among organizations. Last, policy-related challenges refer to local, state, and national laws that can impact the provision of services.

Organizational-Level Challenges

Staff and clients identified six barriers to the provision of BHS that originated at the organizational level. These included factors related to the lack of capacity of CSB staff to provide services and limitations in service delivery.

Organizational-Level Challenges to the Provision of BHS

- Workforce inadequacy and staffing issues
- Professional development and training challenges
- CSB services that were insufficient to meet client needs
- Excessive documentation requirements
- EHR/HIT-related challenges
- Funding challenges

Workforce Adequacy and Staffing Issues

Staff Shortages. Inadequate workforce capacity to meet BH demands was one of the largest barriers reported by staff at every CSB. Workforce challenges to providing sufficient BHS included staff turnover, staff recruitment, and staff retention issues. In addition, many CSBs reported understaffing (e.g., unfilled staff positions, overworked staff) as a common barrier to their work. Direct service staff frequently described high caseloads, a lack of time to complete their work, and the need to complete work afterhours even though they were not allowed overtime compensation. Staff shortages were reported at multiple levels in the CSBs and included adult and child psychiatrists, PC physicians, case managers, peer recovery specialists, crisis services staff, and licensed and license-eligible clinicians (e.g., licensed clinical social workers). To mitigate this challenge, CSBs routinely pull staff from other services, but this forces a small number of staff to serve in a variety of roles, which often leads to a decrease in staff morale.

"The outpatient piece of it, part of that is a shortage of, what I perceive as a shortage of, licensed folks. We've had a position open for almost a year in outpatient services and just haven't found—we've had a couple of applications, but not, you know, either they didn't have the right fit with the agency or didn't have enough experience and the expertise that we were looking for." (Rural, small budget CSB)

Workforce shortages also increased wait times. Specifically, psychiatric and OP services at many CSBs have a long waitlist (e.g., 4–6 weeks or longer) for an appointment.

"We've had the wait list probably for about 3 months, 4 months now. And it's a relatively new service for us. […] So, as we started to market the service [OP services], of course, we received higher demand for the service and just couldn't keep up. And that's just with our internal folks that were existing clients, which it goes back to your point earlier—or someone's point—could you serve people who are just walking in and requesting and saying, I want outpatient services. We really don't have the capacity to serve those folks because we're trying to serve people that we're already involved with." (Urban, large budget CSB)

Staff Turnover. The shortage of qualified BH clinicians is exacerbated by high turnover rates. Staff turnover was a barrier frequently mentioned by staff at several CSBs. Staff turnover made it difficult to provide services because the constant introduction of new staff made it challenging to ensure continuity of care and access to appointments for all clients. Near-constant onboarding of new staff also meant trainings had to be repeated for new employees. Trainings that required in-person attendance (as opposed to on-demand training like recorded webinars) meant fewer staff members were available to provide a given service for a period until the training was offered again in the region. Trainings conducted at a distance from the CSB location also posed a challenge because staff members were required to miss work to attend them.

BH Workforce Shortages by Provider Type (reported by CSB staff)

- Child psychiatrists
- Adult psychiatrists
- Peer recovery specialists
- Licensed and license-eligible clinicians
- MH and substance abuse social workers
- Adult MH case managers
- Children's services case managers
- Counselors
- Nurses

"What usually happens is that we get all trained up and then we have staff turnover. And then you look around and you're like, all my staff are now not trained in such and such." (Urban, medium budget CSB)

In addition, staff turnover also meant disruption for clients and for other CSB staff members. High turnover rates increased the risk for staff burnout as the remaining staff took on additional work; in some cases, direct service providers reported carrying large caseloads (e.g., 70 or more clients). It should be noted that caseloads were often comprised of clinically complex individuals which added to clinicians' stress levels.

"Yeah, so some of our challenges with case management. One has been we've had in the last I would say 24 months or the last 2 years, a little bit more turnover than we have seen historically in our case management services. And so that has made it really hard for us to continue to provide the level of care to the same number of people just because someone has to carry that caseload. And it's just hard to keep up with that volume." (Rural, small budget CSB)

"We still have a lot of turnover because we have a lot of people turning over into the private sector." (Urban, medium budget CSB)

"So, we have a high volume of substance use participants. So, we have gone back and done a little more specialization because I'm not comfortable putting someone who's not skilled with the population or doesn't prefer. You either love substance use or you don't. So, we are trying to, and we have a lot of turnovers. We have a lot of very green providers coming in. Not only do they not know enough about it to be helpful, they get eaten alive." (Urban, medium budget CSB)

In addition to turnover, risk for burnout was considerably high among CSB staff at multiple levels. Staff noted a concern about change saturation, as there are many changes occurring simultaneously and constantly (e.g., Medicaid expansion, STEP-VA, BH Redesign). Although they understand and agree

with the impetus for the changes, staff noted a desire for there to be an equal understanding—at the state level—that the changes are being carried out by people who are in the midst of caring for high-risk populations, and that this can lead to burnout.

Staff Recruitment and Retention. Recruitment and retention barriers were also mentioned by CSB staff—in part due to the nature of the work and because of increasing workload/paperwork requirements, low wage competitiveness, and high caseloads. In general, the implementation of STEP-VA and Medicaid expansion made a positive impact in increasing the number of individuals seeking BHS at the CSBs; however, the increased volume of potential clients without an adequate increase to staff capacity resulted in staff carrying higher caseloads. Higher caseloads lead to the frequency and duration of treatment being less than desirable.

"Every day, the numbers [are] increasing because of same-day access. I'm also the person that assigns people to the clinics that comes in from same-day access. So, the majority coming in are seeking methadone or seeking SU[D] services and with the numbers increasing where the caseloads are increasing. And so, my fear is that we're not going to have enough staff to meet the demands of the community." (Urban, small budget CSB)

"I think we all have waiting lists for services and that's because we don't have the staff that we need. We don't have the staff we need because we don't have the funding we need to obtain and retain staff." (Rural, small budget CSB)

"Our same-day access has had a high [staff] turnover because they stay very busy. And when you have two people doing assessments, people waiting at the door and you're trying to get all of the required things done and one of those individuals is out sick and you're the only one." (Rural, small budget CSB)

"We have our teams that are amazing, tremendously dedicated, but they're overwhelmed. Just on the one-on-one basis. So, whenever you have policy changes, regulatory changes, it's a huge shift. The STEP Virginia is pretty big." (Rural, large budget CSB)

Administrative staff at many CSBs reported significant challenges in providing competitive salaries compared with private providers, hospitals, or even MCOs in their regions. The loss of wage competitiveness made it difficult for most CSBs to recruit and retain qualified staff. These recruitment challenges led to a lower quality (e.g., green, unexperienced) workforce, which CSBs ultimately paid more for because they had to provide more training and supervision. Staff at most CSBs reported that low salaries coupled with poor benefits made it challenging to retain qualified staff, such that many staff would come to the CSB to get licensure/training and leave soon after to seek opportunities with higher pay.

"We have had situations where staff come in, they get credentialed up and they're trained, and then they leave for more money. And that's not good for continuity of care for our clients." (Urban, large budget CSB)

"Okay, I think you'll probably hear a theme that we give people—we aren't one of the higher paying boards, even though we're trying to be more competitive. We probably get a lot of people who are new to our service system, who come

in and get experience and then maybe move onto the higher paying jobs." (Rural, medium budget CSB)

"Our challenge is in funding for quality services and accessibility is that – salaries […] compared to the market, we're probably not as competitive. We are competitive with other CSBs, but compared to the private hospitals, compared to other places in our community where you do this sort of work, we're probably not as competitive. So, I think salary is certainly a concern. I think that because we don't have funding, our staff, we continue to serve the volume even though we don't have the numbers to do it. […] We just serve who comes through our door, which then sometimes means that our staff are working, I think, harder because we don't have resources to continue to keep adding more and more staff." (Rural, small budget CSB)

Perceived salary differentials were also a cause of concern among longer tenured staff at some CSBs. These staff noted that their salaries did not seem equitable, even with adjustments, compared to newer, less experienced staff who were offered higher salaries. Another barrier to retaining quality staff was a lack of professional development opportunities. Staff at most CSBs reported having no formal training plan. Minimal training and lack of professional development were cited as barriers at a few CSBs because, although trainings were available, staff were responsible for finding trainings, and arranging staff coverage. Attending trainings meant that their colleague's workloads increased. Staff are trained for several EBPs; however, leadership staff at many CSBs noted the need for additional funding to support staff professional development, including ongoing training for fidelity in their current EBPs and for EBPs required to support STEP-VA implementation.

Professional Development and Training Challenges

Barriers to maximizing the use of training funds and streamlining service delivery were described by many interviewees. CSB administrative staff described several barriers around lack of funding, staff time, and availability of trainings including lack of funding, staff time, availability of trainings.

Lack of Funding for Training. Across many CSBs, interviewees expressed frustration with the lack of funding available from the state for EBP trainings, some of which are now being mandated for STEP-VA. Respondents reported that many EBPs are copyrighted and expensive and that, while they would like to be able to train their clinical staff on EBPs, some are too expensive; thus, CSBs are unable to afford them. Interviewees also indicated their concerns around fidelity to EBPs, noting that paying for the training does not address the fidelity component, which can be very expensive.

Staff Time. Training staff includes not only offering the training resources but also the ability for staff to attend trainings. Interviewees from many CSBs reported difficulties pulling staff offline to send them to trainings. Specifically, interviewees noted that CSBs lose a clinical staff member for an entire day when they send them for a 3-hour training in Richmond.

Availability of Trainings. Interviewees reported that the Commonwealth sometimes offers very useful trainings but that these trainings fill up in an hour (and no additional trainings are added). Without additional trainings, many staff are unable to receive the information. Respondents indicated their desire for the Commonwealth to continually offer these trainings online, so all clinical staff and new hires have an opportunity to participate. Specific trainings that interviewees expressed an interest in included: EMDR, functional family therapy, and DBT.

"So many of those are copyrighted and expensive. And so, our advocacy is always around let's get some evidence-based practices. Or we need the state to do that, but not just one round of training because of staff turnover. They need to kind of continually offer those kinds of trainings to our staff. And that to me is the most efficient way to do it is for the state to do it, not for each of us to get a little pot of money to do it. And if they can do it online, so that there's no travel costs and that kind of stuff, it's good. But some of those people [EBP trainers] also won't do it that way, some of those copyrighted practices." (Urban, medium budget CSB)

"You want us to do evidence-based practices… what does that look like for you to support us in getting there? You provided EBP training that fills up within an hour and nobody else can get in that training." (Urban, small budget CSB)

"The general clinicians probably could use a lot more [training]. Especially when we talk about the new outpatient requirements on STEP Virginia and the focus on evidence based, I think that is going to have some big ripple effects in terms of what we need to do." (Urban, medium budget CSB)

"But the other priority in the organization is the internal support functions. So, for so long, we built services to the community, and I don't think we kept up in an adequate rate with the investment in training. So, we're right now [exploring] getting our internal trainers such that they keep us 100% compliant with those core mandated required trainings, and that we have philosophical trainings around person centered, recovery oriented, folded into that trauma informed approaches, not only to the work we deliver to the community, but our support of each other as an organization providing care that needs to be an organization that is person centered and recovery oriented and give staff time to recover from the work itself." (Urban, large budget CSB)

Limited Service Offerings

Although most CSBs offer a variety of services, some agencies often could not meet all the diverse needs of their clients. For example, a commonly cited barrier to the provision of services was that some services were not offered even though there was a demonstrated need for them. Clients and staff frequently noted that more individualized services, IOP treatment, partial hospitalization, residential treatment, and detoxification services were among the many services desired. Expanded services for children and transitional-aged youth (i.e., 18–24 years) were also frequently mentioned. Most CSBs use peer recovery services (e.g., for warm handoffs during same-day access [SDA] appointments, recovery group facilitators, outreach for overdose patients, jail outreach); however, there are challenges and inconsistences in how peers are engaged and utilized within the CSB. Staff at some CSBs noted that peers are not fully integrated into clinical teams and that limited infrastructure exists to integrate peers into clinical teams sustainably. Staff, clients, and peers voiced a strong desire for more peers to provide recovery support services; however, these challenges prohibit many CSBs from hiring additional peer specialists. Language was also a commonly reported

Additional Services Desired by CSB Clients and Staff Included:

- Child and adult therapists
- Adolescent groups
- Parenting classes
- Smoking cessation services
- Childcare for patients
- Health education

barrier—specifically, a lack of Spanish-speaking staff to serve Spanish-speaking clients—to implementing culturally competent services.

Excessive Documentation Requirements

Direct service providers and administrative staff reported that the amount of documentation required hindered their ability to deliver services. Increased documentation requirements stemmed, in part, from the introduction of MCOs, each of which has different requirements for billing authorizations. Additional information regarding this barrier from the perspective of the direct service staff is included in Section 4.6.

> **"We are grateful for the money, but we spend so much time aligning paperwork and meeting requirements. You can't forget that in this field; the people are the work. You can be more efficient by streamlining paperwork and preauthorization. It takes more of us, and we need more staff."** (Urban, large budget CSB)

Duplicative, redundant forms and documentation requirements increased the amount of time direct service providers spent on clinical documentation. This increase in documentation requirements decreased the face-to-face time clinicians were able to spend with clients. Redundancy in form requirements also introduced the possibility for inaccuracies in documentation, which may negatively impact patient care.

> **"I want to see 40 hours [in a 40-hour work week] documented. Because if you don't document, it didn't happen. It's a lot of documentation. I mean, from the biopsychosocial when they come in and then you have support plans, which are called treatment plans. And then you have medical necessity criteria. And then you have the progress notes. And then you have the quarterly assessments. Some things, like, if you're working in the private sector, it's a lot less than what you're required to do at the CSB. So, it is a lot. I mean, anybody here will say that's the number one source of burnout. It's just the constant documentation and keeping up with it and everything is needed in an exact time. And especially with MCOs, you have to provide that, or you may have to give back money if things are not in place."** (Urban, medium budget CSB)

EHR/HIT-Related Challenges

Frequent system-wide crashes, loss of data, and lack of full interoperability between systems (e.g., intraorganizational, between the CSB and external providers) were major sources of frustration among direct service providers and administrative staff at several CSBs. In the months that the JBS Team conducted site visits to CSBs, JBS staff were present during one of these system-wide outages. When the systems crash, staff resort to completing notes in Microsoft Word and then transferring them to the EHR at a later time (i.e., copy and paste). Staff also mentioned that minimal training for their EHR systems have led to underutilization. See Section 4.1.5 for additional information on EHR systems used by CSBs.

> **"It [the EHR] is being underutilized. It is a great [repository] for data and a good tool, but it isn't used to understand barriers or treatment, or to see if EBPs are being implemented with fidelity. We are missing out, but you need staffing to do this. The EHR is a good tool to capture information that can be helpful in progressing psychiatric services[57]."** (Urban, large budget CSB)

[57] This quote has been paraphrased.

Communication

CSB administrative staff described several barriers around communication. Respondents described a lack of communication from DBHDS with Fiscal Directors regarding updates and changes to policies, procedures, or allocations. In general, respondents reported a desire for clear rules of how the funding can be used.

"I came from a different industry into the CSB network, and I found no resources for finance that the department provided, no sort of interpretive guidance, no specific instruction with respect to reporting, no descriptions of funding sources. So, it's really just kind of feeling one's way through which was surprising, I thought given the fact that a state, effectively a state agency, that the requirements of the job would be more kind of outlined." (Rural, small budget CSB)

"Those emails from the department are a concatenation of those requirements. And I think that's one of the other things that is tough is some of those things shifts a lot of the responsibility on us to make sure we've captured those emails, we've recorded them, we've organized them in such a way that we can go back and say, 'This is how we know that funding is supposed to be used...' which for me as an accountant, it's really hard. Because it is a significant administrative piece." (Urban, medium budget CSB)

Funding Challenges

Funding Sources. Funding sources, and their related management, are the most crucial component of keeping CSBs operating. Interviewees expressed frustration around numerous factors, including how the funding formula is used by the Commonwealth to determine funding allocations for CSBs; why different formulas are used for different funding allocations; and whether the allocations are fairly distributed.

Although general funds (e.g., money that can used flexibly) were once a larger proportion of what CSBs received from the Commonwealth, in recent years, this has changed. Interviewees reported that these funds have not increased in 11 years. In addition, funding from the Commonwealth for specific programs (especially MH programs) has also stayed stagnant over the years and does not account for pay raises, cost of living increases, and the like.

Another challenge for CSBs is the need to create budgets over a year in advance (e.g., before state funding is announced) due to how difficult this makes the financial planning process. In addition, inconsistent funding (e.g., unexpected funds from DBHDS for PACT, human immunodeficiency virus) make it difficult for administrators to plan budgets and annual expenses. Also, funds promised by DBHDS that fall through are a source of frustration and make planning problematic.

"We've been flat funded by the state for 10 years maybe or more." (Urban, medium budget CSB)

"Each CSB is different. They receive different types of funding than other CSBs. I think DBHDS tries to make comparisons amongst CSBs and that's not necessarily easy." (Rural, small budget CSB)

"I think the funding formula has been so controversial. If you give it for need, then Northern Virginia gets upset." (Rural, large budget CSB)

"I want to make sure that [our CSB] holds a peer seat to the larger CSBs and that we get our share of the resources." (Rural, small budget CSB)

"I would say, we never know at the beginning of the year what money we're going to receive and when to plan. But somehow we need to create this budget and balance it in terms of your expenses and your revenues when you don't even know if you're going to get more money." (Rural, small budget CSB)

Fiscal Tools and Resources. The need for additional tools and resources was described by interviewees. Across many CSBs, administrators expressed a desire to have more guidance for CSB Fiscal Directors, given the rate of turnover across CSBs. Interviewees also indicated a need for training resources that could be made available to staff working with clients.

"I participate in the Finance Directors' Committee. We meet twice a year now and there's always discussion about the fact that we have so many new Finance Directors coming onboard. There's evidently a high turnover in Finance Directors also…at the CSB level. And some of the new newer Finance Directors, they don't feel like they have a lot of guidance from DBHDS. The committee itself is actually developing some training documents for other Finance Directors to kind of give them some guidance on how to muddle through this world of DBHDS reporting and funding and that kind of thing." (Rural, small budget CSB)

Revenues. Respondents reported that there has been a need to increase, and in some cases double, the capacity in the finance department to obtain the same amount of revenue since MCOs have come on board (e.g., due to failure of MCOs to make payments, much longer wait times for payments to come). In addition, participants discussed difficulties trying to make up the revenue lost from cuts taken based on Medicaid expansion assumptions for revenue, especially given the limited choice of line items that CSBs had to choose from to cut the dollars. Interviewees also reported difficulties around trying to figure out how to bill for clients whose needs cross the spectrum (e.g., clients with autism).

"We have a number of indigent individuals that we see, and we see the most highly complex cases and very often those are individuals with no insurance. Now, Medicaid expansion should be helping with that. But so far we haven't seen that we are getting reimbursed to the extent of the amount of the cut that we had to take in our state funds." (Urban, large budget CSB)

"The cuts we got last year that we were supposed to make up for in Medicaid revenue, we haven't. So, yeah, that hurts." (Rural, small budget CSB)

"[Funding is sufficient] as long as the MCOs are doing their part to pay the CSBs. That's the issue. We've struggled a lot more on the billing side and collecting our payments for services than we ever have." (Rural, medium budget CSB)

"I understand they're trying to streamline and make money, but when you have six MCOs with six different nuances of whether they want it faxed, they want it there, they want this, they want that. We've doubled our capacity in the finance

department just to get the same amount of money, just to get the same amount of money." (Rural, small budget CSB)

"I'll go back to our folks with autism. That is a group that we struggle with. What part of the agency do we serve them? They absolutely have mental health needs. They absolutely have developmental disability needs. And we haven't really kind of landed on the best place to be able to provide the services that they need. And it's a combination, quite honestly. It's not one or the other." (Urban, medium budget CSB)

Telepsychiatry. Administrators discussed the use of telepsychiatry and the challenges that surround it. Participants reported that the lack of reimbursement for telepsychiatry, which often does not save CSBs money due to the costs of overhead, equipment, and hourly rates was particularly challenging.

"So, telemedicine is really expensive. We don't recoup that. We recoup maybe two thirds, if we get paid. Because you have to consider all the overhead costs. Because we pay for the equipment. We pay for Lifesize. We pay for computers. We pay for the nurse." (Rural, small budget CSB)

"It's just that everybody thinks tele psych saves money, but you know it doesn't. Because we have to have another staff sitting in the room usually with the client. And so, it always kills me when they're like, oh, telepsych will solve it all and it's cheaper. And it's like, no, it's not. So, reimbursement for kind of all facets at telepsych would be really good." (Urban, medium budget CSB)

Community-Level Challenges

Staff and clients identified three barriers to the provision of BHS that originated at the community level. These included factors related to limited community resources to support client needs outside of the CSB that impact the provision of services within the CSB and knowledge about CSB services in the community.

Community-Level Challenges to the Provision of BHS

- Client access to services
- Lack of awareness of the CSB or CSB services
- Lack of available community resources to support client needs

Client Access to Services

In the semistructured interviews and focus groups, staff described community conditions that made the provision of BHS at the CSBs more difficult. Community characteristics identified as barriers were not universal across all CSBs. However, several community-level barriers were common to multiple CSBs.

Lack of Transportation. CSB clients and staff reported that transportation was a tremendous barrier to receiving services. In many areas across the Commonwealth, access to reliable transportation or availability of public transportation did not exist. Not all clients had access to a car, and the cost of public transit in some locations posed a significant financial hardship for some clients. Clients who did not have transportation relied on friends and family for transport; however, several reported that it became problematic for them because of the length of appointments. In addition, some clients found it difficult to get to follow-up appointments because of the lack of transportation. In some cases, staff attempted to mitigate this problem by providing transportation using their personal vehicles, advising clients to expect a lengthy process, or telling clients to come earlier in the day to avoid longer wait times.

This problem was more pronounced in rural communities and heavily impacted vulnerable, low-income clients, and those without cars. Because fewer providers are available in health professional shortage areas, clients must travel further for behavioral healthcare. Even though some CSBs have offices in multiple locations, not all locations offer an expanded service array. In many cases, each CSB has a primary location that offers a greater variety of services than their satellite offices. The length of transit time to get to treatment using public transportation or any other transit method was often noted as a barrier in itself, even when clients could afford the fares.

"I'm in [Name of City], and the only service I have is group and this is the only place it's offered. I don't have a license, so someone has to bring me here for the 30-minute drive back and forth. … in traffic it can take up to 30 minutes to get here, and there's a CSB in [Name of City]. But the services that are offered [there] are different. This one has more of the services and that one does not. And that goes back to maybe that population's needs are different, I'm not really sure. […] the [Name of City] office is more like a satellite office with this one being the main office. So, they offer some services but not all of them." (Urban, small budget CSB)

Although Medicaid does offer transportation services, most clients and staff reported that this service was unreliable; in many cases the transport did not arrive or arrived late, which caused clients to arrive late or miss appointments. Medicaid transportation services also often picked up clients too early, preventing them from receiving all of the services to which they were entitled.

Lack of Awareness of the CSB or CSB Services

Administrative staff, direct service providers, and clients all reported a lack of awareness within the community about the services that are offered by the CSB. A frequently reported barrier in this area was insufficient marketing or advertising to spread the word about CSB services in the community. As a result, potential clients were not always aware of the services offered by the CSB and were less likely to seek services. In many cases, it was unclear if the lack of awareness was due to limited outreach to the community by the CSB or due to the stigma associated with BH and services for SUDs. Administrative staff members from some CSBs also noted specific populations that were particularly hard to reach, such as males, minority populations, and individuals with low literacy levels, and that their agency needed new strategies to reach them.

Inadequate Community Resources

Staff at several CSBs noted that a lack of available community resources to support client needs hindered the provision of some services. Staff at some CSBs mentioned the need to refer clients out for services such as psychiatric and OP MH services but noted that these types of providers were scarce in many communities. Because some CSBs do not offer or have shortages in these areas, this is particularly problematic, as community providers may not be a viable treatment option for clients who use Medicaid or cannot afford to pay for services.

Many CSB staff cited the degree to which adequate housing—including recovery, transitional, or supportive housing—was available in the community as a significant barrier. Clients needed affordable housing both during treatment (except for those CSBs that had residential programs that provided housing) and after treatment. Staff from some CSBs indicated there was often insufficient capacity to meet the needs of clients for housing that also provided a space for safe recovery.

Policy-Related Challenges

CSB staff identified three barriers to the provision of BHS at a policy level that are roadblocks to service delivery. These included factors related to legislative mandates, environmental challenges, and fiscal policies that impacted the provision of services.

Policy-Related Challenges to the Provision of BHS

- STEP-VA implementation challenges
  - Lack of communication
  - Challenges working with MCOs
  - Medicaid reimbursement rates
- Insufficient funding
- Inadequate infrastructure
  - Lack of space
  - Inadequate technology infrastructure
  - Administrative infrastructure

STEP-VA Implementation Challenges

Staff universally agreed that the impetus behind STEP-VA and the goals of the legislation were warranted, but they noted that the amount of time to implement the changes was insufficient. In addition, most viewed it as "an unfunded mandate" that was rolled out too quickly. The sentiment from many staff was that STEP-VA legislation was, "too much, too fast, with not enough money" to effectively implement services. SDA was cited as both a barrier and a facilitator, as the CSB saw more clients seeking services but did not have the capacity to adequately serve the influx of new consumers. Although SDA is available, staff noted that because of staff shortages and a lack of infrastructure to support the service, there were not enough slots for all the clients that required services. As a result, clients were frequently told to come back on the next available SDA day. Staff at some CSBs reported that the CSB was only able to offer the services a few days a week for limited hours during those days.

"With same-day access coming in at the same time, we saw an increase in our caseload. I mean, honestly my guess is that if we didn't have same-day access, we probably would have been fine with continuing to manage the flow for case management. But with same-day access really widening that door of availability to us, it has increased the number of referrals to case management, which coupled with the shortage of staff has just been a little bit harder to get people in as quickly as we'd like." (Rural, small budget CSB)

Staff also expressed concern about how to fund and operationalize crisis intervention and mobile crisis services. In rural/remote areas with limited or no wireless network coverage, leadership staff at many CSBs cited safety concerns as the mandate would require sending staff out into potentially dangerous situations that could increase the response time of law enforcement if needed. Staff also noted difficulties meeting the 10-day requirement for getting clients into services after an initial assessment.

Lack of Communication. Another barrier, reported by administrative staff at many CSBs, was lack of clear and consistent communication and expectations from DBHDS about STEP-VA and having sufficient funding to support successful implementation and sustainability. The desire for timely and clear communication was mentioned by several staff because a lack of communication hindered development of adequate fiscal planning.

Challenges Working With MCOs. As noted previously, six MCOs manage the payment and delivery of Medicaid-reimbursed services throughout the Commonwealth (see Section 4.5 What Has Been the Impact Thus Far of STEP-VA and Medicaid Expansion and Medicaid Managed Care on Provision of BHS?). The most frequently reported barrier by administrative and direct services staff at nearly all CSBs was the inconsistencies they encountered while working with six MCOs.

In addition, staff universally noted that there seemed to be a misunderstanding about the populations CSBs served and a lack of understanding from the MCOs regarding chronic mental illness. Specifically, staff noted that community-based, supportive services significantly aid in recovery and keep people out of hospitals long term are typically only authorized for 6 months. For example, staff reported that authorization for PSR and MH skills building services are frequently denied because clients who have progressed (e.g., after 6 months) no longer qualified for services, so they were discharged. As such, MH skills building has been one of biggest challenges because of the "plateau problem." When clients plateau (and MCOs cease services), it leaves clients at high risk for a new crisis and rehospitalization. Furthermore, MCOs are also challenging to work with around detox and crisis stabilization, as they require clients to be released in 3 days when the standard detox protocol is 5 days.

Staff noted that CSBs faced the following additional challenges in working with MCOs:

- Time for authorizations has increased (e.g., time to submit and time to get a response, length of authorizations, increased documentation). In addition, the CSBs have had issues with Current Procedural Terminology codes and obtaining authorizations.
- Constantly changing, inconsistent rules regarding approval of services, and many more "hoops to jump through" make it difficult to predict what's going to happen at the client level, program level, and even with fiscal management. The current managed care system feels punitive.
- Reimbursement levels are largely disproportionate with the cost of services.

Staff also mentioned that CSBs were given very little notice when processes or requirements were changed, which was a huge challenge because it required more information for clinicians to enter. In many cases, these changes were duplicative or redundant. Duplicate documentation for authorization forms significantly increased the amount of time clinicians needed to complete the forms. Staff expressed severe frustration with submitting information to each MCO in many different ways and mentioned a desire for a universal reporting mechanism used among all MCOs. The challenges CSBs face in working with MCOs culminates in the need to work harder to get paid for the services they provide, which consumes valuable staff time and resources.

Medicaid Reimbursement Rates. Another barrier mentioned by many staff was that Medicaid rates were not adequate to cover the true cost of services as the rates for some services have remained unchanged for decades (e.g., PSR has had the same reimbursement rate since the early 1990s). Staff at many CSBs reported that their agencies do not bill for some services (e.g., peer services) because the rates are so low that it would not cover the cost and requirements of the services. In addition, Medicaid funding to support PACT services is also challenging because billing rates do not cover the cost of those services.

"Well, the peers, because of the [Medicaid] reimbursement—we can't afford them. If we had higher reimbursement for peers, we could utilize our peer specialists for peer-run support groups for folks who just needed to kind of connect and stabilize who might not need to get to our doctor." (Rural, large budget CSB)

Insufficient Funding

Another salient challenge inhibiting CSBs from providing quality BHS was insufficient funding and funding cuts, a concern mentioned by staff members from multiple CSBs. In an environment in which funding availability is limited, some CSBs were forced to cut some services, including services like MH skills building. In some cases, CSBs received only a fraction of the required 10% match from their

localities, which meant they were forced to make up the difference in other ways. An additional challenge noted by many staff was the amount of restrictive funding, which makes it difficult for CSBs to pay for other necessary components, including human resources, IT, training, fiscal, and physical infrastructure. For additional information on funding barriers, see Section 4.4 How Are Funds Used to Support Provision of BHS in Virginia?

"It keeps growing in terms of just the support that we're expected to provide, the clients that we're expected to serve, the amount of reporting that we're supposed to do. And a lot of the funding that we get, you get this pot of money up front and 5 years later, you're still getting the same amount. But yet, you're supposed to still be serving at least what you were before and hopefully more, but yet it's more expensive to hire employees. And so, it's kind of, you get into this, there's never enough money. You can't keep good people because you can't give raises because we're not getting additional funding to provide those raises." (Rural, small budget CSB)

Well, for substance use specifically, I mean, the amount of money that's coming down for opioids to me is a big problem because it's not an opioid crisis. It's an addiction crisis. And they're tying the outcome so narrowly to opioids that it does make it a little hard to use. (Rural, large budget CSB)

Inadequate Infrastructure

Lack of Space. Limited space for clients was also cited as a barrier to the provision of BHS, according to members of administrative staff from several CSBs. Sometimes the CSB's physical space was not appropriate for the service it needed to provide (e.g., rooms large enough to comfortably accommodate group sessions), including limited quiet spaces for clients in crisis. Another space-related challenge was an agency's facility not having enough private office space for intake screenings, individual counseling sessions, and any additional assessments to be conducted so that the client's privacy was appropriately protected. CSB staff have employed various workarounds (e.g., office sharing, offering telecommuting where possible) to combat challenges associated with a lack of space but have done so at the expense of staff time.

"Case managers are all sharing offices, so there's two in offices. So every time they have an assessment, one person is normally getting out of the office and trying to find another office or we're just bunking them in with two other people in the office because ultimately they can't call another client while there's a client in there because you're violating confidentiality. We also don't have laptops, because we switched to desktops to save money so when they have to move, they don't even have their computer to move to another office." (Rural, medium budget CSB)

"We do need more space and probably better space. Like, for example, the lobby here, there's no bathroom accessible for the clients. That's challenging. So, what's the plan? The clinician has to go walk with them and wait outside. The facility issue is big, and we try to do as much as we can. Like we just built this room out a year ago, which is great. It added extra space. So, we're doing small stuff around the edges. But when you talk about bathrooms, that's where it becomes more problematic." (Urban, medium budget CSB)

Staff at some CSBs mentioned that the physical layout and configuration of the CSB office also posed a problem for clients seeking services or in crisis. For example, one staff member at an urban, large budget CSB noted that "the lobby can be very triggering to people … we have cops come in through the back so it's not super triggering, but sometimes if they come up through the front, that's real triggering for a lot of people."

> **"I know all of our people come in through the lobby, so it's hard to separate people, but some of our people like the children asked if there is a separate place where they could go and be away from the adults. I know some of the clinicians that specialize in trauma stuff, they were saying that their clients have felt triggered and have had panic attack because of the stuff that happens there [in the CSB lobby]."** (Urban, medium budget CSB)

Inadequate Technology Infrastructure. Another commonly cited barrier to the provision of BHS was a lack of technology infrastructure to meet service demands and the STEP-VA requirements. Staff at several CSBs mentioned that they did not have the necessary equipment to effectively meet the data requirements related to STEP-VA. Staff also noted that it was challenging to provide a way to conduct a secured collaborative documentation process without the use of updated equipment (e.g., new monitors, laptops).

Administrative Infrastructure. Adequate infrastructure is needed to support, monitor, and manage all the elements of STEP-VA. This is particularly true as it relates to supporting the fidelity of implementation of multiple EBPs and the increased demands necessary to be successful within a managed care environment. To support STEP-VA implementation, other foundational pieces also need to be in place. For example, interviewees discussed the need to build up administrative support and infrastructure needs for the additional reporting and data collection to meet performance indicators that is part of STEP-VA. Several interviewees voiced concern about the restrictions on STEP-VA funds and the lack of flexibility to be able to use them to address infrastructure needs.

> **"One of the things that bothered me—a lot of what we've done with STEP-VA in particular because that's the most recent [mandate]—there's no money built for infrastructure. We're hiring staff, but we have no place to put them. So, whenever we come to the table and say, 'We want to hire X staff.' Where are you going to put them is the question, and we have to figure out how to do that. Plus, there's no administrative overhead."** (Urban, medium budget CSB)
>
> **"All those things we need to start getting into, which is why our priority last year at the budget process was to ramp up admin. With all these new requirements with STEP Virginia, having six MCOs, the administrative requirements have just exploded."** (Urban, medium budget CSB)

As mentioned previously, staff at many CSBs reported challenges in the use of peer recovery services, most notably as it relates to a lack of infrastructure that integrates peers into clinical teams sustainably; this may involve raising Medicaid billing rates for peer services. Staff also noted that there is insufficient capacity to adequately support peer professional development and supervision. One additional challenge related to the implementation of peer services is that staff found it difficult to help

peers get past their criminal histories due to Virginia's Barrier Crime laws[58]. For example, draft regulations have included language excluding peer staff from being able to provide client transport if they have had a driving under the influence charge in the past 2 years.

"That's been a real challenge finding people. And a lot of the individuals on the SUD side in their prior life, when they were using, they have felony charges and things. And so really getting them back to work is hard. […] In any kind of employment. Even working with them outside of our own recovery services, finding an employer that will work with folks with a felony charge. And the barrier crimes list, instead of maybe getting looser over time because we've advocated over the years to take this barrier crime off the list or this crime off the list as being a barrier, instead it gets more rigid. And so, it's like, gosh, if we open it up to discussion with the General Assembly instead of that helping, it gets worse. So that's really been a challenge for us across the state." (Rural, small budget CSB)

"Peers are great, and I think it's a great resource. But we're very stringent in Virginia as far as who can be a peer. And 5 years off of probation; that's a long time. Because by the time they've been off probation for 5 years, they're normally not attached to us and coming in for services. So, for us to grant people who have best practices and have been through that, they're going to have to relax the rules a little bit on that. So, we've been having a hard time finding peers, but now we have more. We have like four now, five. We're up to five. But we're not getting any reimbursement for it." (Rural, small budget CSB)

"I think an issue too in that we have some opportunities for some vacancy even in SUD services is barrier crimes. When you're looking at people with a lived experience in substance use disorder, they have barrier crime issues that they have crimes that they have been charged, with felonious crimes, that preclude them from being employees. They don't get their background checks. They don't pass their background checks. So that is an issue for us because then that impacts our workforce." (Rural, medium budget CSB)

4.3.4 Facilitators to Provision of BHS

Administrative staff, direct service providers, and clients in the interviews and focus groups conducted during the assessment also described facilitating factors that made it easier for them to provide, access, and receive BHS. Similar to the analysis on barriers, the analysis on facilitators to CSBs was guided by the adapted socioecological model (see Section 4.3.1, Figure 4.34). Analysis of qualitative data from the interviews and focus groups found that factors that acted as facilitators were found at three levels—organizational, community, and policy.

[58] The term "barrier crimes" refers to crimes as defined Code of Virginia § 37.2-416 with barrier crimes listed in §19.2-392.02 that automatically bar an individual convicted of those crimes from employment or volunteer services in adult substance abuse treatment programs or other healthcare settings including the CSB system. (http://www.dbhds.virginia.gov/library/substance%20abuse%20services/OSAS-GuidanceBulletin200501.pdf)

Organizational-Level Facilitators

Some of the most frequently mentioned facilitators were at the organizational level. Staff and clients identified four facilitators to the provision of BHS that originated at the organizational level. These included factors related to the characteristics of staff that had a positive impact on client's likelihood of improvement.

Organizational-Level Facilitators to the Provision of BHS

- Availability of services
- Staff characteristics and support
- Workforce training/professional development
- Funding facilitators

Availability of Services

Variety of Services. Although gaps in services were listed as a barrier to the provision of services, the myriad of services that *are* available to clients through the CSB is a significant facilitator in providing services. Having a continuum of services at the CSBs was beneficial in areas with limited health provider options because it provided client resources for staff to refer them to and work with. As mentioned previously in Section 4.1 What Are the Key Characteristics of Virginia's Publicly Funded BH System?, CSBs provide a range of services including, but not limited to, peer recovery services, pharmacotherapy evaluation and medication management, MAT, gender-specific services (e.g., Project LINK for women), children's services, PSR, individual and group therapy, and a variety of skills groups.

Consumer Ability to Obtain Services

Approximately 83% (n=241) of consumers reported they can access needed services at their CSB. The JBS Team observed no differences between clients who receive services at CSBs located in primarily rural and urban settings.

Transportation. As discussed in Section 4.3.3 Barriers to the Provision of BHS, many clients had transportation difficulties that were a barrier to both accessing CSB services and maintaining consistent attendance once they began treatment. The means of transportation varied by location and depended on the surrounding community. CSBs located where public transportation was available, usually cities and metropolitan areas, were more likely to provide clients with passes or transit vouchers. A few CSBs located in rural areas with less developed public transportation provided vehicles for staff to transport clients.

Use of Telehealth. As noted in Section 4.1.6 To What Extent Do CSBs Use Telehealth Services?, more than half the consumer focus group survey respondents indicated that their CSB uses telehealth to deliver services. Given the shortage of BH providers, the use of telehealth was a significant facilitator in the provision of services. For example, to address the shortage in psychiatrists, staff at many CSBs reported that their agency established relationships with long-distance providers and supplemented the workforce with telepsychiatry. Some CSBs have been providing telehealth services for a decade or more and reported that acceptance among clients was often positive. For those CSBs that started providing it in more recent years, CSBs have worked with their clients to make it a more palatable experience. For example, nurses are present for telehealth/telepsychiatry services, and if clients are uncomfortable with telehealth/telepsychiatry services (e.g., videoconferencing), the CSBs allowed counselors to accompany clients during the sessions to ease their discomfort. Staff at several CSBs mentioned that nonclinical telehealth services were also used, such as preadmission screenings, training, and health education.

Peer Recovery Services. Staff and clients from every CSB reported the use of peer services was a facilitator to delivering BHS. Clients reported that working with individuals with lived experience made them better equipped to build and rebuild support networks, which helped facilitate the recovery

process. Peers served as advocates—for clients and the CSBs—as they worked to promote a culture that maximized the point of view, experiences, and care preferences of the clients they mentored.

"When they [clients] say things like 'I don't want to die today', that is the power of peer support because that would not have happened if we did not go do that together. That seed was planted. Whether it grows or whether it dies, I have no control over that. But the seed was planted and it's there. In terms of peer support here, I kind of highlighted what was shared in the previous meeting about how it is so hard for people to come here and get help, to any type of mental health support anywhere. So if we're able, if peers are able to meet them literally in the parking lot and walk with them, hand-in-hand, and to do their intake, letting them know and reassuring them that they are in a safe space now, that they are going to get help. That's like life changing. That's life saving. I mean, maybe somebody doesn't have to die from mental health or substance abuse, you know?" (Urban, large budget CSB)

CSBs used peer recovery services numerous ways including, but not limited to, providing community outreach, facilitating support groups, connecting clients with recovery support services, serving as a bridge between SDA and first appointments, and presenting at CIT trainings. In addition, peer services are integrated into a variety of programs including MAT, Project LINK, drug court, and PACT teams. For programs like drug court, peer specialists perform outreach work and provide coaching, mentorship, and support to clients through recovery as challenges arise from everyday activities. Furthermore, peers are knowledgeable about local resources, provide valuable education, aid in crisis intervention, and are trained in multiple recovery pathways.

"So, I think that that's probably the power of peer support and why it's so needed. Because I mean, yes, like, statistics are one thing and textbook smarts is another thing. And going to school and getting all the degrees is so great. But that lived experience is unparalleled." (Urban, large budget CSB)

"We don't have any jails in our catchment area. Our folks go to other places for jail. And so, to have a peer-type person that can travel and go to these other places and do that kind of outreach, I think, we really need that." (Rural, small budget CSB)

"We've got another girl that works, that is in the PSR program, and she's worked for us for years. We've got an emergency services worker who has been a peer and has worked for us. Another girl came in as a peer for drug court, and now she's a counselor for us. So, we haven't always described them as peer services, but we've hired people with real life experience, and they bring that experience with them and it helps them do better." (Rural, medium budget CSB)

"That's our peer engagement. So, when somebody comes in for same-day access, the peers will be the first person to meet them, and the peers will do what we call their 'legals'. So, their nonclinical stuff. They'll get the release of information signed… all the boring stuff… But that also gives them a moment to engage with them to say this is my name. I've been where you are. If you need anything, I'm a nonclinical person that you can always just call and talk to. Then they take them over to get the financial information. If the individual wants the peer to stay with them during the financial process, they will… And

then the peer goes and takes them back into the waiting area until it's time for the clinician to take them." (Rural, small budget CSB)

"We also have an office of family affairs, consumer family affairs, where we directly hire peers into the CSB to provide services as well. Like downstairs, we have a peer that works there in the waiting room to do welcoming. We have a peer that's trained and works in emergency services, a number of peers that work in our outpatient level of care. And then all of our peer run drop-in centers are obviously run by peers." (Urban, large budget CSB)

Staff Characteristics and Support

Dedicated, Knowledgeable Staff. Clients, administrative staff, and board members from each CSB described CSB staff as dedicated, hard-working, deeply committed individuals who often go above and beyond to meet the diverse needs of their clients. For example, clients frequently reported that their counselors or case managers provided transportation to and from appointments to fill gaps or assisted clients in filling out job applications. All levels of CSB staff from multiple agencies displayed a strong sense of community within their organizations and demonstrated high levels of passion for their work. In many cases, staff were natives of the communities or neighborhoods in which the CSBs were located, which gave them a unique perspective on the needs and challenges of their communities. Because of this unique link to the community, staff were knowledgeable about the local service community and had contacts within other agencies that were reported as facilitators. Staff knowledge and clinical expertise enabled clinicians to deliver more effective services, both in one-on-one sessions and in group sessions.

"We have some really dedicated staff that work really well with the clients. I think our nurse, it's interesting because the doctor's office is right next to mine and the nurses' office is right there, and there's no soundproofing. So, I can hear all kinds of stuff. And the nurse is kind of amazing with the clients. I mean, she's from around here, and she just relates to folks very well." (Rural, small budget CSB)

"Our staff are dedicated beyond belief. That's the number one thing. Despite all the demands that get put on them." (Rural, medium budget CSB)

"We have really good staff here, and they're very, very dedicated. So, one of our bright spots is our culture. We started 46 years ago in a chicken coop, literally, with a handful of people and we are now over 200 people. But we still have a culture of people who care about each other. We care about our clients and we care about each other. It's huge." (Rural, small budget CSB)

"They're absolutely dedicated to the mission. They're very good at their jobs. They're very good at understanding and embracing the populations that they work with. Now they're also really good at working with peers." (Urban, medium budget CSB)

"I think about our seriously mentally ill population. We have people that we've had on our caseloads for longer than I've been employed here. And that gives us the luxury of really knowing and understanding the people and where they live and their families and the resources and lack of transportation and all these kinds of barriers that they have to overcome in a different way. And I think the fact that we have sort of like this core group of employees who've

> **been here for so long is we have sort of a connection ourselves to this area and the people in it and an understanding that of the Appalachian culture because it's who we are and it's different."** (Rural, medium budget CSB)

Workforce Training/Professional Development

As noted in Section 4.3.3 Barriers to the Provision of BHS, staff at many CSBs found it challenging to participate in training or professional development opportunities when they were offered; however, staff from most CSBs felt that there were opportunities to grow and advance professionally, including opportunities to attend trainings that enhance their clinical knowledge. Many CSBs offered reimbursement for trainings, provided an online training platform for employee use (e.g., Relias), hosted internal training sessions relying on staff expertise, or brought training providers onsite. In addition, many CSBs provide pathways within their organizations to remove the financial burden of licensure by providing licensure supervision. Further, several staff reported that their CSBs had a tuition reimbursement program, offered student loan forgiveness, or provided stipends to clinicians who precept students or supervise new clinicians.

> **"We've got programs to help pay off student loans because we are in such a rural community. That's been really positive for us to attract qualified staff is to be accepted in those different programs."** (Rural, medium budget CSB)

Funding Facilitators

Although insufficient funding was noted as a barrier, it was also cited as a facilitator in some cases. Facilitators to support maximizing the use of funds for training and streamlining service delivery were described by many interviewees. CSB administrative staff also described several facilitators around allocated funding and regional trainings.

Affordability of Services

Approximately 81% (n=213) of clients agreed or strongly agreed that they could afford the cost of services. The JBS Team found no differences between clients who receive services at CSBs located in primarily rural and urban settings regarding ratings on the affordability of services.

Allocated Funding. Interviewees discussed how they use funds for trainings. Generally, there is an effort to try to use general funds for training and only use other funds when specifically allocated. Respondents noted their appreciation for being able to use state funding to implement training on telepsych and electronic faxing. Interviewees also reported their appreciation that programs that have funding from the state (e.g., PACT) include a lot of training. Some CSBs obtained grant funding to support specific EBP trainings (e.g., adolescent community reinforcement approach, TB-CBT). Other facilitators included the ability to move money around to support the training needs of staff, the allocation of funds for OP STEP-VA, and the ability to use some of these funds for training. Finally, CSBs noted the importance of looking at how to get staff into training opportunities (e.g., using free online EBP training).

Regional Trainings. Respondents expressed their excitement over the ability to participate in regional trainings. Specifically, interviewees noted their appreciation about the additional training funds associated with STEP-VA. Using these funds, some interviewees indicated their regions are developing some regional trainings (e.g., they bring in an outside trainer to their region to conduct the training rather than having to send clinical staff out).

"He [CSB Executive Director] received some regional money, well, state money, for regional training specifically. And so, he's put on trauma training, children's training, children therapy, family therapy, those kind of DLA trainings, REVIVE! trainings. He's put on a lot of various different trainings for the whole region. If you need it, you know it's here. And a series of trainings. That has been real helpful. I'm sending staff more than I ever have to various trainings." (Urban, small budget CSB)

"There's more training money associated with STEP Virginia, and our region is developing some regional trainings to bring somebody in to do it for the region rather than us having to send people off. So again, I think I can't really address fidelity, but I think it's a plan for the future." (Rural, medium budget CSB)

"I think one of the strengths of all this new funding we're getting is that those programs that got new state funding, they've been getting a lot of training. PACT, for example, I know that they get training. So, the ones who have funding from the state are getting a lot of training." (Urban, medium budget CSB)

"I know we're always looking for dollars to help support some of those trainings. So, I know we've talked even about regional training opportunities and things like that from a Virginia perspective to kind of even bring in more resources because it's costly." (Rural, small budget CSB)

Pooling Resources. CSB administrative staff described several facilitators around pooling resources. First, interviewees cited being able to pool resources with other CSBs for regional programs (e.g., purchasing beds, use of Substance Abuse Residential Purchase of Services grant funds, discharge planning grant) as helpful. Respondents also reported using nearby CSBs as a referral source for specific services (e.g., early intervention services). Finally, interviewees discussed how being able to conduct/attend trainings and regional programs with other CSBs was beneficial.

"Is there ways we can put that pot of money into one pot and then all of us benefit from that, get some services from that? So, we got [a nearby CSB] to actually come into our county and do a couple of services for us. They do early intervention service for us, just because we don't have enough funding to provide that early intervention service." (Rural, small budget CSB)

"One of the things that I know that we've done in this area is we're good to pool resources with other CSBs and do regional type programs and things like that. And that's been a plus for our area." (Rural, small budget CSB)

"My thing is, let's build teams in Southwest Virginia that can meet the needs. And if we can save a little money, let's try to reapply that money where there's other needs, where there's other gaps in the services." (Rural, small budget CSB)

"I think that we are very creative and innovative. I think if you tell us that there's a need, we will find a way to do it." (Rural, small budget CSB)

Maximizing Revenues. Interviewees reported that maximizing Medicaid billing revenue to allow provision of services that state/federal funds do not pay for was useful. Specifically, some noted that having office-based opioid treatment status certifies some CSBs as substance abuse provider agencies, which secures them a slightly higher billable rate. Professionalization of the whole reimbursement arena was also cited as a facilitator to maximizing revenues. The importance of braiding funding effectively was also discussed.

"When I bring in $100,000 more in revenue, that's a clinician. That's the way I think. And so, when I talk with my staff around you've got to improve revenue, I'm going to put that, reinvest that, back into services that we can serve more folks." (Urban, large budget CSB)

"We have really professionalized the whole reimbursement arena. So, they're not your average reimbursements, accounts payable, accounts receivable clerks. I mean, we've professionalized. They are reimbursement specialists. They are credentialing specialists. They are authorization specialists. So, they come with certifications and that sort of thing. And so that has really helped us maximize our revenue for the CSBs." (Urban, large budget CSB)

"I think in general most CSBs do a good job of blending funds." (Rural, medium budget CSB)

Fiscal Tools and Resources. The Fiscal Director group email, created for Fiscal Directors across CSBs to communicate information with each other, was described as helpful by several interviewees. In addition, interviewees discussed the development of training tools for new Finance Directors and expressed their belief that these will be extremely helpful.

"It's the Finance Director Subcommittee. We've just recently started meeting twice a year at the VACSB conferences that they have. Often, we will invite the DBHDS staff to come and speak on a specific topic. Or if we have questions, we can ask them questions. But the committee itself is developing some training materials for new Finance Directors." (Rural, small budget CSB)

"We do have a Fiscal Director group, which is very helpful. It's all fiscal officers, finance officers, of the state, all the CSBs. So, we have an email group. We'll get together every once in a while, whenever we can to talk about these issues and what we're doing." (Rural, small budget CSB)

Other Funding Facilitators. For many CSBs, space is a valuable commodity. Respondents reported that using telework opportunities for case managers to save money on space has been valuable. In rural areas, where driving distances can be a barrier for clients (as described in Section, 4.3.3), the use of mobile MAT unit was described as beneficial.

"Our case management…was a natural fit. So, when it came time to move people out of the building temporarily, we thought let's just try it out and see how it works. Because where are we going to find space and pay for space if this is something that folks can do. So, it worked pretty well for them and so they're still teleworking today. Then we said, well, if it works for ID [intellectual disability], let's see what happens with mental health." (Urban, large budget CSB)

"We're the first in the Commonwealth of Virginia to have a mobile MAT unit, which is sitting out there and it's beautiful. That took a lot of convincing at the department... Of course, we'd love to have more, but right now what we're going to do is once a week. So, north, and then the next week middle, and the next week south. Eventually, we would love to have it on the road as much as need be. But initially, it's going to be once a week." (Rural, small budget CSB)

Interviewees discussed the advantages of using of web applications (e.g., MyStrength app) to reduce no-shows, increase revenue, and better use psychiatric time. Related to marketing and fundraising, interviewees cited that hiring a Director of Public Relations to get the CSB's name out into the community was helpful in building recognition, which in turn supported obtaining other sources for funding.

"The intent of that [the MyStrength app] was to be able to utilize their [psychiatrist] time better to provide services as well as cut down on no-shows so that we can call them to remind the clients of their appointment, send them texts, whatever. And our system does that too, which is great, to remind them, appointment reminders. But again, it cuts down on the no-shows. It makes them more efficient. And hopefully, it increases our billing at the same time." (Rural, large budget CSB)

Community-Level Facilitators

Community-Level Facilitators to the Provision of BHS

- Partnerships and community support
- Client satisfaction

Staff and clients identified two community-level factors that facilitated the provision of BHS at the CSBs. Support from the surrounding community of many CSBs were common facilitators that led to successful service implementation.

Partnerships and Community Support

Across interviews, leadership and direct service staff reported that collaboration, engagement, and partnerships with community stakeholders greatly enhanced the provision of BHS. Strong partnerships kept communication lines open and encouraged referrals. In situations where clients were multiagency involved, communication was critical to effective care coordination. CSBs reported strong collaboration with law enforcement agencies, local hospitals, local nonprofits, faith-based organizations, courts, schools, and various coalitions (e.g., housing, Department of Social Services). These partnerships were instrumental in improving community buy-in and support, which raised the reputation of the CSBs and aided in engaging potential clients into treatment.

Partnership with law enforcement agencies was cited as a significant facilitator. Many CSBs provide CIT to law enforcement. This training has demonstrated positive outcomes. Staff and clients at many CSBs highlighted the success of the CIT for officers. For example, one client noted how her son's illness has required multiple calls to law enforcement and she described a night and day experience of

nontrained officers treating her son as a "punk" and further escalating the situation. She compared this with the CIT-trained officers who treated her son with respect and were able to diffuse the situation, which led to a less stressful experience and outcome for all involved.

"We have really good relations here in this community with law enforcement. They're at a meeting with me once a month. And all local law enforcement from [Name of City], the county, the city, the schools. We partner with them to provide therapeutic day treatment services. And then we do also a lot of the emergency services with the schools. And then we've linked them to our outreach programs. I work closely with DSS, Department of Social Services. If they have a child that's removed from the home and they need us, they call us and we're at the table." (Rural, small budget CSB)

Client Satisfaction

Clients at all CSBs uniformly reported positive experiences, clinical improvements, skill building, and increased capacity to manage illness. Clients from most CSBs described the services as helping them to stay focused, keeping them clean (sober), helping them to cope, improving their quality of life, and saving their lives. In fact, clients from some CSBs reported recommending the services to family, friends, and others in the community, which supported the provision of services to new clients seeking care. Clients reported that staff genuinely cared about the individuals served and their communities at-large. The dedication of staff to providing BHS was universally noted, as clients reported feeling supported and felt the care they received was consistently of high quality. Staff from many CSBs reported that the CSBs consistently collected information on client satisfaction and that this feedback was a facilitator to providing the most effective services possible. For additional details on this facilitator to the provision of BHS, see Section 4.6 Summary of Focus Group Discussion with Clients.

"They helped me to stay clean [sober] most of all because I was a mess before [Name of CSB], I was a mess. I found them to be very helpful with anything that I asked for, any kind of help that I received from them has been helpful. I don't have to be here; I chose to be here because they are helpful." (Rural, small budget CSB)

"I believe case managers are very sincere. They really are concerned about our well-being and how we are doing. I think they go above, sometimes too much, but I think it's all in concern. They want to see us do better. You can tell it's an emotional type thing; they apply themselves toward you they are genuinely concerned, from my experience." (Rural, medium budget CSB)

"There are going to be glitches in whatever you do. Everything is not perfect here, but I love it because it gave me a second chance at life. It gave me an opportunity to look at myself from the inside and not just the outside. I'm truly blessed because a lot of people don't get this opportunity. I'm in transitional housing, I've been able to save money, I got some months clean—it's a blessing, it's a blessing. Like I said, there are some glitches, but all in all I'm still grateful. I'm truly blessed that I have support in my life, that I have support that I can talk to when I'm not going the right way. I've been off the pink cloud a long time ago… I'm in reality today." (Urban, small budget CSB)

"I too am here because of drug court. I was incarcerated for 7 months, I got out in July. So, I haven't been here that long either, but everything that I need I

get here. My medication, I get here, I get the Vivitrol shot through here, which is very helpful because it's extremely expensive and it saved my life. Because, I am a drug addict, so it helps me out a lot. I take my aftercare classes here; my counseling and everything is done here. Everything I need is in one building. I don't have to worry about going all around the city to do what I need to do. And getting in and getting everything done—it is a long process, but that's to be expected, there's a lot you gotta go through. I've been in services in other places in different states, and this is probably one of the most thorough places I've ever been to. (Urban, medium budget CSB)

"They don't leave you out in the cold. I'm proud of this service because they are backlogged bad and they still give you the same respect and treat you just like a human being. And the medication—if I had to pay out of pocket for anything, I'd be broke. And I work at Dunkin' Donuts, I can't afford it. I'm real happy for this program, it changed me." (Urban, medium budget CSB)

"The programs here saved my life, I was on such a downward spiral, I was drinking myself to death. […] And then going to day treatment kept me there until they know I was ready to go; I feel like I am again a very important contributing part of society. For a long time, I was living under a rock like some crazy, horrible— now I've done a whole complete 360. I have learned coping skills through these programs." (Urban, large budget CSB)

"I started in July last year and I had just relapsed after 17 months clean. Now I am one and a half years clean, my life has gotten exponentially better, more stable. It's my decision when I come off of suboxone, I have all the support that I need, from the time I started coming here to where I am now, I have my peer support specialist certification. I'm happy with where my life's going for the past year and a half." (Urban, large budget CSB)

Policy-Related Facilitators

CSB staff identified one facilitator to the provision of BHS at a policy level that enabled service delivery. As described in the adapted socioecological framework (see Section 4.3.1, Figure 4.34) policy-related factors such as local, state, and national laws can impact the provision of services because these factors create conditions that directly influence human services programs and client care. Although it was cited as a barrier, the implementation of mandated services as a result of STEP-VA legislation served as a valuable system resource that aided in the success of CSBs.

Policy-Related Facilitator to the Provision of BHS

- STEP-VA implementation

STEP-VA Implementation

Staff at several CSBs cited successful implementation of STEP-VA components as a facilitator because the mandate expanded demand for and access to services. For a few CSBs, SDA services were provided at several locations on a variety of days, which contributed to a substantial decrease in wait times for services. Despite challenges related to billing for peer services, many staff reported successful integration of peer recovery specialist in the clinical workflow to bridge gaps after SDA.

4.3.5 Barriers and Facilitators to the Provision of Prevention Services

Prevention Directors and CSB prevention staff focus group participants identified barriers and facilitators that specifically influenced the provision of prevention services at the CSBs. An excerpt of these findings is presented below. For more information on prevention focused capacity, see Appendix J: Virginia BH Needs Assessment Focus Group and Survey Results from CSB Prevention Staff and Coalition Members.

Capacity Facilitators–Prevention Services

Relationships with community stakeholders facilitate the delivery of prevention services. When asked what services are working well, all participants consistently spoke about the relationships their CSB/coalition maintains with community stakeholders as being integral to successes. Community partners include nonprofits, coalitions, CSBs, schools, municipal leaders, law enforcement agencies, faith-based organizations and other entities. Relationships were described as beneficial, "not stepping on each other's toes," and not "duplicating [prevention] efforts."

Community stakeholder relationships facilitate delivery of prevention services by connecting CSBs with key populations of focus. For example, one participant talked about their CSB developing and maintaining relationships with community churches where people from "all walks of life and different age groups" gather all in one place. Community partner relationships also provide CSBs with important community context and information about community needs. In terms of capacity or readiness to engage in prevention services, these relationships enable CSBs to "meet [stakeholders] where they're at, not just expect them to show up where [CSBs are] at," which can offset participant burdens often experienced in prevention programming. Community relationship dynamics like these require significant time and effort to develop, nurture, and maintain.

Participants also shared creative and innovative strategies for bolstering capacity:

- Shifting to environmental strategies and media campaigns as a result of not having enough capacity to cover a large geographic region with limited prevention staff. However, only utilizing these strategies can limit the ability to create real changes in communities, as staff are needed to make connections in the community.
- Leveraging staff enthusiasm and innovation: "I would say we have tremendous capacity when it comes to innovation. We have great support in terms of 'Go get them, girl' kind of support. We develop services and deliver services with fervor and enthusiasm."
- Investing in a dedicated grant writer on staff to help secure grant funds, including local funds.
- Employing train-the-trainer strategies to broaden reach/capacity. For example, to address limited certified prevention specialists covering a large geographic area, one CSB trained teachers but encountered challenges, such as turnover of teachers, fidelity to the content, and sustainability of efforts.
- Utilizing interactive social media to access hard-to-reach groups. Coalition members shared wanting to deliver prevention activities via platforms like Facebook Live to reach populations who have transportation/travel barriers or are too busy to attend in-person events.

Capacity Barriers–Prevention Services

There is a lack of statewide funding for prevention. One main capacity constraint that participants across both urban and rural settings spoke about at length was the lack of statewide funds for prevention. Example quotes included, "We operate on a shoestring," and "All of us are grant writing like crazy

trying to braid enough funding together to even do what we're mandated to do." The result, according to participants, is an unstable environment for delivering prevention services, particularly when compared with treatment services. "I just wish we would get the kind of attention and financial support that treatment services receives," was a common sentiment, as was a need to "prove prevention's worth." Funding limitations also emerged from coalition members, who shared that more funding is needed to expand services to meet new needs as well as sustain current service implementation.

Lack of funding is also experienced differently by CSBs. Depending on the locality, CSBs with similar population size or other characteristics can have different capacity. For example, some CSBs only receive federal funds whereas other CSBs with similar populations may have a robust prevention workforce because of local prevention funds. Rural CSBs were less likely to report receiving local funds and feel the challenges of having limited funds and staffing to cover a large geographic region. "I'm one person covering a five-county area... I want you to picture me trying to do all these five-county area merchant education places plus doing suicide prevention and opioid epidemic."

Efforts are directed by funds rather than local needs. Because there are no dedicated state funds towards prevention, efforts are directed or driven by grant funds, which can lead CSBs to feel "yanked" in different directions and like they have "knee-jerk" reactions to grants. This can also lead to feeling like the work continues to expand and CSBs are "trying to do it all" rather than have focused and targeted efforts. "Sometimes I feel like we try to do everything, and I'm not sure that we do everything well," explained one participant, who went on to explain how they are expected to work on suicide prevention, MH, parenting classes, and all the substance abuse prevention work. "Sometimes it's very overwhelming trying to keep up with everything. And some days I feel like I'm not doing the best job at everything."

Similarly, participants discussed how grants are designed to target specific issues (e.g., opioids, underage drinking), which does not always align with local community priorities and needs, and CSBs and coalitions may be forced to work on priorities that are not areas of strength and knowledge. Local grant funds can also be for very localized, specific programs (e.g., school-based interventions), which can limit the CSBs' ability to scale up efforts and expand capacity. Further, grant funds may need to be spent in a short amount of time depending on the funding stream, which can force CSBs to utilize funds in ways that do not support long-term needs and goals.

DBHDS was also described as becoming more "directive" with how funds are utilized, and the focus has changed over time, which means needing to redirect resources. "The state has come up with these four group of services that our staff need to provide, so that has caused us to redirect our resources from ways we had used them traditionally," explained one participant.

Participants also surfaced a need for better compensation to retain staff. Although cost of living or other expenses rise (e.g., health care), salaries do not, which can make it difficult to retain staff. Lower salaries can also make retention of staff difficult, and CSBs may continuously hire and train people only for them to go elsewhere for better salaries. Results from the prevention staff surveys indicated that staff employed by urban CSBs were more likely to be satisfied with their compensation than staff at rural CSBs. Despite this, both urban and rural staff reported high levels of overall satisfaction with their jobs, and rural prevention staff were more likely to indicate that it was "likely" or "very likely" that they would still be working at their CSB in 5 years.

Prevention is understaffed and staff are over overallocated. Because funds are limited and evolving depending on the grant funds that become available, a challenge that participants in all focus groups raised is that CSBs are understaffed and overallocated. One way that this manifests was with CSB

Directors wearing multiple "hats," typically in both treatment and prevention. "We're stretched in many directions that I don't think other Directors normally have to be" and "I do two jobs. I'm a Director of [therapy] because it was my passion, and I kept being a director of prevention." CSB Directors also discussed "working off the clock" or during evening hours and weekends to write grants, enter data into databases, keep up social media campaigns, and the like. Even larger CSBs that indicated having more staff than their peers said they still felt understaffed due to the need for community presentations, requests to go into communities and provide programming, and the like. Less than half of CSBs who participated in the prevention survey indicated that there was adequate staff to implement prevention strategies.

By far, the most frequently cited issue for coalitions was having limited staff, both at the coalition and at their affiliated CSB. Participants don't have enough time to carry out prevention activities without additional staff. Furthermore, coalitions also frequently utilize volunteers on their staff, which are somewhat limited in their capacity to provide services, such as managing a resource table at an event, or "really being out in the community doing things."

Collaboration can be limited. Working collaboratively with other organizations surfaced as a capacity constraint in some cases. Several coalition members discussed schools as being more challenging to collaborate with. They shared that some schools are reluctant to have to notify parents of their students' involvement in prevention activities. Coalition staff referred to this dynamic as "site-based management," where even when buy-in is established with school administration, each school principal is different and requires an additional level of connection for programming to be delivered in their school. This extra layer of buy-in needed is frustrating for some coalition members. As one participant put it, they have to go from the top down and the ground up. One way this relationship dynamic might be improved, one participant said, is to work with schools through new social workers who are being employed by school systems and who are also recruited as members of the coalition.

Further, collaboration with other organizations can be surface level when organizations only do enough work to meet their funders' requirements for collaboration (e.g., reporting on shared outputs in collective impact processes). Effectively engaging volunteers can be challenging when participating in efforts is not directly tied to someone's job responsibilities and paid time. Finally, engaging the military base if in a CSB's catchment area can be difficult, as the base can be unresponsive even though CSBs have services and trainings that could be of benefit (e.g., MH first aid specific for military personnel).

4.3.6 Findings and Recommendations

Key Findings

Organizational-level barriers to the provision of BHS included:

- Workforce inadequacy and staffing issues (e.g., understaffing, staff overworked),
- Professional development and training challenges (e.g., insufficient funding for staff training),
- CSB services that were inadequate to clients (e.g., due to language barriers, limited service offerings),
- Excessive documentation requirements (e.g., length of screening tools, redundant forms),
- EHR/HIT-related challenges (e.g., lack of interoperability, system-wide crashes, lack of vendor support or training), and
- Funding challenges (e.g., communication, funding sources, fiscal tools and resources, revenues, and telepsychiatry).

Community-level barriers to the provision of BHS included:

- Client challenges to accessing services (e.g., lack of transportation, inconvenient location, travel time, cost),
- Lack of awareness of the CSB or CSB services, and
- Lack of available community resources to support client needs (e.g., housing, recovery housing, transitional housing).

Policy-related barriers to the provision of BHS included:

- STEP-VA implementation challenges,
- Medicaid expansion difficulties (e.g., challenges working with MCOs, inadequate Medicaid reimbursement rates),
- Insufficient funding, and
- Inadequate infrastructure (e.g., lack of space, poorly developed administrative infrastructure, technology infrastructure).

Organizational-level facilitators to the provision of BHS included:

- Availability of services (e.g., service variety, transportation, use of telehealth, peer recovery services),
- Staff characteristics and support (e.g., dedicated, supportive, well-trained staff members, effective leadership),
- Workforce training/professional development, and
- Funding facilitators (e.g., pooling resources, maximizing revenues, fiscal tools and resources).

Community-level facilitators to the provision of BHS included:

- Partnerships and community support, and
- Client satisfaction.

Policy-related facilitators to the provision of BHS included:

- STEP-VA implementation.

Recommendations to Address Capacity Issues

- DBHDS should increase direct service provider training opportunities, including in-person and online training, access to training, and the ability of staff to attend available training opportunities. Specifically, CSB staff need access to training around EBPs and should receive training, coaching, and supervising, in support of practice fidelity.

- DBHDS should increase CSB board, leadership, and supervisor training opportunities. CSBs could receive training and consultation for CSBs related to the business practice models necessary for working within an managed care environment, CQI, and the like. CSB training and technical assistance for the adoption of STEP-VA practices and EBPs should be planned and delivered within a framework of evidence-based training and should include ongoing training and consultation for clinical supervisors.

- DBHDS may want to consider conducting a salary study across all CSBs to collect baseline information about salaries for differing levels of staff. CSBs are competing for a limited number of license-eligible/licensed staff.

- DBHDS may want to help CSBs address workforce shortages by implementing new strategies to recruit new graduates into the CSB workforce. One strategy to consider would be working to have loans reimbursed based on working within the CSB system. They may want to consider looking at the federal model that allows for loan forgiveness after 5 years of service.
- DBHDS should consider redefining/amending the statute that speaks to peer specialists and barrier crimes and background checks and may want to consider a waiver system.
- DBHDS should encourage more use of telehealth and mid-level prescribers (e.g., nurse practitioners, physician assistants) to address the lack of psychiatrists and child psychiatrists.
- DBHDS is strongly encouraged to fund a statewide contractor that operates under the guidance of DBHDS that will develop statewide and CSB-specific plans for systems capacity building. The contractor also should provide robust and ongoing training, technical assistance, coaching, and consultation with the goal of successfully supporting STEP-VA implementation, including the adoption of programs and practices with adequate fidelity and service penetration. The contractor should also provide training, coaching, and fidelity assessments on the required EBPs.
- DBHDS should complete the requirements, performance measures, and funding strategies for each step before releasing funding.
    - Although CSBs appreciate flexibility during implementation, sometimes they are given too much flexibility, and what they actually need is concrete, structured direction. For example, it would be helpful if DBHDS required Credible so that they would have a streamlined reporting system.
- CSBs, in collaboration with DBHDS, should undertake a dedicated, and perhaps independently facilitated, process to determine true costs for essential services so that rates for services are informed by current facts.
- DBHDS is encouraged to work with DMAS in guiding MCOs to increase consistency where possible (e.g., standardized prior authorization requirements, utilization review/continuing care authorization, inter-MCO agreements).
- DMAS and DBHDS should reduce paperwork requirements that are not specifically required to measure and report nationally recognized outcomes that the CSBs can use to monitor and improve quality of services and are not tied to a federal or legislative requirement.
- Participants surfaced various ways in which their capacity could be bolstered, including:
    - A need for prevention to be valued and funded, “brought into the fold,” and seen as “the foundation” for assessment and evaluation in the CSB system. This includes “an equitable shake at the resources.”
    - More training and education around prevention topics (e.g., opioids), as CSBs may be tasked to go into the community to promote different priorities without the training or education to do so effectively.
    - Better school engagement and buy-in on data collection, which could be fostered if the groundwork came from “the top,” such as the Department of Education “putting their stamp of approval” on data collection efforts.

- Development of campaigns at the state-level that local CSBs could implement. Although developing individual campaigns ensures that efforts are targeted for local needs, it can also lead to a lot of individual-level work that could be streamlined. “I would like to see statewide advertising that we can just go in and select what we want to use for our local community.”
- More effective collaboration at the state level among offices such as health departments, education, and justice: “In order for us to collaborate on the local level, the state needs to start that collaboration.”
- Better utilization of local needs assessment data to inform the statewide efforts so that what is developed at the state level is informed by the needs assessments and data that communities have already gathered.

4.4 How Are Funds Used to Support Provision of BHS in Virginia?

4.4.1 What Funds Are Used to Support Provisions of BHS?

Quantitative data from the administrator pre-site survey was examined to obtain perspectives from administrative staff regarding the sources of funds used to provide BHS. The following sections summarize the results.

FY2018 Operating Costs for Providing BHS

Table 4.20 displays administrative staff reports of the direct, indirect, and total operating costs for providing BHS at their CSB for FY2018. On average, CSBs reported costs totaling over $23 million to provide BHS. CSBs that primarily serve urban areas reported having significantly greater ($p < 0.05$) direct, indirect, and total operating costs for providing BHS.

The FY2017 budget size designations for small, medium, and very large CSBs appear to be consistent with the FY2018 total operating costs reported by administrative staff. However, FY2018 total operating costs reported for large CSBs were not consistent with the FY2017 budget size designations. As administrative staff were not asked to provide FY2018 operating costs for provision of other BHS—for example, services to support provision of developmental BHS—these costs may underestimate the total operating costs for delivering BHS and appear inconsistent with the FY2017 overall budget size designations.

Table 4.20. Administrative Staff Reports of FY2018 Operating Costs for Providing BHS

	Mean Operating Costs for Provision of BHS		
	FY2018 Direct Operating Costs	FY2018 Indirect Operating Costs	FY2018 Total Operating Costs
All CSBs	$19,301,172.64	$4,190,562.22	$23,273,386.62
Costs by Geographic Areas Served by CSBs			
• Urban	$28,147,863.43	$6,461,813.47	$33,996,578.80
• Rural	$13,671,460.31	$2,641,981.82	$15,962,119.23
Costs by FY2017 Overall Budget Size of CSBs			
• Small (less than $19 million; n=15)	$7,260,295.50	$1,522,059.64	$8,683,134.43
• Medium ($19–$36 million; n=12)	$16,812,574.50	$3,128,728.73	$19,439,311.64
• Large ($36–$100 million; n=12)	$24,940,569.90	$7,207,460.47	$32,268,095.00
• Very large ($100 million plus; n=1)	$150,726,064.00	$20,043,886.00	$170,769,950.00

Budget Allocations for BHS

Administrative staff reported allocating the largest percentage of their annual BHS to provision of MH treatment (61.2%, n=40), followed by substance use treatment (15.9%, n=40), recovery support services (6%, n=33), and prevention services (3.3%, n=39). The were no significant differences in budget allocations between CSBs located in primarily rural and urban settings.

Funding Sources for BHS Provision

Table 4.21 displays administrative staff reports of the funding sources for providing CSB-delivered BHS. Administrative staff reported using multiple funding sources to support BHS. The largest number

of funding sources was used to support MH treatment services. Administrative staff noted that 40% or more funds from the following funding sources were used to fund MH treatment services:

- Federal funds,
- State block grant funds,
- Other state or DBHDS discretionary funds,
- Medicaid,
- Medicare,
- Private payers,
- Client fees (such as co-payment for services, sliding scale fees),
- Local funds, and
- Other funding sources.

Administrative staff noted that 40% or more funds from the following funding sources were used to fund substance use treatment services:

- Federal funds,
- State block grant funds,
- Other state or DBHDS discretionary funds,
- Medicaid,
- Private payers,
- Client fees (such as co-payment for services, sliding scale fees), and
- Local funds.

Administrative staff noted that a comparatively smaller percentage (less than 40%) of funds from federal, state, Medicaid, and other funding sources is allocated for recovery support services. Administrative staff reported that the most funding for recovery support services comes from the following funding sources:

- Federal funds,
- State block grant funds,
- Other state or DBHDS discretionary funds, and
- Medicaid.

Other sources of funding noted by administrative staff to support substance use and MH services include state and federal and other carry-over funds from the previous FY, reserve funding, interest income, other grant funding, fees from CSB-provided trainings provided by the CSB, Children's Service Act[59] funding, and CSB donations to the CSB.

Table 4.21. Administrative Staff Reports of Funding Sources for Providing BHS

Funding Source	Substance Use Treatment		MH Treatment		Prevention Services		Recovery Support Services	
	%	n	%	n	%	n	%	n
Federal funds	97.5	39	95.0	38	87.5	35	37.5	15
State block grant funds	77.5	31	80.0	32	52.5	21	37.5	15

[59] The Children's Services Act is now the name for a law enacted in 1993 that establishes a single state pool of funds to purchase services for at-risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams who plan and oversee services to youth. https://www.virginia.gov/agencies/office-of-childrens-services/

Funding Source	Substance Use Treatment		MH Treatment		Prevention Services		Recovery Support Services	
	%	n	%	n	%	n	%	n
Other state or DBHDS discretionary funds	67.5	27	75.0	30	22.5	9	32.5	13
Medicaid	92.5	37	97.5	39	5.0	2	30.0	12
Medicare	35.0	14	77.5	31	0.0	0	2.5	1
Private payers	65.0	26	87.5	35	0.0	0	7.5	3
Client fees (e.g., co-payment for services, sliding scale fees)	72.5	29	85.0	34	10.0	4	20.0	8
Local funds	57.5	23	97.5	39	40.0	16	25.0	10
Other (Please specify)	37.5	15	42.5	17	27.5	11	5.0	2

Note: Percentages may not add to 100% because of missing data.

4.4.2 Funding Sufficiency to Cover Delivery of BHS

To understand the factors that contribute to why CSBs described their funding as sufficient or insufficient to cover provisions of BHS, the needs assessment team collected and examined qualitative data on funding during semistructured interviews with Executive Directors and Fiscal Directors at the 40 CSBs.

Insufficient funding to support provision of BHS was reported by many interviewees. CSB administrative staff described several components of how funding is used and where additional funding is needed including:

- Programs/facilities, including:
  - Medical detoxification,
  - Inpatient SUD and MH treatment facilities,
  - Mobile medication programs,
  - Crisis intervention team (CIT) programs,
  - Crisis stabilization units,
  - Step-down hospitalization, and
  - Housing;
- Services, including:
  - Children's services,
  - MH services,
  - Prevention services,
  - Psychiatric services, and
  - SUD services;
- Staffing;
- State mandates; and
- Use of local funds for BHS.

Programs/Facilities

Specifically, interviewees reported concerns about closures of medical detoxification facilities, mobile medication programs, and CIT programs due to a lack of funds, as well as general lack of these facilities in several areas. In addition, respondents reported a need for inpatient SUD and MH treatment facilities. On a related note, for some of the CSBs that do not have a PACT team, respondents reported a need for

additional funding to better coordinate case management and adult crisis stabilization units. Crisis stabilization units were described as lacking the necessary funding for physicians, nurses, and security. Finally, many interviewees expressed the need for additional funds for housing support (e.g., step-down housing, residential SUD and MH housing).

"The philosophy, the mission, and the vision is that we serve a population that cannot be served anywhere else. We are the open door. We are the first job for people who can't receive services anywhere else. And if we are being constantly taxed with very, very limited resources, we are not able to deliver on our mission." (Urban, large budget CSB)

"I think we make it work. We serve as many as we can, given what our budget is. But I'm sure there's significant unmet need out there." (Urban, large budget CSB)

"There's a lack of adequate psychiatric beds at the state level and with private hospitals. Now, let's talk about when they come out or what they need to come out. What they need to come out—that is a gap in 24/7 supervision. So, we have crisis stabilization units that have been underutilized in our region because they don't have the right, they're not funded to provide the level of care that these persons coming out of the hospital require." (Urban, large budget CSB)

Services

Respondents from several CSBs relayed concerns about underfunding of children's services, which has led to the closure of MH skill building programs and TDT in schools for some CSBs. With the total funding for TDT programs coming from Medicaid and declining rates in the past 10 years, other CSBs noted concern about their ability to continue providing these services. Other children's services that were reported as underfunded included assertive community treatment and children's mobile crisis.

Both MH and SUD services were reported as receiving insufficient funding. Interviewees noted MH services that need additional funding. These services included skills building, OP and support services, and case management. Some CSBs reported a waiting list for MH case management. Many interviewees also noted the high cost of psychiatric services, as well as related difficulties finding psychiatric providers. Respondents also discussed a host of SUD services and programs that would benefit from additional funding, including MAT services, jail SUD programs, and residential services. Interviewees reported an influx of opioid funding, for which they expressed gratitude; however, many interviewees expressed frustration with the lack of funding to provide services to clients with methamphetamine and alcohol disorders, as these are the top substances of choice in many CSB service areas. In addition, many interviewees acknowledged the need for additional funding for prevention services.

"A lot of times, if you're truly focusing on crisis, you're missing the boat because we should be doing as much on the prevention, more on the prevention side. So, I would say that that's an area that we've really trying to do a better job with is trying to work with folks before they hit that crisis point and have really focused some extra resources on that over the last few years." (Rural, small budget CSB)

"There's always a need for monies, especially for residential or what I would consider something like more independent living for residential needs around substance use." (Urban, large budget CSB)

"Our jails want a lot more services. We have right now, we operate in two jails, an Alpha SUD program, and there's the same seamless transition into our IOPs at our center when they come out. So, it can be very successful, but there's not funding to kind of do all those things." (Urban, medium budget CSB)

"Residential money as needed is probably one of the largest themes that you'll hear a lot of people say. Because the mentally ill people who can't get a job, need some money, a minimum amount of money, HUD housing vouchers or something, for residential support. If they can't keep their place, then they're going to go be on the street. They're going to decompensate. They're going to wind up in a mental hospital. And they're going to wind up back in our services." (Urban, medium budget CSB)

Staffing

Due to inadequate funding, some interviewees reported the need to prioritize positions to be hired (e.g., hiring an emergency services position over a substance use treatment position). Interviewees also reported that staff shortages result in waiting lists and that it is difficult to stay staffed with uncompetitive pay. Respondents reported that additional funding would allow them to keep up with salaries and decrease staff turnover. Insufficient funding was also reported as a contributor to a shortage of licensed (and unlicensed) staff at CSBs. The ability to implement models correctly (e.g., TF-CBT) relies on staff being able to see patients more than once a month.

"That's always been an issue for us is our case managers have twice the amount of people that they really should be seeing. So that's a huge issue for us. But, of course, that's tied to funding…but that's always been our biggest complaint is being able to tie some state funds in to help us with getting properly trained individuals." (Rural, small budget CSB)

"Each full-time doc, we lose, lose, and lose about $250,000 a year...because again, remember we have to see you regardless of billing and pay." (Rural, small budget CSB)

"When I'm paying a psychiatrist or a nurse practitioner, and I'm billing Medicaid for that, I'm losing money every hour I'm paying them. That's all there is to it. So, it's a matter of how much more money am I willing to lose to certain people. So that's our biggie." (Rural, medium budget CSB)

State Mandates

Many interviewees expressed concern about unfunded state mandates. The low reimbursement rates for emergency services programs, which are mandated, means that many CSBs lose money on these programs, which were described by some interviewees as underfunded and understaffed. Peer recovery support programs were also described as underfunded, with specific concerns expressed about the low reimbursement rates for peers. PACT funds were also reported insufficient with some CSBs reporting that less than half of what such programs costs is actually funded. Other CSBs, particularly in rural

areas, expressed a desire to be provided funds to establish a PACT team. In urban areas, there was a desire to expand existing PACT team capabilities.

"The Commonwealth of Virginia, in my opinion, wants champagne services at...Milwaukee's Beast (sic) [prices]." (Urban, small budget CSB)

"It kind of indirectly becomes the county's responsibility or we have to fold the program. We can't fold the program because of the mandates and how it's already been opened out and the way clients are being served. So, in that sense, it's not fully or adequately funded. We get all these mandates, but it's not funded." (Urban, large budget CSB)

"Emergency services, crisis services. We were supposed to stabilize that. It's been underfunded for years and years and years." (Urban, medium budget CSB)

"We've never really been fully funded for emergency services even though it's a mandated service. It's pulled out of other funding sources." (Rural, small budget CSB)

"I've let our peers know that there's no limitation on what I want them to do. Because, quite frankly, the ARTS program is not reimbursing the way that they said they would reimburse us for peers. So, we're not billing for peers. So, if we're not billing for them, I will do whatever the hell I want to do with them. I'd rather not bill for them than bill at $6.15 [per quarter] hour for them and have to have the restraints on them. I would rather be able to use them the way that I feel is effective and not bill." (Rural, small budget CSB)

Use of Local Funds for BHS

Local funds vary across Virginia CSBs, with the minimum mandate being a 10% contribution. However, some CSBs receive more than the 10% mandate, while others receive exactly 10%, and a few receive less than the mandated amount. The use of local funds (by those CSBs receiving more than 10%) to cover costs was described by several respondents who noted that it was only through these additional local funds that they were able to cover the costs of staff raises, allow for the negotiation of nursing salaries, and pay for additional needed staff for state mandated programs (e.g., SDA). CSBs reported using additional local funds for BH programs that included staffing an opioid treatment program, expanding jail diversion teams, improving services in adult detention centers, and funding a child assessment center. Finally, local funds were also used to cover the losses suffered by Medicaid expansion.

CSBs that receive the minimum 10% contribution (or less) reported challenges due to inadequate funding. For example, when local budget cuts occur, CSBs need to cut what was funded by those dollars (e.g., jail programs). In addition, the balance is not always equitable regarding the local contributions and the services received locally, making it difficult in some jurisdictions for CSBs to financially support the needs of their clients. For example, one interviewee noted that their local jurisdictions in a rural area may contribute $100,000 but receive $3 million in services. Although the reality is that CSBs have local and state expectations, there is always a bit of conflict in trying to meet both, as illustrated by the statements below:

"With the local match comes local expectations." (Urban, large budget CSB)

"[Two out of three dollars coming from local sources], which means that really you have a huge accountability to your locality. Sometimes the state will say 'We'd like you to do that.' And we're like, 'Yeah, you're not really funding that.'" (Urban, large budget CSB)

"Of the 40 community service boards, 28 are essentially what we call operating community service boards. So, the latitude that the CSBs have in terms of how they can follow a regulatory action or their relationship with their local municipalities differs greatly, depending on how they're defined. That also drives a big difference in actually the funding that's available and how they're perceived in connection to other services within each municipal area." (Rural, medium budget CSB)

"The only things we really have flexibility of moving is our local funds." (Rural, medium budget CSB)

"As a quick little side note, as the department and the Commonwealth looks to restructure funding to local CSBs, in no way do I believe that those localities who have stepped up and supported these [additional crisis and children's] services should be penalized for that." (Urban, small budget CSB)

4.4.3 Is Funding Sufficient to Cover the Cost of Care and Operations?

Quantitative data from the administrator pre-site survey were examined to obtain perspectives from administrative staff regarding the sufficiency of funds to cover the cost of providing BHS. Table 4.22 below displays the findings.

Administrative staff from more CSBs than not indicated that their CSB does not have sufficient funding for provision of BHS. Administrative staff from 50% or more of CSBs reported that their agency does not have sufficient funding to provide the following services:

- Crisis/emergency services,
- Substance use treatment services,
- MH treatment services, and
- Recovery support services.

In addition, administrative staff from 50% or more CSBs reported that their agency does not have enough funding to provide housing services, particularly for housing to support clients receiving substance use treatment (60%, n=24). Administrative staff also noted the needs for funding to support psychiatric staff, provision of substance use OP and IOP treatment services, forensic programming, and services for transitional-age youth.

Although administrative staff from 50% or more CSBs reported their agency does have sufficient funding to provide prevention services, close to 40% of CSBs noted there was not sufficient funding to provide this service.

Table 4.22. Administrative Staff Reports of Funding Sufficiency for BHS Provision

BHS Type	Not applicable (CSB does not provide this service)		Not at All sufficient (budget deficit)		Funds are sufficient to cover administrative, overhead, and service provision		More than sufficient funds	
	%	n	%	n	%	n	%	n
Crisis/emergency services	0.0	0	67.5	27	30.0	12	0.0	0
Substance use treatment services	0.0	0	55.0	22	45.0	18	0.0	0
MH treatment services	0.0	0	70.0	28	27.5	11	2.5	1
Prevention services	0.0	0	37.5	15	52.5	21	2.5	1
Recovery support services	7.5	3	55.0	22	32.5	13	2.5	1

Note: Percentages may not add to 100% because of missing data.

Funding for Cost and Care of Operations

To understand the factors that contribute to why CSBs described their funding as sufficient or insufficient to cover the cost and care of operations, the needs assessment team collected and examined qualitative data on funding during semistructured interviews with Executive Directors and Fiscal Directors at the 40 CSBs.

Respondents described several components involved in the cost and care of CSB operations including:

- Administrative
  - IT/EHR
  - Infrastructure needs
  - Multiple locations
  - Reporting
  - Restricted funding
- Funding reserves
- Hiring limitations
- Structures
- Transportation
- Use of local funds for operations
- Use of county/city funds for operations

Administrative

Interviewees described a need for additional funds to keep CSB facilities operating, implement necessary upgrades, meet state requests, and conduct daily business. Many interviewees noted that state and federal funds often only include minimal allowances for administrative needs, which limits the CSBs ability to perform necessary upgrades. Current overhead/indirect allowances tend to be a maximum of 10% whereas CSBs report they need to be closer to 15%–20% to realistically cover the administrative costs.

IT/EHR. To meet client needs, manage data, and comply with state software standards for the separation of duties, interviewees underscored the need to have proper IT in place (e.g., EHRs, financial servers, software packages) and to maintain and perform IT upgrades. Many respondents noted the especially high cost of EHRs, ransomware, computers, tablets, and smartphones. Interviewees stated that, although EHRs are used to ensure CSBs are meeting productivity standards and requirements for the state, CSBs are not reimbursed for their cost. Several CSBs reported only being able to afford bare-bones EHR systems (e.g., Credible) and cannot afford the add-on components that come with these systems (e.g., Business Intelligence [BI] package) that would more easily allow the in-depth reporting DBHDS desires.

Numerous respondents mentioned the need for improved Wi-Fi and telephone systems, including EHR-compatible smart phones. Finally, respondents indicated a need for funding to train staff using [EHR] to maximize MCO payments.

"The state hasn't invested enough money and they really need to get an IT data collection system other than CCS where they can get all of our data and let it tell you a story. We have [EHR], that has a model called BI (Business Intelligence). I can't afford BI." (Rural, small budget CSB)

"It's a good EHR. But it has constant problems with it. It's down a lot. Every little improvement that we need on it costs us additional dollars. We've maxed out the number of users that we contract for. So, any new users, we've got to pay more money. So, it just becomes another challenge to be able to improve that system." (Rural, small budget CSB)

"We struggle in data management here. And, again, part of that is because we are so small that money that we're able to get secured from the state, we've tried to put into clinical need, but really where we're lacking from a budget wise is administrative need. We just don't have the IT people." (Rural, small budget CSB)

"The state expects more and more and more, more administrative burdens. They never give us any money for it; and they never give us money for our EHRs." (Urban, medium budget CSB)

Infrastructure Needs. Respondents reported that the level of reporting that is requested from the Commonwealth is high but that the support costs to cover the administration involved in providing a high level of reporting are inadequate. Due to the nature of state and federal funding, interviewees cited that there is inadequate funding built in for infrastructure (e.g., accounts payable, documentation system, billing staff, tracking clients). Other components not built into the infrastructure include discharge assistance planning (which can be up to 10% of a budget), root cause analysis, CQI, and program management costs. With the state asking for a more outcome-based environment, interviewees stressed the need to be appropriately funded to develop the requisite infrastructure.

"It's (funding) very earmarked, which is fine because that's for more accountability. But the problem is between us becoming more Medicaid and insurance dependent, which is much more earmarked, and the General Assembly dollars becoming more earmarked, there is no way to pay for infrastructure costs that are a necessary part of doing business, especially when you have to pay for those supports yourself." (Rural, medium budget CSB)

"Administratively, we do a lot here, like with the CCS reporting, the data reporting, and quality. Now they've gone to level two and level three. You have to do all these root cause analyses. There's not enough staff to do all of that. And as long as I've been in this job, I don't think we've gotten any administrative money." (Rural, small budget CSB)

"Nobody wants to pay for the administrative side of it. Everybody wants the product and feet on the ground doing it. But without the administrative funding to be able to apply for things like that, you can't get them. I mean, we're so lean on the administrative side that nobody has time to barely even do the reporting that we have and stay on top of it." (Rural, small budget CSB)

Multiple Locations. Interviewees from CSBs that have multiple locations discussed the administrative difficulties involved in managing numerous locations. For CSBs located in geographically large areas, these multiple locations make it possible for clients to receive services. However, additional localities require additional infrastructure and staffing, which is often not covered by the funds allocated For example, staffing multiple locations is costly; and state funding, such as SDA funding, does not cover the additional staff (e.g., intake, clinical, nurses) needed when there are multiple locations. The additional infrastructure costs (e.g., space, computers, IT and HR needs) can also be prohibitive.

"I've got four localities. I don't use their human resources department. I don't use their finance department. I don't use their IT department. I don't use their training department. I have to recreate that infrastructure. It isn't just front desk support. It's all that other support I have to recreate." (Rural, medium budget CSB)

Performance Contract Reporting. Respondents stated that, although performance contract reporting was a fairly straightforward process in the past, the current process is excessively and unnecessarily complicated. CSBs struggle to wrestle with state performance contract and regulatory requirements. Furthermore, the lack of communication between DMAS and DBHDS, which often leads to CSBs receiving mixed message on procedures, is also frustrating.

"So, can DBHDS communicate with your licensing entity, which is the regulatory entity, and then also collaborate with DMAS who pays us? Because they're not all on the same page. So, like, our performance contract says one thing and our regulatory entity says another thing." (Rural, small budget CSB)

Restricted Funding. Interviewees reported that most of the state and federal funding they receive is very restrictive in nature (e.g., PACT, Projects for Assistance in Transition from Homelessness, permanent supportive housing, state opioid response [SOR], STEP-VA, federal block funding). One such restriction is that, if this funding is not spent in the allotted time, it has to be sent back. For example, CSBs reported having to send back Pregnancy and Postpartum Women and Substance Abuse Residential Purchase of Services money because there was not enough time allocated for the CSBs to spend the funds.

"So, there are all a lot of parameters or restrictions on that money. You can only use it for certain things. And that's great, but it doesn't allow for if I add four or five new positions in this area, I still have to measure for all the compliance through licensure or any billing that I might be able to do with Medicaid to offset some of the costs. I still have IT support that I have to provide. I have clerical support I have to provide. I have to pay for the billing. I need new space. We're building a new building. All of those things are not included in the salary and benefits. When the money comes in, it's restricted. So, to build out a program is more than a body. And so that is not ever in the equation. Truly." (Rural, small budget CSB)

In addition, interviewees indicated the level of administrative oversight required with the management of restricted funds is very costly because they need to closely monitor and track how restricted money is spent. For example, CSBs need to manage separate budgets for separate pots of funding and separate billing by service categories. In addition, compliance costs are not taken into account with federal and state grants.

> **"I think that's the hard part is it's great what they give us. It's never enough, but it also kind of pigeonholes us into only providing that service with that money."** (Rural, small budget CSB)

Interviewees discussed the need for support structures to hold up federal programs, such as opioid programs. While CSBs expressed their sincere appreciation for these funds, they noted that the funds they receive do not allow for support growth (e.g., increases in administrative staff, pay increases). In addition, because restricted money is allocated into specific pots, CSBs are unable to use money in restricted pots to cover where the actual costs may occur. For example, CSBs can only hire revenue producing staff (licensed, license eligible) with the funds they receive, but CSBs are unable to hire the administrative support staff (e.g., accounts receivable) needed to support them. If restricted money is used to hire staff (e.g., nurse practitioner), these restricted funds do not cover cost-of-living adjustment (COLA) expenses for ongoing employment.

> **"Like the SOR, the State Opioid Response, they give us funds, but the restrictions were detailed restrictions, and we couldn't be able to use the funds. It's a small amount of money. It helped us, but the requirement's not correct."** (Urban, large budget CSB)
>
> **"But every time you add staff, you add clients. It means you add billing. You add payroll. You add bills to pay, accounts payable. And there's nothing that has come out that I've seen from the state in a very long time that would lend to that support. Because what they've done is cut and cut and cut the state general funds. And that's where I would have leeway to do administration."** (Urban, large budget CSB)

Another concern included challenges around how to bill for clients who have overlapping SUD and MH issues. Finally, respondents indicated the timeline of the credentialing process, relative to the money and the short timeline, especially with federal monies, was problematic. Many interviewees underscored the need for more flexible funding to address these challenges. On a positive note, a few CSBs cited that the ability to carryover some funds is extremely helpful.

> **"So, you do have the issue of having individuals who are co-occurring, or they could very well get a mental health case management and also an SU case management. Or they just could be treating their SA component within the mental health case manager. It's just it's very different. And it's hard to sometimes prove to the department this is why we're also using mental health and SA funds in the same particular program. They expect to kind of see it separate."** (Rural, medium budget CSB)
>
> **"I've already sent the burning message. I mean, truly. It's our challenge, just more flexibility around the funding that we receive."** (Rural, small budget CSB)

Funding Reserves

CSBs are required to have adequate savings and an adequate corporate account (e.g., 60 days' worth in savings to sustain their organization). Although many CSBs, particularly largest CSBs, can achieve that threshold, several CSBs find it difficult to keep their reserves at a sufficient level. Specifically, interviewees reported difficulties maintaining that threshold when the state continues to take back money (e.g., restricted funds, Medicaid Expansion).

"We have 3 months [reserves]. And what they don't understand is we have to keep the additional funding there because if you're an operating board like me, I have the nine locations that I'm responsible for. So, if a boiler blows or our air conditioning unit goes out, I had to put a roof on one of my 24/7 facilities, I have to have those resources available. So last year, they were on this soapbox about taking some of the state funding back away from us, which would be a nightmare." (Rural, small budget CSB)

"I think it's a good idea to have a 2-month operating reserve, but it's difficult to maintain that when funding is all over the place, and they're taking federal funds back if we don't spend them. It's just a lot of the general fund dollars haven't increased over the years...we would be able to budget more accurately I think in future years, if we had some discussion and interactions as far as where the money is, what type of money is needed and what services we need the money to fund," (Rural, small budget CSB)

"Something else that's fairly new with the department is talking about our reserve funds and making sure you have that 2-month pot of money, and if you don't. We do have it. So, we don't have the same problem, I think, that some of the other boards have had with coming up with creative accounting to say, 'Yeah, we really do have it.' " (Rural, medium budget CSB)

Hiring Limitations

To obtain additional funding for services, many CSBs obtain grants. Interviewees from several CSBs stated that the inability to hire a grant writer, even though a grant writer could bring in clinical funds, limited their ability to maximize grant funding. Interviewees also reported difficulty in their ability to hire supervisors due to limited funds. In addition, many interviewees discussed difficulties retaining clinical staff once they are licensed—specifically, unlicensed clinicians take positions at CSBs for long enough to obtain the hours and clinical supervision they need to become licensed and then leave the CSB for more lucrative positions at private providers. The cost of clinician licensure is also prohibitive.

"We, of course, have staff costs more and more and more. Every time they add new rules with ARTS and with Medicaid expansion on what they expect, the licensure, supervision and all these other things, there's no money for that." (Urban, medium budget CSB)

Structures

With the implementation of SDA, increasing populations in some areas and Medicaid expansion, many CSBs have seen an increase in clients. Some CSBs require building updates to accommodate this increase of clients. Interviewees discussed the funding needed for new buildings, building upgrades (e.g., additional office space for new staff, lobby bathrooms for clients), the need for additional parking, and necessary maintenance expenditures (e.g., air conditioning).

"We're busting at the seams and facilities, and we are not able to do much about that. And we have stress fractures in our central administration when you talk about HR especially…and those would be due to lack of funding.

There's just not enough financial resources to do all the things that we would like to do for that." (Urban, large budget CSB)

"Then you go further on down to the fact that you have all these facilities that you need to keep up from a maintenance standpoint and you are struggling… It is very difficult for me to have what I would consider to be a good capital plan or a good facility management plan because I don't have the funding to support it." (Rural, small budget CSB)

"I think what struggle with is rapid growth. We're struggling on space. Infrastructure's a big issue for us. And here it's not just can we pile three people into an office instead of two? That's one thing we can do. But we're hitting another infrastructure issue, which is where do we park? Where do we put everybody? Because the parking lots aren't sufficient." (Urban, medium budget CSB)

Transportation

Although CSBs in both rural and urban areas stressed the need for transportation options, the demand for operational vehicles was particularly evident in rural areas where case managers and other CSB staff are often the only source of transportation for many of their clients. Respondents discussed challenges with insufficient auto fleets, antiquated vehicle inventory requiring constant repairs, and breakdowns of vehicles while in use by staff.

"Our agency has 40 vehicles. Our case managers are moving clients around all the time with those vehicles, and it's just not adequate to be able to resolve that issue. We can't have them on the road all the time because the billing for transportation is very minimal." (Rural, small budget CSB)

"You have to go out to families sometimes instead of expecting them to come to you. In a rural area, that's really hard because it requires cars. It requires all the infrastructure that, you know, they give us money and then say you can't use it for vehicles." (Rural, small budget CSB)

Use of Local Funds for Operations

As discussed above, local funds vary across CSBs in Virginia, with the minimum mandate being a 10% contribution; however, some CSBs receive more than the 10% mandate, whereas others receive exactly 10%, and a few receive less than the mandated amount. The use of local funds (by those CSBs receiving more than 10%) to cover costs was described by several respondents who noted that it was only through these additional local funds that they were able to cover necessary operational costs, such as financial payroll software, EHR upgrades and IT upgrades. Transportation was described as a barrier in terms of both time (for case managers) and expense (for car purchase and for upkeep and fuel), particularly in rural areas. For CSBs with ample local funds, these funds were utilized to pay for cars to provide clients transportation.

"One of the big criticisms of CSB is, if you've gone to one CSB, you've gone to one CSB. I think that's crap. I think the biggest difference is where you get your funding from." (Rural, medium budget CSB)

"We went through the CIP process for the county and [CSB name], gave us the money to procure the new EHR for CSB programs." (Urban, large budget CSB)

"It's an antiquated [EHR] system. We've had it for over 10 years. We are in the process of getting a new one. In fact, have a contract with a consultancy agency… who's helping us put an RFP together. In fact, I believe it's already, yeah, we got a lot of county support for that. They are funding it outside of our department budget. It's coming out of the county's capital budget." (Urban, large budget CSB)

"I have the county because we're an administrative policy board. So, we receive a lot of funding from local funding." (Urban, large budget CSB)

"We lost $2 million, I think, if I remember, $2.6 million in total [to Medicaid expansion]. So, that's a big bite. Fortunately, for [CSB name], the county board has stepped in, and they've said that they will fill that gap." (Urban, large budget CSB)

"The IT system, we have this healthcare record system. We have a budget for that. And then we maintain the contract too...we also proposed to [CSB city] if we need to upgrade the system. And then there will be enhancement in the budget. And then we will let city know when it's coming and how much we would need. We put a proposal in last year, but we didn't see that it's going to happen this year. Maybe for next budget cycle, we're going to put a proposal in again for the upgrade. That that will come out of city's IT capital budget." (Urban, large budget CSB)

Use of County/City Funds for Operations

CSBs that operate under the city or county jurisdiction reported advantages and disadvantages to this arrangement. Advantages for CSBs that are part of a city/county government include the cost of IT (e.g., EHRs, computers, software) being covered by city funds as well as cars (e.g., for case managers and other staff to transport clients). In addition, while CSBs may have to abide by the operating budget of their local city/county, their fiscal department needs (including software and necessary administrative support) are also covered by city/county funds. Disadvantages include having to follow the city/county rules, which can make it difficult to hire staff, even when there is funding available, and does not allow for providing bonuses to staff. County interviewees also reported local funds, as well as city/county funds, being utilized to pay for new CSB buildings and building improvements.

"I think also some of it they [the state] want to use from an allocation perspective based on need. But then you've got CSBs, for instance, for us, our county contributes to a third of our budget. Because we're fortunate for that, does that mean that we shouldn't get as much of an allocation from—should we be penalized in our funding from the state because our locality is generous? So, you can look at both schools of thought on that." (Urban, large budget CSB)

"We are a government agency, a local government agency, and it'll take us 6 months to create a position, to get it approved by our city council, even with the money behind it. And so, it's often hard. We're not nimble in being able to say, 'Cool, let's jump on that.' There's a bureaucracy we have to respond to.

So, sometimes that money is there, but it's not as usable as it appears." (Urban, large budget CSB)

"I think that being able to use the city's resources, as long as you're following the rules, and there are a lot of rules, and remember our place, which is a small fish in a big pond, then we get along fine and things get processed. And those resources are essentially free to us." (Rural, medium budget CSB)

KEY FINDINGS

Funding Q1: What Funds Are Used to Support Provisions of BHS?

- Based on the quantitative data provided in the pre-site surveys, on average, CSBs reported costs totaling over $23 million to provide BHS. Administrative staff reported allocating the largest percentage of their annual BHS budget to provision of MH treatment (61.2%, n=40), followed by substance use treatment (15.9%, n=40), recovery support services (6%, n=33), and prevention services (3.3%, n=39).
- A review of the quantitative data indicated that administrative staff reported using multiple funding sources to support BHS.
    - The largest number of funding sources was used to support MH treatment services and substance use treatment services. Specifically, 40% or more funds from the following funding sources were used to fund MH and substance use treatment services respectively: Federal funds, state block grant funds, other state or DBHDS discretionary funds, Medicaid, Medicare, private payers, client fees (such as co-payment for services, sliding scale fees), local funds, and other funding sources.
    - A comparatively smaller percentage (less than 40%) of funds from federal, state, Medicaid, and other funding sources is allocated for recovery support services. The most funding for these services comes from the following funding sources: Federal funds, state block grant funds, other state or DBHDS discretionary funds, or Medicaid.
- A review of the qualitative data collected in key informant interviews indicated there is insufficient funding to support provision of BHS. Several components of how funding is used and where additional funding is needed were described by staff, including: Programs/facilities (such as medical detoxification, inpatient SUD and MH treatment facilities, mobile medication programs, CIT programs, crisis stabilization units, step-down hospitalization, and housing), services (such as children's services, MH services, prevention services, psychiatric services, and SUD services), staffing, state mandates, and the use of local funds for BHS.
    - **Programs/Facilities.** Inadequate funds to support provision of BHS have led to ongoing concerns about closures of medical detoxification facilities, mobile medication programs, and CIT programs, as do concerns over the need for inpatient SUD and MH treatment facilities to compensate for the lack of adequate psychiatric beds at the state level and with private hospitals.
    - **Services.** Inadequate funds to support provision of BHS have led to CSBs being in a position where they may not be able to continue providing MH skills building programs and TDT in schools.

- **SUDs.** The influx of opioid funding has supported clients with opioid disorders; however, the lack of funding to provide services to clients with methamphetamine and alcohol disorders, which are the top substances of choice in many CSB service areas, persists.
- **State Mandates.** Unfunded/underfunded state mandates (e.g., emergency services, peer recovery services) remain a key concern for CSBs.

Funding Q2: Is Funding Sufficient to Cover the Cost of Care and Operations?

- Based on the quantitative data provided in the pre-site surveys, administrative staff from 50% or more of CSBs reported that their agency does not have sufficient funding to provide the following services: Crisis/emergency services, substance use treatment services, MH treatment services, and recovery support services.
- A review of the quantitative data indicated that administrative staff also reported insufficient funding around the following services:
  - Administrative staff from 50% or more CSBs reported that their agency does not have enough funding to provide housing services, particularly for housing to support clients receiving substance use treatment (60%, n=24).
  - The need for funding to support psychiatric staff, provision of substance use OP and IOP treatment services, forensic programming, and services for transitional-age youth was also noted.
  - Close to 40% of CSBs noted there was not sufficient funding to provide prevention services.
- A review of the qualitative data collected in key informant interviews indicated there is insufficient funding to cover the cost of care and operations. Several components involved in the cost and care of CSB operations were described by staff including: Administrative (such as IT/EHR, infrastructure needs, managing multiple locations, reporting, and restricted funding), funding reserves, hiring limitations, structures, transportation, use of local funds for operations, and use of county/city funds for operations.
  - **Administrative.** Funding is often insufficient to keep CSB facilities in order, implement necessary upgrades, meet state requests, and conduct business on a daily basis. For example, CSBs are not reimbursed for the cost, maintenance, or upgrades of EHRs, which are used to ensure productivity standards and that state requirements are met.
  - **Infrastructure Needs.** The level of reporting requested by the Commonwealth is high, but the support costs to cover the administration involved in providing this high level of reporting are inadequate, as is the funding for built-in for infrastructure (e.g., accounts payable, documentation system, billing staff, tracking clients).
  - **Restricted Funds.** A large portion of the state and federal funding CSBs receive is very restrictive in nature, which leads to several challenges. These include having to return funding when it is not spent in the allotted time and a high level of administrative oversight required with the management of restricted funds.
  - **Infrastructure Funds.** Support structures are necessary to hold up federal programs, but CSBs are unable to use money in restricted pots to cover where the actual costs may

occur. These include not being able to hire support staff (e.g., administrative staff) or to provide COLA increases to staff hired with allotted funds.

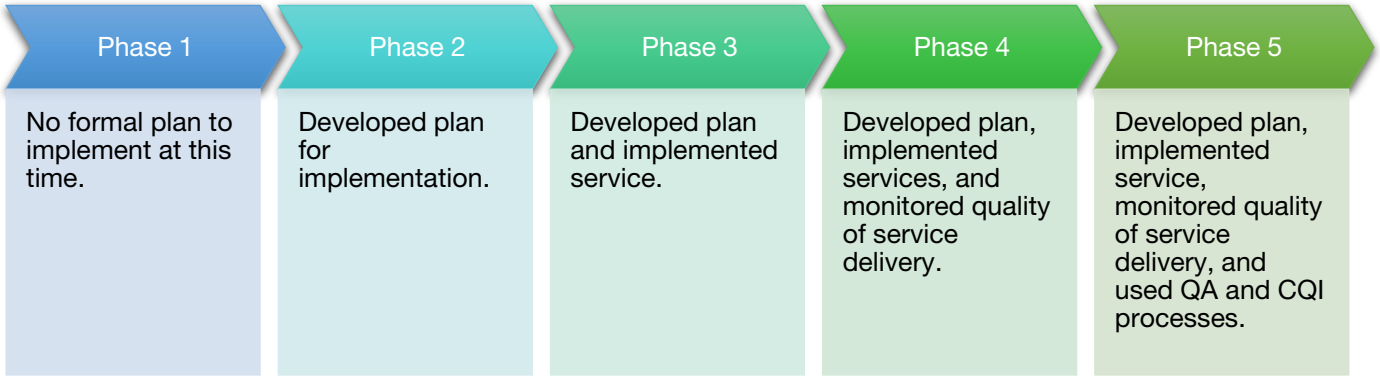
- **Transportation.** Transportation is a challenge both in terms of time (for case managers) and expense (e.g., vehicle acquirement, maintenance, fuel), particularly in rural areas. Although CSBs in both rural and urban communities stressed the need for transportation options, a demand for operational vehicles was particularly evident in rural areas, where case managers and other CSB staff are often the only source of transportation for many clients.

4.5 What Has Been the Impact Thus Far of STEP-VA and Medicaid Expansion and Medicaid Managed Care on Provision of BHS?

4.5.1 To What Extent Have CSBs Adopted and Implemented STEP-VA?

CSB leadership and administrators across the 40 CSBs were asked to describe their organization's progress related to STEP-VA implementation and service delivery. Specifically, they were asked to rank their organization's progress with implementing each of the 10 STEP-VA service categories and the 10 STEP-VA EBPs according to a scale ranging from having no formal implementation plan to having a fully developed plan, service implementation, monitoring, and CQI processes in place. Findings on implementation of STEP-VA were obtained from multiple data sources—quantitative data from the administrator pre-site survey and qualitative data collected during site visit interviews—were aggregated and are summarized below.

Figure 4.35. STEP-VA Implementation Phases



Implementation Progress of STEP-VA Services

Table 4.23 presents the current status of implementation of STEP-VA services and EBPs across the 40 CSBs visited by the JBS Team.

Overall, results indicate that over 90% of CSBs surveyed reported that they have developed a plan and implemented STEP-VA services in:

- SDA,
- PC screening, and
- Patient-centered treatment planning.

Fifty percent of CSBs surveyed reported that they have developed a plan and implemented STEP-VA services in:

- SDA,
- PC screening,
- Patient-centered treatment planning,
- OP BHS,
- BH crisis intervention and stabilization services,
- PSR services,

- Targeted case management (for adults and children), and
- Peer support and family support services.

Approximately 40% of CSBs reported that they currently monitor the quality of service delivery using QA strategies and CQI processes to support implementation of STEP-VA services in:

- SDA,
- Patient-centered treatment planning,
- OP BHS,
- PSR services, and
- Targeted case management (for adults and children).

Table 4.23. Implementation of STEP-VA Services by Implementation Phase

STEP-VA Services	Percentage and Number of CSBs Implementing STEP-VA Services at Each Phase of Implementation				
	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
SDA (n=40)	0.00% (0)	0.00% (0)	10.00% (4)	45.00% (18)	45.00% (18)
PC screening (n=39)	0.00% (0)	7.69% (3)	53.85% (21)	33.33% (13)	5.13% (2)
Patient-centered treatment planning (n=40)	2.50% (1)	5.00% (2)	27.50% (11)	35.00% (14)	30.00% (12)
OP BHS (n=38)	2.63% (1)	23.68% (9)	15.79% (6)	36.84% (14)	21.05% (8)
BH crisis intervention and stabilization services (n=37)	29.73% (11)	16.22% (6)	16.22% (6)	16.22% (6)	21.62% (8)
PSR services (n=38)	34.21% (13)	5.26% (2)	13.16% (5)	15.79% (6)	31.58% (12)
Targeted case management (for adults and children) (n=38)	15.79% (6)	5.26% (2)	15.79% (6)	28.95% (11)	34.21% (13)
Peer support and family support services (n=37)	24.32% (9)	16.22% (6)	35.14% (13)	21.62% (8)	2.70% (1)
Veterans BHS (n=35)	51.43% (18)	25.71% (9)	11.43% (4)	11.43% (4)	0.00% (0)
Care coordination (n=36)	61.11% (22)	11.11% (4)	22.22% (8)	2.78% (1)	2.78% (1)

Phase 1: No formal plan to implement at this time.
Phase 2: Developed plan for implementation
Phase 3: Developed plan and implemented service
Phase 4: Developed plan, implemented service, and monitored quality of service delivery
Phase 5: Developed plan, implemented service, monitored quality of service delivery, and used QA and CQI processes

Implementation Progress of STEP-VA EBPs

Table 4.24 presents the current status of implementation of targeted EBPs to support STEP-VA services across the 40 CSBs.

Overall, results indicate that at least 70% of CSBs surveyed reported that they have developed a plan and implemented EBPs to support STEP-VA services in:

- CBT,
- Long-acting injectable psychotropic medication,
- MAT,

- MI/MET, and
- WRAP®.

Fifty percent of CSBs surveyed reported that they have developed a plan and implemented EBPs to support STEP-VA services in:

- CBT,
- IDDT,
- Long-acting injectable psychotropic medication,
- MAT,
- MI/MET,
- TF-CBT, and
- WRAP®.

In addition, 50% of CSBs reported that they are currently monitoring the quality of service delivery of EBPs to support implementation of STEP-VA services in:

- Long-acting injectable psychotropic medication and
- MAT.

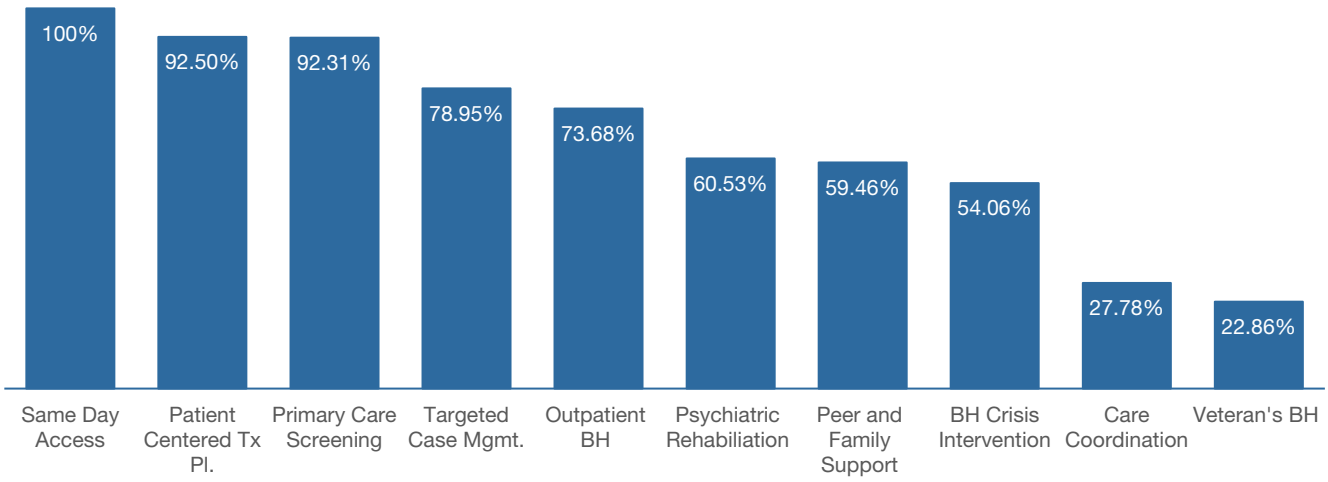
Table 4.24. Current Status of Implementation of EBPs to Support STEP-VA

EBP to Support Implementation of STEP-VA	Percentage and Number of CSBs Implementing EBPs at Each Phase of Implementation					
	Not Applicable	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
CBT (n=38)	2.63% (1)	18.42% (7)	7.89% (3)	44.74% (17)	18.42% (7)	7.89% (3)
Family psychoeducation (n=39)	15.38% (6)	35.90% (14)	7.69% (3)	23.08% (9)	10.26% (4)	7.69% (3)
IDDT (n=38)	10.53% (4)	26.32% (10)	5.26% (2)	18.42% (7)	34.21% (13)	5.26% (2)
Illness management and recovery (n=36)	8.33% (3)	30.56% (11)	27.78% (10)	13.89% (5)	13.89% (5)	5.56% (2)
Long-acting injectable psychotropic medication (n=39)	2.56% (1)	5.13% (2)	5.13% (2)	33.33% (13)	28.21% (11)	25.64% (10)
MAT (n=39)	2.56% (1)	2.56% (1)	12.82% (5)	30.77% (12)	30.77% (12)	20.51% (8)
MI/MET (n=39)	5.13% (2)	2.56% (1)	2.56% (1)	56.41% (22)	15.38% (6)	17.95% (7)
Recovery After an Initial Schizophrenic Episode (n=37)	32.43% (12)	43.24% (16)	5.41% (2)	0.00% (0)	8.11% (3)	10.81% (4)
TF-CBT (n=37)	2.56% (1)	7.69% (3)	28.21% (11)	41.03% (16)	17.95% (7)	2.56% (1)
WRAP® (n=38)	5.26% (2)	7.89% (3)	15.79% (6)	44.74% (17)	15.79% (6)	10.59% (4)

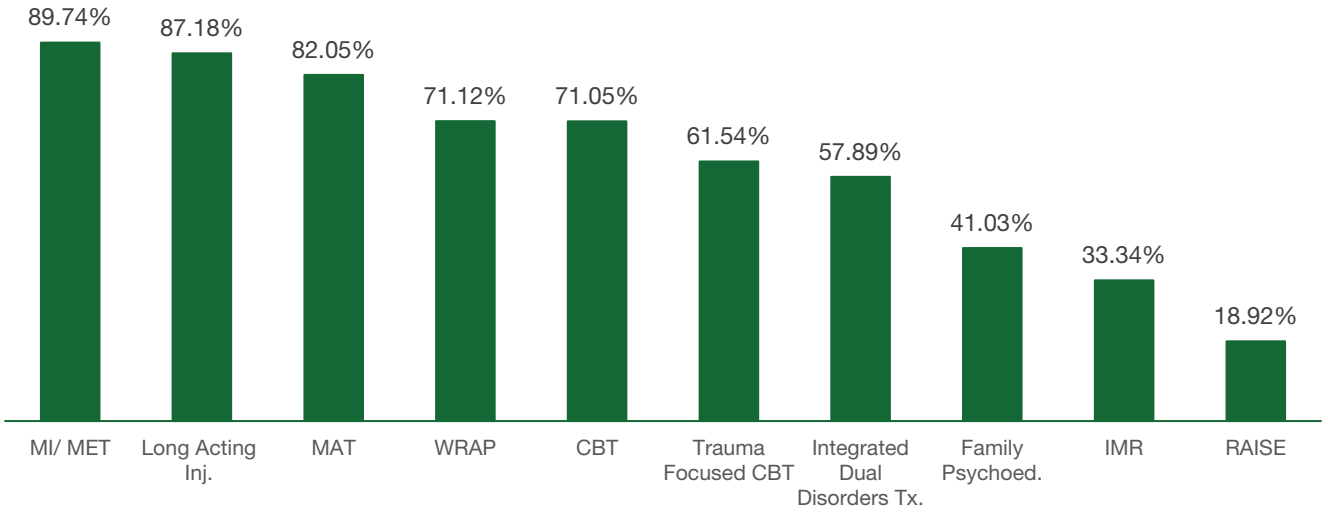
Phase 1: No formal plan to implement at this time.
Phase 2: Developed plan for implementation
Phase 3: Developed plan and implemented service
Phase 4: Developed plan, implemented service, and monitored quality of service delivery
Phase 5: Developed plan, implemented service, monitored quality of service delivery, and used QA and CQI processes

All CSBs have taken action to implement programs and services described within STEP-VA. Monitoring and CQI are viewed as essential parts of the delivery of these systems to support and assure implementation fidelity and success. CQI systems require resources that should be factored into overall systems planning.

Percent of CSBs That Have Developed a Plan and Initiated a STEP-VA Service



Percent of CSBs That Have Developed a Plan and Implemented STEP-VA EBPs



CSB Leadership and Administrative Staff Perspectives on STEP-VA Implementation

Across the board, CSB leadership and administrative staff recognized the value of STEP-VA and valued the positive direction in which Virginia was headed. CSBs were unified in their desire to best serve the BH needs of Virginians and offer them the right services in the right place at the right time. CSBs were grateful for the opportunity to begin offering essential services they had previously been unable to deliver, including more robust OP services, expanded SUD services, MH case management, and mobile crisis support.

Strong leadership support is a facilitator to implementation. Necessary aspects of leadership support include strategic planning for implementation, encouraging buy-in from CSB staff, shared perspective of benefit of STEP-VA services for consumers, and mobilizing resources (e.g., funding, staffing) to support implementation.

Barriers to implementation include timeliness; lack of clear communication; availability of resources (e.g., funding, staffing) to support implementation and sustainability of services; and insufficient support, consultation, and training for implementation to build CSB staff capacity in necessary knowledge and skills.

Facilitators to STEP-VA Implementation:

- All CSB administrative staff reported that they agreed or strongly agreed that they had support and buy-in from leadership for their plans to implement STEP-VA. In addition, over 94% (n=37) of CSB administrative staff reported that they agreed or strongly agreed that they had support and buy-in from direct service staff for their plans to implement STEP-VA.
- Over 94% (n=37) of CSB administrative staff reported that they agreed or strongly agreed that their plans for implementing STEP-VA services include (or will include) implementation of EBPs to support STEP-VA.

Barriers to STEP-VA Implementation:

- Over 56% (n=22) of CSB administrative staff reported that they disagree or strongly disagree that the current plans for implementing STEP-VA are realistic.
- Approximately 97% (n=38) of CSB administrative staff reported that they disagree or strongly disagree that their agency has sufficient funding to implement STEP-VA.
    - Over 74% (n=29) of CSB administrative staff reported that they disagree or strongly disagree that their plan for implementing STEP-VA has a sound financing strategy.
    - Over 48% (n=19) of CSB administrative staff reported that they disagree or strongly disagree that they have designated state funding to support implementation of STEP-VA activities.
- Nearly half (n=19) of CSB administrative staff reported that they disagree or strongly disagree that they have staff with the skills needed to implement STEP-VA programs and practices.

- Half (n=114) of direct service provider staff surveyed reported that there was not adequate staff available to provide services to clients.
- Almost 60% (n=23) of CSB administrative staff reported that they disagree or strongly disagree that they have access to adequate training and technical assistance services to support fidelity in implementation of STEP-VA programs and services.

4.5.2 The Impact of STEP-VA on the Provision of BHS in Virginia

STEP-VA is Increasing Access to BHS

SDA. All 40 CSBs have implemented the first service of STEP-VA—SDA to BH intake and assessment. This system change reduced wait times for individuals who previously had to schedule appointments, sometimes up to 45 days in advance. Nineteen of the 20 CSBs that currently track assessment data reported assessing at least 70% of individuals on the day they walk in during designated hours. However, the number of hours and locations available for same-day assessments varies significantly across CSBs, and it appeared that the availability of same-day assessments was insufficient to meet community demand for services. One agency reported that on several occasions, six, eight, and on one occasion 12 persons arrived at the same time seeking services, and that the demand overwhelmed their capacity. All CSBs reported that they are admitting more persons as a result of STEP-VA's SDA.

PC Screening. Multiple CSBs reported success with integrating PC screening with their adult patients. Many CSBs include lab work (e.g., lipid profiles and metabolic testing [A1C] to detect adult-onset diabetes). As a result of enhanced screening, CSBs are strengthening relationships with community health centers and local PC providers. These are important steps in BH and PC integration.

Systems Capacity Support Needs Are Significant

Workforce Adequacy

- Interviewees discussed the use of STEP-VA funds for hiring additional staff. Although some interviewees reported STEP-Virginia monies helped them to secure positions under special revenue, as well as provide the ability to raise salaries nominally, others stated that finding clinical staff has been difficult, even when provided with the funds (e.g., due to workforce shortages, rural location of sites). The lack of ability to hire administrative staff with STEP-VA funds was also cited as a concern among interviewees. CSBs acknowledged that they were hiring new staff to fill needed roles for STEP-VA delivery, but even with the additional staffing capacity, the service needs of their population surpass the increased staffing.
- All CSBs described workforce shortages in medical and BH providers. Sites described excessive lengths of time needed in recruitment, sometimes taking a year and more to recruit a psychiatrist. CSB leaders stated that salaries (particularly for prescribers) are not competitive with the private sector, and that levels of reimbursement fall significantly short of the true cost of prescribers' salaries. Numerous facilities described using locum tenens psychiatrists and contracting for telepsychiatry but viewed these as stop-gap measures as these services are expensive. Furthermore, these services address the immediate need for prescribing but do not lend well to team-based care. Workforce adequacy was a theme echoed across all CSB departments.
- Delays in services were commonly cited due to staff shortages and the increased number of patients seeking services as result of SDA.

- Although all programs have provided staff training in EBPs, few CSBs have systems in place to guide and support fidelity of implementation. Most training has been provided either online or in a workshop model and do not afford the level of follow-up support that is necessary to facilitate skills transfer and practice integration. In addition, most trainings described did not include building clinical supervisor capacity to precept newly trained staff in the adoption of these new EBPs.

"Well, one of the things that we worry about is with all of these new initiatives, they're all direct service related. And so how do we support that administratively without any injection of money to the administrative staff?" (Urban, medium budget CSB)

"We need to get a person in here to kind of analyze the data because I think that's needed. But again, where's the funding for the position? And I think STEP-Virginia, there's a lot of different data metrics, which I think it's great that we need to look at the data to see how you're doing instead of just kind of the anecdotal...one of the CSBs actually asked to be able to fund a position to kind of do some of that and it got pushed back. That no, that's not what the funding's for." (Rural, small budget CSB)

Funding Adequacy

To understand the factors that influence funding needs related to STEP-VA, the needs assessment team collected and examined qualitative data on funding during semistructured interviews with Executive Directors and Fiscal Directors at the 40 CSBs. Respondents described their experiences and financial needs related to STEP-VA overall, as well as the three steps implemented to date (i.e., SDA, OP, and PC), and provided their perspective on one of the upcoming steps (mobile crisis). The recent implementation of STEP-VA has brought on changes to services for the 40 CSBs that have impacted their funding. Across the board, interviewees expressed their belief that the standardization that STEP-VA brings across the state is positive. However, based on their experience to date, interviewees believe that the implementation timeframe of STEP-VA has been "too much, too fast." Respondents detailed several areas, including allotment of funds, sufficiency of funds, infrastructure needs, staffing, and training.

Allotment of Funds. Respondents stated that that the Commonwealth needs to provide more guidance about how CSBs should use allotted STEP-VA funds. Interviewees cited that there is a need for the state to be clear on the process of how and why specific funding is allocated, as well as how services will be sustained if funding ends. Relatedly, interviewees relayed that they found it frustrating when the state asked them for plans and estimates of what their CSBs needed and then went on to only provide a fraction of those projected needs. Finally, frustration about how allocations were formulated for the distribution of funding to the different CSBs was expressed by some interviewees. For example, allowances for an increased cost of living to CSBs in

Although CSBs valued STEP-VA, funding to deliver the required services was insufficient at levels of penetration that are responsive to demand. CSBs recognize that DBHDS hopes Medicaid will be optimized to support STEP-VA service adoption; however, low rates of Medicaid reimbursement and multiple challenges with the rollout of Medicaid managed care are confounding variables creating significant barriers to the success of STEP-VA.

Northern Virginia was frustrating for other CSBs who may have increased costs due to their more rural locations.

Although CSBs valued STEP-VA, funding to deliver the required services was insufficient at levels of penetration that are responsive to demand. CSBs recognize that DBHDS hopes Medicaid will be optimized to support STEP-VA service adoption; however, low rates of Medicaid reimbursement and multiple challenges with the rollout of Medicaid managed care are confounding variables creating significant barriers to the success of STEP-VA. Service penetration is directly related to funding adequacy, workforce availability, and (in some cases) infrastructure.

"I have tremendous concern even in STEP VA that we're creating all these programs we're not going to be able to sustain. Because somebody is going to lose interest and we'll move onto the next thing. STEP-VA is coming too hard and too fast." (Rural, small budget CSB)

"It's a difficult conversation to have. So, each time they're giving up funds, they're doing it a different way. Same-day access, everyone got the same pot of money. They just gave out money for outpatient. When they gave out money for outpatient, they included an extra 15% for the Northern Virginia boards because our cost of living is so much more expensive here. So, each time they're doing these funding allocations, it's a different methodology." (Urban, medium budget CSB)

"We should not be getting STEP Virginia mandates and services that are written into state code without the sufficient funds from the state to run them." (Urban, large budget CSB)

Sufficiency of Funds. While some interviewees indicated that the amount of STEP-VA funding to date has been sufficient, as well as their appreciation at having revived the funding as promised, more interviewees reported that the funding was insufficient. For STEP-VA to succeed, many respondents cited their belief that more money need to be invested in it. Interviewees suggested that the desired outcomes of STEP-VA need to be defined, a clear implementation plan (e.g., a roadmap) needs to be designed, and then the CSBs need to be consulted to determine accurately the funds that need to be in place to succeed.

"I think STEP Virginia has a lot of good ideas, and I think that it could build quality services, but you've got to have the staffing to do it. You have to have the resources to do it. And in order to do that, you need money. So that's the barrier to doing what the state is asking us to do. And the timeframe." (Urban, small budget CSB)

"So, explaining the different [STEP-VA] phases I think has been a challenge and the pace and trying to match the pace with the money that's been allocated versus the expectations of that." (Urban, large budget CSB)

"I think a challenge with STEP-Virginia has been that we identified what it would take to implement a certain step statewide and we might get a third of the money from the general assembly. And yet, the department would want

you to try to implement everything that you wanted to implement with full funding." (Rural, small budget CSB)

"I think the biggest issue, that I think you're not going to hear from other people, is the strategy for the funding that the department has taken. The CSBs take the position that we're not going to look to do all this aspirational stuff without the funds there because then we'll just end up with more unfunded mandates, a legitimate concern." (Rural, medium budget CSB)

Training. Sixty-four percent (n=205) of direct service provider staff surveyed reported that they were satisfied or very satisfied with the training they received to support implementation of STEP-VA services. In addition, approximately 64% (n=206) of direct service provider staff reported that they were satisfied or very satisfied with the training they received on EBPs to support implementation of STEP-VA. Interviewees also expressed their appreciation about the additional training funds associated with STEP-VA (e.g., OP). The desire for additional trainings was discussed, specifically around the need for more training on military cultural competence to be able to serve veterans better. Respondents also hope to see additional trainings available to staff on the numerous EBPs included within STEP-VA. These findings indicate a need for additional training to support staff implementation of services and EBPs to support STEP-VA.

"As we begin to move into STEP-Virginia outpatient and the evidence based practices, I think that that is part of our effort at this time to really look at how we maximize some of that training, how we take advantage of training that our staff have had…for me, I struggle to wrap my brain around at this time, is the evidence-based practice training requirements and the cost associated with it and maintaining to fidelity, and managing that within a turnover workforce.." (Urban, small budget CSB)

"The general clinicians probably could use a lot more [training]. Especially when we talk about the new outpatient requirements on STEP VA and the focus on evidence based; I think that is going to have some big ripple effects in terms of what we need to do." (Urban, medium budget CSB)

SDA. Respondents shared their experiences with the implementation of the SDA step. Interviewees across CSBs stated that they agreed with the reasoning behind the implementation of SDA and believe it is an important service for them to provide. Respondents shared that the funds provided were used to hire staff (e.g., intake staff, engagement staff) at many CSBs; for those CSBs who already had SDA in place prior to the mandate, interviewees indicated they were able to expand their services with the funds provided. Whereas some interviewees noted that the SDA funding that they received was sufficient to cover their staffing needs, many interviewees at other CSBs indicated a need for additional funding to successfully implement this step. Specifically, respondents indicated that supplemental funding was necessary for additional intake staff to handle the increased volume of clients as well as the required 10-day turnaround time for clients and to support the staffing needs of those CSBs with multiple localities/jurisdictions. Relatedly, respondents indicated that additional assessments and longer intake times make it more difficult to accommodate all of the clients coming in for services. The need for

additional funds to support ongoing services for clients coming in through SDA was also cited (to prevent waitlists).

Interviewees expressed their appreciation of the funds provided and indicated that receiving ongoing funds was also helpful. However, respondents also discussed concerns, such as a lack of clarity on how the funding for the SDA step was determined for CSBs. Specifically, interviewees voiced frustration that all CSBs received the same amount of funding, although different CSBs offer different amounts of SDA services per week (e.g., some CSBs have daily SDA services, whereas others have offer services a few days a week with shorter hours). In addition, concern was voiced that revenues have not increased from offering SDA, but that instead there has been a loss of revenue. Due to these concerns, some CSBs stated that they are limiting outreach for SDA because they are already at capacity. CSBs operating multiple satellite locations do not have resources to add staff members at each site with current funding. This means that roll out of services, such as SDA, may occur at only one place in the service area and not throughout the catchment area, which limits access to services within large geographic areas.

"With the additional assessments and the longer time that it's taking on intake, that it's creeping up…are we able to accommodate everybody that's coming in the door every day" (urban, large budget CSB)

"Like, okay, here's money for two new positions. Well, we have seven clinics. Our licensed people in some of those other smaller clinics are the supervisors. So, when and how are we going to do same-day access? I need enough money for 10 staff, not two." (Rural, small budget CSB)

"As a financial guy, whatever money I'm given is sufficient. Like, we're not going to end the year negative in order to meet these objectives. So, I think a good example was same-day access. The state gave us $270,000. We staffed it up. It has gone through the roof... at least a 40% increase [in clients seeking services] ... So, we staffed up to what the $ 270,000 allowed us... And then with that came the mandate to begin treatment within 10 days, which was totally unrealistic. There was no funding associated with that part. So, when I receive an unfunded mandate like that, we do our best and carry on. If we had more funding, we'd be able to serve more people." (Urban, medium budget CSB)

"Quite honestly, the implementation is way too fast in my opinion. And there's not enough money. I mean, if you gave us a bunch of money, we could probably get it done. But, for instance, with our same access, we were given $195,000. Well, that's great and take it, but it really only scratches the surface of it." (Rural, small budget CSB)

OP. Respondents shared their experiences with the implementation of the OP step. Interviewees shared that the funds provided were used to hire staff (e.g., licensed clinical social workers, SUD counselors, MH specialists, therapists) at many CSBs; however, some CSBs struggled with the ability to fill clinical staff positions that the OP funding allowed for. Whereas some interviewees noted that their CSBs already had OP services in place and were able to use the funding provided to build on or support these existing OP services, interviewees at other CSBs indicated a need for additional funding to successfully implement this step. Specifically, respondents indicated that further funding was necessary for additional clinical staff, especially for those CSBs with multiple localities/jurisdictions. In addition, concern was voiced that the more OP grows, the more funding will be needed to prevent waitlists, which some CSBs

already stated they have (e.g., as CSBs bring in more clients, clinicians will need to be available to serve those clients).

Interviewees expressed their appreciation of the funds provided and the renewal of those funds. Although some interviewees expressed their desire for the state to be more flexible about the use of OP funds, others noted their gratitude about the flexibility they did receive from the state on their use of OP funds (e.g., on infrastructure, to increase current OP salaries rather than hiring unnecessary OP staff). Respondents also discussed concerns, such as a lack of clarity on how the funding for the OP step was determined for CSBs and the changes made by the state on how to implement OP funding (e.g., original plan of spending 3 years to stabilize adult MH OP services changed to decision that CSBs had to invest 50% of the provided funds in children's services.

"At this point today, because STEP-Virginia has been implemented and we have some dedicated state funds for outpatient, we can say, yes, there is enough money and we're just having a hard time finding the people right now. What will happen is in a year or two from now when we hire all the staff and we start taking that caseload on, then we will have more people at the front door again that we can't serve." (Rural, medium budget CSB)

PC. Interviewees discussed their experiences with the implementation of the PC step. Respondents shared that the funds were used to hire staff (e.g., nurses, doctors, administrative technician) and set up office space. Whereas some interviewees noted that their CSBs already had PC mechanisms in place and were able to use the funding provided to build on these existing PC services, interviewees at other CSBs indicated a need for additional funding to successfully implement this step. Specifically, respondents indicated that additional funding was necessary for some of the PC components (e.g., case management of PC screening, follow-up activities).

Several interviewees expressed their appreciation of the funds provided. Respondents also discussed concerns, such as smaller CSBs receiving less money for the PC step and the funding provided not aligning with expectations (e.g., Phase One funds became the only funds CSBs received).

"If we really have to start connecting to the primary care physician, and that's a good thing, but that's a whole other lengthy process of hurry up and wait, and call them, and we need this, and call them. If you did the metabolic screening, may we please have the results? I called you last week. I haven't gotten those results yet... So, I think we may end up needing resources to fully implement, making sure that's happening the way it needs to happen." (Rural, medium budget CSB)

"But I've only got a little bit of money to do primary care screenings. Primary care screening is just a joke if you don't have a primary care person." (Rural, large budget CSB)

"We were in a better position than most boards because we already were doing the majority of the screenings, they want us to do and we were using medical assistance to do that; they're not billable stuff. But then we stopped paying for them and used the money to pay for their services. So that was a helpful thing." (Rural, small budget CSB)

Mobile Crisis. Respondents discussed their concerns about the mobile crisis step. Continual changes to the parameters of how mobile crisis will be defined was a concern amongst interviewees, as was the idea of regionalization. Interviewees stated that many of the "regions" being described are too geographically large to be able to reach clients in the allotted time, and that any decisions to conduct mobile crisis regionally should be left up to the CSBs, who can do so when it makes sense.

Across the board, interviewees described their concern about the need for additional funding for mobile crisis. Currently, $7.8 million has been allocated for this step; based on the scope Virginia is hoping to achieve with mobile crisis, respondents believe this is a gross underestimate of what will be required to accomplish mobile crisis successfully, given the geographic size of the Commonwealth and its needs.

> **"The next step is mobile crisis and that's the one I'm worried about the most. Because the department has some […] idea that you can have a regional mobile crisis team. And for Region 3, that's from Roanoke down to the tip of Virginia and over to Danville."** (Rural, medium budget CSB)

The JBS Team is concerned that the Commonwealth and the public might be experiencing an inaccurate narrative regarding STEP-VA progress. Specifically, this relates to the level of penetration of STEP-VA services into the populations of focus as reflected in the following:

- Many CSBs operate multiple service sites where intake occurs; however, SDA can only be supported at a few CSB sites.
- MAT for OUD is "available" through most of the CSBs; however, with few exceptions, the numbers of MAT patients served is relatively small—often fewer than 50 patients. Based on certain planning/service capacity models, MAT service delivery for OUD should be exponentially greater.
- The PACT model, which is proven to reduce hospitalizations, is only available in a few parts of Virginia. Several of the Commonwealth's largest CSBs have one or perhaps two PACT teams. When compared with other states, comparably sized service areas operate four to eight PACT teams.

CSBs shared some concerns that the limitations of MAT services may be (in part) due to implicit bias regarding use of agonist or partial agonist therapies for treating OUD.

Effective Planning for Implementing STEP-VA Remaining Elements

Driven by key stakeholders within the Commonwealth of Virginia, STEP-VA was rolled out with the CSBs in what has been described as an "aggressive" timeline and with a sense of urgency. Anecdotally, we have heard that providers who voiced concern about the rollout were viewed as "not being on board" or being resistant to change. As we listened to and learned of providers' experiences adopting these new service elements, we chose to frame this understanding based on implementation science, as summarized below.

Studies on new service implementation into health care and other organizations indicates that efforts must be focused at both an organizational level (i.e., to increase organizational readiness to adopt new practices) and a service delivery system level (i.e., reorganizing how care is provided to support the new practice; changes in staff roles; new knowledge and skills and necessary infrastructure enhancements, such as revisions within existing electronic healthcare records) and, commonly, both are necessary to integrate and sustain EBPs[60–62]. Organizational readiness refers to "the extent to which organizational members are prepared (e.g., buy-in, sustained commitment, technical knowledge and skills, and adequate resources) to implement organizational change[63]. Building and maintaining the organization's commitment to change and the ability of the members of the organization to understand how the new practice could be adopted and incorporated into existing practices are both important to the successful adoption of the new practice[64]. Further, adapting new practices to fit a setting's culture and context significantly increases the likelihood that the practice is ultimately accepted and adopted. Without reasonable planning and necessary adaptation, interventions usually come to a setting as a poor fit, are resisted internally, and require deliberate efforts to engage and activate key staff to accomplish implementation[61].

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Further, implementation scientists note that organizations are most successful with complex systems change when they have an ongoing relationship with a trusted support provider to develop and implement change plans that are informed by evidence [65,66]. This support system optimally includes:

- Implementation planning support that embraces the unique culture and context of each location. "What works in Fairfax County might not work so well in Wise County."
- Ongoing training and coaching with a strong focus on application.
- Site-specific consultation and technical assistance.
- Relevant tools.
- Use of CQI processes.

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Provider Perspectives on the Rollout of STEP-VA

- CSBs reported that they had to rush to roll out SDA and subsequent STEP-VA services and felt that the rollout would have been more effective if sufficient time had been given on the front end to complete requirements, implement performance measures, establish allocation amounts, and train the workforce.
- CSBs reported that STEP-VA requirements were not being communicated with sufficient time and specificity to develop site-specific plans, identify necessary accommodations, and train impacted staff to implement as required.
- DBHDS and the CSBs are halfway through a 4-year implementation timeline, but seven of the nine services remain to be implemented. Given the scope of this transformation at all 40 CSBs, the current deadline is likely too short to effectively plan and implement each step. Rushing the remaining steps risks ineffective implementation and eroding progress made on the first two steps.
- CSBs were on schedule to begin Step Two by July 2019, which required a PC screening for consumers at higher risk for physical health issues. All 40 CSBs began receiving funding to check the blood pressure and body mass index of consumers with SMI or SED. After this initial change is fully operational, CSBs will be required to expand PC screenings to all consumers. Whereas PC and BH integration is generally understood and endorsed, due to issues related to workforce adequacy, CSBs voiced concern that the added work required to do this will negatively affect other, high-priority STEP-VA services, such as expanded OP and crisis services. Further, several CSB medical providers described "push back" from MCOs when the provider sought to do appropriate lipid profile and metabolic screening (e.g., A1Cs).
- CSBs described training, technical assistance, and other supports as insufficient in scope and duration to meet their needs in supporting successful implementation of STEP-VA programs and services.
- CSBs stated that sufficient oversight and coordination is needed, and implementation support is necessary and critical for effective implementation. Virginia DBHDS did not have a full-time staff person dedicated to STEP-VA for the first 18 months. The agency hired a STEP-VA Project Manager in February 2019. Senior leadership was still provided by the (former) Commissioner and Chief Deputy Commissioner, who were also leading other major initiatives and overseeing agency operations. CSBs described at times fragmented communication between DBHDS and the CSBs.
- Prior to STEP-VA implementation, CSBs had varying levels of capacity to offer the core services that are part of STEP-VA. CSBs that were not previously offering these core services are at a disadvantage during rollout, as they had to determine funding mechanisms, new service types, staff roles, policies, and procedures and hire new providers.
- Although consumers' needs are assessed more rapidly as a result of SDA, clients are not necessarily receiving needed follow-up services after the assessment. Some CSBs reported that they are struggling to provide follow-up services—such as OP BHS, psychiatry, MAT, or case management—within the 10-day goal.

4.5.3 Findings and Recommendations on the Impact of STEP-VA Implementation

Findings

- All CSBs have taken action to implement programs and services described within STEP-VA. Monitoring and CQI are essential components of the delivery of these systems to support and ensure implementation fidelity and success. CQI systems require resources that should be factored into overall systems planning.
- STEP-VA is increasing access to BHS. Whereas CSBs have reported serving more persons as a result of SDA, the increased demand frequently exceeds workforce capacity in the system to meet the demand for clinical and case management services.
- The degree of service penetration and fidelity must be considered in the implementation of STEP-VA. Current funding to deliver STEP-VA services and EBPs is insufficient at levels of penetration that are responsive to demand (service penetration is directly related to funding adequacy, available workforce, and infrastructure).
- Strong leadership support is a critical facilitator to STEP-VA implementation. Necessary aspects of leadership support include strategic planning for implementation, encouraging buy-in from CSB staff, shared perspective of benefit of STEP-VA services for consumers, and mobilizing resources (e.g., funding, staffing) to support implementation.
- Barriers to STEP-VA implementation include timeliness; lack of clarity and communication; availability of resources (e.g., funding, staffing) to support implementation and sustainability of services; and insufficient support, consultation, and training for implementation to build CSB staff capacity in necessary knowledge and skills.
- At least one of the STEP-VA metrics is viewed as misaligned with patients' needs. Persons with SMI often need immediate case management before engaging psychotherapeutic treatment services.

Recommendations

- DBHDS is strongly encouraged to fund a statewide contractor that operates under DBHDS' guidance to develop statewide and CSB-specific plans for systems capacity building. The contractor should provide robust and ongoing training, technical assistance, coaching, and consultation with the goal of successfully supporting STEP-VA implementation and CQI processes, including the adoption of programs and practices with adequate fidelity and service penetration.
- CSB training and technical assistance for the adoption of STEP-VA practices and EBPs should be planned and delivered within a framework of evidence-based training and should include ongoing training and consultation for clinical supervisors.
- DBHDS should complete the requirements, performance measures, and funding strategies for each STEP-VA service before releasing funding.
- CSBs, in collaboration with DBHDS, should undertake a dedicated and perhaps independently facilitated process to determine true costs for essential services so that rates for services are informed by current facts.

- Based on a written and endorsed plan for systems change with negotiated action steps and timelines, DBHDS might consider extending the deadline for remaining STEP-VA services to begin at CSBs.

4.5.4 How Has Medicaid Expansion and Medicaid Managed Care Impacted Provision of BHS?

Expanded Populations in the MH/SUD Environment in Virginia

CSB Medicaid Clients. Virginia began its active participation in Medicaid expansion on January 1, 2019. As previously noted, enrollment data for Virginia reported 388,615 adults newly enrolled in Medicaid as of February 2020. Although some CSBs reported seeing an increase in new clients as a result of Medicaid expansion, a number of CSB leadership noted that CSB caseloads had not seen a significant increase in new clients as a result of Medicaid expansion but were individuals the CSBs had previously supported who were uninsured or enrolled in Virginia GAP at the time but who were now eligible for Medicaid coverage as a result of expansion.

"A large number of the individuals that we're seeing now are covered by Medicaid due to expansion. Probably half of them are already coming here and they were covered by the GAP, the Governor's Assistance Program. So, we don't actually see any more from [funding] those individuals. There are a few services that Medicaid reimburses at a higher rate, but most of them it's the same rate as they were before. So that's maybe 30% of the population are people that were already coming here." (Urban, large budget CSB)

Medicaid Enrollment. CSB leadership and administrators noted factors that may have contributed to the lower-than-anticipated increase in new clients as a result of Medicaid expansion. These contributing factors include stigma associated with receiving Medicaid services, income eligibility and navigating the Medicaid enrollment process as continued barriers to accessing Medicaid benefits.

"I think that it's safe to say in certain areas of Virginia, and I mean, I've grown up [here] and know how people are, they are too proud. They are way too proud. They don't want to get handouts. That's what they say. So, I had a conversation with one of my friends the other day. She says she's eligible [for Medicaid], but she's not going to apply." (Urban, medium budget CSB)

"There is a lot of people in [our] area that are also working poor. So, the people are not qualifying for Medicaid based on the family of four size. They have just enough income to push them over and not for the adults to qualify for Medicaid. So just a lot of need here." (Urban, medium budget CSB)

Provider Competition. Whereas CSBs expressed optimism in the ability of Medicaid expansion to increase demand for needed MH and SUD services throughout Virginia, there is a growing concern among some CSB leadership and administrative staff that the newly insured individuals may choose to seek services from private practices who accept Medicaid insurance, instead of the CSB, further impacting funding and reimbursement levels to the CSBs as well as their ability to meet the demand and needs of their clients.

"The other thing I'm also concerned about is that what Medicaid expansion could do in the long run is actually create more private providers and take clients, take those billable clients, out of the CSB system. Meaning that if the private providers, there's now a funding source for these clients, that they'll expand their services to take those clients. And I think one of the things that is kind of a sore spot that most I think CSBs have is that stigma. We do the best we can to keep lobbies clean, keep entrances clean and all that stuff and make it a good appealing place. But it's very difficult to compete with those private providers. And I think that could be a long-term thing that we need to watch for is that we've seen an increase in those services, but it could go the other direction." (Urban, medium budget CSB)

Funding Adequacy

In anticipation of Medicaid expansion, CSBs received a significant decrease in state funding for BH services with the expectation that funds would be recouped from the newly insured Medicaid clients presenting at the CSB's for service. However, interviewees reported not seeing a significant increase in new clients as a result of Medicaid expansion. Although efforts were made by the state to reinstate partial funding to the CSBs during the FY, many CSBs have reported experiencing a loss in total revenue due to funding reductions from the state, coupled with the administrative, billing, and reimbursement challenges of MCOs.

"And for FY20, it's $1.2 million [loss in state revenue to the CSBs], with the expectation that we will have a number of clients that will be coming in the door through Medicaid expansion to make up for the loss of revenue from the state. The state put together a plan after CSB, Executive Directors, financial people, kept going back to them [asking] what is your contingency? How are you going to make us whole if we're not able to make that money up through Medicaid expansion? And so late in the budget process, somebody came up with the idea, well, we're going to take money from a special fund and set it over here. It's $7 million to try to make people whole. Well, you took more than $7 million out of the budget. So, right now we're in the throes of putting together documentation to determine how many clients we've served since January through Medicaid expansion, what services they received, how much money we have received. And we're nowhere near not even our $660,000. So we want to get some piece of that 7 million." (Urban, medium budget CSB)

"Unfortunately, we serve a population that may or may not have Medicaid. And so, we're not getting a lot of reimbursement for these assessments. We're not making money off the same-day access. So, we're losing money on mandated services. I think with the local demographics here, frankly, we don't really anticipate much. I don't anticipate much in the way of increased clientele or an increase in consumer use because of Medicaid expansion. Given the levels of poverty, I think it's going to be modest, maybe we see a modest increase in levels of service." (Urban, small budget CSB)

Supporting the Population

To adequately address the BH needs of individuals in the expanded Medicaid population, support STEP-VA, and achieve the goals of the implementation of Medicaid managed care, the clinical service mix and systems capacity must be adequate. Specifically, the goals of these initiatives must prioritize reducing

the number of bed days in state facilities, improving access to care, and supporting whole person care across the CSBs. We found several measures of note.

Table 4.25. 2018 SAMHSA URS Output

State	Total population	Individuals supported	State Mental Health Agency MH expenditures per person	Number served in state hospitals	State hospital utilization per 1000	Median length of stay for state hospitals	30-day state hospital readmission rate	Access to care adult	Access to care children and families
West Virginia	1,815,857	40,708	$111.20	802	0.44	28 days	18.9%	92.2%	89.3%
North Carolina	10,273,419	101,046	$123.53	2542	0.25	44 days	7.4%	91.2%	84.9%
Virginia	8,470,020	123,101	$106.00	7343	0.87	14 days	9.3%	84%	78.5%
Washington	7,405,743	202,298	$178.77	2576	0.35	92 days	1.5%	77.1%	77.0%
Arizona	7,016,270	210,687	$11.82	217	0.03	89 days	0.0	-------	------
Tennessee	6,715,984	350,085	$102.00	7021	1.05	5 days	8.9%	89.2%	87.1%
New Jersey	9,005,644	358,324	$108.29	2952	0.33	140 days	4.8%	97.4%	81.6%
Averages	**7,243,277**	**198,036**	**$106**	**3349**	**0.47**	**59 days**	**7.26%**	**88.5%**	**83.1%**

*(2019, June 20). Retrieved from https://www.samhsa.gov/data/report/2018-uniform-reporting-system-urs-output-tables[2]

Table 4.25 shows the major categories of comparison reviewed related to the Commonwealth of Virginia. In general, items noted in green indicate Virginia has a positive outcome for that measure compared with the other states. Virginia's median length of stay in its state-operated facilities is 14 days, which is relatively short compared with the average of the other states (i.e., 59 days). Lengths of stay that are low indicate the likely use of the state hospital for acute care needs. The national average is 90 days, indicating the use of state facilities for more chronic, long-term needs[67].

Virginia relies on state psychiatric hospitals at a higher rate than many other states, with a shorter length of stay and higher-than-average 30-day readmission rate. This may indicate that the state hospitals in Virginia are being used at least in part to address acute needs of individuals versus the historic use of state hospitals for those with severe and persistent mental illness. The high rate of readmission indicates the need for more robust community supports and specific focus on transition of care functions for case management.

Whereas Virginia spends the average amount per capita compared with the other states in the table, focus should be on the number of individuals supported in each state system. For instance, New Jersey—with a similar total population and a per capita spending of $108.29—supported over 358,000 thousand individuals compared with Virginia's approximately 123,000 individuals while having a significantly lower utilization of state hospitals. Virginia has an above-average utilization of inpatient beds in state facilities.

Shifting or aligning funding to support robust community options can increase access to care while reducing trauma and high costs associated with hospitalization.

[67] Expenditure disclaimer: The figures in Table 4.24 are being researched to determine whether the expenditures represent a combination of Medicaid, state funds, and block grants. To accurately compare, total funds should be applied vs a single source of funding. This is extremely important due to expansion.

"Well, my hope would be, my dream would be, that people who need help are coming [for services] that didn't come before [due to Medicaid expansion]…so that you're spending more in places like outpatient and less in places like crisis civilization and emergency services and the emergency rooms for the hospitals, that at some point it starts working. That would be the hope. And if it worked out that way, you might even have a better financial model. But I think the hope for the most part for me, is how [Medicaid expansion] impacts the community and the clients." (Urban, large budget CSB)

Clinical and Administrative Workforce Necessary to Achieve Outcomes for Expanded Population

The service delivery system for BHS funded by Medicaid expansion in Virginia involves several layers. DMAS receives funding from CMS and distributes this funding through MCOs to the CSBs and private providers for the delivery of MH and SUD services. In addition, DBHDS is responsible for distributing state funds and performing regulatory oversight.

Clinical and Administrative Support Needs. When considering systems capacity required to adequately serve an expanded Medicaid population and interface with multiple MCOs, it is important to remember that clinical (licensed and unlicensed personnel) and administrative support needs are significant. HHS published a report in 2016 that outlined considerations for states expanding Medicaid. Several factors referenced in the report are relevant to this project. They include:

- The existence of "silos" among agencies. Interviewees at the state and county levels noted "silos" or evidence of conducting business unilaterally as opposed to collegially between state Medicaid agencies, other state agencies, and county-level BH agencies (i.e., CSBs).
- Supporting sufficient staff capacity to process new applications and facilitate enrollment.
- Enacting successful strategies for addressing issues, including coalition building, requiring cooperation between previously siloed agencies, and support for state-level governmental and legislative bodies, especially in considering the elements of the 1115 Waiver.
- Providing clear guidance regarding data systems and documentation standards.
- Promoting shared language among stakeholders.

CSB leadership and administrative staff expressed the following concerns related to the clinical and administrative support needs of the CSBs:

"Since the Medicaid expansion, yeah, there [have been changes to Medicaid guidelines and requirements]. And the state could do better when they make changes on this, they need to be inclusive in the loop the CSB staff. Because, if they are sending the change without consulting the CSB staff, the new procedure or a new policy that they are sending us is not going to be practical. They need to get feedback from us before they make a change. That's my opinion." (Urban, large budget CSB)

"Their constant changing of the rules and regs and the lack of timely communication is an issue. All of a sudden, we find out we're supposed to be doing something that if you didn't read the detail on some emergency reg, you know. So that's a challenge. But when you're as big as they are, I imagine that's just a general complaint." (Rural, small budget CSB)

Workforce Adequacy. In addition, service expansion have placed a strain on CSB workforces. The recruitment and retention of qualified/licensed clinicians is a significant workforce gap that hinders CSB readiness to address expanded need and affect CSB capacity to carry out expectations and meet performance standards.

> **"If I had the people, I wouldn't mind setting up other satellite clinics, but you just have to have the clinicians. And for the reimbursement the way that they have built the Medicaid model, in order to get any type of reimbursement, you almost have to have a license or licensed eligible clinician in order to provide the service."** (Rural, small budget CSB)

4.5.5 The Impact of Managed Care on CSBs and Their Capacity to Operate Within a Managed Care Environment

> **"There's consequences for the Medicaid expansion in the sense that there's money taken [from the CSBs] to be given back to the State of Virginia because it thinks you're recouping these costs through Medicaid expansion. But the reality is because of the way the MCOS's are operating and the changes in the rules and the constant back-and-forth, that you are actually losing revenue."** (Urban, medium)

Across the interviews with CSB leadership and staff, themes arose related to the effect of managed care on CSB operations. The most salient themes included:

- A significantly increased amount of documentation for clinicians, prescribers, and support staff;
- General inconsistency between or burdensome requirements from MCOs in areas such as authorization requirements, level of care criteria, and delays in network credentialing;
- Delays in MCO payments and authorizations; and
- MCO staff not seeming to understand that CSBs primarily serve persons with chronic conditions, including SMI, SED, and serious SUDs and that these persons generally require longer-term care.

Increased Documentation

CSBs consistently indicated that paperwork has increased significantly but without a reduction in previous documentation requirements. Examples include reporting the DLA-20 and other required DBHDS and DMAS documents where content is redundant with prior authorization for services. Interviews referenced as much as 50% or more of staff time being spent on documentation, which reduces morale. This resulted in some staff leaving the CSB system for the private sector, where, in their view, the burdens of documentation are more in balance with clinical responsibilities. Depending on the organization of the CSB, paperwork requirements may directly influence access to clinical services as staff are not available to provide direct services.

> **"I would say [increased documentation] has been a detriment to the services… and it takes staff to do it. We have clinicians who would otherwise be delivering services, talking back and forth with MCOs, or, we've had to convert administrative positions to deal with that burden."** (Urban, large budget CSB)

Clinician Credentialing

Data indicate that some CSBs have significant staff vacancies and that MCO credentialing of new hires can take up to 6 months.

Inconsistency of MCOS–Authorizations, Billing, and Reimbursement for Services

One significant factor in adapting to the managed care environment is the need to interact with six MCOs (versus interacting with one agency—DMAS) to bill Medicaid and receive funding, to enroll as a provider, and to get the necessary service authorizations. This increases the complexities of providing services and becomes even more complicated when MCOs are inconsistent in their policies. For instance, some MCOs require prior authorizations for some services, whereas other MCOs do not. Reports indicate challenges in getting MCOs on the phone for peer-to-peer discussions on medications or to answer case-specific questions about authorizations. For example, one MCO might deny the authorization for a medication that another MCO approves for the same use. Other examples include different criteria for PSR recertification or different periods. Having to navigate multiple systems that are not consistent, have different timeframes, or have different level of care criteria makes providing efficient and effective care more difficult.

"The managed [care organizations] are a headache by itself because they would like to save money…they don't give us clear direction how to submit the bills to them. And when they're denied…there is no clear instruction why it was denied and the reasons. So, it's really a challenge for the us dealing with managed care." (Urban, large budget CSB)

"So, I think it would've been better if [the State] would have ended up maybe with two [MCOs] rather than having six. Because they just are not all on the same page. Some of them provide hearing services, some of them don't. Some of them provide eyeglass services, some of them don't..." (Rural, small budget CSB)

"For our new Medicaid expansion clients…you can see that we've billed in the 6 months, $264,000, and we've collected $108,000, which is 41%." (Urban, large budget CSB)

Table 4.26 was created by reviewing the most recent Medicaid fee schedules available for states previously compared. Tennessee and New Jersey are not included due to the inability to obtain fee schedules for those states. The rates represent commonly used OP codes across the nation. The effect of managed care, as discussed above, along with the information available related to common Medicaid rates suggests further review of current Medicaid rates could assist CSBs in addressing barriers created through the managed care system.

"The Medicaid rates are far too low. You know, Medicaid rates have not changed in 3 decades. Have you gotten a raise in the last 3 decades?" (Rural, medium budget CSB)

Table 4.26. State Medicaid Reimbursement Comparison

Services	Virginia	West Virginia	North Carolina	Arizona	Washington	Average
Assessment 90791	$74.86 per event	$98.91 per event	$125.39 per event	$214.64 per event	$106.58 per event	$124.08 per event
Evaluation and Management 99203	$72.91 per event	$74.76 per event	$81.69 per event	$75.81 per event	$102.24 per event	$81.48 per event
Evaluation and Management 99213	$49.24 per event	$72.56 per event	$54.82 per event	$52.15 per event	$55.23 per event	$56.80 per event
Therapy 53+ minutes 90837	$83.09 per event	$96.83 per event	$99.42 per event	$109.28 per hour	$105.33 per event	$102.29 per event

CSBs consistently cited services such as case management, peer services, psychiatry services, and transportation services as having significantly low Medicaid reimbursement rates that have not been increased in a number of years.

"Another challenge with Virginia is a lot of our Medicaid rates have been stagnant for years, and we're so heavily dependent upon Medicaid. We serve a lot of the Medicaid population here. About 75% of my budget's Medicaid, but we're getting the same amount. So, the budget hasn't really grown a lot." (Rural, small budget CSB)

"We do have transportation issues, like some rural boards might have. Our bus lines are limited in the city. We have a lot of rural area. Medicaid is very challenging regarding reimbursement for transportation, which is …just a laborious and labor-intensive process of getting it billed and that kind of stuff. And a lot of our clients don't have Medicaid who need transportation." (Urban, medium budget CSB)

"[Psychiatry] pays the lowest, the worst. So, psychiatrists for CSBs costs $200,000 plus or minus $50,000, depending on benefits and cost of living here. So, if you go to Northern Virginia, they're going to have to pay their psychiatrist $300,000 or $400,000 probably. But in most of the areas of Virginia, $200,000 plus or minus $30,000. So, you have that full-time psychiatrist. You manage their schedule. They see three people in an hour, catch some intakes in there. But what happens is that that $250,000 salary, you may get $150,000 in Medicaid reimbursement." (Rural, medium budget CSB)

The Impact of Medicaid Managed Care on STEP-VA Success

By the actions of the MCOs since their inception in Virginia, certain concerns have been evident:

1. MCOs do not appear to differentiate the service needs of the principal populations with chronic conditions served by the CSBs from the BH needs of the general population. Although the overarching CSB goals for patient populations and the general population may be similar (i.e., improved functional status and quality of life), the objectives, clinical services, and strategies are different. Reduced hospitalizations, reduced emergency services, reduced police and court involvement, and stability in community living arrangements are some of the expected objectives for CSB populations. To achieve these objectives, ongoing programs such as PACT teams, PSR, case management, and pharmacotherapies are essential. MCOs appear not to differentiate the needs of a patient with a 20-year history of schizophrenia and multiple hospitalizations from a

single mother with moderate social anxiety. One patient requires long-term care and support while the other is an excellent candidate for 12 sessions of CBT.

2. Based on reports, statements made by MCO leadership (and DMAS) to the JBS Team, and the actions of MCOs, it appears that MCOs are inclined to reduce access to services as a cost saving measure and that DMAS is interested in reducing spending and expenditures related to community-based BH services over time. This is concerning, as high levels of state hospital admissions will not be "right-sized" unless an adequate system of care for the populations served by CSBs exists. Data previously described for community-level BHS utilization in Virginia (123,101 patients compared to New Jersey, a similarly sized state that serves 358,324 patients) strongly indicate the need for expanded (not contracted) community-based care. Conversely, this correlates with hospitalization utilization in Virginia with 7,343 state hospital admissions and New Jersey with 2,952 admissions. These factors pose a confounding variable that will negatively influence STEP-VA's success.

"[We] were talking recently about Vivitrol, which is now Medicaid billable for Medication Assisted Treatment, but they're not authorizing it because it's $1,000 a shot. So, [with] the MCOs, you have to go so far down a line to get an effective treatment because of the MCO authorization protocols." (Urban, medium budget CSB)

"We have a number of indigent individuals that we see and we see the most highly complex cases and very often those are individuals with no insurance. Now, Medicaid expansion should be helping with that. But so far we haven't seen that we are getting reimbursed to the extent of the amount of the cut that we had to take in our state funds." (Urban, large budget CSB)

"It costs us here in this community about a million and a half dollars to run our PACT program. We do not get enough in Medicaid billing to cover the cost of that program. And the state has to give us, I think they give us $850,000 a year in state general funds to operate that program because the Medicaid rate won't cover it. So, I think that's problematic when your system—when a true evidence-based program is provided, there's not enough Medicaid reimbursement to cover it." (Rural, medium budget CSB)

Infrastructure Necessary to Thrive in a Managed Care Environment

After reviewing the CSBs, several competencies are recommended and should be addressed in supporting CSBs to thrive in the managed care world. Those competencies are:

- Reporting and outcomes,
- Health analytics, and
- Financial complexity.

> High levels of state hospital admissions will not be "right-sized" unless there is an adequate system of care for the populations served by the CSBs. Data previously described for community-level BHS utilization in Virginia (123,101 patients compared with New Jersey, a similarly sized state that serves 358,324 patients) strongly indicate the need for expanded (not contracted) community-based care. Conversely, this correlates with hospitalization utilization in Virginia with 7,343 state hospital admissions and New Jersey with 2,952 admissions. These factors pose a confounding variable that will negatively influence STEP-VA's success.

Reporting and Outcomes

Through surveys and interviews, CSBs indicated the provision of multiple reports to DBHDS or DMAS, including information for the CCS 3 report, the DLA-20 multiple times a year, and other reporting. These data are submitted to the requesting agency with little feedback or useable data returned to the CSBs. Data integrity was also described as a concern. If these data were aggregated and analyzed by the agency or agencies to which they were submitted and then made available to the CSBs that submitted them, this valuable feedback could be helpful in the CSBs' internal quality and clinical reviews. When asked about specific national outcomes collected, such as Healthcare Effectiveness Data and Information Set measures, the CSBs indicated they are not collecting those measures. Many were unable to clearly verbalize what outcomes they are measuring (if any) or how the results are incorporated into quality improvement activities.

Health Analytics

Whether through STEP-VA or managed care, the goal of whole-person care is to address both the individual's BH and physical health needs. Health analytics require monitoring of selected health issues (e.g., A1Cs; lipid profiles; chronic issues like diabetes, high blood pressure, and obesity) and a system that can make those data points useable. Health analytics pave the way for population-based and care management interventions that can improve the overall health of individuals and the populations served.

Financial Complexity

Prior to the six MCOs' involvement in Virginia Medicaid services, the CSBs had one Medicaid payer—DMAS. Now, with six major payers, resources must be invested in strengthening the capabilities of the CSBs' finance departments and systems to help them rise to that level of complexity. CSB financial systems must be able to consistently and correctly bill for the same service in multiple ways, monitor billing and accounts receivables regularly, and assertively address claim delays and denials. Otherwise, CSBs are at risk of losing large sums of revenue or having significant accounts receivables that in several cases were described as in the millions of dollars. When systems can perform these more complex procedures and have an adequate IT infrastructure and "back office" staff, there is little effect on the CSB. If systems currently in place cannot handle this, often there are workarounds attempted, manual processes created, and staff labor added to the business operations of the CSB. As MCOs move forward with value-based contracting at some future date, CSB financial and IT systems will be further stressed to accommodate completely new ways of billing for services and receiving payment. The overall healthcare system is moving in this direction, and if CSBs do not have both the financial skills

and systems in place that can flex to accommodate and respond to these increasingly complex requirements, they will demand their current systems adapt in ways to which they are not configured, increasing the strain on these systems.

> **"I think our billing department's going to have to improve. I do personally worry that long term, the billing team that we have in place may not have the experience or resources needed to be successful in this growing, expanding situation. I'm also concerned that it will be a tremendous cost if we have to partner with an outside agency to help for billing. And so those are the two kind of things I'm constantly weighing is how do we get our team up to the skill sets they need. With the Cerner implementation that we're going through, we're spending a lot of time with them, kind of going through optimization stuff. It's been frankly painful some of the things that we're not doing – some of the standard things that we should be doing, like posting automatic payments, working off the aging versus just other reports. And so, I think that's the big thing."** (Urban, medium budget CSB)

4.5.6 Findings and Recommendations on the Impact of Medicaid Expansion and Medicaid Managed Care in Virginia

Findings

- On January 1, 2019, Medicaid expansion took effect in Virginia, resulting in a 43% increase in enrollment into Medicaid and CHIP from previous years[68]. As of February 15, 2020, a total of 388,615 new adults were enrolled in Medicaid, of which 270,967 are below 100% FPL, indicating they may not have been eligible if not for Medicaid expansion[69].
- In anticipation of Medicaid expansion, CSBs received a significant decrease in state funding for BH services with the expectation that funds would be recouped from the newly insured Medicaid clients presenting at the CSB's for service. However, many CSB leadership and administrative staff reported that caseloads have not seen a significant increase in new clients as a result of Medicaid expansion but were individuals the CSBs had previously supported who were uninsured or enrolled in Virginia GAP and now eligible for Medicaid as a result of expansion. Whereas efforts were made by the state to reinstate partial funding to the CSBs during the FY, many CSBs have reported experiencing a loss in total revenue due to funding reductions from the state coupled with the administrative, billing, and reimbursement challenges with the MCOs.
- In Virginia, state psychiatric hospitals are utilized at a higher rate, with a shorter length of stay, and higher-than-average 30-day readmission rate than other comparable states. The high rate of readmission indicates the need for more robust community supports and specific focus on transition of care functions for case management.
- Limited staffing capacity and expansion of services have placed a strain on existing CSB workforces. The recruitment and retention of qualified/licensed clinicians is a significant gap in the workforce necessary to address the expanded need. These gaps affect the capacity to carry out expectations and meet performance standards.

[68] MACPAC 2019. Medicaid and CHIP Enrollment, Selected Months in 2013–2019. https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-11.-Full-Benefit-Medicaid-and-CHIP-Enrollment-Selected-Months-in-2013–2019.pdf Downloaded January 10, 2020.
[69] DMAS 2019. Virginia DMAS 2019. https://www.dmas.virginia.gov/#/dashboard Downloaded January 15, 2020.

- With the emergence of Medicaid managed care in Virginia, CSBs have experienced significant barriers that have added challenges and administrative burdens on CSB infrastructure and increased administrative costs for operations and service delivery. These challenges and burdens include:
    - Significant increases in the amount of documentation for CSB clinicians, prescribers, and support staff;
    - Current Medicaid rates do not sustain services;
    - General inconsistency and burdensome requirements from the MCOs in areas such as payment and authorization requirements, level of care criteria, and network credentialing; and
    - Delays in payments and authorizations from MCOs.
- With six major payers, resources must be invested in strengthening the capabilities of the CSBs' finance departments and systems to help them rise to that level of complexity. The CSB financial systems must be able to consistently and correctly bill for the same service in multiple ways, monitor billing and accounts receivables regularly, and assertively address claims delays and denials. Otherwise, CSBs are at risk of losing large sums of revenue or having significant accounts receivables that in several cases were described as in the millions of dollars. When systems can perform these more-complex procedures and have an adequate IT infrastructure and "back office" staff, there is little effect on the CSB.

  CSBs are required to complete multiple reports to DBHDBS or DMAS, including information for the CCS 3 report, the DLA-20 multiple times a year and other reporting to capture health outcomes and performance. Currently, these data are submitted to the requesting agency but with little feedback or useable data returned to CSBs. If these data were aggregated and analyzed by the agency or agencies to which they are submitted and then made available to the CSBs that submitted them, it could inform and improve CSBs internal quality and clinical reviews. Many CSBs were unable to clearly verbalize what outcomes they are measuring (if any) or how the results are incorporated into quality improvement activities

Recommendations

- DBHDS is strongly encouraged to align its funding to support robust community options that can increase access to care while reducing the trauma and high costs associated with hospitalization.
- As STEP-VA is a signature initiative of the Virginia legislature intended to transform the BH systems of care, alignment of DBHDS and DMAS goals and efforts is critical. DBHDS and DMAS may want to consider a facilitated process between the two agencies for better alignment of goals and opportunities for improved collaboration and cooperation.
- DBHDS is strongly encouraged to work with DMAS in guiding MCOs to increase consistency where possible (e.g., standardized prior authorization requirements, inter-MCO agreements).
- DMAS and DBHDS are strongly encouraged to reduce paperwork requirements not specifically required for the measurement and reporting of nationally recognized outcomes and not tied to a federal or legislative requirement that CSBs can use to monitor and improve quality of services.
- DBHDS and DMAS should review current rates compared to the true cost of providing services. With burdensome paperwork, there is less time for CSBs to provide billable services, making sustainability and "Medicaid optimization" even further from reality.

- CSBs, DMAS, and DBHDS should agree on one set of nationally recognized or local performance measures that indicate quality and outcomes and can be used for quality improvement.
- DBHDS should facilitate and support the adoption of an IT solution for CSBs and DBHDS that can measure and report on agreed-upon measures and develop a data strategy that can ensure reporting and outcome/data management is a high priority. This should include specific data points for CSBs to collect to address determined health issues and allow CSBs to obtain data about the health problems and disparities that need to be addressed in their population. To this end, CSBs will need to develop data-driven interventions (e.g., specific care coordination interventions [clinical pathways] for individuals who are positive for a specific health need) to address the overall health of the individual. This data capability also promotes involvement with PC physicians, breaking down silos between BH and physical health providers. This should include the development of staff training to use the collected data.
- DBHDS should facilitate and support CSB investment in sophisticated financial systems/vendors that can process transactions among the multiple payers along with multiple methods of reimbursement, with capacity to track receivables and claims status in a timely manner.

4.6 What Feedback Has Been Provided by BH Direct Service Staff and Consumers Regarding Provision and Receipt of BHS?

4.6.1 Summary of Focus Groups Discussions with Direct Service Providers

The JBS Team conducted a focus group with 329 CSB direct service providers who provide treatment and recovery services at each of the 40 CSBs. Each focus group lasted 1 hour. Focus group participants were asked to complete a survey before the discussion; 320 surveys were completed. Most groups had between six and 12 participants representing the following areas: Prevention, MH, and SUD services; children, youth, and adult services; and inpatient, OP, and emergency services. Participants worked at various locations, including the CSB site, hospital, jail, school, transitional home, clubhouse, and client home. Participant responsibilities represented in the focus groups included, among others, counseling or therapy, case management, recovery, clinical supervision, crisis emergency staff, SDA clinician, peer specialist, detoxification/withdrawal, discharge planning, day program management, and jail-based treatment.

The majority or most of the 320 direct service providers who completed the survey identified as:

- Female–79.7% (n=255).
- White–71.6% (n=229).
- Non-Hispanic–96.2% (n=308).
- Being between 35-44 years of age–32.8% (n=105).
- Holding a master's degree–63.7% (n=204).
- Having worked at the CSB for 5 years or more–43.8% (n=140).
- Having multiple roles–20.6% (n=66).

Table 4.27. Description of Direct Service Provider Focus Group Participants (N=320)

Participant Characteristics	Summary Descriptive Information
Gender	Males: 62 (19.4%) Females: 255 (79.7%) Other gender[e]: 3 (0.9%)
Age	18-24 years: 3 (0.9%) 25-34 years: 81 (25.3%) 35-44 years: 105 (32.8%) 45-54 years: 74 (23.1%) 55-64 years: 50 (15.6%) 65 years and over: 7 (2.2%)
Ethnicity[c]	Hispanic: 12 (3.8%) Not Hispanic 298 (93.1%)
Race[a]	Alaska Native: 0 (0.0%) American Indian: 2 (0.6%) Asian: 7 (2.2%) Black or African American: 79 (24.7%) Native Hawaiian or Other Pacific Islander: 0 (0.0%) Other Race ('Mixed', 'Southeast Asian'): 3 (0.9%) White: 229 (71.6%)
Education[d]	High school diploma/General Educational Development (GED) test: 11 (3.4%) Associate degree: 10 (3.1%) Bachelor's degree: 78 (24.4%) Master's degree: 204 (63.7%) Doctorate: 10 (3.1%) Professional degree (e.g., RN, MD, PharmD): 2 (0.6%) Other education (e.g., credentials, certificates): 5 (1.6%)

Participant Characteristics	Summary Descriptive Information
Role at CSB[b]	Project coordinator: 18 (5.6%) Case manager: 95 (29.7%) Counselor/therapist: 145 (45.3%) Recovery specialist: 25 (7.8%) Part-time/fee for service staff: 3 (0.9%) Other role—clinical supervisor: 19 (5.9%) Other role—crisis and emergency staff: 13 (4.1%) Other role—SDA intake clinician: 8 (2.5%) Other role: 74 (23.1%)
Length of Time in Role[c]	Less than 1 year: 32 (10.0%) 1–2 years: 84 (26.3%) 3–4 years: 63 (19.7%) 5 years or more: 140 (43.8%)

[a] Percentage might add to more than 100% because direct service providers could identify with more than one race.
[b] Percentage might add to more than 100% because direct service providers could identify with more than one role.
[c] Percentages do not add to 100% because of missing data.
[d] Percentage might add to more than 100% because direct service providers could have more than one educational degree.
[e] No additional information regarding the other gender category was provided by respondents.

The following summary is based on notes taken at each session. Bulleted statements are based on remarks as recorded by notetakers. Quantitative (survey) results are presented in the boxes. See the Methods section for more information on the focus group process.

Job Satisfaction

The majority of focus group participants find their jobs purposeful and fulfilling, and they expressed deep satisfaction from the work they do. Remarks from participants reflected the following statements:

Satisfaction With Working at CSB
Nearly 90% of survey respondents (n=285) were satisfied or very satisfied with working at their CSBs. Satisfaction ratings did not differ between survey respondents in rural and urban settings.

- Most days, direct service providers like their jobs.
- Direct service providers enjoy helping clients become self-sufficient and get their needs met.
- Direct service providers feel a sense of reward when the children and adolescents they have worked with come back and provide updates.
- Direct service providers do not perform this work for the paycheck or the glory but rather to help clients achieve their goals.

Many felt that the quality of work was high, although many concerns about quality surfaced in the context of specific subjects, addressed in the sections that follow. Focus group remarks reflected the following:

- CSB staff and the quality of services they provide are “phenomenal”.
- CSB staff go “over and above” to take care of clients.

At many CSBs, there is an esprit de corps that contributes to this job satisfaction. Words like "passionate," "dedicated," "wonderful," and "extraordinary" were used to describe colleagues. Many focus group participants feel they are part of a unified, supportive team. Focus group remarks reflected the following:

- Staff work as a team and take care of each other.
- Staff care deeply about the clients.
- The support of the team is what keeps some staff members from quitting.
- Everyone is supportive, from kitchen staff to IT to maintenance staff.

Satisfaction with the Quality of Services Provided
Nearly 90% of survey respondents (n=287) reported they were satisfied or very satisfied with the quality of services provided. Satisfaction ratings did not differ between survey respondents in rural and urban settings.

More than 96% of survey respondents (n=305) reported they were satisfied or very satisfied with the relationships they had with their fellow staff members.

Although most participants reported satisfaction with their jobs, they also expressed some concerns. Participants reported that, within some CSBs, the sense of being on a team did not extend to all program areas or across program areas; the term "silo" came up in some discussions. For example, one CSB operates in two jails, but the staff at each location do not communicate with each other. Focus group remarks reflected the following:

- One team at a CSB may work well together, whereas another at the same CSB may lack cohesiveness and trust.
- At one CSB, some staff members don't speak to each other.

A common theme was the tension between having a job that was liked but an unsustainable workload. Several participants mentioned that client cases have become more complex and time consuming compared with those from years past (e.g., higher levels of medical and psychiatric comorbidity, and challenging social conditions). Focus group remarks reflected the following:

- No one want wants to quit; everyone wants to meet the needs of clients and support the leadership team. However, that may not be possible because the workload is so great.
- Staff can feel like they have multiple fulltime jobs.
- Caseloads have increased—in some instances doubling from 35 to 70 or more.

Some 65% of survey respondents (n=208) reported that it was likely or very likely that they would continue to work at their CSB in 5 years. Likelihood did not differ between survey respondents in rural and urban settings.

Understaffing and high turnover was a concern expressed by many participants. They reported that some CSBs are unable to maintain a full staff due to workforce issues in their area. Many CSBs experience considerable turnover, which puts more responsibility on those who remain. For example, in the previous year, one CSB had openings for 30 positions. Focus group remarks reflected the following:

- CSBs have lost direct service providers to MCOs.
- When therapists leave, it costs the CSB money to retrain the replacements, who are then expected to pick up the large case load left from the previous staff.
- Some clients have stopped coming due to staff turnover.

Compensation

Satisfaction with salary and benefits varied across and within CSBs. Some focus group participants mentioned the low pay compared with the private sector, whereas others said the pay was better. Some participants expressed concerns about inconsistencies in pay; for example, some participants stated that the salary level for unlicensed therapists was reasonable, but it was too low for licensed therapists. Participants said that licensure supervision is a prerequisite of working at a CSB, but that once the license is received, therapists tend to leave to get higher paying jobs with other agencies. A few noted discrepancies where new hires start at salaries equal or higher than equivalent personnel who started at an earlier date.

Nearly 60% of survey respondents (n=190) were satisfied with the compensation they receive, including benefits. Provider satisfaction ratings did not vary by location (rural or urban) nor by the overall budget of the CSB.

Most survey respondents (48.1%, n=154) reported an annual income of between $40,000–$59,000.

Professional development opportunities varied. Focus group participants reported receiving training through their CSB that included parent-child interaction therapy, Trauma Focused-Cognitive Behavioral Therapy, Motivational Interviewing, play therapy, circle-based security, and suicide training. Additional training participants desired included modality, EMDR, DBT, substance abuse trainings, cultural diversity information, and trauma for veterans, as well as the fidelity/adherence needed to support them.

Several participants reported receiving reimbursement for trainings that provide continuing education credits; however, many of them also described obstacles to training, such as having to arrange for coverage while in training, not receiving reimbursement for training costs such as travel, not being allowed to use work time for training, and being interrupted by patients while participating in online webinar trainings. A few participants also reported that, although their CSB provided good staff trainings, they were not repeated for new staff. Training for licensure can be difficult if no personnel are available for supervision locally or anywhere within the CSB catchment. This can be a problem for CSBs, because certain interventions can only be conducted by licensed or license-eligible clinicians. Focus group remarks reflected the following:

Nearly 75% of survey respondents (n=235) reported that 20% or less of their time is spent on professional or career development; of those, 40.3% (n=129) reported that 10% or less of their time is spent on professional development.

- Direct service providers do not want to practice outside their scope, but some CSBs do not have the appropriately credentialed staff for a particular intervention and thus need alternatives.

Peer Recovery Specialists

Peer recovery specialists help relieve pressure on clinicians by using their lived experience to connect with people coming in for treatment. Although, as one focus group participant noted, it is important that peers not be asked to do what they are not qualified to do, there is much peers *are* able to do to bring clients into services and keep them engaged. Tasks mentioned as valuable include: Coaxing nervous new clients to enter the facility, compassionately waiting with them for services (including emergency services), helping to facilitate support groups, answering calls on warmlines, transporting clients (e.g., to community support meetings, rehabilitation, probation appointments), providing an orientation to MAT, providing support during medication dispensing, meeting with clients who are in crisis or resistant to

treatment, and helping clients transition from incarceration back into the community. Clinicians spoke highly of the assistance peer recovery specialists provide. Focus group remarks reflected the following:

- Clients identify with peer support specialists and sometimes get frustrated with clinicians who do not have lived experience.
- Peer specialists blend in well with the rest of the CSB team.
- Peer specialists can mean the difference between clients coming back in for services or not.
- Therapist cannot be available to clients 24/7, but peer support specialists can.
- Peer services exponentially encourage people in their recovery.

Nearly 80% of survey respondents (n=253) were satisfied or very satisfied with their experiences collaborating with peer support services.

Note: Satisfaction was not unanimous according to the survey, but no negative comments about peer support were recorded in the focus group interviews. This discrepancy calls for further exploration.

Supervision and Administration

Staff at many CSBs said they felt supported by their direct supervisors. Reporting on clinical supervision practices, some focus group participants described monthly individual meetings and weekly interdisciplinary meetings to share information and staff cases. Others reported monthly supervision and an "open-door policy" (this phrase came up many times during focus groups). Some said they were able to obtain their licenses because they had agency support to meet their clinical supervision requirements. Focus group remarks reflected the following:

- Some providers can go to their supervisors at any time when they have questions or to do a case consult.
- Some providers feel supported by their administrators.
- Some supervisors are "in the trenches" with staff.

Not every provider, and not every team within a CSB, is satisfied with supervision. For example, at one CSB, supervisors have presented direct service time requirements as a punitive system, threatening to fire staff who do not meet the standards. A few participants reported that supervision is minimal because the supervisor is too busy. Some participants mentioned long travel distances to meet with their clinical supervisors. One mentioned that scheduled supervisory meetings can be superseded by crisis response. A few participants mentioned uneven treatment by supervisors. Focus group remarks reflected the following:

- In some cases, a different supervisor might make the situation better.
- In one case, a provider's supervisor abruptly changed from providing no supervision to constant supervision; neither was good.
- In one case, a provider's supervision was less clinical supervisory and more like managerial dictates.
- Supervisors are overworked, too.

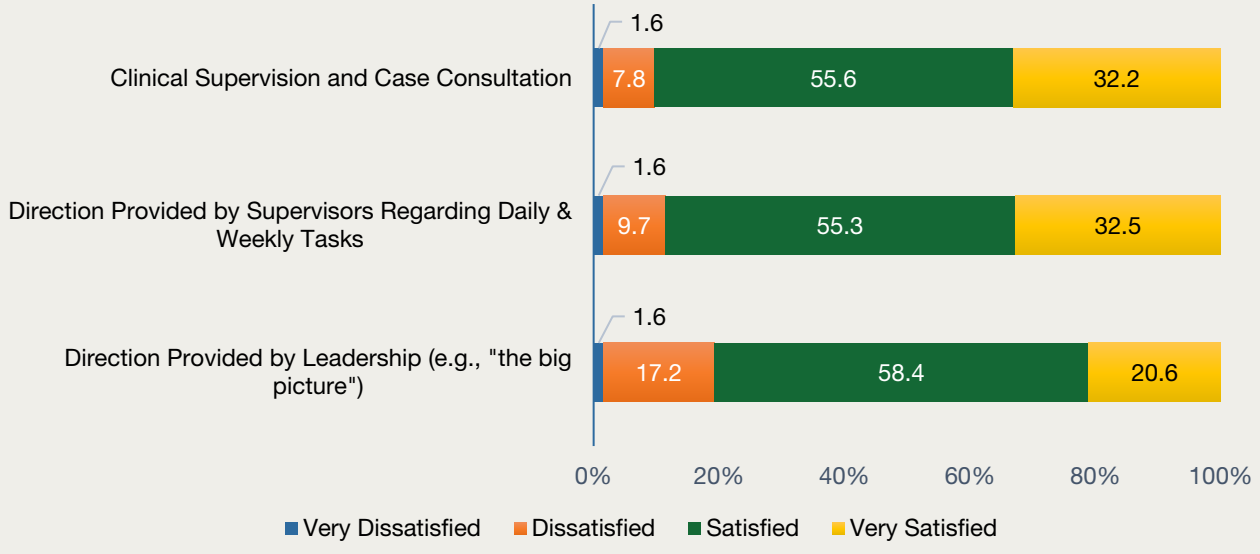
Many focus group participants felt supported by their administration. They reported that the team culture at their CSB emanates from leadership, and that leadership is accessible. As an example of good communication, staff at one CSB appreciated the weekly inspirational and informational emails that the Executive Director sends them; the Executive Director also forwards to staff emails received from the

state. Another person noted that the senior Director travels to remote sites once a month to visit with all staff there. At some CSBs, participants said that when staff members make a suggestion, such as for training on LGBTQ, leadership consistently follows up. Focus group remarks reflected the following:

- One CSB's strength is it's a strong team with good flow of information and a strong sense of caring for clients that is shared by all staff including leadership.
- Another CSB's strength is that leadership, including the Executive Director, is readily available to staff.
- At one CSB, there is minimal distance between all levels of staff, which allows for innovation and new ideas.
- Feeling supported by supervisors and upper management makes it easier to perform job functions.

A minority of focus group participants reported problems with leadership. The recurring theme was the lack of communication. For example, one person reported that when staff was asked to adopt a comprehensive needs assessment (CNA), they received only a PowerPoint with no communication from leadership; the supervisor had not been oriented to the CNA, either, and thus was of no help. At another CSB, staff reported a lack of communication about what the rest of the organization was doing. For example, one person was not aware that the CSB offered MAT until learning about it through the focus group discussion. Some participants said that their upper management is "clueless" to the capabilities of the direct service providers and of the challenges they face. Some participants also described a negative culture emanating from management that made work life difficult. Focus group remarks reflected the needs for CSB leadership to provide timely communication, consistency, and connection with staff.

Nearly 80% of survey respondents (n=253) reported they were satisfied overall with the direction and supervision provided by administrative staff. Nearly 90% of survey respondents (n=253) reported they were satisfied overall with the direction and supervision provided by supervisory staff.



Note: Percentages may not add to 100% because of missing data.

STEP-VA

As noted above, many of the focus group participants find their work fulfilling; however, many also describe an increasing workload that is moving them close to the breaking point. STEP-VA implementation is central to the discord between work satisfaction and dissatisfaction. Participants praised the goals and objectives of STEP-VA and its early accomplishments, but they also expressed frustration with the speed and order by which reforms are being introduced, which places new demands without an equivalent increase in resources and by the many constraints that prevent them from successfully performing under this new system. Some noted that DBHDS does not seem to understand the experiences of STEP-VA implementation on the ground. Other participants expressed a desire for more time to plan for STEP-VA services and more opportunity to provide feedback to CSB and state leadership on how best to implement the reforms. Focus group remarks reflected the following:

- STEP-VA has reduced waiting lists for admissions significantly.
- The STEP-VA changes are appreciated by providers, but providers need to figure out how to make SDA most effective for current staffing capacities.
- The DBHDS has certain changes it wants providers to do, but it doesn't support providers with the training, technical assistance and resources to do them well.
- Unrealistic timing for actions happens routinely. For instance, a mandate for a new activity to start on July 1 was delivered to CSBs on June 28.

Knowledge of STEP-VA varies across CSBs. Some staff felt well informed and received training on it whereas others wanted more information. Participants in several focus groups were unfamiliar with the term at all. Many expressed a desire for training on STEP-VA, including a timeline. Focus group remarks reflected the following:

- At one CSB, staff receive a lot of communication about oncoming developments.
- At another CSB, staff had only just learned of STEP-VA.

Some participants expressed concern that greater planning needs to be done before certain services can be rolled out effectively. Participants in one group used the example of mobile crisis, noting that 20% of the CSB's catchment area, which extends into mountain valleys, does not have cell phone service. Focus group remarks reflected the following:

- For one CSB, the "law of the hills" operates in a part of its region; it would be wrong to expect crisis workers to travel there unaccompanied by law enforcement.

SDA

SDA was generally praised and considered to be a positive change that benefits clients. Several focus group participants mentioned that it has considerably reduced the number of no-shows compared with a system where first appointments were scheduled weeks in advance. Participants noted that SDA was enabling clients to get some of their needs addressed immediately, which enabled them to properly focus on their BH concerns. Several participants also said that clients leave SDA knowing when their next appointment is, which can be a relief. Focus group remarks reflected the following:

- Staff at one CSB are proud that they moved to SDA before it was required.
- A CSB makes use of SDA to train clients on NARCAN ® (the opioid overdose reversal medication), connect clients with housing services, and help clients fill out Medicaid enrollment forms.

- SDA is engaging people when they are motivated.
- Through SDA, a CSB is able to take better care of clients on the front end with referrals for support services.
- SDA is bringing in clients who are "ready to go".

At the same time, it is clear from the focus group discussions that "SDA" means different things to different CSBs, and the SDA process at a given CSB clearly has an impact on how providers feel about the work they are doing.

At no CSB does SDA mean 24/7 access: Days and hours for SDA intake differ significantly between CSBs and between programs within the same CSB. Some CSBs have staff dedicated to SDA, whereas other CSBs pull staff from their regular duties on a scheduled or ad hoc basis to fulfill SDA obligations. In any one location, demand for SDA varies by the hour and the day. There can be a line at the door when SDA hours open. Clients often show up as a couple or in groups. And there are days when no clients come in for same day services.

The time between when a client shows up for SDA and when they are seen by staff varies considerably. Clients may have to wait hours and thus sometimes they leave. Some CSBs try to accommodate clients when there is a rush, such as by providing food or asking clients to come back later in the day or the next day. In some cases, staff make appointments for clients who came in for SDA to have their intake on another day. Staff at several CSBs reported that some clients find SDA challenging because intake hours are mostly during the weekday and that is when the clients are working or when the child needing services should be in school. One person in crisis can back up the process for others waiting to be seen. Many CSBs struggle with staffing SDA to meet demand, which can vary tremendously from day to day. This variability creates challenges for staffing and for providers (who may suddenly be called in during a rush) trying to plan their day. Focus group remarks reflected the following:

- Predicting the inflow of clients for SDA is like predicting traffic.
- One CSB gets most of the clients through intake within about 3 hours, about 50% of the time.
- Clients first in the door typically are seen fairly quickly.
- A provider tells clients to arrive early and bring a chair.
- The long wait is a barrier and sometimes clients go into crisis while waiting.

Two hours was the most common estimate for the time required to complete an SDA intake, but other estimates ranged from 90 minutes to as much as 5 hours. Several participants mentioned that when there is an influx of SDA clients, they compress initial intake to 60 minutes, with the remaining information collected at first appointment. Focus group remarks reflected the following:

- Some days no one comes into the facility through SDA; on other days, 10 new clients come in.
- The first visit is about "let's just get this done," and it's at the next visit that client engagement truly begins.

Services provided at initial intake vary. At some locations, an initial screen is conducted (to check need for emergency services); at others, an clinical assessment is started and/or completed, and the client leaves with a first appointment scheduled and/or case management services initiated. At still other locations, clients may also get initial therapy.

Some focus group participants mentioned that the SDA intake is often incomplete because assessors are insufficiently knowledgeable about both substance abuse and mental disorders to fully diagnosis. Others

said that their CSB did not have a good triage system for assessments, and the initial report is often missing information or that clients are misreferred. SDA may not swiftly lead to therapeutic treatment. Many participants reported that their CSB has a goal of scheduling first appointments within a certain time frame, such as 7–10 days; however, for many services, there is a waitlist. For certain programs, there can be a gap of 2–5 weeks between initial intake and initiation of treatment (e.g., MAT or jail inpatient). Some clients are disappointed, because they think same-day *access* means same-day *services.* At many CSBs, participants reported that group therapy may be used to fill this gap, but for some clients, an initial placement in group is not a good fit (e.g., if they are dealing with a personal life crisis). Focus group remarks reflected the following:

- Sometimes SDA can take days to complete intake.
- SDA intake can feel like a conveyor belt.
- Before SDA, people had to wait for an appointment, but when they had an appointment they would be seen when they came in. With SDA, new clients come in but there may not be a counselor available.
- Clients come through SDA and then they "bottleneck (for follow-up services)."

Not all clients come into services through SDA. Some phone in, and others transition from the hospital or jail. Others are court ordered, referred, or submit requests from jail (e.g., for MAT). It can be a "juggling act" to balance the priority and order of all these incoming clients, and CSBs vary in how they handle it. Several participants reported that their CSB reserves and offers appointment slots to those clients that prefer it (e.g., to help accommodate work schedules and children's schedules).

More than 70% of survey respondents (n=228) were satisfied or very satisfied with the intake process.

In short, focus group participants support SDA. However, a shortage of staffing is the biggest barrier to effective implementation. Finding the best approach to SDA is an ongoing process, and each CSB is a laboratory seeking to find the best way to make it work. Focus group remarks reflected the following:

- SDA service provision at a given CSB is evolving and improving over time.
- A CSB may try several different processes to make SDA work.

Documentation

The general consensus among focus group participants is that documentation requirements have increased substantially under STEP-VA and seriously impedes the actual work providers were hired to do. Many focus group participants emphasized that they chose the BH field to work with clients, so the growing amount of (often redundant) documentation is a deep source of frustration. Some participants estimated the client contact/paperwork is 50/50 or even 40/60. One person said that, in emergency services, up to 90% of the time is devoted to paperwork. Several participants reported working extra, uncompensated hours or forgoing some of their annual leave to keep up with the documentation. Focus group remarks reflected the following:

- Clinical staff are tasked with significant clerical work. The terms "redundant," "redundancy," "repetitive," or "duplication of effort" came up scores of times in relation to documentation. Many noted that SDA intake takes so long because the intake forms and screening tools are so repetitive.

- Several participants reported that interpretive summaries are required in multiple documents. The DLA-20 and American Society of Addiction Medicine patient placement criteria in particular were cited as documentation that adds more redundancy than value.

According to several participants, a case manager's (required) assessment is 100% redundant with the clinician's assessment from intake. Required quarterly assessments of treatment plans were noted by others as more redundant than valuable. Focus group remarks reflected the following:

- It can feel like clients are being "assessed to death."
- With all the paperwork, patients wander off topic.
- The same documentation is repeated every 6 months.
- New documentation has been added, with none being taken away.
- Decision makers need to let therapists "do therapy" instead of filling out redundant forms.

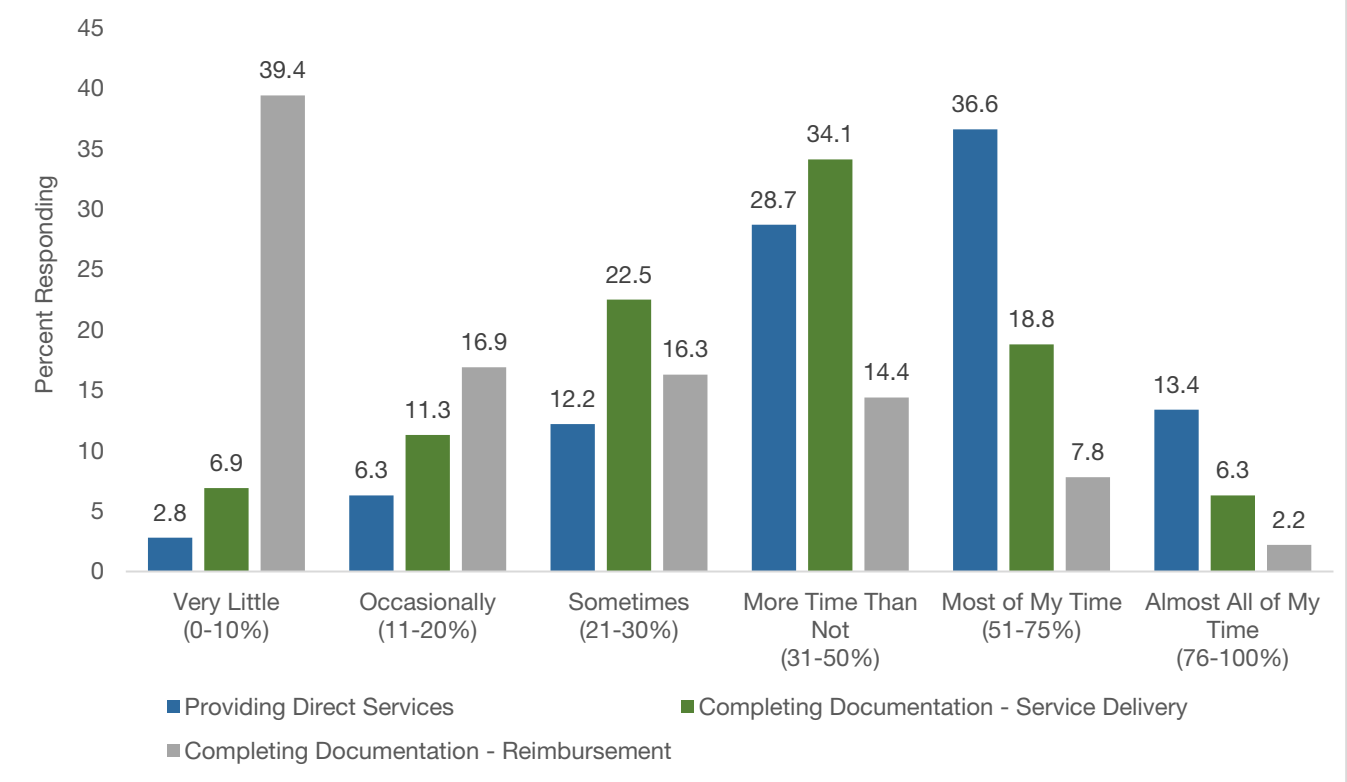
Specific documentation demands add to staff stress. For example, it was noted that emergency services must be billed for within 24 hours; this creates stress on the crisis workers, who must complete the billing because the billing department at the agency is small. Others reported that, when providing group therapy, documentation into each client's record is required. Multiple participants noted that documentation time negatively impacts their productivity hours, which then negatively affects them at their annual review. Focus group remarks reflected the following:

- CSBs have lost therapists because of the paperwork demands.
- Caseworkers have left because of the paperwork demands.

Focus group participants noted that clients suffer under the documentation demands and find it overwhelming, depersonalizing, and oppressive. Some mentioned clients dropping out in the face of the onerous documentation process. As an example of the frustrations, one person noted that clients must have all of their information with them before they can get services, but if they are coming from the hospital, the intake summary from that stay may not be available for weeks. Other participants noted that clients may not have their proof of residence or insurance or income information with them when they come into SDA, leading to long delays. Focus group remarks reflected the following:

- The abundant requirements for measurable information are imposing negative consequences on clients.
- The amount of required documentation is burdensome and adds no value.
- The paperwork is for the CSB and the state and not for the patient; some patients don't come back because they are not getting what they need.
- It's hard to imagine sitting for 3 hours for an intake when healthy, much less when affected by SMI.
- It's hard to imagine enduring such a long intake as a child.

As indicated in the graph on the next page, great variability was reported in time spent providing direct services, completing documentation for service delivery (e.g., authorizations), and completing documentation for reimbursement.



Note: Percentages may not add to 100% because of missing data.

Collaborative Documentation

Opinions significantly differed on collaborative (also called concurrent) documentation. Some focus group participants reported receiving training on it. Some have adjusted to it and like it. Several participants said it allows an opportunity to offer feedback and reflect on what was just accomplished together. Others noted that it is effective with some, though not all, clients; new clients or clients with severe issues can balk at the process. Focus group remarks reflected the following:

- Collaborative documentation is a learning process for both the provider and the client.
- During collaborative documentation, the patient is thinking, "I'm in crisis. You're really sitting there typing this down right now?"
- Some clients at baseline can be paranoid, and it is not appropriate to type their statements during the interaction with them. However, with clients who are doing well, collaborative documentation can make notes shorter, more precise, and person centered.

Others had negative and even emotional responses to collaborative documentation. Focus group remarks reflected the following:

- When talking with Spanish-speaking clients, it is culturally inappropriate to at the same time be typing into the computer in English.
- Collaborative documentation is not workable and can destroy connections with patients.
- Some providers feel that collaborative documentation is disrespectful.
- Some providers viscerally hate collaborative documentation.

MCOs

Recent changes have occurred within the past 2 years with the addition of Medicaid expansion and the related need for CSBs to work with MCOs. Many focus group participants appreciated Medicaid expansion for allowing a larger population to access services; however, across the board, participants complained about MCOs due to the additional burden of work they have incurred.

Each of the six MCOs has different documentation requirements and processes (e.g., different forms, different submission requirements), and participants said it is challenging to keep track of the differences. Although CSBs were originally informed that clients could not easily change MCOs, that has not been the case. When individual clients do switch (or are switched), it adds to the confusion. As MCOs differ in the providers they contract with (e.g., for dental care), patients within a CSB may have different access to services and different distances they must travel for those services. To compound the complexity, Medicaid requirements may differ from state requirements.

Each MCO requires the exact same credentialing information from each individual service provider, but it must be inputted for review separately into all six MCO systems, creating yet another administrative burden.

To many of the focus group participants, the amount of information MCOs require has been rising inversely to a marked decline and delay in authorizations. They note that expensive services, such as integrated care treatment IDDT/PACT, are more frequently denied, even though they are justified and save money in the long term (e.g., by preventing rehospitalization). Some services are approved for ludicrously short periods; an example was approval of children's **day treatment** for just **1** hour once a month. Another example was reauthorization required every 4 days for patients in PSR. Several participants talked about receiving one-fourth of the units of service requested, and that the client must discontinue treatment while reauthorization is being considered. Others complained of cuts to pharmacy benefits. Clinicians also stated that barriers by MCOs essentially nullifies intended benefits of Medicaid expansion. Focus group remarks reflected the following:

- A provider can spend more time justifying service than providing it.
- It is detrimental to clients when MCOs stop services in the middle of treatment.
- MCO staff communication is highly problematic.
- At the CSBs, the focus has turned away from the clients and toward documentation and Medicaid billing.
- Medicaid expansion occurs, and then all the promised benefits of expansion are pulled back.

Focus group participants reported unjust denials across program areas—TDT, PSR, MH skill building, and PACT. One person said her clients now must choose between PSR and skills building, whereas previously they could be supported by both. Others said approvals of authorization requests had declined significantly (e.g., from 90%–40%) in the past year (60% of requests are denied). Participants noted that clients who obtain stability are then denied continued services, leading to relapse. Still others described unfair prerequisites to service; for example, a person living in a car is not considered homeless and thus is ineligible for certain services, such as housing assistance. Focus group remarks reflected the following:

- Service authorizations do not seem to follow any particular logic. One goes smoothly, whereas the next gets delayed or denied.
- The authorization process is different for every MCO and different for every reviewer.

Focus group participants said that patients are anxious around billing issues and distracted by them. Several focus group participants attributed the problem to a lack of MCO understanding of what it means to work with a person with severe chronic illness. Focus group remarks reflected the following:

- Someone who has severe schizoaffective disorder is not going to function the same way as someone who may have a milder case and is very compliant with medication, and is able to work. There's a large disparity in functioning between the two cases, but the MCO only sees the diagnoses and equates the two.
- A CSB has had to tell people in desperate need of services that they can no longer continue because the insurance is company telling them, "You no longer meet the medical criteria."
- Many clients are not going to improve, but they need services so that they don't decompensate.
- MCOs don't understand that if someone has achieved a certain level of stability, it's typically because of the services in place.
- MCOs seem to think that if a client hasn't been hospitalized in a year, that client is cured.

Transportation

Focus group participants said that lack of adequate transportation for clients is a massive challenge that consumes providers' time and frustrates everyone. Inadequate transportation is especially a problem for CSBs that serve geographically large catchment areas or that serve locations where public transportation is minimal.

Clients who do not drive or do not have a current driver's license may have to depend on family or friends for a ride, or may have to walk, although in many cases services are not a walkable distance away. Some clients cannot afford the gasoline to drive to services, especially when those services are distant from their homes. The available transportation methods, such as public buses, may not run early or late enough in the day to accommodate certain client appointments.

Many focus group participants reported that the Medicaid cab service is cumbersome to use because rides must be reserved a day or more in advance. The service is also unreliable, with frequent no-shows and clients frequently stranded waiting for a pick-up. The cab's rigid scheduling means that clients may have to arrive at their appointment hours early, wait hours for their return ride, or depart from services hours earlier than expected. Some MCOs have contracted with transportation providers that might be as much as 50 miles away from the CSB site, which can contribute to the failure to make timely pickups. In some cases, the vehicle makes multiple pick-ups, which adds significant time to the ride for any one person. Medicaid transport also may not run after daytime business hours, so clients cannot make it to evening programs.

Medicaid transport is also not uniformly provided across services; that is, an MCO may cover transport for some services (e.g., crisis, doctor's appointments, recovery meetings) but not others (e.g., group counseling). Having to make transportation arrangements with six different MCOs makes things more difficult because each has its own systems and requirements. Focus group remarks reflected the following:

- People going through legal processes aren't supposed to drive, so they have to make choices such as, "Do I go to the group, or do I risk getting arrested?"
- Some clients refuse to utilize Medicaid transportation and will just say "no" to it.

Direct service providers often go to extraordinary lengths to make transportation available. This adds to the workload of clinicians and care managers, as they devote time to teaching clients how to navigate public transportation or help clients arrange Medicaid cab services. In some CSBs, case managers and peer specialists serve as drivers.

One person reported that the team's psychiatrist makes home visits with a case manager or clinician to prescribe medications for clients who lack transportation. Some CSBs have their own vehicles for transportation for certain programs, such as the clubhouse, or as a backup in case the Medicaid cab does not come. However, those CSBs with vehicles often reported there were not enough vehicles to cover clients' transportation needs. One person reported that Project LINK (for pregnant and parenting women) provides gas vouchers, and a MAT program provides funding for transportation to clients who have met milestones and are compliant. Others said that the agency used to have drivers for group sessions, but reimbursement for that was replaced under Medicaid expansion with Medicaid transport, which is much less convenient for reasons just described. Thus, group therapy attendance has declined. Focus group remarks reflected the following:

- Transportation is a major variable impacting care.
- Providers at one CSB try to arrange appointments around the bus schedule.
- Using case managers as transportation providers is a huge waste of resources.

IT

A minority of focus group participants described EHR systems that worked well, but a larger number described outdated and inefficient workflow processes and IT systems that were troublesome to use or that alienated clients (e.g., clients uncomfortable with electronic signatures). Some CSBs use multiple information-gathering tools that are not compatible; thus, information cannot be shared across them and must be re-inputted. Some CSBs use a mix of paper and electronic recordkeeping systems. Some participants felt their IT department worked well with staff to make effective templates that matched workflow; others did not have the same positive relationship with IT. Several participants mentioned that they need better training to use IT systems efficiently. Related issues for some CSBs are difficulty getting Wi-Fi in rural areas and difficulty accessing the EHR system when out in the field. Focus group remarks reflected the following:

- Staff members at one CSB exchange information using technology from the 1970s, when faxes were invented.
- What clinicians describe as system requirements, and how IT interprets those requirements, may be quite different.
- There may be features of a CSB's IT system that that would make operations more efficient, but staff haven't necessarily been trained on them.

A few CSBs use a very old EHR, which was generally characterized as primitive and problematic. Focus group participants whose CSBs use newer EHR software system generally found it user friendly, and considered it an improvement over earlier systems. Participants reported doing workarounds (e.g., completing

Nearly 80% of survey respondents (n=251) reported they were satisfied or very satisfied with their experience using EHRs; however, a discrepancy exists between this high percentage and the passionate conversations about the problems with direct service staff and IT. It could be that providers appreciate the promise, but not the full reality, of EHRs.

notes in Word before copying them into the EHR) and mistrusting HER generated reports because of the system's unreliability. Some reported that the EHR system is underused because staff do not know how to extract helpful data or reports; several mentioned that they needed more training.

4.6.2 Summary of Focus Groups Discussions With Clients

A focus group with consumers of BHS was conducted at each of the 40 CSBs. A total of 291 consumers participated in the focus groups, which ranged in size from 3–13 and lasted up to 1 hour. For the most part, focus group participants included clients enrolled in both MH and services for SUDs; in addition, parents of children enrolled in services also participated in some focus groups. Focus group participants were asked to complete a survey before the discussion; 276 surveys were completed. Participants describe their experiences with a variety of services including the clubhouse, therapy to address mental illness or addiction, peer support, support groups, medication, coping skills classes, crisis services, hospitalization, transitional employment, drug court, and case management.

The majority or most of the 276 clients who completed the survey identified as:

- Female–52.1% (n=146).
- White–68.1% (n=188).
- Non-Hispanic–93.1% (n=257).
- Being between 45 and 64 years of age–48.5% (n=134).
- Having a high school diploma or general educational development certificate–54.0% (n=149).
- Receiving multiple services (80.8%), including
  - MH treatment–77.2% (n=213).
  - Case management–60.0% (n=160).
  - Substance use treatment–42.6% (n=118).
  - Recovery support services–40.2% (n=111).
  - OP services–37.3% (n=103).

Table 4.28. Description of Consumer Focus Group Participants (N=276)

Participant Characteristics	Summary Descriptive Information
Gender[a,d]	Males: 126 (45.7%) Females: 146 (52.1%) Other gender: 3 (0.4%)
Age[a]	18-24 years: 9 (3.3%) 25-34 years: 57 (20.7%) 35-44 years: 60 (21.7%) 45-54 years: 68 (24.6%) 55-64 years: 66 (23.9%) 65 years and over: 15 (5.4%)
Ethnicity[a]	Hispanic: 19 (6.9%) Not Hispanic: 230 (83.3%)
Race[b]	Alaska Native: 8 (2.9%) American Indian: 8 (2.9%) Asian: 8 (2.9%) Black or African American: 83 (30.1%) Native Hawaiian or Other Pacific Islander: 0 (0.0%) Other Race ('Arab & Black Mixed', 'Creole'): 5 (1.8%) White: 188 (68.1%)

Participant Characteristics	Summary Descriptive Information
Education[a]	Some high school: 51 (18.5%) High school diploma/General Educational Development test: 149 (54.0%) Associate degree: 30 (10.9%) Some college: 8 (2.9%) Bachelor's degree: 24 (8.7%) Master's degree: 4 (1.4%) Doctorate: 0 (0.0%) Professional degree (e.g., RN, MD, PharmD): 1 (0.4%) Other education (e.g., vocational training): 6 (2.2%)
Services Received at CSB[c]	Substance use treatment: 118 (42.6%) MH treatment: 213 (77.2%) Crisis/emergency services: 89 (32.2%) Inpatient/residential services: 47 (17.0%) IOP services: 67 (24.3%) OP services: 103 (37.3%) Recovery support services: 111 (40.2%) Case management: 160 (60.0%) Other services (e.g., housing services, drug court): 55 (19.9%)

[a] Percentages do not add to 100% because of missing data.

[b] Percentage might add to more than 100% because consumers could identify with more than one race.

[c] Percentage might add to more than 100% because consumers could receive more than one service.

[d] No additional information regarding the other gender category was provided by respondents.

The following summary is based on notes taken at each session. Bulleted statements are based on remarks as recorded by notetakers. Quantitative (survey) results are presented in the boxes. See the Methods section for more information on the focus group process.

As can be expected, focus group participants have had unique life journeys, each with a turning point that brought them into the CSB: Self-realization of needing help, recommendation of a family member or friend, court order into treatment, arrest for driving under the influence, death of a loved one, hospitalization, or other. Lengths of connection with the CSB system (either in one or multiple regions) varied significantly. Some had received services for less than a year whereas others reported service lengths in the range of 5–25 years. One person reported a 38-year connection.

Overall Satisfaction

Many focus group participants expressed gratitude for the therapeutic help they have received. One person reported being hospitalized 29 times but none since being connected to the CSB's MH services. Phrases like "I would be dead" or "It saved my life" were uttered more than a score of times by focus group participants. The words "supportive," "blessing," and "grateful" also were spoken numerous times each to characterize specific programs or staff. Focus group remarks reflected the following:

- The CSB didn't give up on a client.
- The CSB was there for a client through several relapses.
- A client's life is "amazing" compared with the time before services were accessed.
- A client has achieved 122 days of abstinence and is bursting with happiness about that.
- The CSB is there for people with both MH and SUDs so that they don't have to go to jails or institutions.

Underscoring the courage it takes to seek treatment, the words "anxiety," "nervous," or "nerve-wracking" were used many times by focus group participants describing their first experiences with the CSB. Yet many participants described a warm welcome and expressed appreciation for being treated nonjudgmentally and respectfully by CSB staff. Focus group remarks reflected the following:

Nearly 90% of survey respondents (n=245) reported they were satisfied or very satisfied with the quality of care they received at the CSB. There were no differences between survey respondents who receive services at CSBs located in primarily rural and urban settings in their satisfaction ratings.

- The CSB has been very welcoming, starting with the first visit.
- The CSB indicated to a client that needed services would be provided, which was a great relief.
- The CSB treated the client like a human being, not like a freak.
- The CSB was respectful of a client with a Mennonite background.
- At the CSB, a client felt like "someone gives a damn."
- The CSB has gone "above and beyond" for a client.
- The CSB staff wouldn't allow a client to give up.

Outcomes From Services

Many focus group participants described dramatic, positive changes to their lives as a result of the MH or SUD treatment they received. Among the changes mentioned were reduced hospitalizations, improved physical health, new employment, permanent housing, improved financial stability, and strengthened family relations. Many mentioned greater mental clarity and an improved outlook on life. Others mentioned help with goal setting or learning a life skill, such as learning to: Take ownership of one's own recovery, control anger, respect boundaries, problem solve, cope, be responsible with medication, or become more independent. Several reported that they could barely talk prior to receiving services; others spoke of learning how to address their isolation and anxiety and their fears of socializing. Several participants noted that the CSB services provided them with more structure to their lives. Focus group remarks reflected the following:

- A client now feels respected by family members, who appreciate what the client is doing to become healthy.
- A client's memory has improved, and life has become less chaotic.
- A client lost everything but now has an apartment, a job, sobriety, stability, and happiness.
- The CSB program provided a client with structure, stability, and accountability.
- A client who formerly was a frequent hospital patient is now on a medication regimen and has not been rehospitalized.
- A client realizes that if one "does the work," a good future is possible.
- A client gains insight from every group session and feels a strong need for it.

Focus group participants reported receiving ancillary services that helped them focus on recovery, such as housing assistance; emergency assistance with overdue utility bills or groceries; help obtaining identification, such as a Social Security card or birth certificate; or meals (e.g., at the clubhouse). Several participants reported that they were helped by the education they received about their own illness. Also mentioned was help with medical needs, such as medication management, dental needs,

and getting hearing aids or eyeglasses. Several also reported acquiring a new skill such as knitting and swimming. Many participants reported that they had trained or been certified in peer recovery support, and several expressed the goal of becoming peer support specialists. Focus group remarks reflected the following:

- Having one's illness explained through group sessions and other encounters can make it easier to manage the condition.
- Because of naloxone opioid overdose rescue training received from the CSB, a client was able to save a person's life.

Socialization opportunities, especially those provided through clubhouses (which offer PSR and skill building), were a significant source of satisfaction to the participants in the focus groups. Many reported that the clubhouse supported their recovery and also provided them with meaningful activities, including jobs at the clubhouse, such as serving meals or answering the telephone. Focus group remarks reflected the following:

- The clubhouse allows clients to be around positive friends who support abstinence.
- With the clubhouse, a client is not as lonely compared with staying at home.
- Without the clubhouse, a client might have nothing else to do but stay at home and watch television.
- One client's job is to cook for the 80 other clubhouse participants. This responsibility has helped the client get healthier.

Between 90%–95% (n=257) of survey respondents agreed or strongly agreed that, because of the services and care received at their CSB, they are better able to manage their concerns and that their overall quality of life has improved. Survey respondents from CSBs located in primarily rural areas reported somewhat higher levels of agreement regarding their ability to better manage their concerns than those from urban CSBs, but the difference was not significant.

Accessing Services

Experiences accessing services were diverse. Some focus group participants reported quick intake, while others described drawn-out processes. As mentioned above, many of the participants in the focus groups have been connected with their CSBs for several years; it was not always clear from discussions which intake experiences occurred after or before SDA was implemented. In any event, certain paths into service were characterized as faster than others (e.g., after hospital stay, through the criminal justice system, when in crisis, while an inpatient). Some reported that they had to call repeatedly, or "work the system," to get a particular service. Several participants mentioned that insurance type affects access. Several reported being helped by Medicaid expansion. Focus group remarks reflected the following:

- A client was waitlisted for MAT but was immediately moved into that program once staff learned she was pregnant.
- A client did not receive individual therapy until 4 years after enrolling with the CSB.

Variance in experiences was reported both across and within CSBs. Some focus group participants reported ease in navigating the system, whereas others expressed frustration with obvious gaps in care and challenges with accessing the right care at the right time. The words "smooth" or "simple" were used many times by participants to describe access into services, but the words "wait" or "waitlist" in relation to initial access or access to specific services (e.g., case management, psychiatry) were said some hundred times. For example, many participants mentioned that it was not hard to get into group

therapy, but individual therapy or psychiatric services were harder to obtain. Focus group remarks reflected the following:

- Once assigned to a case manager, a client had a smooth experience obtaining services.
- A client who came into a CSB through SDA was caught driving while intoxicated while on the waitlist for services.
- A client was able to meet with a counselor quickly after SDA but then faced a 2-month wait to see a doctor.

Many CBSs have multiple locations. Not all services are offered at all locations of a given CSB, and the quality of services may vary by location. Some focus group participants described commuting to a main location, even though the satellite was closer to home, to receive specific needed services. One person reported being sent to detox in two different places: One was 8 hours away, and the other was not as far, but she was "treated like a prisoner." A parent said that the CSB does a good job with services for people who come in for voluntarily commitment but a poor job providing services to people who have been involuntary committed (and are more difficult to work with).

Other participants reported needing to visit the CSB for several different tasks (e.g., urine testing, to pick up prescriptions, for group sessions), which can be a time challenge when appointments are not combined into one visit. Others mentioned the logistical challenge (e.g., arranging transportation, adjusting work schedules and childcare) presented when receiving one or more services offered at different locations.

Assessment of Staff

CSB staff were generally described in positive terms. Several focus group participants described receiving support from a whole team, including the therapist, case manager, clinical supervisor, and others. Several participants specifically mentioned the front desk staff as being welcoming (in an exception, at one CSB, the front desk staff were described as needing more training). Many described close relationships with certain staff members, which helped them commit to their recovery. Several described collaborative processes for determining treatment plans. Focus group remarks reflected the following:

- A client considers the CSB team as family.
- In a 25-year association with one CSB, a client has dealt with some 40–50 staff, of whom only one was described as uncaring and unprofessional.
- A client is motivated by the desire not to let staff down.
- A client had full input into setting treatment goals.

That said, some complaints about staff emerged in client focus group discussions. One person reported that, on two occasions, the operators of the help line were not empathetic. One person said she was put off by false empathy from staff who do not have lived experience with BH disorders. Focus group remarks reflected the following:

- A client wishes staff had listened more carefully at the beginning.
- When staff say, "I understand," a client wonders if they really do.
- A client can tell through body language and tone whether staff is being respectful, and sometimes they aren't.

Case managers were generally well respected. The phrase "they go above and beyond" (e.g., sharing cell phone numbers, working long hours, taking clients grocery shopping) came up many times in relation to staff serving in this position. Focus group remarks reflected the following:

- The case manager is a friend.
- The case manager was invested in the client's well-being.
- A client who has no outside support because loved ones are dead feels supported by the case manager.

Not all experiences with case management were positive. Although many focus group participants appreciated the help that they received with goal setting, a few mentioned that their case managers tried to impose goals, such as smoking cessation. A few participants complained that case managers were not telling clients about available services (e.g., the housing program). Many reported frequent staff reassignments; case manager "burnout" was noted several times. One client said information shared with the therapist was reshared with the case manager, which she felt was a violation of privacy.

Descriptions varied regarding the ease of accessing case managers. Some said they could drop in or call anytime; others said they could text. And still others said they had to make appointments. Some reported quick callbacks, while others said they had to wait a day or more. One person said the case managers do not return voice mails.

A couple of participants noted that, if they wanted an additional service, they were required to go through case management even though they felt they did not need that extra intervention. Another person said case management meetings were repetitive and boring. Focus group remarks reflected the following:

- It is upsetting when case managers change frequently.
- Case managers vary in their knowledge of mental illness.
- Some case managers are burned out.
- Some case managers do not set end goals but instead pay attention to quantitative measures, such as number of groups attended.

Some focus group participants described complicated personal situations that likely contributed to their frustration with case management. For example, one client's case worker would not give him permission to be absent from the MAT clinic for 3 days, even though he needed to travel to testify in a legal case of his father's; the case manager reported him to his parole officer for planning to leave the state. Another client was going through MH court and had false positives on her urine checks because of medications she was taking. This caused some jail time and short-term custody problems; she felt her case worker did not advocate properly for her.

One person described a catch-22. Her son is going to be released from jail, and he is not allowed to return home. He'll need help from the CSB to arrange housing, but a case manager cannot help him until he's released from jail and goes through intake. This means he'll be temporarily homeless, which puts him at risk for recidivism.

Peer specialists were appreciated for providing empathetic companionship and assistance throughout their interactions with the CSB. Focus group participants noted that peers were generous with their time; were encouraging, inspirational, and never judgmental; and could understand because they have "been

in their shoes." As noted above, many participants reported that they have become peer support specialists or aspire to work in peer recovery. Focus group remarks reflected the following:

- Having peer support throughout helps immensely.
- Peers are one of the best aspects of the CSB because "they really get it."
- Peers understand and have been through the situation themselves, which makes it easier to talk to them.
- Peers are central to recovery, especially for those times when you just need someone to talk to and listen and who really understands.
- Peers are the friends that one doesn't really have "on the street."

For the most part, medical doctors received positive assessments from the focus group participants, but several times they were described less favorably. One client reported that learning how to be assertive has helped the medical relationship. Many reported a high rate of turnover in the doctor position. A few participants expressed a preference for a doctor over a nurse practitioner. Some participants expressed discomfort with telemedicine appointments, reporting that they are impersonal and that the doctor can miss visual clues (e.g., tapping or tics). Focus group remarks reflected the following:

- One client's doctor is described as thoughtful and reviews all medications with the client.
- One client's doctor is very sensitive and compassionate, not just about medication management but also about anything else that needs to be done.
- One client feels uncomfortable around the doctor, whose face has a sour look.
- One client did not receive an explanation from the doctor about the medication's effects.
- One client's doctor does not listen and gives the client no opportunity to speak.
- Doctors don't explain much because they don't spend a lot of time in an appointment.

Between 90%-95% of survey respondents (n=255) agreed or strongly agreed that their providers are knowledgeable about the care they need.

Nearly 80% of survey respondents (n=215) agreed or strongly agreed that their providers help them to obtain other health services needed, such as medical and dental services.

Nearly 95% of survey respondents (n=259) agreed or strongly agreed that they feel comfortable talking with their providers.

More than 90% of survey respondents (n=251) agreed or strongly agreed that they have enough time to talk with their providers.

Documentation

There was some discomfort expressed by focus group participants about the level of documentation required by CSBs. Participants indicated that the volume and repetitiveness of intake paperwork could be frustrating. Focus group remarks reflected the following:

- A client had to complete a 230-question questionnaire.
- A great deal of paperwork goes behind everything the staff have to do.

- The extensive documentation can compel clients into walking away from treatment.
- When a person is in crisis, the CSB staff should not be focused on the paperwork.

Several participants reported that, although they were already in the system, they had to go through a lengthy documentation process to requalify for services. In contrast, another client's impression of reentry was shaped by the welcome more than the paperwork. Focus group remarks reflected the following:

- The lengthy documentation process causes frustration when one is trying to resume services.
- One CSB has an open-door policy for people who want to return after dropping out of services. There's a sense of, "You are always welcome no matter what happens, even if you mess up."

Payment for Services

Reflecting the variety of reimbursement methods, the focus group participants had different experiences with the financial aspects of CSB services. For example, different experiences were reported even within the same CSB. At one CSB, it was noted that, when consumers were unable to pay, they were issued "red tickets," indicating they were ineligible for further services until their outstanding balance was paid. Several participants mentioned billing problems or concerns about prescription costs. Focus group remarks reflected the following:

- A client's health insurance doesn't pay for prescriptions, and the client had to get another insurance for that; however, the client was in a better situation than people who have no insurance or disability coverage.

Transportation

Some focus group participants mentioned living within walking distance of the CSB or being able to take public transportation to get to services. Other participants used a van service provided by the CSB or use case managers, but they noted that the same transportation is not available for all services. Many participants described the challenges relying on family and friends for rides or on Medicaid-provided transportation. One participant said the CSB is now working with Lyft and Uber to provide transportation, and that is working better. Focus group remarks reflected the following:

- A client was surprised to learn after arriving at the CSB for assessment that the process would take more than 2 hours; this led to an awkward conversation with the person who was providing the ride.
- When a transit van picks up several people, the person who gets on first may not reach the CSB for 3–4 hours. That person is also dropped off last, making the return home equally long.
- A client who lives a 20-minute drive from the CSB must catch the bus at 8 a.m. to get to the CSB for an 11:30 a.m. program.

Management of the CSB

Focus group participants demonstrated insight into management aspects, such as staffing, funding, and internal communications. For example, some participants critiqued the CSB's failure to have specific staff assigned for SDA intake; it was explained that, when regular staff must rotate into SDA, they have less time for their assigned clients. A great many participants mentioned staff shortages and turnover. Some participants reported they had to wait several weeks to be assigned a counselor because staff kept leaving. Other participants described their frustration with constant turnover of clinicians, which leads to having to start anew with each new clinician. Several participants expressed a wish for more funding to

meet demand, add services, and to increase staff compensation to reduce turnover. Focus group remarks reflected the following:

- A very high number of people within the CSB region need services.
- The staff hiring process needs to be faster.
- A client quit services for a period because turnover required retelling one's history to each replacement, and this became too annoying.

Several focus group participants expressed concern that service delays caused by staff and funding shortages put clients at risk. Several participants reported knowing people who have died after being told there was a several-month waiting list. Focus group remarks reflected the following:

- People who are waitlisted may not live long enough to reach the top of the list.
- Clients have worried about their own chance of dying before accessing services.
- When clients are told the wait list is three months, they lose interest and don't pursue it anymore; some die.
- When people are waiting, they lose strength and motivation for change.

Focus group participants revealed varying levels of awareness of the range of services offered by their own CSB. In one focus group, one participant was surprised to learn that certain services were available through the clubhouse when another participant mentioned it. In contrast, a client at a different CSB described a kiosk system, which allows clients at intake to see the list of all services offered.

Several focus group participants reported recent reductions in service such as tighter limits on the number of therapy sessions or the reduction in duration of a program. Other participants also reported that their CSB had discontinued previously provided services, such as individual therapy, skills building, social support activities (e.g., field trips to a bowling alley or pool), and training to become a peer recovery specialist. Another participant reported that the clubhouse vans had been replaced by less convenient insurance/Medicaid transportation. Others reported being personally cut off from services they had been receiving. Focus group remarks reflected the following:

- When a client is told they only have a limited number of sessions, they constantly think about that and may try to space appointments so as not to run out in the event there is a crisis.
- Even a person who has been sober for years may still need support.

Some focus group participants expressed concerns about scheduling. Several participants were unhappy with the fact that appointments could not be consistently scheduled (e.g., weekly). One person mentioned a new two-part scheduling system where clients are assigned a day to call to be scheduled into a window of time (e.g., 8:45 a.m.–10:20 a.m.) for a 15-minute appointment on another date; because of the window, a person can wait a significant amount of time after they arrive. Several participants mentioned that it is hard to get to therapy or group because those activities are scheduled during work hours. Focus group remarks reflected the following:

- It becomes tough with family and other responsibilities when clients do not have a routine and standing appointment.
- The two-part scheduling system of "making an appointment to make an appointment" can feel like a setup for failure.

Community Awareness

Participants in the focus groups explained that although the need for treatment of BH disorders and for case management services (e.g., housing or food assistance) is similar across the state, attitudes differ. In some places, people are afraid to reach out for services because of stigma. One group complained that their CSB is "behind the times" and itself is only beginning to accept that addiction is a disease and not a moral condition. Focus group remarks reflected the following:

- Clients may try to hide the fact that they are accessing services; if hiding it is not possible, they don't access the services.
- It's important to educate the community outside the CSB about substance abuse.
- In one community, the faith community is not involved and instead shuns the people receiving services.

Several focus group participants expressed concern for others out in the community who do not know the CSBs exist, the services they offer, or how to access them. They wanted to see their CSBs conduct more outreach to reach more hard-to-reach populations. There was also a request for better triage so that clients in desperate need are served first. Focus group remarks reflected the following:

- The system needs the same type of outreach and education that occurred around prevention of human immunodeficiency virus.
- There are probably a lot of people with special needs, such as autism, who don't know how to access services.
- The CSBs could do a better job getting the word out, specifically for services for SUDs.
- There would be more clients if more people knew about the CSBs.

Client Suggestions

Many focus group participants mentioned that the CSB overall needed more funding to enhance its services and that transportation options need to improve. One person mentioned that safety at the CSB was an issue, and that separate waiting areas for different kinds of clients might be helpful. Specific suggestions for how services could be improved included adding, expanding, or reinstating services on the list below. Note: CSBs vary in their current array of services; thus, suggestions cannot be generally applied to all CSBs.

- Therapeutic services (e.g., EMDR, services for co-occurring disorders, parenting groups, family and couples therapy, music therapy, individual [not just group] trauma therapy, group for clients with depression due to chronic health issues, exercise, tools for staying healthy after treatment, smoking cessation, aromatherapy, acupuncture, meditation)
- Skill-building services, and not just for clients in PSR (e.g., money management, computer skills, resume building, conversation skills, building healthy relationships, becoming a peer recovery specialist, understanding your family member's mental illness)
- Walk-in crisis inpatient center (in lieu of hospitalization)
- Social activities (e.g., arts and crafts) and outings
- Making the clubhouse available to everyone, not just clients with mental disorders
- Employment opportunities (e.g., in the clubhouse)
- Job coaching and connections to job opportunities
- Permanent supportive housing

- Evening services
- Services for clients who are deaf
- Smoking areas and financial help with cigarettes
- Ways to ease anxiety before intakes (e.g., providing a stuffed animal to hold)
- Education of corrections staff about mental illness
- Childcare

Among services participants mentioned as wishing they could add were: Groups for parents of children with SMI/SED, crisis stabilization for children and for adults with intellectual/developmental disabilities, transitional programs that keep clients out of hospital and jail, in-house programs (e.g., MAT, psychological evaluation), and housing (transitional and permanent).

Recommendations

Direct service providers and clients are directly impacted by the changes being implemented to the Commonwealth's BHS, and they have considerable insight and wisdom to contribute that could help ensure that reforms are workable and effective. Therefore, DBHDS is strongly encouraged to include representation from these two stakeholder groups in planning and implementation processes.

CSB clients recommend that DBHDS do the following:

- Address the significant workforce challenges shared by most, if not all, CSBs, including the challenges of understaffing, overwork and burnout, turnover, inadequate opportunities for professional development and clinical supervision, inadequate compensation, and salary discrepancies.
- Address the challenges introduced by the multiple MCOs, including redundant and excessive information demands, problems with authorizations and reauthorizations, the vastly increased billing burden, and the lack of understanding on the MCO side of the population served by the CSBs.
- Enhance communications from the state to the CSBs and within each CSB. Likewise, encourage communications across CSBs, including information sharing and cross-training, with each CSB teaching the others from its areas of strength.
- Work with other state systems to address problems that adversely affect client access to services and recovery, specifically the needs for better transportation; more housing, including supportive housing; more employment opportunities; and reduced community stigma related to mental and substance use disorders.

5. FINDINGS AND RECOMMENDATIONS

WHAT ARE THE KEY CHARACTERISTICS OF VIRGINIA'S PUBLICLY FUNDED BH SYSTEM?

Finding: The annual cultural competence training provided at CSBs does not allow any kind of uniformity of approach or knowledge, and it is not intended to cover subpopulations that are particularly relevant for each community.

Recommendation: Promulgating an evidence-based cultural competency training for all CSBs to use will address this. Providing annual demographic data by community will also help CSBs understand where more in-depth knowledge is needed.

Finding: One barrier to effectively providing services to diverse populations is the limited outreach to those groups, aimed at reducing barriers to service engagement.

Recommendation: The prevention model used by many CSBs is a good example of inclusive community engagement. Using prevention coalitions to reach underserved populations can increase participation in treatment.

Finding: Because services at CSBs are stretched so thin, CSBs focus on providing services to those who might more easily access treatment. This may not include underserved and unique populations.

Recommendation: Statewide standards on translation, interpretation, and culturally sensitive engagement practices as part of SDA can help to decrease stigma around starting services at CSBs.

Finding: CSBs typically made efforts to match clients to service providers based on common background and/or experience.

Recommendation: State-funded cultural brokers operating in each of the CSBs would make this easier and would allow for much more effective outreach and engagement to underserved populations. This would be akin to what is done in recovery services, using peers to match to client need from the first contact on.

Finding: CSBs reported wide variety in their ability to access, and likelihood to use, translation and interpretation services. They are responsible for arranging these services on their own; thus, the perceived lack of need by staff affects this access.

Recommendation: DBHDS should consider funding a translation/interpretation services that is available to all CSBs, with clear guidance on how and when to access it.

What is the Need for BHS in Virginia?

Finding: Most clients who receive substance use and MH services from CSBs are in rural areas, are adults, and identify as White.

- There were significant increases across FYs in the percentage of clients from the following demographic groups:
  - Females,
  - Adolescents (ages 12–17 years),
  - Adults (age 26 years and older), and
  - White/nonminority clients and racial and ethnic minority clients, including clients who identify as Hispanic and clients who identify with two or more races.
- There were significant increases across FYs in the percentage of clients from the following at-risk clinical populations:
  - Pregnant females with SUDs,
  - Justice-involved individuals involuntarily admitted to treatment, including incarcerated persons, and
  - Family members dependent on someone in the military.

Recommendation: Given the increasing percentage of Hispanic clients, clients dependent on a family member in the military, and clients from rural areas seeking BHS, CSBs may want to use strategies (e.g., translators, Spanish-language direct service providers, transportation, telehealth) and build partnerships (e.g., military family resource organizations) to facilitate greater access to services for these client populations.

Finding: Across FYs, there were significant decreases in the percentage of clients under age 18 at risk of SED; however, there were significant increases in the percentage of clients under age 18 with SED.

- Most clients with SED were:
  - Ages 12–17 years (adolescents).
  - More likely to be male and White.
  - More likely to reside in rural areas.

Recommendation: CSBs should continue to build on their success in reaching the SED and at-risk for SED client populations, and they should continue to work in collaboration with state hospitals schools and related institutions to access and provide services to this growing client population. Although both administrative and direct service staff noted declines in the provision of TDT and other school-based services, these findings warrant continuing to provide such services in school settings to help school-age children at risk for SED and those having SED.

Finding: There were significant increases in the percentage of clients with SED who identified as Hispanic and identify with two or more races.

Recommendation: Given the increasing percentage of SED client populations, respectively, who identify as Hispanic, identify as member of racial minority groups, and

live in rural areas, CSBs may want to use strategies that facilitate greater access to services for these populations.

Finding: Across FYs, there were significant increases across multiple regions in the percentage of clients over age 18 with SMI.

- Most clients with SMI were:
  - Age 26 and older (adults).
  - More likely to be male and White.
  - More likely to reside in rural areas.

Recommendation: CSBs should continue to build on their success in reaching the SMI client populations, and they should continue to work in collaboration with state hospitals schools and related institutions to access and provide services to this growing client population.

Finding: There were significant increases in the percentage of clients with SMI who identified as Black or African American, identified as Hispanic, or identified with two or more races.

Recommendation: Given the increasing percentage of SMI client populations, respectively, who identify as Hispanic, identify as member of racial minority groups, and live in rural areas, CSBs may want to use strategies that facilitate greater access to services for these populations.

Finding: Despite significant decreases in the percentage of clients having alcohol and cocaine/crack as their primary SUD, alcohol, marijuana/hashish, heroin and other opioids, and cocaine/crack were the primary SUD problems reported across FYs. There were significant increases across FYs in clients having the following primary SUDs:

- Marijuana/hashish,
- Opioid, including heroin and other opioids, and
- Methamphetamine use.

Recommendation: Although increases in federal and state funding and other efforts to target the opioid epidemic in the Commonwealth of Virginia are clearly warranted, funding and other efforts are needed to address increases in methamphetamine use. DBHDS is encouraged to make funding available so that any SUD is treated.

Finding: Alcohol is the most common substance of abuse for adults and is the second most common for adolescents and young adults.

Recommendation: Despite decreases across FYs in the number of clients with alcohol and cocaine/crack SUDs, respectively, the number of clients continuing to report these

substances as their primary SUD indicates that funds and other efforts to target continued use of these substances is warranted.

Finding: Based on the percentage of clients across FYs who had any SUD (46.3%) and were at risk of SED, had SED, or had SMI (60.2%), respectively, CSBs are continuing to see clients who have co-occurring disorders[70].

Recommendation: CSBs should continue to provide services to address clients with serious MH issues and who also misuse substances.

Finding: Overall, the prevalence for SUDs showed a downward trend across adolescents (ages 12–17 years), young adults (18–25 years), and adults age 26 years and older from the 2009–10 to 2016–17 calendar years. In contrast, the prevalence for several MH conditions (e.g., major depressive episode, suicidality, any mental illness) has shown an increase over this same time period. By the age of 18, over half of the population in Virginia has experienced one or more ACEs.

An estimated 987,000 individuals age 18 years and older (15.5%) received MH services in the past year for calendar years 2016–17.

An estimated 494,000 individuals (7.1%) age 12 years and older needed but did not receive treatment for substance use in calendar years 2016–17.

Recommendation: Vigorous outreach efforts may be needed to ensure that (1) children at risk for developing MH concerns and (2) individuals age 12 and older who have an SUD are aware of the substance use and MH services currently provided by CSBs and understand how they can access these needed services. Such outreach efforts might include, but are not limited to, continued support for prevention and treatment providers to expand on current outreach efforts to school systems to reach youth populations in need of BHS.

What is the Capacity of Virginia's System to Provide BHS?

Finding: Inadequate workforce capacity to meet BH demands was one of the largest barriers reported by staff at every CSB. Workforce challenges to providing sufficient BHS included staff turnover, staff recruitment, and staff retention issues.

Recommendation: DBHDS may want to help CSBs address workforce shortages by implementing new strategies to recruit college graduates into the CSB workforce. One strategy to consider would be to have loans reimbursed based on working within the CSB system. DBHDS may want to consider looking at federal model that allows for loan forgiveness over 5 years of service.

[70] Data regarding the number of unduplicated clients who received substance use and/or MH services from CSBs and had co-occurring disorders was only available through FY2015. As such, analyses to examine characteristics of clients with co-occurring disorders could not be conducted on this client population.

Finding: Administrative staff at many CSBs reported significant challenges in providing competitive salaries compared with private providers, hospitals, or even MCOs in their regions.

Recommendation: DBHDS may want to consider conducting a salary study across all CSBs to collect baseline information about salaries for differing levels of staff. CSBs are competing for a limited number of license-eligible/licensed staff.

Finding: CSB administrative staff described several barriers around professional development and training including a lack of funding, staff time, and availability of trainings.

Recommendation: DBHDS should increase direct service provider training opportunities, including in-person and online training, access to training, and the ability of staff to attend available training opportunities. Specifically, CSB staff need access to training around EBPs and should receive training, coaching, and supervising, in support of practice fidelity.

Finding: Direct service providers and administrative staff reported that the amount of documentation required hindered their ability to deliver services.

Recommendation: DMAS and DBHDS should reduce paperwork requirements that are not specifically required to measure and report nationally recognized outcomes that the CSBs can use to monitor and improve quality of services and are not tied to a federal or legislative requirement.

Recommendation: DBHDS is encouraged to work with DMAS in guiding MCOs to increase consistency where possible (e.g., standardized prior authorization requirements, utilization review/continuing care authorization, inter-MCO agreements).

Finding: Frequent system-wide crashes, loss of data, and lack of full interoperability between systems (e.g., intraorganizational, between the CSB and external providers) were major sources of frustration among direct service providers and administrative staff at several CSBs.

Recommendation: Each CSB should adopt an IT solution that can measure and report on agreed upon measures and develop a data strategy that can ensure reporting and outcome/data management is at the forefront of all that they do. This includes the development of staff training to use the collected data. However, it should be noted that CSBs cannot make infrastructure improvements, including new IT systems, unless funding formulas include funding for infrastructure improvements.

Finding: CSBs reported challenges with funding not covering the costs of services being provided.

Recommendation: CSBs, in collaboration with DBHDS, should undertake a dedicated, and perhaps independently facilitated, process to determine true costs for essential services so that rates for services are informed by current facts.

Finding: Respondents reported that there has been a need to increase, and in some cases double, the capacity in the finance department to obtain the same amount of revenue since MCOs have come on board (e.g., due to failure of MCOs to make payments, much longer wait times for payments to come).

Recommendation: CSBs need to invest in sophisticated financial systems/vendors that can process transactions among the multiple payers along with multiple methods of reimbursement with capacity to track receivables and claims status in a timely manner.

Finding: CSB clients and staff reported that transportation was a tremendous barrier to receiving services. In many areas across the Commonwealth, access to reliable transportation or availability of public transportation did not exist.

Recommendation: DBHDS should convene a committee made up of CSB staff from rural and urban sites to formulate a plan for addressing the transportation issues that limit access to services.

Finding: Staff at several CSBs noted that a lack of available community resources to support client needs hindered the provision of some services.

Recommendations: DBHDS should work with other state systems to address external problems that adversely affect client access to services and recovery, specifically the needs for better transportation; more housing, including supportive housing; more employment opportunities; and reduced stigma related to mental and substance use disorders.

Finding: Staff universally agreed that the impetus behind STEP-VA and the goals of the legislation were warranted, but they noted that the amount of time to implement the changes was insufficient. In addition, most viewed it as "an unfunded mandate" that was rolled out too quickly.

Recommendation: DBHDS is strongly encouraged to fund a statewide contractor that operates under the guidance of DBHDS that will develop statewide and CSB-specific plans for systems capacity building. The contractor also should provide robust and ongoing training, technical assistance, coaching, and consultation with the goal of successfully supporting STEP-VA implementation, including the adoption of programs and practices with adequate fidelity and service penetration. The contractor should also provide training, coaching, and fidelity assessments on the required EBPs.

Recommendation: Based on a written and endorsed plan for systems change, DBHDS might consider extending the deadline for all STEP-VA services to begin at CSBs until a date to be determined.

Finding: The most frequently reported barrier by administrative and direct services staff at nearly all CSBs was the inconsistencies encountered working with the six MCOs.

Recommendation: CSBs are encouraged to develop a defined strategy for working with MCOs. Scheduling regular meetings/maintaining regular contact/designating a specific contact person within the CSB to liaison with the MCOs is a best practice that several CSBs have used to increase collaboration with MCOs.

Finding: A significant barrier mentioned by many staff was that Medicaid rates were not adequate to cover the true cost of services, as the rates for some services have remained unchanged for decades (e.g., PSR has had the same reimbursement rate since the 1990s).

Recommendation: DBHDS and DMAS should review current rates compared with the true cost of providing services. With burdensome paperwork, there is less time for CSBs to provide billable services, making sustainability and "Medicaid optimization" even further from reality.

Finding: A salient challenge inhibiting CSBs from providing quality BHS was insufficient funding and funding cuts, a concern mentioned by staff members from several locations. In an environment in which funding availability is limited, some CSBs were forced to cut services, including services like MH skills building.

Recommendation: DBHDS and DMAS should review current rates compared with the true costs of providing services. In addition, priority should be given to services that keep individuals out of the hospital and in the community.

Finding: Prevention Directors and CSB prevention staff focus group participants identified barriers and facilitators that specifically influenced the provision of prevention services at the CSBs, including funding, training, data collection, campaign development, effective collaboration, and utilization of needs assessment data.

Recommendation: More training and education are needed around prevention topics (e.g., opioids), as CSBs may be tasked to go into the community to promote different priorities without the training or education to do so effectively. Various ways in which capacity to provide services can be strengthened include:

- Better school engagement and buy-in on data collection, which could be fostered if the groundwork came from "the top," such as the Department of Education "putting their stamp of approval" on data collection efforts.
- Development of campaigns at the state level that local CSBs could implement. Although developing individual campaigns ensures that efforts are targeted for local needs, it can also lead to a lot of individual-level work that could be streamlined. "I would like to see statewide advertising that we can just go in and select what we want to use for our local community."

- More effective collaboration at the state level among offices, such as health departments, education, and justice: "In order for us to collaborate on the local level, the state needs to start that collaboration."
- Better utilization of local needs assessment data to inform the statewide efforts so that what is developed at the state level is informed by the needs assessments and data that communities have already gathered.

How are funds used to support provision of BHS in Virginia?

Finding: A review of qualitative and quantitative data found that several services/programmatic areas were underfunded.

Recommendation: Additional funds appear to be needed for the following: Inpatient SUD and MH treatment facilities, medical detoxification facilities, mobile medication programs, CIT programs, emergency services, crisis stabilization units, step-down hospitalization, peer recovery services, and housing. DBHDS might initiate a data driven determination of need process to quantify "bed" needs by region.

Finding: A review of the qualitative data collected in key informant interviews indicated there is insufficient funding to cover the cost of care and operations. Components involved in the true cost and care of CSB operations were described by staff including: Administrative (e.g., IT/EHR, managing multiple locations, reporting) and infrastructure needs (e.g., reporting, financial management systems). Restricted funds were listed as a barrier to using funds to their maximum capacity and also required extensive administrative oversight to manage these funds.

Recommendation: CSBs, in collaboration with DBHDS, should undertake a dedicated, and perhaps independently facilitated, process to determine true costs for essential services so that rates for services are informed by current facts.

Finding: Transportation is a challenge in terms of time (for case managers) and expense (e.g., vehicle acquirement, maintenance, fuel) for service delivery, particularly in rural areas. In addition, transportation is difficult for receipt of services (e.g., clients seeking services). Although CSBs in both rural and urban communities stressed the need for transportation options, a demand for operational vehicles was particularly evident in rural areas, where case managers and other CSB staff are often the only source of transportation for many clients.

Recommendation: Additional funds are needed to improve client access to reliable transportation. CSBs, in collaboration with state and private transportation entities, and DBHDS should work together regarding funding and to explore possible partnerships. In addition, CSBs should work to coordinate a ride-/cost-sharing program and expand telehealth where possible to decrease travel time required for clients to access care.

What Has Been the Impact Thus Far of STEP-VA, Medicaid Expansion and Medicaid Managed Care on Provision of BHS?

Finding: All CSBs have taken action to implement programs and services described within STEP-VA. Monitoring and CQI are essential components of the delivery of these systems to support and ensure implementation fidelity and success.

Recommendation: CQI systems require resources that should be factored into overall systems planning.

Finding: STEP-VA is increasing access to BHS. Whereas CSBs have reported serving more persons as a result of SDA, the increased demand frequently exceeds workforce capacity in the system to meet the demand for clinical and case management services.

Recommendation: DBHDS should review STEP-VA funding formulas to address the increased demand for services.

Finding: The degree of service penetration and fidelity must be considered in the implementation of STEP-VA. Current deliver STEP-VA services and EBPs is insufficient at levels of penetration that are responsive to demand (service penetration is directly related to funding adequacy, available workforce, and infrastructure).

Recommendation: DBHDS should review STEP-VA funding formulas to ensure they consider the increased demand for services and the requirements for delivering EBPs with fidelity.

Finding: Strong leadership support is a critical facilitator to STEP-VA implementation. Necessary aspects of leadership support include strategic planning for implementation, encouraging buy-in from CSB staff, shared perspective of the benefit of STEP-VA services for consumers, and mobilizing resources (e.g., funding, staffing) to support implementation.

Recommendation: DBHDS should work in coordination with CSBs to develop a written and endorsed plan for systems change with negotiated action steps and timelines. In addition, the state may want to consider providing a package of models or best practices/key considerations/principles for instituting systems change activities.

Finding: Barriers to STEP-VA implementation include timeliness; lack of clarity and communication; availability of resources (e.g., funding, staffing) to support implementation and sustainability of services; and insufficient support, consultation, and training for implementation to build CSB staff capacity in necessary knowledge and skills.

Recommendation: DBHDS is strongly encouraged to fund a statewide contractor that operates under DBHDS' guidance to develop statewide and CSB-specific plans for systems capacity building. The contractor should provide robust and ongoing training, technical assistance, coaching, and consultation with the goal of successfully supporting STEP-VA implementation and CQI processes, including the adoption of programs and practices with adequate fidelity and service penetration. In addition, DBHDS should complete the requirements, performance measures, and funding strategies for each STEP-VA service before releasing funding.

Finding: CSB training and technical assistance for the adoption of STEP-VA practices and EBPs should be planned and delivered within a framework of evidence-based training and should include ongoing training and consultation for clinical supervisors.

Recommendation: DBHDS is strongly encouraged to fund a statewide contractor that operates under DBHDS' guidance to develop statewide and CSB-specific plans for systems capacity building. The contractor should provide robust and ongoing training, technical assistance, coaching, and consultation with the goal of successfully supporting STEP-VA implementation and CQI processes, including the adoption of programs and practices with adequate fidelity and service penetration.

Finding: With the emergence of Medicaid managed care in Virginia, CSBs have experienced significant barriers that have added challenges and administrative burdens on CSB infrastructure and increased administrative costs for operations and service delivery. These challenges and burdens include:

- Significant increases in the amount of documentation for CSB clinicians, prescribers, and support staff;
- Active recruitment and loss of clinicians to MCOs;
- Current Medicaid rates do not sustain services;
- General inconsistency and burdensome requirements from the MCOs in areas such as payment and authorization requirements, level of care criteria, and network credentialing; and
- Delays in payments and authorizations from MCOs.

Finding: Limited staffing capacity and expansion of services have placed a strain on existing CSB workforces. The recruitment and retention of qualified/licensed clinicians is a significant gap in the workforce necessary to address the expanded need. These gaps affect the capacity to carry out expectations and meet performance standards.

Recommendation: The following recommendations related to MCOs and Medicaid should be considered:

- DBHDS is encouraged to work with DMAS in guiding MCOs to increase consistency where possible (e.g., standardized prior authorization requirements, utilization review/continuing care authorization, inter-MCO agreements).
- DMAS and DBHDS should reduce paperwork requirements that are not specifically required to measure and report nationally recognized outcomes that the CSBs can use to monitor and improve

quality of services and are not tied to a federal or legislative requirement. In addition, paperwork should be based on a common set of data elements that should be reflected in the data collection forms and EHR systems.

- DMAS should have clear and realistic definitions related to service delivery outcomes, and these outcomes should be related to the diagnosis of the person being treated.
- CSBs, DMAS, and DBHDS should agree on one set of nationally recognized or local performance measures that indicate quality and outcomes and can be used for quality improvement and to compare CBSs with CSBs, MCOs with MCOs, and the Commonwealth of Virginia with other states on key measures.

Finding: Prior to the six MCOs' involvement in Virginia Medicaid services, the CSBs had one Medicaid payer—DMAS. Now, with six major payers, resources must be invested in strengthening the capabilities of the CSBs' finance departments and systems to help them rise to that level of complexity. The CSB financial systems must be able to consistently and correctly bill for the same service in multiple ways, monitor billing and accounts receivables regularly, and assertively address claims delays and denials. Otherwise, CSBs are at risk of losing large sums of revenue or having significant accounts receivables that in several cases were described as in the millions of dollars. When systems can perform these more-complex procedures and have an adequate IT infrastructure and "back office" staff, there is little effect on the CSB.

Recommendation: BHDS should facilitate and support CSB investment in sophisticated financial systems/vendors that can process transactions among the multiple payers along with multiple methods of reimbursement, with capacity to track receivables and claims status in a timely manner.

Finding: MCOs do not appear to differentiate the service needs of the principal populations with chronic conditions served by the CSBs from the BH needs of the general population. Although the overarching goals for the CSB patient populations and general populations may be similar (i.e., improved functional status and quality of life), the objectives, clinical services, and strategies are different. Reduced hospitalizations, reduced emergency services, reduced police and court involvement, and stability in community living arrangements are some of the expected objectives for CSB populations. To achieve these objectives, ongoing programs such as PACT teams, PSR, case management, and pharmacotherapies are essential.

Recommendation: As STEP-VA is a signature initiative of the Virginia legislature intended to transform the BH systems of care, alignment of DBHDS and DMAS goals and efforts is critical. DBHDS and DMAS may want to consider a facilitated process between the two agencies for better alignment of goals and opportunities for improved collaboration and cooperation.

Finding: CSBs are required to complete multiple reports to DBHDS or DMAS, including information for the CCS 3 report, the DLA-20 multiple times a year and other reporting to capture health outcomes and performance. Currently, these data are submitted to the requesting agency but with little feedback or useable data returned to CSBs. If these data were aggregated and analyzed by the agency or agencies to which they are submitted and then made available to the CSBs that submitted them, it could inform and improve CSBs internal quality and clinical reviews. Many CSBs were unable to clearly verbalize what

outcomes they are measuring (if any) or how the results are incorporated into quality improvement activities.

Recommendation: DBHDS should facilitate and support the adoption of an IT solution for CSBs and DBHDS that can measure and report on agreed-upon measures and develop a data strategy that can ensure reporting and outcome/data management is a high priority. This should include specific data points for CSBs to collect to address determined health issues and allow CSBs to obtain data about the health problems and disparities that need to be addressed in their population. To this end, CSBs will need to develop data-driven interventions (e.g., specific care coordination interventions [clinical pathways] for individuals who are positive for a specific health need) to address the overall health of the individual. This data capability also promotes involvement with PC physicians, breaking down silos between BH and physical health providers. This should include the development of staff training to use the collected data.

What Feedback Has Been Provided by BH Direct Service Staff and Consumers Regarding Provision and Receipt of BHS?

Finding: Direct service providers and clients are directly impacted by the changes being implemented to the Commonwealth's BHS, and they have considerable insight and wisdom to contribute that could help ensure that reforms are workable and effective.

Recommendation: DBHDS is strongly encouraged to include representation from these two stakeholder groups in planning and implementation processes.

Finding: There are significant workforce challenges shared by most, if not all, CSBs, including the challenges of understaffing, overwork and burnout, turnover, inadequate opportunities for professional development and clinical supervision, inadequate compensation, and salary discrepancies.

Recommendation: The following workforce recommendations should be considered:

- Each CSB should develop staff wellness policies to support staff retention and help to prevent burnout.
- DBHDS may want to consider conducting a salary study across all CSBs to collect baseline information about salaries for differing levels of staff. CSBs are competing for a limited number of license-eligible/licensed staff.
- DBHDS may want to help CSBs address workforce shortages by implementing new strategies to recruit new graduates into the CSB workforce. One strategy to consider would be working to have loans reimbursed based on working within the CSB system. DBHDS, may want to consider looking at the federal model that allows for loan forgiveness after 5 years of service.
- DBHDS should develop systems to facilitate workforce competency development.

Finding: There is a need for enhanced communications from the state *to* the CSBs and *within* each CSB as well as information sharing among CSBs.

Recommendation: DBHDS should develop a communications plan to ensure that information is being consistently communicated to CSBs. In addition, DBHDS should leverage the informal and formal communication networks within the CSBs to support shared learning/cross-training among CSBs.

Finding: Consumers and direct service providers alike reported external problems that adversely affect client access to services and recovery, specifically the needs for better transportation; housing, including supportive housing; greater employment opportunities; and reduced stigma related to mental and substance use disorders.

Recommendation: DBHDS may want to consider actively working with other state systems to address external problems (social determinants) that adversely affect client access to services and recovery.

Appendix A.

List of Abbreviations

ABBREVIATIONS/TERMINOLOGY

AA	Alcoholics Anonymous
ACA	The Patient Protection and Affordable Care Act
ACE	Adverse childhood experience
ACS	American Community Survey
ARTS	Addiction and Recovery Treatment Services
ASIST	Applied Suicide Intervention Skills Training
BH	Behavioral health
BHA	Behavioral health authority
BHS	Behavioral health services
BI	Business Intelligence
BRFSS	Behavioral Risk Factor Surveillance System
CARS	CSB Automated Reporting System
CBT	Cognitive–behavioral therapy
CCBHC	Certified Community Behavioral Health Clinic
CCS 3	Community Consumer Submission 3
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CIT	Crisis intervention team
CMS	The Centers for Medicare & Medicaid Services
CNA	Comprehensive needs assessment
COLA	Cost-of-living adjustment
CQI	Continuous quality improvement
CSAP	Center for Substance Abuse Prevention
CSB	Community services board
DBHDS	Virginia Department of Behavioral Health and Developmental Services
DBT	Dialectical behavior therapy
DLA-20	Daily Living Activities-20
DMAS	Department of Medical Assistance Services

Abbreviations/Terminology

EBP	Evidence-based practice
EHR	Electronic health record
EMDR	Eye movement desensitization and reprocessing
FPL	Federal poverty level
FY	Fiscal Year
GAP	The Virginia Governor's Access Plan
HHS	U.S. Department of Health and Human Services
HIT	Health information technology
HIV	Human immunodeficiency virus
IDDT	Integrated dual disorders treatment
IOP	Intensive outpatient
IT	Information technology
JBS	JBS International, Inc.
JLARC	Joint Legislative Audit and Review Commission
LGBTQ	Lesbian/gay/bisexual/transgender/queer/questioning
MAT	Medication-assisted treatment
MCO	Managed care organization
MET	Motivational enhancement therapy
MH	Mental health
MHBG	Mental Health Services Block Grant
MI	Motivational interviewing
NA	Narcotics Anonymous
NSCH	National Survey of Children's Health
NSDUH	National Survey on Drug Use and Health
OMNI	OMNI Institute
OP	Outpatient
OUD	Opioid use disorder
PACT	Programs for Assertive Community Treatment
PBPS	Performance-Based Prevention System

Abbreviations/Terminology

PC	Primary care
PSR	Psychosocial rehabilitation
QA	Quality assurance
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SDA	Same-day access
SED	Serious emotional disturbance
SMART	Self-Management and Recovery Training
SMI	Serious mental illness
SOR	State opioid response
SPQM	Service Process Quality Management
STEP-VA	System Transformation Excellence and Performance – Virginia
SUD	Substance use disorder
TDT	Therapeutic day treatment
TF-CBT	Trauma-focused cognitive–behavioral therapy
URS	Uniform Reporting System
VCU	Virginia Commonwealth University
VDH	Virginia Department of Health
WRAP	Wellness Recovery Action Plan
YRBS	Youth Risk Behavioral Survey
YRBSS	Youth Risk Behavior Surveillance System

Appendix B.

CSB Administrator Pre-site Survey

CSB Administrator Pre-Site Visit Survey

In order to identify and prioritize behavioral health care service and recovery support service needs, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) would like to learn about you and the behavioral health services provided by your Community Service Board (CSB) to address substance use and mental health. Please answer the following questions and **please submit the completed survey no later than COB XXX, 2019**. Your help in answering these questions is greatly appreciated.

Please note: We understand that this survey may be filled out by multiple individuals in your agency with expertise in specific programmatic areas. We ask that the Executive Director or his/her designee take responsibility for ensuring that the survey is completed thoroughly by the appropriate staff.

1. **CSB: {NAME OF COMMUNITY SERVICES BOARD}**

2. **Please list below information on the following locations for your CSB:**

Main CSB Office Billing Address: _____
Address *City* *Zip Code*

Service Location 1: _____
Name *Address* *City* *Zip Code*

What service(s) are provided at Service Location 1? (Please select all that apply)

- ☐ Acute psychiatric inpatient services
- ☐ Acute substance use disorder inpatient services
- ☐ Medical detoxification inpatient services
- ☐ Day treatment or partial hospitalization services
- ☐ Other, please specify: _____
- ☐ Outpatient services
- ☐ Rehabilitation services
- ☐ Employment services
- ☐ Prevention services
- ☐ Housing/residential services
- ☐ Case management services
- ☐ Recovery support services
- ☐ Medication assisted treatment
- ☐ Crisis/emergency services

Service Location 2: _____
Name *Address* *City* *Zip Code*

What service(s) are provided at Service Location 2? (Please select all that apply)

- ☐ Acute psychiatric inpatient services
- ☐ Acute substance use disorder inpatient services
- ☐ Medical detoxification inpatient services
- ☐ Day treatment or partial hospitalization services
- ☐ Other, please specify: _____
- ☐ Outpatient services
- ☐ Rehabilitation services
- ☐ Employment services
- ☐ Prevention services
- ☐ Housing/residential services
- ☐ Case management services
- ☐ Recovery support services
- ☐ Medication assisted treatment
- ☐ Crisis/emergency services

Service Location 3: _____
Name *Address* *City* *Zip Code*

What service(s) are provided at Service Location 3? (Please select all that apply)

- ☐ Acute psychiatric inpatient services
- ☐ Acute substance use disorder inpatient services
- ☐ Medical detoxification inpatient services
- ☐ Day treatment or partial hospitalization services
- ☐ Other, please specify: _____
- ☐ Outpatient services
- ☐ Rehabilitation services
- ☐ Employment services
- ☐ Prevention services
- ☐ Housing/residential services
- ☐ Case management services
- ☐ Recovery support services
- ☐ Medication assisted treatment
- ☐ Crisis/emergency services

Service Location 4: _____

Name *Address* *City* *Zip Code*

What service(s) are provided at Service Location 4? (Please select all that apply)

- ☐ Acute psychiatric inpatient services
- ☐ Acute substance use disorder inpatient services
- ☐ Medical detoxification inpatient services
- ☐ Day treatment or partial hospitalization services
- ☐ Other, please specify: _____
- ☐ Outpatient services
- ☐ Rehabilitation services
- ☐ Employment services
- ☐ Prevention services
- ☐ Housing/residential services
- ☐ Case management services
- ☐ Recovery support services
- ☐ Medication assisted treatment
- ☐ Crisis/emergency services

Service Location 5: _____

Name *Address* *City* *Zip Code*

What service(s) are provided at Service Location 5? (Please select all that apply)

- ☐ Acute psychiatric inpatient services
- ☐ Acute substance use disorder inpatient services
- ☐ Medical detoxification inpatient services
- ☐ Day treatment or partial hospitalization services
- ☐ Other, please specify: _____
- ☐ Outpatient services
- ☐ Rehabilitation services
- ☐ Employment services
- ☐ Prevention services
- ☐ Housing/residential services
- ☐ Case management services
- ☐ Recovery support services
- ☐ Medication assisted treatment
- ☐ Crisis/emergency services

3. **What is the city(cities) and county(counties) where your CSB provides services?**

_____ _____
(City) *(County)*

_____ _____
(City) *(County)*

_____ _____
(City) *(County)*

The following questions ask about the consumers and target populations that receive behavioral health services at your CSB.

4. **What is the total, unduplicated number of consumers that received behavioral health services from your CSB in the past state fiscal year (FY 2018)?** _____

5. **What is the total, unduplicated number of male and female consumers from the following age groups that received behavioral health services from your CSB in the previous state fiscal year (FY 2018)? Please indicate in the table below.**

Consumer Age Groups	Consumer Gender		TOTAL Number of Consumers Served in Age Group
	Males	Females	
Infants and Young Children (ages 0 – 5 years)			
Children (ages 6 – 11 years)			
Adolescents (ages 12 – 17 years)			
Young Adults (ages 18 – 25 years)			
Adults (ages 26 years and older)			
TOTAL NUMBER SERVED (*total should match number listed in Question 4*)			

6. **Using the table below, please indicate the number of male and female consumers from the following racial and ethnic groups that received behavioral health services from your CSB in the past state fiscal year (FY 2018). We understand that consumers may identify with more than one racial group, and that as a result the total number of consumers may exceed the totals reported in Questions 4 and 5.**

Consumer Ethnic Groups	Consumer Gender		TOTAL Number of Racial and Ethnic Group Consumers Served
	Males	Females	
Hispanic, Latino, or Spanish origin			
Consumer Racial Groups			
Alaskan Native Tribal Affiliation(s): _____			
American Indian Tribal Affiliation(s): _____			
Asian			
Black/African American			
Native Hawaiian or Other Pacific Islander			
White			
Multi-race (consumers identify with more than one race)			
Other, please specify _____			
Other, please specify _____			
Other, please specify _____			
Other, please specify _____			

7. **Are you currently collecting data on non-binary gender populations (e.g., transgender)?** ☐ Yes ☐ No

   If ***YES*** – please provide the total number of non-binary gender populations that received behavioral health services in FY 2018: _____

   If ***NO*** - do you have plans to collect data on this population in the future? ☐ Yes ☐ No

8. **What percent of the total number of consumers that received behavioral health services from your CSB in FY 2018 were homeless or living in a shelter?** _____ percent

9. **Approximately what percent of the total number of consumers that received behavioral health services from your CSB in FY 2018 had a household income at or below the federal poverty level (FPL)?**
   _____ percent

10. **The table below lists certain populations at risk of developing substance use and mental health disorders. Using the table, please answer the following questions about each at-risk population listed and your CSB.**

    a. **Is the at-risk population served by your CSB?**

       If ***YES*** – *the at-risk population is served by your CSB* - please list: _____

    b. **The total, unduplicated number of consumers that received behavioral health services in the past state fiscal year (FY 2018)**
    c. **The programs and specific evidence-based and/or best practices used (if any) (e.g., cognitive behavioral therapy, family therapy) to address the behavioral health concerns of the at-risk populations**

At-Risk Population	a. Served by Your CSB?	b. Unduplicated Total Number Served (FY2018)	c. Names of any Specific Programs, Evidence-Based or Best Practices
Pregnant women with substance use issues	☐ Yes ☐ No		
Individuals involved with the criminal justice system (e.g., prisons, jails, juvenile justice system) as perpetrators or as victims of crime	☐ Yes ☐ No		
Individuals at risk due to environmental and adverse childhood experiences (ACEs)	☐ Yes ☐ No		
Returning veterans and their family members	☐ Yes ☐ No		
Children with or at risk of developmental disabilities (e.g., Part C early intervention)	☐ Yes ☐ No		
Individuals with intellectual and/or developmental disabilities with co-occurring conditions.	☐ Yes ☐ No		
Populations experiencing Serious Emotional Disturbance (SED)			
Children (ages 6-11 years)	☐ Yes ☐ No		
Adolescents (ages 12-17 years)	☐ Yes ☐ No		
Populations experiencing Serious Mental Illness (SMI)			
Young adults (ages 18-24)	☐ Yes ☐ No		
Adults (ages 25 and older)	☐ Yes ☐ No		
Populations experiencing substance use disorders			
Adolescents (ages 12-17 years)	☐ Yes ☐ No		
Young adults (ages 18-24)	☐ Yes ☐ No		
Adults (ages 25 and older)	☐ Yes ☐ No		
Populations experiencing co-occurring mental health and substance use disorders			
Adolescents (ages 12-17 years)	☐ Yes ☐ No		
Young adults (ages 18-24)	☐ Yes ☐ No		
Adults (ages 25 and older)	☐ Yes ☐ No		

11. **Approximately what percentage of your consumer population reports difficulty reading and/or understanding written medical or health information forms due to low health literacy?**

- ☐ None (0%)
- ☐ A few (less than 10%)
- ☐ Some (11-30%)
- ☐ Many (31% - 50%)
- ☐ Most (51-70%)
- ☐ Majority (71-85%)
- ☐ Almost all (86-100%)
- ☐ Not Applicable (e.g., your CSB does not collect this information)

12. **What are the primary languages spoken by your consumer population?** (Please check all that apply)

- ☐ English
- ☐ Spanish
- ☐ French/Creole
- ☐ German
- ☐ Korean
- ☐ Chinese
- ☐ Tagalog
- ☐ Other, please specify _____

13. **What criteria are used, if any, to match service providers with consumers/clients/families?** (Please check all that apply)

- ☐ Providers assigned based on availability.
- ☐ Shared experience with substance use disorders and/or mental health disorders
- ☐ Racial/ethnic background match
- ☐ Sexual orientation (e.g., LBGTQ) match
- ☐ Language/linguistic match (e.g., providing services in consumer's/client's preferred language)
- ☐ Gender match
- ☐ Other, please specify _____
- ☐ None (e.g., your CSB does not match service providers with consumers/clients/families)

The following questions ask about the programs and activities used to support delivery of behavioral health services at your CSB.

14. **Which of the following service types listed in the table below are offered as part of your programs to provide substance use treatment and/or mental health treatment?**

Please also use the table below to answer the following questions for each service type provided by your CSB:

a. What evidence-based and/or best practices are used in providing this service?
b. What is the service program capacity – or the maximum number of consumers that can receive this service at any given time?
c. What is the total number of consumers your CSB is contracted to serve over a one-year period?
d. What is the total number of consumers that received this service in FY2018?

Service Type	Part of Substance Use Treatment Program?	Part of Mental Health Treatment Program?	a. Names of Evidence-Based or Best Practices Used	b. Program Capacity - Maximum Number of Consumers Can Serve at a Given Time	c. Number of Consumers (or beds days) Contracted to Serve Over One-Year Period	d. Total Number of Consumers Served in FY 2018
Emergency Services	☐ Yes ☐ No	☐ Yes ☐ No				
Motivational Treatment Services	☐ Yes ☐ No	☐ Yes ☐ No				
Assessment and Evaluation Services	☐ Yes ☐ No	☐ Yes ☐ No				
Acute Psychiatric Inpatient Services	☐ Yes ☐ No	☐ Yes ☐ No				
Acute Substance Use Disorder Inpatient Services	☐ Yes ☐ No	☐ Yes ☐ No				
Community-Based Substance Use Disorder Medical Detoxification	☐ Yes ☐ No	☐ Yes ☐ No				

Service Type	Part of Substance Use Treatment Program?	Part of Mental Health Treatment Program?	a. Names of Evidence-Based or Best Practices Used	b. Program Capacity - Maximum Number of Consumers Can Serve at a Given Time	c. Number of Consumers (or beds days) Contracted to Serve Over One-Year Period	d. Total Number of Consumers Served in FY 2018
Inpatient Services						
Outpatient Services	☐ Yes ☐ No	☐ Yes ☐ No				
Home based therapeutic services	☐ Yes ☐ No	☐ Yes ☐ No				
Case Management Services	☐ Yes ☐ No	☐ Yes ☐ No				
Medication Assisted Treatment Opioid Treatment Program Methadone	☐ Yes ☐ No	☐ Yes ☐ No				
Medication Assisted Treatment Opioid Treatment Program Buprenorphine /Injectable Naltrexone	☐ Yes ☐ No	☐ Yes ☐ No				
Assertive Community Treatment	☐ Yes ☐ No	☐ Yes ☐ No				
Day Treatment or Partial Hospitalization	☐ Yes ☐ No	☐ Yes ☐ No				
Ambulatory Crisis Stabilization Services	☐ Yes ☐ No	☐ Yes ☐ No				
Psychosocial Rehabilitation Services	☐ Yes ☐ No	☐ Yes ☐ No				
Sheltered Employment	☐ Yes ☐ No	☐ Yes ☐ No				
Individual Supported Employment	☐ Yes ☐ No	☐ Yes ☐ No				
Group Supported Employment	☐ Yes ☐ No	☐ Yes ☐ No				
Intensive Residential Services	☐ Yes ☐ No	☐ Yes ☐ No				
Residential Crisis Stabilization Services	☐ Yes ☐ No	☐ Yes ☐ No				
Intensive Residential Services	☐ Yes ☐ No	☐ Yes ☐ No				

Service Type	Part of Substance Use Treatment Program?	Part of Mental Health Treatment Program?	a. Names of Evidence-Based or Best Practices Used	b. Program Capacity - Maximum Number of Consumers Can Serve at a Given Time	c. Number of Consumers (or beds days) Contracted to Serve Over One-Year Period	d. Total Number of Consumers Served in FY 2018
Supervised Residential Services	☐ Yes ☐ No	☐ Yes ☐ No				
Supportive Housing Services	☐ Yes ☐ No	☐ Yes ☐ No				

15. **Does your CSB provide <u>recovery support services</u>?** ☐ Yes ☐ No

If ***YES*** – please answer the following questions using the table below:

a. Which of the following types of recovery services are offered by your CSB?
b. What types of evidence-based or best practices used by your CSB in providing this service (e.g., Warmline, Whole Recovery Action Plan [WRAP©], relapse prevention)?
c. What is the targeted number of consumers or individuals to be served annually by each service or program provided by your CSB?
d. What is the total number of consumers that received this service in FY2018?

Recovery Service Type	a. Service Offered?	b. Names of Specific Evidence-Based or Best Practices	c. Target Number of Consumers to be Served Annually	d. Total Number of Consumers Served in FY 2018
Peer recovery support services (e.g., mentoring, coaching)	☐ Yes ☐ No			
Alcoholics Anonymous, Narcotics Anonymous, and/or other self-help groups	☐ Yes ☐ No			
Care coordination services	☐ Yes ☐ No			
Housing/residential services	☐ Yes ☐ No			
Employment services	☐ Yes ☐ No			
Family support services (e.g., respite care, parent training, advocacy training)	☐ Yes ☐ No			
Education support services	☐ Yes ☐ No			
Assertive Continuing Care (ACC)	☐ Yes ☐ No			
Peer certification	☐ Yes ☐ No			

16. **Does your CSB provide <u>substance use prevention mental health promotion services</u>?** ☐ Yes ☐ No

If ***YES*** — please answer the following questions using the table below:

a. Which of the following Center for Substance Abuse and Prevention (CSAP) strategies listed below are being used by your CSB?
b. What specific prevention programs or activities, including evidence-based or best practices, used by your CSB to implement the CSAP strategy (e.g., tobacco reduction interventions, Warmline, Whole Recovery Action Plan [WRAP©], relapse prevention)?
c. What was the targeted reach (or targeted number of persons to be served), if known, for each of the prevention programs provided by your CSB in FY 2018?
d. What was the total number of consumers served by your CSB using <u>individual-based prevention programs and/or strategies</u> in FY 2018?

e. What was the total number of consumers served by your CSB using <u>population-based prevention programs and/or strategies</u> in FY 2018?

CSAP Strategy Type	a. Strategy used?	b. Names of Specific Prevention Programs, Evidence-Based or Best Practices	c. Target Reach for Specific Prevention Programs in FY 2018
Information dissemination	☐ Yes ☐ No	•	•
Education	☐ Yes ☐ No	•	•
Alternative activities	☐ Yes ☐ No	•	•
Environmental	☐ Yes ☐ No	•	•
Community-based process	☐ Yes ☐ No	•	•
Problem identification (ID) and referral	☐ Yes ☐ No	•	•
d. Total served in FY2018 – Individual-based strategies: _____		**e. Total served in FY2018 – Population-based strategies**: _____	

17. **How long does it take to access substance use and/or mental health services offered by your CSB?**

_____

For each of the services listed in the table below, please select the response that best describes the average time for consumers to receive the following services.

Behavioral Health Service Type	Same day	1 – 7 days	8 – 14 days	15 – 21 days	22 - 30 days	Other (Please specify)
Crisis Services	☐	☐	☐	☐	☐	☐
Substance use treatment – inpatient and residential services	☐	☐	☐	☐	☐	☐
Substance use treatment – outpatient and intensive outpatient services	☐	☐	☐	☐	☐	☐
Home based therapeutic services	☐	☐	☐	☐	☐	☐
Substance use prevention services	☐	☐	☐	☐	☐	☐
Mental health treatment – inpatient and residential services	☐	☐	☐	☐	☐	☐
Mental health treatment – outpatient and intensive outpatient services	☐	☐	☐	☐	☐	☐
Mental health promotion services	☐	☐	☐	☐	☐	☐
Recovery support services	☐	☐	☐	☐	☐	☐

18. **Does your CSB use telehealth, virtual care technologies or mobile services for substance use and mental health prevention, treatment, and recovery services?** ☐ Yes ☐ No

IF YES, what types of telehealth and virtual care strategies are used by your CSB? (Please check all that apply)

- ☐ Mobile health (mHealth) applications (apps) (e.g., to access health resources, support)
- ☐ mHealth wearables (e.g., to monitor vital signs, medication adherence)
- ☐ Telemedicine platforms (e.g., Zoom, Skype)
- ☐ Digital messaging platforms
- ☐ Mobile health units
- ☐ Other, please specify _____

The following questions ask about the staff and workforce that provide direct service delivery of behavioral health services at your CSB.

19. **The following questions ask about the number and background of staff employed by your CSB to provide behavioral health services: (a) *direct service staff* and (b) *peer staff who are receiving or have received services at your CSB and are employed as peers to deliver direct services*.**

    What is the total number of direct service and peer staff that provide behavioral health services for your agency?

    Total number of direct service staff: _____

    Total number of peer staff: _____

Using the table below, please provide the information indicated for direct service staff and peer staff across the types of service areas listed. *We understand that staff may work across more than one service area. For the table below, please provide information for staff that work at least half-time or 50% FTE for a service listed*.

Behavioral Health Service Type	Total Number of Direct Service Staff	Total Number of Licensed Direct Service Staff	Total Number of Certified Direct Service Staff	Total Number of Peer Staff	Total Number of Unlicensed Staff	Total Number of Certified Peer Staff
Crisis/ emergency services						
Substance use treatment – inpatient and residential services						
Substance use treatment – outpatient and intensive outpatient services						
Prevention services - Substance use prevention services						
Mental health treatment – inpatient and residential services						
Mental health treatment – outpatient and intensive outpatient services						
Prevention services - Mental health prevention/ promotion services						
Recovery support services						

20. **The table below asks about the average caseload of direct service staff and supervision provided to support their provision of behavioral health services for your CSB. Please provide the information indicated for direct service staff across the types of service areas listed.**

Behavioral Health Service Type	Average Weekly Caseload (or direct service hours) or Not Applicable	How often is supervision provided for direct service staff?					
		Not provided	Quarterly	Monthly	Twice Monthly	Weekly	Other (Please specify)
Crisis/ emergency services		☐	☐	☐	☐	☐	☐
Substance use treatment – inpatient and residential services		☐	☐	☐	☐	☐	☐
Substance use treatment – outpatient and intensive outpatient services		☐	☐	☐	☐	☐	☐
Prevention services - Substance use prevention services		☐	☐	☐	☐	☐	☐
Mental health treatment – inpatient and residential services		☐	☐	☐	☐	☐	☐
Mental health treatment – outpatient and intensive outpatient services		☐	☐	☐	☐	☐	☐
Prevention services - Mental health prevention/ promotion services		☐	☐	☐	☐	☐	☐
Recovery support services		☐	☐	☐	☐	☐	☐

21. **For which of the following services does your agency use subcontractors for providing behavioral health services?** (Please check all that apply)

- ☐ Crisis/ emergency services
- ☐ Acute psychiatric inpatient services
- ☐ Acute substance use disorder inpatient services
- ☐ Medical detoxification inpatient services
- ☐ Day treatment or partial hospitalization services
- ☐ Outpatient services
- ☐ Case management services
- ☐ Consumer run services
- ☐ Medication assisted treatment
- ☐ Rehabilitation services
- ☐ Employment services
- ☐ Housing/residential services
- ☐ Substance use prevention services
- ☐ Mental health prevention services
- ☐ Recovery support services
- ☐ Other, please specify _____

22. **How often do you experience turnover in direct service staff across the following service areas**?

Behavioral Health Service Type	Not Applicable (CSB does not provide this service)	Monthly	Quarterly	Yearly	Every 2-3 years	Every 4+ years
Crisis/ emergency services	☐	☐	☐	☐	☐	☐
Substance use treatment – inpatient and residential services	☐	☐	☐	☐	☐	☐
Substance use treatment – outpatient and intensive outpatient services	☐	☐	☐	☐	☐	☐
Prevention services - Substance use prevention services	☐	☐	☐	☐	☐	☐
Mental health treatment – inpatient and residential services	☐	☐	☐	☐	☐	☐
Mental health treatment – outpatient and intensive outpatient services	☐	☐	☐	☐	☐	☐
Prevention services - Mental health prevention/ promotion services	☐	☐	☐	☐	☐	☐
Recovery support services	☐	☐	☐	☐	☐	☐

23. **Which option best describes the current staffing capacity of your CSB to provide each of the following services**?

Behavioral Health Service Type	Not Applicable (CSB does not provide this service)	Demand Exceeds Capacity/ Service Overutilized	At Capacity	Excess Capacity/ Service Underutilized
Crisis/ emergency services	☐	☐	☐	☐
Substance use treatment – inpatient and residential services	☐	☐	☐	☐
Substance use treatment – outpatient and intensive outpatient services	☐	☐	☐	☐
Prevention services - Substance use prevention services	☐	☐	☐	☐
Mental health treatment – inpatient and residential services	☐	☐	☐	☐
Mental health treatment – outpatient and intensive outpatient services	☐	☐	☐	☐
Prevention services - Mental health prevention/ promotion services	☐	☐	☐	☐
Recovery support services	☐	☐	☐	☐

The following questions ask about <u>the sources of funding</u> used to support delivery of behavioral health services at your CSB.

24. **Using the table below, what were the total costs for providing substance use and mental health behavioral health services at your CSB For FY 2018?**

Total Direct Costs for Providing Services	**$**
Total Indirect Costs for Providing Services *(including any administrative and overhead expenses to support service provision)*	**$**
Total Operating Costs for Providing Services *(total should reflect sum of direct and indirect costs)*	**$**

25. **What percent of your total annual budget for providing substance use and mental health behavioral health services at your CSB is spent in the following programmatic areas?**

Substance use treatment: _____ percent
Mental health treatment: _____ percent
Prevention services: _____ percent
Recovery support services: _____ percent

26. **What are the funding sources and approximate percent amounts for provision of the following types of behavioral health services at your CSB? Please make sure the total percentages listed in the table match the total percent for each service listed in Question 25**

Funding Source	Substance Use Treatment		Mental Health Treatment		Prevention Services		Recovery Support	
Federal Funds	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
State Block Grant Funds	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Other State or DBHDS Discretionary Funds	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Medicaid	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Medicare	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Private Payers	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Client fees (e.g., co-payment for services, sliding scale fees)	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Local funds	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Other (Please specify)	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
Other (Please specify)	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%	☐ Yes ☐ No	%
TOTAL PERCENT	%		%		%		%	

27. **To what extent is the current funding sufficient to cover the annual operating cost of providing the following behavioral health services at your CSB?**

Behavioral Health Service Type	Not Applicable (CSB does not provide this service)	Not at all sufficient (budget deficit)	Sufficient (funds cover administrative, overhead, and service provision)	More than sufficient funds
Crisis/ emergency services	☐	☐	☐	☐
Substance use treatment	☐	☐	☐	☐
Mental health treatment	☐	☐	☐	☐
Prevention services	☐	☐	☐	☐
Recovery support services	☐	☐	☐	☐
Housing/residential services	☐	☐	☐	☐
Other services (Please specify)	☐	☐	☐	☐

The following questions ask about implementation of System Transformation Excellence and Performance in Virginia (STEP-VA) activities your CSB.

28. **Which of the following options best describes your progress toward implementing the following STEP-VA evidence-based practices (EBP) at your agency**? Please select only one option.

STEP-VA Evidence-Based Practice (EBP)	**Not Applicable**	**Phase 1:** No formal plan to implement at this time	**Phase 2:** Developed plan for implementation	**Phase 3:** Developed plan and Implemented service	**Phase 4:** Developed Plan, implemented service, and monitor quality of service delivery	**Phase 5:** Developed Plan, implemented service, monitor quality of service delivery, and use quality assurance, continuous quality improvement processes
Cognitive behavioral therapy	☐	☐	☐	☐	☐	☐
Family psycho-education	☐	☐	☐	☐	☐	☐
Integrated dual disorders treatment	☐	☐	☐	☐	☐	☐
Illness management and recovery	☐	☐	☐	☐	☐	☐
Long-acting injectable psychotropic medication	☐	☐	☐	☐	☐	☐
Medication-assisted treatment	☐	☐	☐	☐	☐	☐
Motivational interviewing/ Motivational enhancement therapy	☐	☐	☐	☐	☐	☐
Recovery After Initial Schizophrenic Episode (RAISE)	☐	☐	☐	☐	☐	☐
Trauma-focused cognitive behavioral therapy	☐	☐	☐	☐	☐	☐
Wellness recovery action planning	☐	☐	☐	☐	☐	☐

29. **What is the total number of staff who received training in the following STEP-VA evidence-based practices (EBP) at your agency**?

STEP-VA Evidence-Based Practice (EBP)	**Not Applicable**	**Total Number of Staff that Received EBP Training**
Cognitive behavioral therapy	☐	
Family psychoeducation	☐	
Integrated dual disorders treatment	☐	
Illness management and recovery	☐	
Long-acting injectable psychotropic medication	☐	
Medication-assisted treatment	☐	
Motivational interviewing/ Motivational enhancement therapy	☐	
Recovery After Initial Schizophrenic Episode (RAISE)	☐	

STEP-VA Evidence-Based Practice (EBP)	Not Applicable	Total Number of Staff that Received EBP Training
Trauma-focused cognitive behavioral therapy	☐	
Wellness recovery action planning	☐	

30. **Which of the following options best describes your progress toward implementing the following STEP-VA services at your agency**? Please select only one option.

STEP-VA Services	**Phase 1:** No formal plan to implement at this time	**Phase 2:** Developed plan for implementation	**Phase 3:** Developed plan and Implemented service	**Phase 4:** Developed Plan, implemented service, and monitor quality of service delivery	**Phase 5:** Developed Plan, implemented service, monitor quality of service delivery, and use quality assurance, continuous quality improvement processes
Same day access	☐	☐	☐	☐	☐
Primary care screening	☐	☐	☐	☐	☐
Patient-centered treatment planning	☐	☐	☐	☐	☐
Outpatient behavioral health services	☐	☐	☐	☐	☐
Behavioral health crisis intervention and stabilization services	☐	☐	☐	☐	☐
Psychiatric rehabilitation services	☐	☐	☐	☐	☐
Targeted case management (for adults and children)	☐	☐	☐	☐	☐
Peer support and family support services	☐	☐	☐	☐	☐
Veterans behavioral health services	☐	☐	☐	☐	☐
Care coordination	☐	☐	☐	☐	☐

31. **Please check the box that represents how much you agree with the following statements regarding your implementation of STEP-VA.**

Our implementation of STEP-VA implementation plans…	Strongly Disagree	Disagree	Agree	Strongly Agree
Has support and buy-in from leadership	☐	☐	☐	☐
Has support and buy-in from staff	☐	☐	☐	☐
Includes implementation of STEP-VA evidence-based programs and practices	☐	☐	☐	☐
Is informed by a realistic implementation plan	☐	☐	☐	☐
Has sufficient funding to support implementation of STEP-VA activities	☐	☐	☐	☐
Has designated state funding to support implementation of STEP-VA activities	☐	☐	☐	☐
Has staff that have the skills needed to implement STEP-VA programs and practices	☐	☐	☐	☐
Uses data to guide assessment, evaluation, and continuous quality improvement of STEP-VA activities	☐	☐	☐	☐
Has access to support services (e.g., data collection, health information technology services) to support implementation	☐	☐	☐	☐
Has access to training and technical assistance services to support fidelity in program and service implementation	☐	☐	☐	☐

Our implementation of STEP-VA implementation plans…	Strongly Disagree	Disagree	Agree	Strongly Agree
Please specify (e.g., ATTC, local contract, state-funded training and technical assistance)_____				
Has a sound financing strategy	☐	☐	☐	☐

The following questions ask about the strategies used to support quality assurance (QA) and continuous quality improvement (CQI) at your CSB.

32. **Please check the box that best represents how much you agree with the following statements about your CSB QA and CQI practices.**

	Strongly Disagree	Disagree	Agree	Strongly Agree
Substance Use and Mental Health Treatment				
Data is used to identify substance use and mental health treatment priorities	☐	☐	☐	☐
There is sufficient infrastructure to support data collection and data entry requirements for treatment.	☐	☐	☐	☐
Our performance management systems are sufficient for tracking delivery of substance use and mental health treatment services Please specify system used:_____	☐	☐	☐	☐
Data collected from our performance management systems are used to evaluate the quality of treatment services delivered	☐	☐	☐	☐
Prevention Services				
Data is used to identify priorities for prevention services	☐	☐	☐	☐
There is sufficient infrastructure to support data collection and data entry requirements for prevention.	☐	☐	☐	☐
Our performance management systems (e.g., Performance Based Prevention System [PBPS]) are sufficient for tracking delivery of prevention services. Please specify system used:_____	☐	☐	☐	☐
Data collected from our performance management systems are used to evaluate the quality of prevention services delivered	☐	☐	☐	☐
Recovery Services				
Data is used to identify priorities for recovery services	☐	☐	☐	☐
There is sufficient infrastructure to support data collection and data entry requirements for recovery.	☐	☐	☐	☐
Our performance management systems are sufficient for tracking delivery of recovery services Please specify system used:_____	☐	☐	☐	☐
Data collected from our performance management systems are used to evaluate the quality of recovery services delivered	☐	☐	☐	☐

THANK YOU for completing the CSB Administrator Pre-Site Survey!

Appendix C.

CSB Consumer Satisfaction Survey

CSB Consumer Satisfaction Survey

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) would like to learn about you and your experience with receiving various services through this agency.

Who is being asked to complete this survey? Consumers who are participating in the focus group at this agency are being asked to complete this survey before participating in the focus group. This survey is targeted at gaining information from consumers who have received services at this Community Services Board (CSB) to address their mental health and/or substance use.

How much time will the survey take to complete? The survey includes 37 questions, some of which have checkboxes, and some of which have places where you can write in an answer. The survey should take about 20 minutes to complete.

Do I have to answer all the questions in the survey? You may answer only the questions you choose to answer. If you feel uncomfortable with a question, you can skip that question. Your participation in this survey is completely voluntary. You are completely free to discontinue participating in the survey at any time.

Will my answers to the survey be kept private or confidential? Yes – your responses to this survey are anonymous. The survey does not ask for any information that could identify you. The survey only asks for information that will be helpful in looking at the results of the survey (for example, demographic information) to see how your agency can better provide services to clients like you. We will also combine the responses from everyone who completes the survey into a summary report with other findings from your agency.

Please let the focus group facilitators know if you have any questions about the survey. Once you have completed the survey, the focus group facilitators will collect the survey from you.

Your help in answering these questions is greatly appreciated! Thank you!

---

1. CSB Name: {NAME OF COMMUNITY SERVICES BOARD}

The following questions ask about your personal background and services received at this agency.

2. What is your gender? ☐ Male ☐ Female ☐ Other (Please specify): _____

3. What is your age? ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 and over

4. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

5. What is your race? (Please select all that apply)

☐ White
☐ Black/African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian
Tribal Affiliation: _____
☐ Alaskan Native
Tribal Affiliation: _____
☐ Other, please specify _____

6. What is the highest level of education that you have completed?

☐ Some high school
☐ High School Diploma/GED
☐ Associates Degree
☐ Bachelor's Degree (BS, BA)
☐ Master's Degree (MS, MA, MSW, LCSW, MPH)
☐ Doctorate (PhD, EdD, PsyD, DSW)
☐ Professional Degree (RN, MD, PharmD)
☐ Other, please specify _____

7. Why type of insurance coverage do you have? (Please select all that apply)

- ☐ Private insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ Family access to medical insurance security (FAMIS)
- ☐ Not insured
- ☐ Other (please specify) _____

8. What services have you received at this agency? (Please select all that apply)

- ☐ Substance use services
- ☐ Crisis/emergency services
- ☐ Intensive outpatient services
- ☐ Inpatient/ residential services
- ☐ Detox services
- ☐ Mental health services
- ☐ Outpatient services
- ☐ Recovery support services
- ☐ Case management
- ☐ Other, please specify _____

The following questions ask about your experience with accessing services at this agency.

9. Were you able to obtain the services you needed at this agency? ☐ Yes ☐ No ☐ Unsure

10. Approximately how long did it take from the time you requested services to when you received them?

☐ Same day ☐ 1-7 days ☐ 8-14 days ☐ 15-21 days ☐ Longer than 21 days

Please check the box that shows how much you agree with the following statements about accessing services at this agency.

	Strongly Agree	Agree	Disagree	Strongly Disagree
11. I can get to the services I need within 30 minutes (or less) from my home	☐	☐	☐	☐
12. I am able to obtain services in my preferred language	☐	☐	☐	☐
13. I can afford the cost of services	☐	☐	☐	☐
14. It is easy for me to use public transportation to travel to this agency for services	☐	☐	☐	☐
15. My agency provides mobile and/or electronic health (eHealth, Patient Portal) services as an option for me to access the care I need	☐	☐	☐	☐
16. I am able to contact my provider(s) outside of my scheduled appointments	☐	☐	☐	☐
17. My agency is open during hours that are convenient for me	☐	☐	☐	☐

Please check the box that shows how much you agree with the following statements about the care and services you received at this agency.

	Strongly Agree	Agree	Disagree	Strongly Disagree
18. The services and care I receive are sensitive to my cultural background	☐	☐	☐	☐
19. I have enough time to talk with my provider(s)	☐	☐	☐	☐

	Strongly Agree	Agree	Disagree	Strongly Disagree
20. My provider(s) helped me to obtain other health services I need, such as medical and dental services	☐	☐	☐	☐
21. I feel comfortable talking with my provider(s)	☐	☐	☐	☐
22. My provider(s) are knowledgeable about the care I need	☐	☐	☐	☐
23. I am now better able to manage my concerns because of the services I receive	☐	☐	☐	☐
24. My overall quality of life has improved because of the services and care I received	☐	☐	☐	☐

25. Overall, how satisfied are you with the quality of care that you have received at this agency?

☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very satisfied

THANK YOU for completing the CSB Consumer Survey!

Appendix D.

CSB Direct Service Provider Survey

CSB Direct Service Provider Survey

In order to identify and prioritize behavioral health care service and recovery support service needs, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) would like to learn about you and the behavioral health services provided by your agency. Please answer the following questions and please submit the completed survey before your scheduled onsite focus group. Your help in answering these questions is greatly appreciated and your answers will be kept confidential.

1. **CSB: {NAME OF COMMUNITY SERVICES BOARD}**

The following questions ask about your background and your role at your Community Services Board (CSB).

2. **What is your role in this organization?** (Please select all that apply)

   ☐ Project coordinator
   ☐ Case manager
   ☐ Counselor/therapist
   ☐ Recovery specialist
   ☐ Part-Time/Fee for service staff
   ☐ Other, please specify _____

3. **For how long have you served in this role at this CSB?**

   ☐ Less than one year
   ☐ 1 - 2 years
   ☐ 3 - 4 years
   ☐ 5 years or more

4. **What is your gender?** ☐ Male ☐ Female ☐ Other (Please specify): _____

5. **What is your age?** ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 and over

6. **Are you of Hispanic, Latino, or Spanish origin?** ☐ Yes ☐ No

7. **What is your race?** (Please select all that apply)

   ☐ White
   ☐ Black/African American
   ☐ Asian
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ American Indian
   Tribal Affiliation: _____
   ☐ Alaskan Native
   Tribal Affiliation: _____
   ☐ Other, please specify _____

8. **What is the highest level of education that you have completed?**

   ☐ Some High School
   ☐ High School Diploma/GED
   ☐ Associates Degree
   ☐ Bachelor's Degree (BS, BA)
   ☐ Master's Degree (MS, MA, MSW, LCSW, MPH)
   ☐ Doctorate (PhD, EdD, PsyD, DSW)
   ☐ Professional Degree (RN, MD, PharmD)
   ☐ Other, please specify _____

9. What is your yearly personal income?

- ☐ Less than $10,000
- ☐ $10,000 - $19,000
- ☐ $20,000 - $29,000
- ☐ $30,000 - $39,000
- ☐ $40,000 - $49,000
- ☐ $50,000 - $59,000
- ☐ $60,000 - $69,000
- ☐ $70,000 - $79,000
- ☐ $80,000 - $89,000
- ☐ $90,000 - $99,000
- ☐ $100,000 - $149,000
- ☐ $150,000 or more

10. For which of the following do you provide direct services? (Please select all that apply)

- ☐ Crisis/emergency services
- ☐ Intensive outpatient services
- ☐ Inpatient/ residential services
- ☐ Outpatient services
- ☐ Recovery support services
- ☐ Case management
- ☐ Other, please specify _____

11. What are the primary client populations for which you provide services? (Please check all that apply)

- ☐ Children (ages 0 – 11 years old)
- ☐ Adolescents (ages 12 - 17 years old)
- ☐ Young adults (ages 18 – 24 years old)
- ☐ Clients with severe mental illness/severe emotional disturbance
- ☐ Clients involved with the criminal justice system
- ☐ Clients with intellectual and/or developmental disabilities
- ☐ Veterans and their families
- ☐ Specific gender(s) (Please specify) _____
- ☐ Specific racial or ethnic groups (Please specify) _____
- ☐ Specific subpopulations experiencing environmental and adverse childhood experiences (ACEs) (Please specify) _____
- ☐ Other (please specify) _____

12. On average, approximately how many clients/families do you see in a week?

- ☐ Up to 10 per week
- ☐ 11 – 20 per week
- ☐ 21 – 30 per week
- ☐ 31 – 40 per week
- ☐ Over 40 per week (please specify) _____

The following questions address the accessibility of services at your provider location and should be answered according to your programmatic area.

Please check the box that represents how accessible you feel services are to clients.

13. Are adequate staff available to provide services to clients? ☐ Yes ☐ No ☐ Unsure

14. How long does it typically take for a client to be able to access services?

☐ Same day ☐ 1-7 days ☐ 8-14 days ☐ 15-21 days ☐ Longer than 21 days

15. **There are resources at my CSB to help clients access services (e.g., public transportation nearby, shuttle service, travel vouchers, free parking, extended hours):**

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

16. **Are services available in the preferred language of clients?** ☐ Yes ☐ No ☐ Unsure

Please check the box that represents how satisfied you are with each item.

How satisfied are you with the following?	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
17. Direction provided by leadership (e.g., "the big picture")	☐	☐	☐	☐
18. Direction provided by supervisors regarding daily and weekly tasks	☐	☐	☐	☐
19. Training provided to support implementation and delivery of STEP-VA services	☐	☐	☐	☐
20. Training provided to support implementation of STEP-VA evidence-based practices (EBPs)	☐	☐	☐	☐
21. Relationships with coworkers	☐	☐	☐	☐
22. Compensation you receive (including benefits)	☐	☐	☐	☐

Please check the box that represents how much time you spend on the following tasks.

Approximately how much of your time each week do you spend doing the following?	Very Little (0–10%)	Occasionally (11– 20%)	Sometimes (21 – 30%)	More time than not (31 – 50%)	Most of my time (51 – 75%)	Almost all of my time (76%– 100%)
23. Providing direct services	☐	☐	☐	☐	☐	☐
24. Completing documentation to support service delivery (e.g., case notes)	☐	☐	☐	☐	☐	☐
25. Completing documentation to obtain funding reimbursement	☐	☐	☐	☐	☐	☐
26. Professional/ career development	☐	☐	☐	☐	☐	☐

Next, we would like to learn about your experience in delivering services.

Please check the box that represents how you rate your experience with each item.

Please rate your experience with each of the following items.	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
27. Ease of scheduling	☐	☐	☐	☐
28. Time clients spend on waitlists	☐	☐	☐	☐
29. Intake processes	☐	☐	☐	☐
30. Use of capacity management systems (e.g., to manage waitlists, prioritize specific populations, provide interim services)	☐	☐	☐	☐

Please rate your experience with each of the following items.	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
31. Strategies used to engage clients (e.g., education, outreach)	☐	☐	☐	☐
32. Strategies used to reduce "no-shows" for assessments and treatment services	☐	☐	☐	☐
33. Collaboration with peer support services	☐	☐	☐	☐
34. Use of evidence-based practices (EBPs)	☐	☐	☐	☐
35. Coordination with primary care services (e.g., medical and dental)	☐	☐	☐	☐
36. Clinical supervision and case consultation received	☐	☐	☐	☐
37. Use of electronic health records	☐	☐	☐	☐
38. Access to pharmacotherapy services	☐	☐	☐	☐

39. Overall, how satisfied are you with working at this agency?

☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very satisfied

40. How likely are you to continue working at this agency 5 years from now?

☐ Not at All ☐ Somewhat Likely ☐ Likely ☐ Very Likely

41. Overall, how satisfied are you with the quality of services that are provided by this agency?

☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very satisfied

THANK YOU for completing the CSB Direct Service Provider Survey!

Appendix E.

Direct Staff Survey – Prevention staff

Virginia Public Behavioral Health System Needs Assessment - CSB Prevention Service Provider Survey

In order to identify and prioritize behavioral health prevention service needs, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) would like to learn about you and the behavioral health prevention services provided by your agency. Please answer the following questions and please submit the completed survey before your scheduled focus group. Your help in answering these questions is greatly appreciated and your answers will be kept confidential.

* 1. What is the name of your Community Service Board (CSB)?

Virginia Public Behavioral Health System Needs Assessment - CSB Prevention Service Provider Survey

The following questions ask about your background and your role at your CSB.

2. What is your role in this organization? (Please check all that apply)

- [ ] Director of prevention services
- [ ] Prevention services coordinator
- [ ] Epidemiologist
- [ ] Public health administrator
- [ ] Program-specific staff
- [ ] Prevention specialist
- [ ] Prevention support staff
- [ ] Other (please specify)

3. For how long have you served in this role at this CSB?

- ○ Less than one year
- ○ 1 -2 years
- ○ 3 - 4 years
- ○ 5 years or more

4. What is your gender?

- ○ Male
- ○ Female
- ○ Other (please specify)

5. What is your age?

- ◯ 18 - 24 years of age
- ◯ 25 - 34 years of age
- ◯ 35 - 44 years of age
- ◯ 45 - 54 years of age
- ◯ 55 - 64 years of age
- ◯ 65 years and over

6. Are you of Hispanic, Latino, or Spanish origin?

- ◯ Yes
- ◯ No

7. What is your race? (Please check all that apply)

- ☐ Asian
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other (please specify)

8. Are you affiliated with any American Indian or Alaskan Native tribe?

- ◯ Yes
- ◯ No

9. What is your tribal affiliation?

10. What is the highest level of education that you have completed?

- ○ Some High School
- ○ High School Diploma/GED
- ○ Associates Degree
- ○ Bachelor's Degree (BS, BA)
- ○ Master's Degree (MS, MA, MSW, LCSW, MPH)
- ○ Doctorate (PhD, EdD, PsyD, DSW)
- ○ Professional Degree (RN, MD, PharmD)
- ○ Other (please specify)

11. What is your yearly personal income?

- ○ Less than $10,000
- ○ $10,000 - $19,000
- ○ $20,000 - $29,000
- ○ $30,000 - $39,000
- ○ $40,000 - $49,000
- ○ $50,000 - $59,000
- ○ $60,000 - $69,000
- ○ $70,000 - $79,000
- ○ $80,000 - $89,000
- ○ $90,000 - $99,000
- ○ $100,000 - $149,000
- ○ $150,000 or more

12. What are the primary populations for which your CSB provides prevention services? (Please check all that apply)

- ☐ Children (ages 0 – 11 years old)
- ☐ Adolescents (ages 12 - 17 years old)
- ☐ Young adults (ages 18 – 24 years old)
- ☐ Individuals with severe mental illness/severe emotional disturbance
- ☐ Individuals involved with the criminal/juvenile justice system
- ☐ Individuals with intellectual and/or developmental disabilities
- ☐ Other (please specify)
- ☐ Veterans and their families
- ☐ Members of the LGBTQ community
- ☐ Low income individuals/families
- ☐ Specific racial or ethnic groups
- ☐ Specific subpopulations experiencing environmental and adverse childhood experiences (ACEs)
- ☐ Unsure

13. For what specific groups or subpopulations does your CSB provide prevention services?

Virginia Public Behavioral Health System Needs Assessment
- CSB Prevention Service Provider Survey

The following questions address the accessibility of prevention services at your service location (CSB).

14. Are adequate staff available to implement prevention strategies?

- Yes
- No
- Unsure

15. Are the prevention services offered by your CSB successful in reaching targeted individuals and/or populations?

- Yes
- No
- Unsure

16. Do targeted individuals/populations receive prevention services when and where they need it?

- Yes
- No
- Unsure

17. Are there resources at your CSB to help individuals access prevention programming (e.g., assistance with transportation, convenient hours, funds to support community awareness)?

- Yes
- No
- Unsure

18. Are prevention services available in the preferred language of targeted individuals/populations?

- Yes
- No
- Unsure

19. How satisfied are you with the following?

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
Direction provided by leadership (e.g., “the big picture”)	○	○	○	○
Direction provided by supervisors regarding daily and weekly tasks	○	○	○	○
Support for coalition building/interaction	○	○	○	○
Training provided to support implementation of evidence-based prevention strategies	○	○	○	○
Relationships with coworkers	○	○	○	○
Compensation you receive (including benefits)	○	○	○	○

20. Approximately how much of your time each week do you spend doing the following?

	Very Little (0 – 10%)	Occasionally (11-20%)	Sometimes (21 – 30%)	More time than not (31 – 50%)	Most of my time (51 – 75%)	Almost all of my time (76% - 100%)
Planning or implementing prevention strategies	○	○	○	○	○	○
Completing documentation to support service delivery (e.g., Performance Based Prevention System [PBPS] data entry, staff hours)	○	○	○	○	○	○
Professional/ career development	○	○	○	○	○	○

Next, we would like to learn about your experience with implementing prevention strategies.

21. Please rate how well your CSB does the following:

	Excellent	Above Average	Average	Below Average	Poor	Not Applicable
Implementing evidence-based practices	○	○	○	○	○	○
Implementing environmental-level strategies	○	○	○	○	○	○
Utilizing data to select strategies	○	○	○	○	○	○
Identifying risk and/or protective factors for substance use	○	○	○	○	○	○
Using the Performance Based Prevention System (PBPS) and/or other reporting systems	○	○	○	○	○	○
Monitoring/evaluating prevention strategies	○	○	○	○	○	○
Conducting needs assessments	○	○	○	○	○	○
Developing/engaging coalitions	○	○	○	○	○	○
Sharing data with stakeholders	○	○	○	○	○	○
Engaging the community	○	○	○	○	○	○
Completing planning processes (e.g. logic modeling)	○	○	○	○	○	○
Implementing prevention programming with fidelity	○	○	○	○	○	○
Identifying gaps in prevention services	○	○	○	○	○	○

22. How likely are you to continue working at this agency 5 years from now?

- ○ Not at all likely
- ○ Somewhat Likely
- ○ Likely
- ○ Very likely

23. Overall, how satisfied are you with your job at this agency?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Satisfied
- ○ Very satisfied

24. Overall, how satisfied are you with the quality of prevention services that are provided by this agency?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Satisfied
- ○ Very satisfied

25. We will also be conducting virtual (online) focus groups with coalition representatives to better understand the role of coalitions in the Virginia prevention system, and to surface themes in strengths and barriers to providing prevention services. If you work with a coalition, we would like to ask you to share the contact information from one of the coalition leaders or active coalition members who we could invite to participate in the focus group. Please list below the name and contact information of the coalition member you nominated, and they will be contacted to schedule the focus group.

Name of Coalition	
Coalition Leader/Active Member First and Last Name	
Coalition Leader/Active Member Title	
Coalition Leader/Active Member Email	
Coalition Leader/Active Member Phone Number	

THANK YOU for completing the CSB Prevention Service Provider Survey!

Appendix F.

Prevention Director Brief Survey

Virginia Public Behavioral Health System Needs Assessment - CSB Prevention Director Brief Survey

In order to identify and prioritize behavioral health prevention service needs, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) would like to learn about you and the behavioral health prevention services provided by your agency.

We are asking directors of prevention services to complete a brief survey to provide information about the prevention services provided by their CSB. Your answers regarding the prevention services offered by your CSB will be kept confidential.

We are also asking prevention directors to nominate a prevention staff provider to participate in a virtual (online) focus group in which they will discuss their experiences with providing prevention services. Information about the virtual focus groups for prevention staff will be provided in a future communication.

Your help in answering these questions is greatly appreciated!

* 1. What is the name of your Community Service Board (CSB)?

2. What type of prevention services are offered by your CSB? (Please check all that apply)

- [ ] Universal (services given to individuals in general population, not directed at a specific risk group)
- [ ] Selective (services given to individuals targeted as having high risk for substance and/or behavioral health disorder)
- [ ] Indicated (services given to individuals already using substances or identified as having a behavioral health disorder)
- [ ] Harm Reduction
- [ ] Other (please specify)

3. Approximately how many individuals do your prevention services serve or reach in a month?

- ( ) Under 100
- ( ) 100-1,000
- ( ) 1,000-5,000
- ( ) 5,000-25,000
- ( ) 25,000-50,000
- ( ) 50,000-100,000
- ( ) 100,000-250,000
- ( ) Over 250,000

4. What are the primary funding sources used to support prevention services at your CSB? (Please select all that apply)

- [ ] Virginia Substance Abuse Prevention Block Grant
- [ ] Virginia State Opioid Response Grant (SOR)
- [ ] Virginia Partnership for Success Grant (PFS)
- [ ] Local level funding
- [ ] Other State Level funding
- [ ] Other funding (please specify other funding sources, including other state level funding)

5. Do the prevention services provided by your CSB target a specific substance?

- ( ) Yes
- ( ) No

6. Please select the substance(s) your work targets below. (Please check all that apply)

- [ ] Alcohol
- [ ] Amphetamine/Methamphetamine
- [ ] Tobacco
- [ ] Heroin
- [ ] Marijuana
- [ ] Prescription drug misuse
- [ ] Other (please specify)

7. Do the prevention services provided by your CSB target a specific behavioral health disorder or individual risk factor?

- ○ Yes
- ○ No

8. Please select the disorders/risk factors your work targets below. (Please check all that apply)

- [ ] Substance use disorders
- [ ] Overdoses
- [ ] Mental health disorders
- [ ] Suicide
- [ ] Other (please specify)
- [ ] Family problems
- [ ] Legal issues (e.g. arrests, incarceration, debt)
- [ ] Adverse childhood experiences (ACEs)
- [ ] Homelessness

9. Do the prevention services provided by your CSB target a specific community risk or protective factor(s)?

- ◯ Yes
- ◯ No

10. Please select the risk factor(s) your work targets below. (Please check all that apply)

- [ ] Availability of substances
- [ ] Ease of access to substances
- [ ] High rate of substance use
- [ ] Community norms/attitudes favorable to substance use
- [ ] Poverty
- [ ] Other (please specify)
- [ ] Attachment to neighborhood/community
- [ ] Policies targeted at decreasing substance misuse
- [ ] Poverty
- [ ] Environmental influences

11. We will be conducting virtual (online) focus groups with one (1) prevention staff representative from each CSB to identify strengths and barriers to providing prevention services in Virginia. We would like to you to nominate one of your prevention service providers to participate in the focus group. We would like the prevention staff member you nominate to have been actively engaged in the planning and delivery of prevention services at your CSB. If you are the only prevention staff member in your organization, please nominate yourself! Please list below the name and contact information of the prevention staff member you nominated, and they will be contacted to schedule the focus group.

Prevention Staff Member First and Last Name	
Prevention Staff Member Title	
Prevention Staff Member Email	
Prevention Staff Member Phone Number	

THANK YOU for completing the CSB Prevention Director Brief Survey!

Appendix G.

CSB Site Visit Interview Guides

COMMUNITY SERVICES BOARD (CSB)
BOARD PRESIDENT
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the President of the Board/or designee for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as President of the Board/or designee are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** Do you have other responsibilities besides overseeing Clinical Services?

B. CAPACITY

2) What are the behavioral health (BH) priorities for your CSB?
    a. **Probe:** What is the Board's process for determining these priorities?
    b. **Probe:** How has the Board used data to determine these priorities?

3) Do you foresee any changes in the types of BH services your organization will offer over the next five years to respond to the demand? If yes, why and what changes do you foresee?
    a. **Probe:** Mental health (MH) and substance use disorder (SUD) services.

4) Please describe how you collaborate with key community stakeholders or coalitions to advance or leverage your efforts.

5) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

6) Are there efforts to recruit staff that are representative of the population served? If yes, please describe those efforts.

C. WORKFORCE

7) Does your Board membership meet the required composition for CSBs?
    a. **Probe:** If yes, how does this impact the Board's decision-making process?
    b. **Probe:** if no, what are the challenges in meeting this requirement?

D. FUNDING

8) Please describe the budget, resource allocation process, and use of human resources for your CSB.

9) Is the funding you receive sufficient to deliver quality MH and SUD services to your client population? Please explain.
    a. **Probe:** What are some of the limitations?

10) Are you seeking additional funding opportunities (other than DBHDS funding)? If yes, which ones? If not, why not?

E. OUTCOME INFORMATION

11) Are there any current programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

F. ADMINISTRATIVE

12) Does your CSB have the infrastructure/organizational systems to address the likely changes that will occur in 2-3 years (e.g. human resources, health information technology, staff development)?

13) Describe the Board's process for providing guidance to CSB leadership on effectively implementing administrative priorities, strategies and goals?

G. STEP-VA

14) What has been your organization's response to implementing STEP-VA**?**

15) Does your CSB have a plan or strategy in place for STEP-VA implementation?
    a. **Probe:** If yes, please describe the plan (who is doing what, by when? what's working, what not, what should be changed?)

16) Please describe your CSB's current capacity to provide STEP-VA services and EBPs.
    a. **Probe:** Please describe any recognized EBPs you are currently delivering to support STEP-VA implementation.

17) What additional capacity needs to be in place for you to fully implement STEP-VA?
    a. **Probe:** Money, training, certification, technical knowledge?

18) Please describe any facilitators you have found helpful related to STEP-VA implementation in your CSB.

19) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

H. MEDICAID

20) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
    a. **Probe:** Changes or impact to your programs?
    b. **Probe:** Changes or impact to the BH system in Virginia?
    c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

21) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
    a. **Probe:** If not, what are the barriers?
    b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

22) What are the biggest challenges or areas of concern with Medicaid Expansion?
    a. **Probe:** Working with managed care organizations or other third-party payers?
    b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
    c. **Probe:** Workforce development?
    d. **Probe:** Desired clinical/programmatic outcomes?

I. BRIGHT SPOTS

23) Describe a BH program/initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
EXECUTIVE DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Executive Director for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Executive Director are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and how you spend your time each week.
    a. **Probe:** How did these prepare you for your role as Executive Director?
    b. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    c. **Probe:** Do you have other responsibilities besides serving as Executive Director?

B. CAPACITY

2) What are the service priorities for your CSB?
    a. **Probe:** How do you determine these service priorities?
    b. **Probe:** How have you used data to determine these service priorities?

3) Are there programs where you have concerns regarding level of demand (e.g., over/under utilization)? Please explain.

4) Are there certain client groups whom you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

5) Are there certain client groups for whom you think you need to build capacity to better serve? How do you know? Please explain.

6) Please describe how you collaborate with key community stakeholders or coalitions to advance your efforts.

7) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

8) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** Staffing shortages, surplus and turnover?

9) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs? (e.g. salary, caseload, certification need, pay, rural area, etc.)

10) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

11) [See Q&A #23 Pre-site Visit Survey] According to the data we previously collected, you noted that there was not sufficient capacity to provide ___; ___; ___; ___ services. Please tell us more about how you determine the capacity or workforce needed to provide services.

D. FUNDING

12) Please describe the budget, resource allocation process, and use of human resources for your CSB.

13) Is the funding you receive sufficient to deliver quality MH and SUD services to your client population? Please explain.
    a. Probe: What are some of the limitations?

14) Are you seeking additional funding opportunities (other than DBHDS funding)? If yes, which ones? If not, why not?

E. OUTCOME INFORMATION

15) Are there any current programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns?

F. CONTINUOUS QUALITY IMPROVEMENT

16) Are you able to collect and analyze data about the services you provide and the clients you serve so that you can monitor impact and effectiveness of services and make decisions?
    a. **Probe:** If yes, please describe your system for data collection.
    b. **Probe:** If not, please describe what is lacking.

17) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe. (e.g. incentives, EBPs, training, fidelity, etc.)

ADMINISTRATIVE

18) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

19) [See Q&A #21 Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe** How has this sub-contract been performing? Areas of concern?

G. STEP-VA

20) Does your CSB have a plan or strategy in place for STEP-VA implementation?
    a. Probe: If yes, please describe the plan (who is doing what, by when? what's working, what not, what should be changed?)

21) Please describe your CSB's current capacity to provide STEP-VA services and EBPs.
    a. Probe: Please describe any recognized EBPs you are currently delivering to support STEP-VA implementation.

22) [See Q&A #28 & #30 in the Pre-site Visit Survey] According to the data we previously collected, your agency described its progress for implementing STEP-VA services as being in Phase ___, and for STEP-VA EBPs, as being in Phase ___.
    a. **Probe:** What progress has your CSB made in implementing STEP-VA?
    b. **Probe:** Describe how this reflects your process with implementing STEP-VA at your CSB.
    c. **Probe**: What have you accomplished and what do you still need to accomplish?
    d. **Probe**: Have you collected any outcomes related to STEP-VA implementation?

23) What additional capacity needs to be in place for you to fully implement STEP-VA?
    a. Probe: Money, training, certification, technical knowledge?

24) Please describe any facilitators you have found helpful related to STEP-VA implementation in your CSB.

25) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

H. MEDICAID

26) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
    a. **Probe:** Changes or impact to your programs?
    b. **Probe:** Changes or impact to the BH system in Virginia?

c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

27) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
   a. **Probe:** if not, what are the barriers?
   b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

28) What are the biggest challenges or areas of concern with Medicaid Expansion?
   a. **Probe:** Working with managed care organizations or other third-party payers?
   b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
   c. **Probe:** Workforce development?
   d. **Probe:** Desired clinical/programmatic outcomes?

H. BRIGHT SPOTS

29) Describe an area related to service delivery and/or administrative practices where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
CLINICAL DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, and needs you may have as the Clinical Director for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Clinical Director are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing Clinical Services?

B. CAPACITY

2) What are the mental health (MH) and substance use disorder (SUD) treatment priorities for your CSB?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

3) What are the strengths and challenges to providing treatment services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

4) Are there MH or SUD treatment programs where you have concerns regarding level of demand (e.g., over/under utilization)? Please explain.

5) Are there certain client groups whom you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

6) Are there certain client groups for whom you think you need to build capacity to better serve? How do you know? Please explain.

7) How does your organization manage behavioral health crisis (e.g. suicide, domestic abuse, relapse, overdose)?

8) Please describe any telehealth services used to support provision of MH and SUD treatment services.
9) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

10) How does your CSB support clients with varying literacy levels?
    a. **Probe:** What processes does your CSB have for identifying client literacy levels?

C. WORKFORCE

11) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** Staffing shortages, surplus and turnover?

12) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs (e.g. salary, caseload, certification need, pay, rural area, etc.)?

13) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

14) [Note: See Q&A #23 Pre-site Visit Survey] According to the data we previously collected, you noted that there was not sufficient capacity to provide ___; ___; ___; ___ services. Please tell us more about how you determine the capacity or workforce needed to provide services.

D. FUNDING

15) Is the funding you receive sufficient to deliver quality MH and SUD treatment services to your client population? Please explain.
    a. Probe: What are some of the limitations?

E. CLIENT SERVICES AND CHARACTERISTICS

16) Are there certain populations that you think have difficulty accessing MH and SUD services? If yes, please explain.
    a. **Probe:** Which populations?
    b. **Probe:** What makes it difficult for them to access BH services?
    c. **Probe**: What additional services, staffing, treatment models might be needed?

F. OUTCOME INFORMATION

17) Do you have systems in place to monitor the impact and effectiveness of services? If yes, please describe.

18) How do you give/receive outcomes information to the state (e.g. CCS-3, satisfaction, etc.)?

19) What are your CSB's benchmarks for follow-up after hospitalization?
    a. **Probe:** Are 70% timely follow up for community hospitalization within 7 days and 80% timely follow up from a state facility within 7 days your CSB's current benchmarks? If yes, what are these benchmarks based upon?

b. **Probe:** Are you able to share your latest data on how you did during the last review of this data?

20) Are there any MH or SUD treatment programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.
    a. **Probe:** What evidence-based practices (EBPs) are used for MH and SUD treatment services?
    b. **Probe:** How did you access training for these EBPs?

21) Are there any current programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

G. CONTINUOUS QUALITY IMPROVEMENT

22) Are you able to collect and analyze data about the treatment services you provide and the clients you serve so that you can monitor the impact and effectiveness of services and make decisions?
    a. **Probe:** If yes, please describe your system for data collection.
    b. **Probe:** If not, please describe what is lacking.

23) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe (e.g. incentives, EBPs, training, fidelity, etc.).

H. ADMINISTRATIVE

24) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

25) [See Q&A #21 Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe** How has this sub-contract been performing? Areas of concern?

I. STEP-VA

26) Does your CSB have a plan or strategy in place for STEP-VA implementation?
    a. **Probe:** If yes, please describe the plan (who is doing what, by when? what's working, what not, what should be changed?)

27) Please describe your CSB's current capacity to provide STEP-VA services and EBPs.
    a. **Probe:** Please describe any recognized EBPs you are currently delivering to support STEP-VA implementation.

28) [See Q&A #28 & #30 in the Pre-site Visit Survey] According to the data we previously collected, your agency described its progress for implementing STEP-VA services as being in Phase ___, and for STEP-VA EBPs, as being in Phase ___.
    a. **Probe:** What progress has your CSB made in implementing STEP-VA?

b. **Probe:** Describe how this reflects your process with implementing STEP-VA at your CSB.
c. **Probe**: What have you accomplished and what do you still need to accomplish?
d. **Probe**: Have you collected any outcomes related to STEP-VA implementation?

29) What additional capacity needs to be in place for you to fully implement STEP-VA?
   a. Probe: Money, training, certification, technical knowledge?

30) Please describe any facilitators you have found helpful related to STEP-VA implementation in your CSB.

31) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

J. MEDICAID

32) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
   a. **Probe: C**hanges or impact to your treatment program(s)?
   b. **Probe: C**hanges or impact to the BH system in Virginia?
   c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

33) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
   a. **Probe:** If not, what are the barriers?
   b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

34) What are the biggest challenges or areas of concern with Medicaid Expansion?
   a. **Probe:** Working with managed care organizations or other third-party payers?
   b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
   c. **Probe:** Workforce development?
   d. **Probe:** Desired clinical/programmatic outcomes?

K. BRIGHT SPOTS

35) Describe a MH or SUD treatment program/initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
MEDICAL DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Medical Director for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Medical Director are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

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At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing psychiatry services?

B. CAPACITY

2) What are the psychiatry service priorities for your CSB?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

3) What are the strengths and challenges to providing BH and medical treatment? Please explain.
    a. **Probe:** Eligibility, financial resources, insurance coverage?
    b. **Probe:** Availability of services in geographic area?

4) What efforts have been undertaken to integrate primary care and behavioral health care?
    a. **Probe:** Partnerships with Federally Qualified Health Centers or other primary care providers?

5) Are there certain client groups whom you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

6) Are there certain client groups for whom you think you need to build capacity to better serve? How do you know? Please explain.

7) How does your organization manage behavioral health crisis (e.g. suicide, domestic abuse, relapse, overdose)?

8) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

9) How does your CSB support clients with varying literacy levels?
    a. **Probe:** What processes does your CSB have for identifying client literacy levels?

C. WORKFORCE

10) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** Staffing shortages, surplus and turnover?

11) Do you provide Medication Assisted Treatment (MAT)?
    a. **Probe:** If yes, how has MAT been accepted by staff?
    b. **Probe:** If no, what are your plans for providing MAT?

12) How does your CSB handle pharmacy services?
    a. **Probe:** Does your CSB have its own formulary (e.g. partnerships)?

13) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs? (e.g. salary, caseload, certification need, pay, rural area, etc.)

D. CLIENT SERVICES AND CHARACTERISTICS

14) Are there certain populations that you think are difficult to reach with MH and SUD services? If yes, please explain.
    a. **Probe:** Which populations?
    b. **Probe:** What makes it difficult for them to access BH services?
    c. **Probe**: What additional services, staffing, treatment models might be needed?

E. OUTCOME INFORMATION

15) Do you have systems in place to monitor the impact and effectiveness of services? If yes, please describe.

16) Are there any programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective?
    a. **Probe:** What evidence-based practices (EBPs) are being used?
    b. **Probe:** How did you access training for these EBPs?

17) Are there any current programs/services for which you have concerns, based on outcomes and/or the data you have available? If yes, please talk about those programs and concerns

CONTINUOUS QUALITY IMPROVEMENT

18) Are you able to collect and analyze data about the services you provide and the clients you serve so that you can monitor the impact and effectiveness of services and make decisions?
    a. **Probe:** If yes, please describe your system for data collection.
    b. **Probe:** If not, please describe what is lacking.

19) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe. (e.g. incentives, EBPs, training, fidelity, etc.)

F. ADMINISTRATIVE

20) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

G. STEP-VA

21) Currently, do you have direct involvement in STEP-VA planning? If yes, please describe your role.

22) Please describe your CSB's current capacity to provide STEP-VA services and EBPs.
    a. Probe: Please describe any recognized EBPs you are currently delivering to support STEP-VA implementation.

23) What additional capacity needs to be in place for you to fully implement STEP-VA?
    a. Probe: Money, training, certification, technical knowledge?

24) Please describe any facilitators you have found helpful related to STEP-VA implementation in your CSB.

25) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

H. MEDICAID

26) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
    a. **Probe:** Changes or impact to your program(s)?
    b. **Probe:** Changes or impact to the BH system in Virginia?
    c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

27) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.

a. **Probe:** if not, what are the barriers?
b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

28) What are the biggest challenges or areas of concern with Medicaid Expansion?
   a. **Probe:** Working with managed care organizations or other third-party payers?
   b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
   c. **Probe:** Workforce development?
   d. **Probe:** Desired clinical/programmatic outcomes?

I. BRIGHT SPOTS

29) Describe a MH or SUD treatment program/initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
PREVENTION DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Prevention Director for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Prevention Director are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing Prevention Services?

B. CAPACITY

2) What are the prevention priorities for your CSB?
    a. **Probe:** What process do you use to complete your prevention plan?
    b. **Probe:** Are there specific substances or risk and protective factors that your prevention efforts target?
    c. **Probe:** How do you determine the priorities?
    d. **Probe:** How have you used data to determine these priorities?

3) What are the strengths and challenges to providing prevention services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

4) Are there prevention programs where you have concerns regarding level of demand (e.g., over/under utilization)? Please explain.

5) Are there certain populations that you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

6) Are there certain populations that you think you need to build capacity to better serve? How do you know? Please explain.

7) Please describe how you collaborate with key community stakeholders or coalitions to advance your efforts and build awareness about your services?

a. **Probe:** Presence of a coalition specifically created for planning purposes? If yes, please explain.

8) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

9) Please describe the following characteristics about your staff:
   a. **Probe:** Staff strengths, challenges and needs?
   b. **Probe:** staffing shortages, surplus and turnover?

10) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs? (e.g. salary, caseload, certification need, pay, rural area, etc.)

11) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

D. FUNDING

12) Is the funding you receive sufficient to deliver prevention services to your target population(s)? Please explain.
   a. Probe: What are some of the limitations?

E. CLIENT SERVICES AND CHARACTERISTICS

13) Are there disparities related to substance use or consequences across different populations in your community? If yes, how do you identify and address these?

14) If you could improve one thing about clients' experience when seeking prevention services, what would that be?

F. OUTCOME INFORMATION

15) Please describe your CSB's prevention data collection system.
   a. **Probe:** Do you use fidelity and data collection tools? If yes, please describe.
   b. **Probe:** Are there challenges within the system? If yes, please explain.

16) Do you have systems in place to monitor the impact and effectiveness of prevention services?

17) Are there any prevention programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.
   a. **Probe:** What evidence-based practices (EBPs) are used for prevention services?
   b. **Probe:** How did you access training for these EBPs?

18) Are there any current prevention programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

G. CONTINUOUS QUALITY IMPROVEMENT

19) Are you able to collect and analyze data about the services you provide and the people you encounter / serve so that you can monitor the impact and effectiveness of services and make decisions?
    a. **Probe:** If yes, please describe your system for data collection.
    b. **Probe:** If not, please describe what is lacking.
    c. **Probe:** Does your system allow you to track outcomes? Please explain.

20) Do you have systems in place to assure prevention services are delivered with quality? If yes, please describe.
    a. **Probe:** Incentives, evidence-based practices, training, fidelity, etc.

H. ADMINISTRATIVE

21) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

22) [See Q&A #21 Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe** How has this sub-contract been performing? Areas of concern?

I. BRIGHT SPOTS

23) Describe a prevention program/ initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
RECOVERY PROGRAM DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Recovery Program Director for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Recovery Director are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing Recovery Services?

B. CAPACITY

2) What are the recovery priorities for your CSB?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

3) What are the strengths and challenges to providing recovery services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

4) Are there certain client groups whom you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

5) Are there certain client groups for whom you think you need to build capacity to better serve? How do you know? Please explain.

6) How does your organization manage behavioral health crisis (e.g. suicide, domestic abuse, relapse, overdose)?

7) Please describe any telehealth services used to support provision of recovery services.

8) Please describe how you collaborate with key community stakeholders or coalitions to advance your efforts.

9) Do you work with multiple pathways of recovery (e.g. Faith-based, Medication Assisted Treatment, Mutual Aid)? If yes, please describe.

10) Do you work with harm reduction (e.g. syringe exchange, naloxone rescue, fentanyl test strips)? If yes, please describe.

11) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

12) How does your CSB use peer staff?

13) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** Staffing shortages, surplus and turnover?

14) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs? (e.g. salary, caseload, certification need, pay, rural area, etc.)

15) Describe your process for recruiting and training peer staff.

16) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

D. FUNDING

17) Is the funding you receive sufficient to deliver recovery services to your client population? Please explain.
    a. Probe: What are some of the limitations?

E. CLIENT SERVICES AND CHARACTERISTICS

18) If you could improve one thing about clients' experience when seeking recovery services, what would that be?

F. OUTCOME INFORMATION

19) Do you have systems in place to monitor the impact and effectiveness of services? If yes, please describe.

20) Are there any recovery programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.
    a. **Probe:** What evidence-based practices (EBPs) are used for recovery services?
    b. **Probe:** How did you access training for these EBPs?

G. CONTINUOUS QUALITY IMPROVEMENT

21) Are you able to collect and analyze data about the recovery services you provide and the clients you serve so that you can monitor the impact and effectiveness of services and make decisions?
   a. **Probe:** If yes, please describe your system for data collection.
   b. **Probe:** If not, please describe what is lacking.

22) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe. (e.g. incentives, EBPs, training, fidelity, etc.)

H. ADMINISTRATIVE

23) How do you determine your administrative priorities (e.g. EHR/IT System)?
   a. **Probe:** Use of data? Presence of a strategic plan?

24) [See Q&A #21 Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
   a. **Probe** How has this sub-contract been performing? Areas of concern?

I. STEP-VA

25) Does your CSB have a plan or strategy in place for STEP-VA implementation?
   a. Probe: If yes, please describe the plan (who is doing what, by when? what's working, what not, what should be changed?)

26) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

J. MEDICAID

27) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
   a. **Probe:** Changes or impact to your recovery programs?
   b. **Probe:** Changes or impact to the BH system in Virginia?
   c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

28) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
   a. **Probe:** if not, what are the barriers?
   b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

29) What are the biggest challenges or areas of concern with Medicaid Expansion?
    a. **Probe:** Working with managed care organizations or other third-party payers?
    b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
    c. **Probe:** Workforce development?
    d. **Probe:** Desired clinical/programmatic outcomes?

K. BRIGHT SPOTS

30) Describe a recovery program / initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
DIRECTOR OF WOMEN'S SERVICES
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Director of Women's Services for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Director of Women's Services are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing Women's Services?

B. CAPACITY

2) What are your CSB's priorities for Women's Services?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

3) What behavioral health services are offered specifically for women?
    a. **Probe:** Are there programs where you have concerns regarding level of demand (e.g. over/under utilization)?

4) What are the strengths and challenges to providing women's services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

5) Are there programs where you have concerns regarding level of demand (e.g., over/under utilization)?

6) Are there certain sub populations of the women you serve that you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

7) Are there certain sub populations of the women you serve for which you think you need to build capacity to better serve? How do you know? Please explain.

8) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

9) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** Staffing shortages, surplus and turnover?

10) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs? (e.g. salary, caseload, certification need, pay, rural area, etc.)

11) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

D. FUNDING

12) Is the funding you receive sufficient to deliver quality MH and SUD services to your client population? Please explain.
    a. Probe: What are some of the limitations?

E. CLIENT SERVICES AND CHARACTERISTICS

13) If you could improve one thing about clients' experience when seeking women's services, what would that be?

F. OUTCOME INFORMATION

14) Do you have systems in place to monitor the impact and effectiveness of women's services? If yes, please describe.

15) Are there any women's programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.
    a. **Probe:** What evidence-based practices (EBPs) are used for women's services?
    b. **Probe:** How did you access training for these EBPs?

16) Are there any current programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

G. CONTINUOUS QUALITY IMPROVEMENT

17) Are you able to collect and analyze data about the services you provide and the clients you serve so that you can monitor the impact and effectiveness of services and make decisions?

a. **Probe:** If yes, please describe your system for data collection.
b. **Probe:** If not, please describe what is lacking.

18) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe (e.g. incentives, EBPs, training, fidelity, etc.).

H. ADMINISTRATIVE

19) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

20) [See Q&A #21 in the Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe** How has this sub-contract been performing? Areas of concern?

I. STEP-VA

21) Does your CSB have a plan or strategy in place for STEP-VA implementation?
    a. Probe: If yes, please describe the plan (who is doing what, by when? what's working, what not, what should be changed?)

22) Please describe your CSB's current capacity to provide STEP-VA services and EBPs.
    a. Probe: Please describe any recognized EBPs you are currently delivering to support STEP-VA implementation as it relates to women's services.

23) [See Q&A #28 & #30 in the Pre-site Visit Survey] According to the data we previously collected, your agency described its progress for implementing STEP-VA services as being in Phase ___, and for STEP-VA EBPs, as being in Phase ___.
    a. **Probe:** What progress has your CSB made in implementing STEP-VA?
    b. **Probe:** Describe how this reflects your process with implementing STEP-VA.
    c. **Probe**: What have you accomplished and what do you still need to accomplish?
    d. **Probe**: Have you collected any outcomes related to STEP-VA implementation?

24) What additional capacity needs to be in place for you to fully implement STEP-VA?
    a. Probe: Money, training, certification, technical knowledge?

25) Please describe any facilitators you have found helpful related to STEP-VA implementation in your CSB.

26) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

J. MEDICAID

27) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
   a. **Probe:** Changes or impact to your program(s)?
   b. **Probe:** Changes or impact to the BH system in Virginia?
   c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

28) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
   a. **Probe:** if not, what are the barriers?
   b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

29) What are the biggest challenges or areas of concern with Medicaid Expansion?
   a. **Probe:** Working with managed care organizations or other third-party payers?
   b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
   c. **Probe:** Workforce development?
   d. **Probe:** Desired clinical/programmatic outcomes?

K. BRIGHT SPOTS

30) Describe a women's program/ initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
DIRECTOR OF CHILDREN'S SERVICES
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Director of Children's Services for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Director of Children's Services are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

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At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing Children's Services?

B. CAPACITY

2) Have you adopted a specific model for children services? If yes, please describe.
    a. **Probe:** What services are offered specifically for children (and families)?
    b. **Probe:** What evidence-based practices (EBPs) are being used?

3) What ages are currently being served by your program?

4) What are the mental health (MH) and substance use disorder (SUD) priorities for your program?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

5) What are the strengths and challenges to providing children's services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

6) Are there programs where you have concerns regarding level of demand (e.g., over/under utilization)?

7) Are there certain client groups you serve that you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

8) Are there certain client groups that you serve for which you think you need to build capacity to better serve? How do you know? Please explain.

9) How does your organization manage behavioral health crisis for children (e.g. suicide, domestic abuse, relapse, overdose)?
    a. **Probe:** What innovative approaches are being utilized for children?

10) Please describe how you collaborate with key community stakeholders or coalitions to advance your efforts.

11) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

12) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** staffing shortages, surplus and turnover?

13) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs? (e.g. salary, caseload, certification need, pay, rural area, etc.)

14) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

D. FUNDING

15) Is the funding you receive sufficient to deliver quality MH and SUD services to your client population? Please explain.
    a. Probe: What are some of the limitations?

16) Are there specific funding strategies for the services you would like to deliver?

E. CLIENT SERVICES AND CHARACTERISTICS

17) How are you connected with the rest of the continuum of care?

18) How are you connected with Prevention Services?

19) Are home-based therapeutic (HBT) services provided by your CSB? If yes, please describe.
    a. **Probe:** If no, do you have a relationship with those providers for HBTF (e.g. business associate agreement, memorandum of understanding, etc.)

20) If you could improve one thing about clients' experience when seeking children's MH/SUD services, what would that be?

F. OUTCOME INFORMATION

21) Do you have systems in place to monitor the impact and effectiveness of children's services? If yes, please describe.

22) Are there any children's programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.
    a. **Probe:** What EBPs are used for children's services?
    b. **Probe:** How did you access training for these EBPs?

23) Are there any current programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

G. CONTINUOUS QUALITY IMPROVEMENT

24) Are you able to collect and analyze data about the services you provide and the clients you serve so that you can monitor the impact and effectiveness of services and make decisions?
    a. **Probe:** If yes, please describe your system for data collection.
    b. **Probe:** If not, please describe what is lacking.

25) Do you have systems in place to assure treatment services for children are delivered with quality? If yes, please describe those systems.
    a. **Probe:** Incentives, evidence-based practices, training, fidelity, etc.

H. ADMINISTRATIVE

26) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

27) [See Q&A #21 in the Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe** How has this sub-contract been performing? Areas of concern?

I. MEDICAID

28) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
    a. **Probe:** Changes or impact to your program(s)?
    b. **Probe:** Changes or impact to the BH system in Virginia?
    c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

29) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
    a. **Probe:** if not, what are the barriers?
    b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

30) What are the biggest challenges or areas of concern with Medicaid Expansion?
    a. **Probe:** Working with managed care organizations or other third-party payers?
    b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
    c. **Probe:** Workforce development?
    d. **Probe:** Desired clinical/programmatic outcomes?

J. BRIGHT SPOTS

31) Describe a children's program/ initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
DIRECTOR OF HOUSING SERVICES
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction

Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Director of Housing Services for this CSB.

Background and Purpose

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings

Your opinions and experiences as Director of Housing Services are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing Housing Services?

B. CAPACITY

2) What are your CSB's priorities for Housing Services?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

3) What are the strengths and challenges to providing housing services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

4) Is it more challenging to find housing for clients or to get the necessary clinical supports in place to assure housing is a success? Please explain.

5) Are there certain client groups that you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

6) Are there certain client groups for which you think you need to build capacity to better serve? How do you know? Please explain.

7) How does your program manage behavioral health crisis (e.g. suicide, domestic abuse, relapse, overdose)?

8) Please describe how you collaborate with key community stakeholders or coalitions to advance your efforts.

9) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

10) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** staffing shortages, surplus and turnover?

11) Are there positions that are difficult to recruit and retain? If yes, what is contributing to those needs (e.g. salary, caseload, certification need, pay, rural area, etc.)?

12) Do you have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

D. FUNDING

13) Is the funding you receive sufficient to deliver quality housing services to your client population? Please explain.
    a. Probe: What are some of the limitations?

E. CLIENT SERVICES AND CHARACTERISTICS

14) Are there certain populations that you think have difficulty with accessing housing services? If yes, please explain.
    a. **Probe:** Which populations?
    b. **Probe:** What makes it difficult for them to housing services?
    c. **Probe**: What additional services or staffing might be needed?

15) Are there certain client characteristics that make it more difficult to place in housing services? If so, please describe.

F. OUTCOME INFORMATION

16) Do you have systems in place to monitor the impact and effectiveness of housing services? If yes, please describe.

17) Do you collect data on housing retention? If yes, please explain.

18) Are there any housing programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.

19) What evidence-based practices (EBPs) are used for housing services?

a. **Probe:** Permanent supportive housing, Housing First, recovery housing, or apartment programs?
b. **Probe:** How did you access training for these EBPs?

20) Are there any current programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

G. CONTINUOUS QUALITY IMPROVEMENT

21) Are you able to collect and analyze data about the services you provide and the clients you serve so that you can monitor the impact and effectiveness of services and make decisions?
a. **Probe:** If yes, please describe your system for data collection.
b. **Probe:** If not, please describe what is lacking.

22) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe (e.g. incentives, EBPs, training, fidelity, etc.).

H. ADMINISTRATIVE

23) How do you determine your administrative priorities (e.g. EHR/IT System)?
a. **Probe:** Use of data? Presence of a strategic plan?

24) [See Q&A #21 in the Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
a. **Probe** How has this sub-contract been performing? Areas of concern?

I. MEDICAID

25) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
a. **Probe:** Changes or impact to your program(s)?
b. **Probe:** Changes or impact to the BH system in Virginia?
c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

26) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
a. **Probe:** if not, what are the barriers?
b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

27) What are the biggest challenges or areas of concern with Medicaid Expansion?
a. **Probe:** Working with managed care organizations or other third-party payers?
b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?

c. **Probe:** Workforce development?
d. **Probe:** Desired clinical/programmatic outcomes?

J. BRIGHT SPOTS

28) Describe a housing program/initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
FISCAL DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Fiscal Director for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Fiscal Director are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** Do you have other responsibilities besides overseeing Fiscal Services?

B. FUNDING

2) Please describe the budget, resource allocation process, and use of human resources for your CSB.
    a. Probe: How do you tie your budget to state performance contracts and local government budget processes?

3) Is the funding you receive sufficient to deliver quality MH and SUD services to your client population? Please explain.
    a. Probe: What are some of the limitations?
    b. Probe: What are the primary funding sources (e.g. Federal funds, DBHDS, Medicaid, private payers, local sources, etc.) used to support the provision of services to clients?

4) Are you seeking additional funding opportunities (other than DBHDS funding)? If yes, which ones? If not, why not?

5) Are there specific services that your CSB would like to offer, but are unable to because of funding? If yes, what services? Please explain.

6) Are there any statutory, policy, or other restrictions on the funding received that make it difficult to spend funds on behavioral health service provision?

7) How are sliding fee scale services dealt with by the business office?

C. CLIENT SERVICES AND CHARACTERISTICS

8) What kind of data do you provide to other members of the leadership team that supports their decision making (e.g., payer mix, percentage of scheduled no-show appointments, units of services delivered, etc.)?
    a. **Probe:** Do you separate billing by service category (e.g. Children's Services, Prevention Services, Housing, etc.)?

D. CONTINUOUS QUALITY IMPROVEMENT

9) Do you participate in the agency's CQI process? If so, please describe your role.

E. ADMINISTRATIVE

10) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

11) [See Q&A #21 in the Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe** How has this sub-contract been performing? Areas of concern?

12) Has your CSB been able to make necessary infrastructure improvements (e.g., IT systems, building improvements, staff training)?
    a. **Probe** If yes, please describe improvements made.
    b. **Probe:** If not, what is lacking and what do you attribute it to?

F. STEP-VA

13) Have you participated in planning discussions regarding financially sustainable models for STEP-VA services?

14) Are there any fiscal concerns or potential barriers you would like to mention as it relates to funding implementation of STEP-VA in your CSB? If yes, please explain.

G. MEDICAID

15) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
    a. **Probe: C**hanges or impact to your treatment program(s)?
    b. **Probe: C**hanges or impact to the BH system in Virginia?
    c. **Probe:** What changes are you **hoping** Medicaid expansion will bring?

16) Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.

a. **Probe:** If not, what are the barriers?
b. **Probe:** Do you have the infrastructure to calculate costs by services or conduct cost modeling?

17) Please describe your CSB's cost modeling process.
    a. **Probe:** Is it different in the context of cost by service for Medicaid Expansion? Please explain.

18) What are the biggest challenges or areas of concern with Medicaid Expansion?
    a. **Probe:** Working with managed care organizations or other third-party payers?
    b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
    c. **Probe:** Workforce development?

H. BRIGHT SPOTS

19) Describe an area related to your CSB's fiscal practices where your CSB excels. What is leading to this program's/ initiative's success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
INFORMATION TECHNOLOGY DIRECTOR
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as the Director of Information Technology (IT) for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as Director of IT are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services? Providing clinical supervision?
    b. **Probe:** Do you have other responsibilities besides overseeing IT Services?

B. CAPACITY

2) Does your CSB have a Health IT (HIT) plan? If yes, please describe.

3) Does your CSB have data sharing agreements in place? If yes, please describe these agreements and the groups or agencies you have agreements with.
    a. **Probe:** HIPPA, Business Associates Agreements (BAA), Qualified Services Organization Agreements (QSOA), etc.

4) What are the IT priorities for your mental health (MH) and substance use disorder (SUD) services?
    a. **Probe:** How do you determine these priorities?
    b. **Probe:** How have you used data to determine these priorities?

5) What is the current level of end user satisfaction with the electronic health record (EHR) system?

6) Are there other IT systems that you use for program operations and management?

7) Has your CSB used IT to support the provision of telehealth services for use by your CSB? If yes, please explain.

C. WORKFORCE

8) What type of training would you recommend for staff to support use of HIT?

a. **Probe:** Please describe any specific challenges that have required more robust training for staff.

D. CLIENT SERVICES AND CHARACTERISTICS

9) Does your CSB have a patient portal?

10) How is information currently shared between the CSB and other service providers?
    a. **Probe:** Interoperability, and data sharing agreements like BAAs and QSOAs).

E. OUTCOME INFORMATION

11) Do you have systems in place to monitor the impact and effectiveness of services? If yes, please describe.

F. CONTINUOUS QUALITY IMPROVEMENT

12) Do you have systems in place to collect and analyze data about the services provided? If so, please describe.

13) If you could improve one thing about the data collection and reporting system, what would that be?

G. ADMINISTRATIVE

14) How do you determine your administrative priorities (e.g. EHR/IT System)?
    a. **Probe:** Use of data? Presence of a strategic plan?

15) [See Q&A #21 in the Pre-site Visit Survey] According to the data we previously collected, your ___ services are provided by a sub-contractor. Why have you chosen to provide services in this way?
    a. **Probe:** How has this sub-contract been performing? Areas of concern?
    b. **Probe:** How does this sub-contractor access your CSB's EHR (do they access the EHR on their own)?
    c. **Probe:** How is data extracted?

H. STEP-VA

16) Does your CSB have a HIT plan or strategy in place for STEP-VA implementation?
    a. Probe: If yes, what do you know about the plan (who is doing what, by when? what's working, what not, what should be changed)?
    b. Probe: If no, what additional factors need to be in place to implement HIT or other technology to support STEP-VA?

17) What additional capacity needs to be in place for your CSB to fully implement STEP-VA?
    a. **Probe:** Money, training, certification, technical knowledge?

18) Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB.

I. MEDICAID

19) As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to the HIT system at your CSB?

20) What are your biggest challenges or areas of concern with Medicaid Expansion?
    a. **Probe:** Working with managed care organizations or other third-party payers?
    b. **Probe:** Contracting, reporting, billing, denials, eligibility, credentialing?
    c. **Probe:** What is the desired penetration/treatment prevalence?
    d. **Probe:** what are the desired clinical / programmatic outcomes?

J. BRIGHT SPOTS

21) Describe an area related to EHR, data collection and reporting, where your CSB excels. What is leading to this program's/ initiative's success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
PEER RECOVERY SPECIALIST – DIRECT SERVICE PROVIDER
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for speaking with us today. My name is ___and with me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to talk to you about what it is like as a Peer Recovery Specialist at this CSB, and specifically, the good aspects and challenges you might experience as you work to meet the needs of your clients.

Background
Our company, JBS International, was funded by the State of Virginia, (specifically, The Virginia Department of Behavioral Health and Developmental Services or DBHDS) to do research on Virginia's mental health (MH) and substance use disorder (SUD) services and to visit all 40 CSBs to speak with their directors, service providers, and clients about the services that are needed and each CSB's ability to provide those services.

Purpose
Your opinions and experiences as a Peer Recovery Specialist are very important. The information you share today will be combined with the information we gather from all the CSBs we visit across Virginia. Findings from our assessment will be used to provide recommendations to DBHDS that support improvements to the behavioral health system.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes findings and observations from our visit that can be used for planning.

Privacy

Names and identities will not be used in any reports. Only combined results will be included in reports. If there is anything in the report that you feel is not correct, please let us know and we will make the changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview?

COMMUNITY SERVICES BOARD (CSB)
PEER RECOVERY SPECIALIST – DIRECT SERVICE PROVIDER
INTERVIEW GUIDE

NOTE TO INTERVIEWER: If granted permission, turn on tape recorder and verify that it is recording.

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your job as a Peer Recovery Specialist at this CSB.

1) In a couples of sentences, please tell us about your job and what you do (1-2 sentences).
    a. **Probe:** Do you have other tasks in addition to your work as a Peer Recovery Specialist? Please explain.

B. CAPACITY

2) Please tell us about the peer services at your CSB?

3) What are the best aspects (strengths) and the most difficult aspects (challenges) of providing peer-led recovery services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

4) Do you work with different types of recovery programs (e.g. Faith-based, Medication Assisted Treatment, Alcoholics Anonymous, Narcotics Anonymous, Mutual Aid etc.)? If yes, please tell me about it.

5) Do you work with. syringe exchange, naloxone rescue, fentanyl test strips or other harm reduction models? If yes, please describe.

6) How does your program manage suicide, domestic abuse, relapse, overdose or other behavioral health crises?

7) What processes does your CSB have for providing diverse or culturally competent recovery services? (e.g. having staff who speak different languages, offering interpreters, ability to engage with different groups/communities beyond translating materials, partnerships with organizations serving minority populations, etc.)

C. WORKFORCE

8) How does your agency use peer staff?

9) Describe your CBS's process for recruiting training, and keeping (retaining) peer staff?

10) Do you currently engage in continuing education?

11) What part of your peer education helped you most as you prepared to work in this position?

12) What topics do you wish your peer education covered to help you better prepare for the kind of work you do in your role?

13) Do you find that your role and responsibilities on this team is clear to you?

14) How do your supervisors and directors feel about the use of peer staff?
    a. **Probe:** Is leadership and other treatment and recovery staff supportive and collaborative with peer staff?

D. CLIENT SERVICES AND CHARACTERISTICS

15) **Probe:** Are there certain clients or groups (e.g., people leaving the prison system, people living in remote areas, mothers with young children) that you think are hard to reach with peer services? If so, why?
    a. **Probe:** What makes it hard for clients to receive services?

16) If you could improve one thing about clients' experience when seeking recovery services, what would that be?

E. OUTCOME INFORMATION

17) How have peer recovery services helped the clients you have served? Can you describe the effect of peer recovery services on the clients you have worked with?

F. CONTINUOUS QUALITY IMPROVEMENT

18) If you could improve one thing about peer services, what would that be?

G. BRIGHT SPOTS

19) Describe a peer program/idea where your CSB does extremely well. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
PREVENTION SPECIALIST – DIRECT SERVICE PROVIDER
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track, for the next hour or less. Today, we would like to engage in a conversation with you about the values, successes, concerns, or needs you may have as a Prevention Specialist for this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as a Prevention Specialist are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

To maximize your time today, we collected data in advance on the services provided and the client groups served by this CSB. Today's questions will help us to understand the organizational strengths, facilitators, barriers and challenges, including supervisor perception for desired change (if any).

A. CSB INVOLVEMENT

Getting started, I would like to take a few minutes to better understand your role and involvement in this CSB.

1) In a few sentences, please describe your job responsibilities and what your role entails.
    a. **Probe:** What percent of your time is spent in clinical program management and documentation? Providing direct services?
    b. **Probe:** Do you have other responsibilities besides Prevention Services?

B. CAPACITY

2) What are the prevention priorities for your CSB?
    a. **Probe:** How are those priorities determined?
    b. **Probe:** How is data used to determine these priorities?
    c. **Probe:** How are you involved in setting these priorities?

3) What are the strengths and challenges to providing prevention services? Please explain.
    a. **Probe:** Financial resources, staff capacity?
    b. **Probe:** Availability of services in geographic area?

4) Are there prevention programs where you have concerns regarding level of demand (e.g., over/under utilization)? Please explain.

5) Are there certain populations that you think you have reasonable capacity to serve and do a good job of serving? How do you know? Please explain.

6) Are there certain client groups for whom you think you need to build capacity to better serve? How do you know? Please explain.

7) Please describe how you collaborate with key community stakeholders or coalitions to advance your efforts and build awareness about your services?
    a. **Probe:** Presence of a coalition specifically created for planning purposes? If yes, please explain.

8) What processes does your CSB have for providing culturally competent MH and SUD services? (e.g., language/culture, engagement w/different communities/subpopulations).

C. WORKFORCE

9) Please describe the following characteristics about your staff:
    a. **Probe:** Staff strengths, challenges and needs?
    b. **Probe:** staffing shortages, surplus and turnover?

10) Does your CSB have a training plan for staff or offer continuing education? If yes, please describe that plan. If no, please discuss your training methodology.

D. FUNDING

11) Is the funding you receive sufficient to deliver prevention services to your target population(s)? Please explain.
    a. Probe: What are some of the limitations?

E. CLIENT SERVICES AND CHARACTERISTICS

12) Are there disparities related to substance use or consequences across different populations in your community? If yes, how do you identify and address these?

13) If you could improve one thing about clients' experience when seeking prevention services, what would that be?

F. OUTCOME INFORMATION

14) Does your CSB/program have systems in place to monitor the impact and effectiveness of prevention services?

15) Are there any prevention programs/services that have demonstrated positive outcomes? If yes, please discuss the components of these programs and what make them effective.
    a. **Probe:** What evidence-based practices (EBPs) are used for prevention services?
    b. **Probe:** How did you access training for these EBPs?

16) Are there any current prevention programs/services for which you have concerns, based on the data you have available? If yes, please talk about those programs and concerns.

G. CONTINUOUS QUALITY IMPROVEMENT

17) Are you able to collect and analyze data about the services you provide and the people you encounter/ serve so that you can monitor the impact and effectiveness of services and make decisions?
    a. **Probe:** If yes, please describe your system for data collection.

b. **Probe:** If not, please describe what is lacking.
c. **Probe:** Does your system allow you to track outcomes? Please explain.

18) Do you have systems in place to assure treatment services are delivered with quality? If yes, please describe (e.g. incentives, EBPs, training, fidelity, etc.).

H. BRIGHT SPOTS

19) Describe a prevention program/ initiative where your CSB excels. What is leading to this success?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
CLIENT FOCUS GROUP
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's group discussion. My name is ___and I will be the facilitator. With me is ___, and ___, who will assist with taking notes and keeping us on track, for the next hour or so. Today, we would like to engage in a conversation with you about the values, successes, concerns, and needs you may have as clients of this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as clients are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the interview to help verify our notes. Do we have your permission to record this interview? **NOTE TO INTERVIEWER:** If granted permission, turn on tape recorder and verify that it is recording.

A. ACCESS TO SERVICES

First, we want to get a sense of how easy it has been for you to access the services you were seeking and needed. Specifically, we'd like to know what works, what is challenging and what you would change.

1. When you *first tried to access services*, how easy was it to get services from this agency? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

2. How easy has it been over the *past three months* for you to get services from this agency? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

Additional probes for consideration:

- Are services available when you need them?
- Are services available during hours that work for your schedule?
- Are services available close to your home?
- Is transportation available and convenient?
    - Are services available in your spoken language?
    - Are services affordable?

B. CLIENT SATISFACTION

Next, we'd like to get a better understanding of your satisfaction with the services and staff at this organization. Again, what works, what is challenging and what would you change?

3. How satisfied were you with the services you received here? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

Additional probes for consideration:

- Did the staff treat you with respect?
- Did the staff believe that you could grow and make changes?

C. EXPERIENCE OF CARE AND RECOVERY SUPPORT

Now**,** we would like to hear from you about the care you received and your experience while receiving services.

4. Were you involved in your care planning? Did you work with your provider(s) in planning your care? Please explain. ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

   Additional probes for consideration:
   - Was your care monitored and revised as needed?
   - Did you feel comfortable with the way your provider communicated with you?
   - Was your care sensitive to your cultural background?
   - Did you receive the care that you thought you needed?
   - Did your care plan include working with other organizations to receive additional services such as housing, medical and dental, vocational?
   - Did your provider give you strategies to help support behavior change in day-to-day life and support your overall health and recovery? Please explain.

D. RESULT OF CARE AND RECOVERY

Finally, we'd like to get a sense of how those services may have impacted your health and recovery.

5. How have the services you received and the staff that you worked with helped to support your health and recovery? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

   Additional probes for consideration:
   - Did you get better?
   - Were you better able to take charge of managing your illness?
   - Were you better able to take charge of your health and recovery?
   - Did you see improvements in your ability to function daily?
   - Did your quality of life improve?

E. ADDITIONAL QUESTION IF TIME PERMITS

6. If you could improve one thing about your experience when seeking mental health and/or substance use disorder treatment services from this agency, what would that be?
   a. **Probe:** Which populations?
   b. **Probe:** What makes it difficult for them to access BH services?
   c. **Probe**: What additional services, staffing, treatment models might be needed?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

COMMUNITY SERVICES BOARD (CSB)
DIRECT SERVICE PROVIDER FOCUS GROUP
INTERVIEW GUIDE

Date:
CSB Name and Location:
Start Time:
End Time:
Lead Interviewer:
Note taker(s):

Respondent Name:
Respondent Title:
Years in Current Position:

Introduction
Thank you for participating in today's group discussion. My name is ___and I will be the facilitator. With me is ___, and ___, who will assist with taking notes and keeping us on track, for the next hour or so. Today, we would like to engage in a conversation with you about the values, successes, concerns, and needs you may have as direct service providers at this CSB.

Background and Purpose
The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of Virginia's behavioral health system to meet the behavioral health needs of Virginian's.

To help inform this needs assessment, we will conduct interviews and focus groups, and distribute questionnaires to administrators, service providers, and clients at all 40 CSBs in Virginia.

Published Findings
Your opinions and experiences as direct service providers are very important. The information you share today will be compiled with the information collected from all the interviews and focus groups we conduct at this CSB and all CSBs across Virginia. Findings from this needs assessment will be used to provide a series of recommendations to DBHDS that support systems improvements and proactively prepare for future systems changes.

For your participation and to show our appreciation to your CSB, we will also develop a report for your CSB that includes high-level findings and observations from our site visit that can be used for planning.

Privacy

Names and identities will not be used in any published reports. Only combined results will be presented in reports. If there is anything in the report that you feel is inaccurate, please let us know and we will make the appropriate changes.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to tape-record the discussion to help verify our notes. Do we have your permission to record? **NOTE TO FACILITATOR:** If granted permission, turn on tape recorder and verify that it is recording.

A. SERVICE DELIVERY

First, we'd like to take time to understand your experience delivering treatment and recovery services to clients. Specifically, we would like to know, what works, what is challenging and any aspects about service delivery that you would change.

1. Can you describe the intake processes for new persons seeking service? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

2. Describe the available clinical practices being utilized at this CSB (i.e. individual, group, family, home-based treatment services, psycho-ed). ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

3. How do your clients access pharmacotherapy evaluation and medication management? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

4. What other allied services and levels of care do you routinely access in the community? ***Facilitator to probe***: What works? What is challenging? What is one thing you would change?

5. Let's talk about how your program manages behavioral health crises (e.g. suicide, domestic abuse). ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

6. Can you describe the use of electronic health records and other required documentation at this CSB? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

7. Please describe clinical supervision and case consultation at this CSB. ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

8. Now let's discuss the progress your CSB has made in STEP-VA Implementation. ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

B. ACCESSIBILITY OF SERVICES

Next, we'd like to get a sense of the accessibility of services and the resources available to help you meet the needs of your clients. Again, we are looking to hear from you on what works, what is challenging, and any aspects related to accessing services that you would change.

9. How accessible are your services for clients? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

Additional probes for consideration:

- Scheduling, waitlists
- Adequate staff
- Availability of client services
- Client services available within a reasonable time frame
- Client services are in an accessible location
- Collaboration with key community stakeholders to advance program efforts (e.g. medical providers, housing programs, schools)
- Services are available in client's spoken languages (probe for language/culture elements- ability to engage with different sub-populations/ communities beyond translating materials to another language—what partnerships exist with organizations/coalitions serving minority populations, etc.)

C. PROVIDER EXPERIENCE

Finally, we'd like to hear from you about your experience as a service provider at this CSB and your level of engagement and satisfaction with your job. ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

10. How would you describe your overall satisfaction with your work experience? ***Facilitator to probe****: What works? What is challenging? What is one thing you would change?*

Additional probes for consideration:

- Direction provided by leadership (management's communication of agency goals)
- Internal communication between employee and senior management (e.g. recognition by management about job performance or daily tasks)
- Relationships with co-workers
- Amount of time spent providing direct services
- Amount of time spent on documentation
- Career development opportunities for learning and professional growth
- Compensation, benefits and job security

D. ADDITIONAL QUESTION IF TIME PERMITS

11. If you could improve one thing about your clients' experience when seeking mental health and/or substance use disorder treatment services from this agency, what would that be?
12. Describe a treatment program/ initiative where your CSB excels? What is leading to this program/ initiative's success?

13. Is there anything else that you think we should have asked about?

NOTES

Please use the space provided below to list high-level notes from this interview. Notes from this page will be collected by JBS staff and used to inform the site visit debrief and site visit report.

Appendix H.

DBHDS Interview Guides

Virginia Behavioral Health System Needs Assessment
Interview Guide for DBHDS Central Office Interviews
Conducted December 11-12, 2019 and December 16-17, 2019

Date:
Start Time:
Respondent Name:
Respondent Title:
Years in Current Position:

Lead Interviewer:
Note taker(s):
End Time:

Introduction

Thank you for participating in today's interview. My name is ___and I will be facilitating our discussion. With me is ___, who will assist with taking notes and keeping us on track for the next hour. Today, we would like to engage in a brief conversation with you about the values, successes, concerns, and needs you may have as Director/Manager or partner with DBHDS as it pertains to Virginia's Consumer Services Boards (CSBs) and the publicly funded behavioral health (BH) system of care across Virginia.

Privacy and Use of Information

This effort is part of the Virginia Behavioral Health Systems Needs Assessment, currently being conducted by JBS International in collaboration with the OMNI Institute and Cansler Collaborative Resources, Inc. Your opinions and experiences are very important to us. Names and identities will not be used in any published reports, only aggregated results will be presented. The information you share with us will be used to help assess the capacity of Virginia's publicly funded BH system. Today's questions will help us to understand departmental strengths and facilitators, barriers and challenges with Virginia's BH system, with an emphasis on STEP-VA, Medicaid expansion and the emergence of managed care organizations (MCOs).

While we are taking detailed notes during our interviews, we would also like to tape-record the interview to help verify our notes. Once the information has been transcribed, all data will be destroyed permanently from our devices. Do we have your permission to record this interview?

NOTE TO INTERVIEWER: If granted permission, turn on tape recorder. Verify that it is recording.

At this time, do you have any questions about what I have explained?

Virginia Behavioral Health System Needs Assessment
Interview Guide for DBHDS Central Office Interviews
Conducted December 11-12, 2019 and December 16-17, 2019

QUESTIONS FOR DBDHS DIRECTORS AND STAFF

1. In a few sentences, please describe your job responsibilities and what your role entails here at DBHDS, as it relates to the CSBs?
   1a. How long have you been in your current position?

   Probe: What works? What is challenging? What is one thing you would like to change?

2. Do you feel that you have sufficient resources (e.g. fiscal and staff capacity) to provide the level of guidance and oversight for CSBs required of your role? Please explain.

   Probe: What works? What is challenging? What is one thing you would like to change?

3. Do you feel that you have access to the technical knowledge needed to provide the level of guidance and oversight for CSBs required of your role? Please explain.
   3a. What is your approach for staying current on relevant policies and regulations, such as STEP-VA, Medicaid expansion, and/or other regulations and policies (probe for staff training, leadership meetings, etc.)?

   3b. What is the communication process for informing the CSBs about the policies and regulations that impact their operations?

   Probe: What works? What is challenging? What is one thing you would like to change?

4. What type of data is needed to provide reasonable oversight, deploy resources and make decisions?
   4a. What sources do you utilize to obtain that data?

   4b. Please describe your department's efforts as it relates to:
   - Data requirements and data requests to CSBs?
   - Tracking and monitoring data elements?
   - Grants and contracts management?

   Probe: What works? What is challenging? What is one thing you would like to change?

5. Describe your level of collaboration and communication across the following departments and agencies:
   5a. Who do you typically partner with across these agencies and departments?
   - The licensing department and staff?
   - Other departments/divisions within DBHDS?
   - DMAS?
   - Managed care organizations?
   - Department of Corrections?
   - Health department supervisors?
   - Child welfare staff?

- The Attorney General's Office?
- Other external partners and stakeholders?

Probe: What works? What is challenging? What is one thing you would like to change?

6. From the perspective of your role within DBHDS, what are the greatest benefits and biggest drawbacks with each of the following areas?
   - STEP-VA?
   - Medicaid Expansion?
   - MCOs?

   Probe: What works? What is challenging? What is one thing you would like to change?

ADDITIONAL QUESTIONS FOR DBHDS INTERNAL STAFF

A. Additional Questions for Interim Director
   1. What is your sense of the capacity needs of the CSBs as it relates to STEP-VA, Medicaid and the MCOs?
   2. Is there a strategic plan in place for building capacity for the CSB? Please describe.
   3. How is data used to guide strategic planning and determine priorities?
   4. Is there a health information technology (HIT) plan? Please explain.

   Probe: What works? What is challenging? What is one thing you would like to change?

B. Additional Questions for Performance Contracts Manager
   1. With several staff retiring from DBHDS, is there current guidance in place for the new contracts? If yes, what does this guidance look like?
   2. What is your sense of the capacity needs of the CSBs as it relates to new applications and enrollment?
      2a. Does staff have the capacity to process new applications and enrollment? Please explain.

   Probe: What works? What is challenging? What is one thing you would like to change?

C. Additional Questions for STEP-VA Project Manager
   1. What is your sense of the capacity needs that CSBs must have for STEP-VA?
   2. Do you have a strategy in place for building capacity for the CSBs? Please describe.

   Probe: What works? What is challenging? What is one thing you would like to change?

D. Additional Questions for Financial and Policy Analyst
   1. What is your sense of the fiscal capacity needs of the CSBs?
   2. Describe the resource allocation process.
   3. How are other funding sources, including Medicaid reimbursements, factored into the funding allocation process?
   4. How are administrative costs factored in?

   Probe: What works? What is challenging? What is one thing you would like to change?

E. Additional Questions for CCS3 Data Manager
   1. What is your sense of the capacity needs of the CSBs as it relates to the data system, data requests and documentation standards?
   2. Do you have a HIT strategy in place for building capacity for the CSB? Please describe.

3. What is the communication process for informing CSBs about policies, regulations and guidance as it relates to the data system, data requests and documentation standards?
4. To what extent are you aware of any redundancies within the CCS3 data system? Please explain.

Probe: What works? What is challenging? What is one thing you would like to change?

F. Additional Questions for Licensing Director and/or Director Adult Community Services:
Probe: What works? What is challenging? What would you like to see changed in the following areas?

1. Standardizing prior authorization and inter-MCO agreements?
2. Standardizing data variables and reporting schedules?
3. Loss of CSB clinicians to MCOs?
4. Identification of nationally recognized measures and outcomes that can be used to monitor and improve quality services?
5. Review of current rates compared to true costs of service provision?
6. The alignment of Medicaid rates to address barriers?
7. Other?

G. Additional Questions for Substance Abuse (SA) Block Grant / Mental Health (MH) Block Grant Evaluator

1. What roles do the evaluators fill? How do they interface with your team?
2. Do you feel like you have the information needed to meet reporting requirements, distribute funds, and understand the impact of services?
3. How do evaluation efforts contribute to and/or mitigate data tracking and reporting requirements?
4. How effective/informative are overall block grant evaluation efforts?
5. To what extent is evaluation integrated within SA & MH Block Grants, across Block Grants, and/or connected to other DBHDS initiatives?

Probe: What works? What is challenging? What is one thing you would like to change?

QUESTIONS FOR EXTERNAL PARTNERS AND STAKEHOLDERS ONLY

1. How does your organization collaborate with DBHDS and the CSBs to advance BH in Virginia?
2. Where do you see the greatest demand for services?
3. Are there certain populations or client groups that you think have difficulty accessing MH and SUD services in Virginia?
4. How have the following impacted BH services in Virginia?
   - STEP-VA
   - Medicaid expansion
   - The managed care organizations

Probe: What works? What is challenging? What is one thing you would like to change?

Appendix I.

CSB Prevention Services Overview

CSB Prevention Services

Introduction and Methods

To inform a larger assessment of behavioral health needs of Virginians, OMNI Institute (OMNI) was subcontracted by JBS International (JBS) in the fall of 2019 to examine Virginia's behavioral health and substance use prevention system. This report presents information on the Virginia behavioral health and substance use prevention system drawn from primary data collected for this assessment as well as current and historical data from state level prevention evaluation efforts since 2014. The following data sources informed this work:

- **Substance Abuse Prevention Block Grant (SABG) Evaluation Data**. SABG is a prevention funding stream for all 40 Community Service Boards (CSBs) across Virginia. It is formula funding provided by SAMHSA to all states. OMNI's partnership with DBHDS to evaluate SABG activities and build CSB capacity to implement prevention programs afforded access to the following SABG datasets:
    - Performance-Based Prevention System (PBPS): The PBPS is the online data entry platform that all CSBs use to record prevention related activities and numbers reached. Data from SABG FY19 (July 2018 - June 2019) is utilized throughout the report.
    - Coalition Readiness Assessments: As part of ongoing needs assessments, each CSB has administered coalition readiness assessments to their partner coalitions to determine the coalition's readiness to address prevention issues in their community. Data from 2016 and 2018 coalition readiness assessments are included.
- **Surveys of the CSB Prevention Workforce**. Two surveys were developed in partnership with JBS to assess the characteristics and experiences of CSB prevention directors and staff members who engage in planning, delivering, and evaluating prevention services. The surveys were administered in September-October, 2019.
    - CSB Prevention Directors: CSB prevention directors answered a 10-question online survey. The survey was sent to all 40 CSBs across the five DBHDS regions. A total of 39 of 40 CSBs (98%) were represented from across all regions. CSB prevention directors were first surveyed and subsequently nominated staff members from their CSB to receive the second survey using a snowball sampling approach.
    - CSB Staff: Following the director survey, 38 CSB prevention staff members representing 35 CSBs participated in the 43-question prevention staff survey, which was administered online.[1]

Callout boxes throughout the report highlight Prevention and Staff survey results.

[1] 38 total staff members responded, three CSBs were represented by two staff members, and five CSBs were not represented.

- **Rural and Urban Classification.** Survey data and SABG evaluation data were split based on CSB classifications as urban or rural areas using the 2017 CSB population estimates from the Weldon Cooper Center for Public Service, UVA, which identified urban areas as having 200 or more people per square mile. Frequency level analyses were performed after splitting the data by urban/rural status in order to identify any key differences between CSBs serving these different geographic areas.

Because the PBPS data covers all SABG prevention activities, it is more comprehensive than the surveys regarding strategies implemented and numbers served. The director and staff surveys provide helpful insight into the perceptions and priorities of the prevention workforce but are not representative of all CSBs, prevention employees, or the services CSBs provide. Taken together, these sources describe the activities, people served, and capacity of the prevention system.

Prevention Infrastructure

Virginia's prevention infrastructure has undergone significant transformation and adjustment over the past several years, bringing it in line with current federal guidance and best practices.

The Director of the Office of Behavioral Health Wellness at DBHDS began implementing capacity-building efforts and changes to prevention evaluation requirements in 2014 and has gradually shifted Virginia's prevention system to a data-driven model that follows current best practices in prevention science. This shift and the focus on a data-driven model has also brought Virginia into alignment with SAMHSA's Strategic Prevention Framework (SPF).[2]

The SPF is a data-driven and dynamic process which focuses on population-level outcomes (rather than individual-level changes). SAMHSA designed the SPF to be implemented with a diverse group of community partners and stakeholders, which is reflective of the CSB and coalition relationships that are leveraged to implement prevention initiatives in Virginia. The SPF consists of a set of steps and principles that are designed to ensure effective substance use prevention services. The SPF includes the following five steps:

[2] A Guide to SAMHSA's Strategic Prevention Framework. Retrieved from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

- Assessment: Systematically assess the needs of the community using data
- Capacity: Build resources and capacity, including community readiness, to address substance use issues
- Planning: Review data and research to select the most appropriate prevention services for the community and target population
- Implementation: Actively provide program services, prevention practices or policy efforts in accordance with strategic plans
- Evaluation: Determine the effectiveness of prevention strategies in reaching desired outcomes

There are also two overarching principles that are intended to be incorporated into each step of the SPF process:

- **Cultural Competency:** Ensure prevention strategies and efforts are interacting appropriately with the target population's cultural background
- **Sustainability:** Ensure prevention outcomes will continue with broad community support, and plans to continue prevention work long-term are in place

DBHDS has partnered with The OMNI Institute, a non-profit research, evaluation, and capacity building consultancy, since 2014 to support the prevention workforce though these transitions and to evaluate prevention efforts funded through the SABG as well as discretionary funding sources including the Partnerships for Success (PFS) Grant and State Targeted Response/ State Opioid Response grants. Across these funding streams, OMNI has provided training and technical assistance (TA) to build evaluation capacity and has guided CSBs and PFS-funded coalitions through the SPF process as follows:

SPF Step	CSB and Coalition Activities (2016-2020)
Assessment	In 2016, all CSBs completed comprehensive needs assessments on substance use in their communities. Needs assessments included primary and secondary data sources, such as state and local substance use data and coalition and community readiness assessments.
Capacity	CSBs and coalitions utilized trainings, templates, and TA from OMNI to build skills required for a data-driven prevention system. In some instances, grant funding also allowed for hiring new staff members to carry out SPF steps.
Planning	In early 2017, CSBs and coalitions engaged community partners in a strategic planning process to translate their needs assessment findings to the selection of prevention strategies designed to fit community needs and resources. OMNI supported communities in the strategic planning process to develop logic models and evaluation plans once strategies were selected. These documents helped establish an inventory of prevention

	activities and evaluation measures across the state, the first time this information was available in a comprehensive manner. CSBs and coalitions have updated evaluation plans annually since their initial creation in 2017.
Implementation	In mid-2017, CSBs and coalitions began implementing the strategies that had been selected through their strategic planning process. They also began tracking all required measures that were laid out in their evaluation plans. At the same time, DBHDS selected the Performance-Based Prevention System (PBPS) data tracking system for all CSBs and coalitions to use to record prevention implementation data.
Evaluation	CSBs and coalitions have been encouraged to share their data with stakeholders and evaluate the impact their strategies are having in their communities. OMNI has also supported DBHDS in completing the federally required reporting for SABG and PFS grants and has prepared several publicly available state-level reports that aggregate CSB and coalition data.

Source: SABG and PFS evaluation data

CSB staff rated that their agency implements prevention programming with fidelity the most highly of the SPF steps ('above average' or 'excellent'):

- Conducts needs assessments: 58%
- Utilizes data to select strategies: 55%
- Shares data with stakeholders: 53%
- Completes planning process: 64%
- Implements prevention programming with fidelity: 80%
- Monitors/evaluates prevention strategies: 55%

Some differences in ratings about SPF capacity emerged between rural and urban CSBs. Rural CSBs were more likely to report above average ratings for implementing prevention programming with fidelity (90% of rural; 69% of urban). Urban CSBs were more likely to report above average ratings for sharing data with stakeholders (63% of urban; 45% of rural).

DBHDS has led several statewide efforts to both support CSBs in their prevention work and to build toward a long-term prevention infrastructure that will guide the future of Virginia's prevention system.

While CSBs and coalitions have worked to build their capacity and follow the SPF, DBHDS has implemented several changes and initiatives at the state level to build infrastructure to support a data-driven system. Key initiatives include:

- Development of a State Epidemiology and Outcomes Workgroup and behavioral health data dashboard. DBHDS worked to establish the Virginia State Epidemiological Outcomes

Workgroup (SEOW) which brings together representatives from several Virginia agencies to address cross-cutting issues relevant to prevention and to provide data critical to addressing these issues. DBHDS partnered with OMNI to facilitate the SEOW and build the Virginia Social Indicator Dashboard (omni.org/vasis), a public online data dashboard that provides state and communities access to data related to substance use and behavioral health. This has been a critical tool for CSBs and coalitions completing needs assessments and strategic planning activities, which rely on current local data to drive decisions.

- Implementation of a new prevention-focused data collection system. In 2017, DBHDS partnered with Collaborative Planning Group, Inc. to utilize their Performance-Based Prevention System (PBPS), which is designed to track prevention and coalition work. This system is used to monitor and evaluate all prevention data and is especially effective because it is a system designed for the type of community prevention initiatives that CSBs engage in, rather than treatment or case management work, which is the typical structure for many data collection systems.
- Completion of a statewide behavioral health needs assessment. In 2018, DBHDS and OMNI completed a statewide needs assessment with input from CSBs and the SEOW. The assessment identified priority substances for Virginia to address in prevention work over the coming years.
- Identification of strategic priorities for the next SABG five-year cycle. Utilizing the data from the 2018 needs assessment, DBHDS engaged in a strategic planning process throughout 2019 to identify strategies that will be required as part of CSBs' SABG activities beginning in mid-2020. These strategies are designed to address the priority substances identified in the needs assessment. DBHDS is also working to specify an updated funding allocation process to better utilize data to allocate any new prevention funding within the Commonwealth.

Taken together, the state and community shifts described above have laid the groundwork for an effective prevention system. As a result, Virginia is poised to move into the next five years with clear goals and evaluation plans to measure the impact of its prevention work.

Prevention Funding

The bulk of prevention funding comes from federal and local sources, with limited to no state prevention funding available.

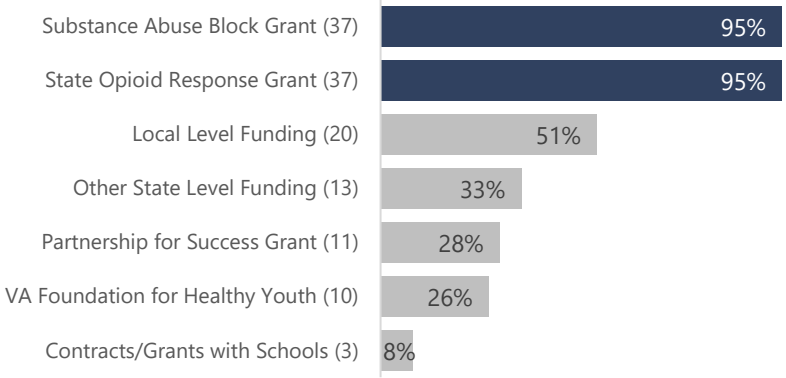
CSB prevention directors report a variety of funding sources that support their prevention work. There is large reliance across CSBs on federal funds passed through DBHDS to the CSBs. In contrast, there is significant variation among CSBs on whether they also receive local funding. Half of prevention directors reported receiving local funds for prevention. CSBs who do not

Prevention directors from urban CSBs were more likely to report local funding (65%) than those from rural CSBs (37%).

receive funding from local governments tend to rely heavily on SABG funding to cover the majority of their routine prevention work.

CSBs' prevention initiatives are most often supported by the **Substance Abuse Block Grant** and **State Opioid Response** grant funding.

Source: Prevention Director Survey



There is no state funding for substance prevention work allocated in the state budget for DBHDS to distribute to CSBs. This has been raised by DBHDS as a critical need for the prevention system and advocacy is underway to encourage state legislators to recognize the value of prevention efforts and allocate prevention funds in the annual state budget. In addition, DBHDS is examining opportunities to shift some SABG funding from treatment to prevention because the expansion of Medicaid that went into effect in Virginia in 2019 covers a portion of treatment needs that were previously covered with SABG funds.

DBHDS is exploring the possibility of adjusting the formula it uses to disseminate funding to CSBs, with an emphasis on data-driven decisions and equity.

For most of its history, SABG funding that has passed through DBHDS to CSBs has been distributed based on a formula that considers the population size of each CSB's catchment area. While population size is a relevant component of funding allocation, DBHDS has been engaged in a strategic planning process to identify new funding formulas that are based on additional indicators, including behavioral health prevalence and consequence related data. This structure would allocate funds based on need, would help address behavioral health inequities that exist across the state, and would ensure enough funding for all CSBs to implement the strategies DBHDS identified in strategic planning as key activities for the next round of SABG funding.

Discussions about how new structures would be constructed are still underway and several pieces of data are being considered in these discussions, including behavioral health indicators from the Virginia Social Indicator Dashboard and the recently developed Behavioral Health Index from Virginia Commonwealth University. Any new funding structure that is developed will rely on local-level data to guide allocations for each of the 40 CSBs, which would not have been possible five years ago before the prevention infrastructure was built around data-driven processes.

Coalitions

Community coalitions play a critical role in the prevention landscape. They supplement the CSB-based prevention workforce and ensure that prevention initiatives are responsive to community needs and interests.

Because of the many structures and focus areas of coalitions, their capacity and their roles in the community vary greatly. All CSBs have relationships with local coalitions, though the form of those relationships differ. In some cases, the CSB runs the coalition and is both the leading organizational body and financial backbone for it. Those CSBs run coalition meetings and are responsible for leading or coordinating coalition initiatives. In other cases, CSB staff are participating members of local coalitions, serving as a representative of the CSB. In these cases, the coalition is usually led by an independent nonprofit with paid staff or is an all-volunteer coalition led by community members. In SABG FY19, CSBs reported participation in at least 55 active coalitions. This includes both leading and supporting roles.

CSB staff ratings of how well their agency engages coalitions and the community:

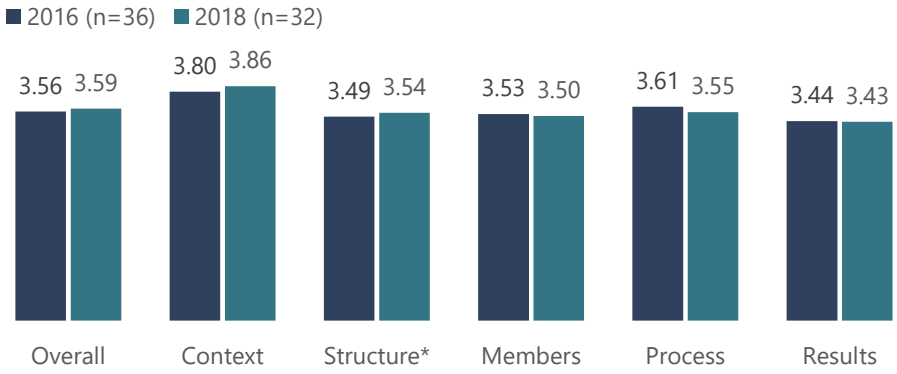
- Develops/engages coalitions: 67% 'above average' or 'excellent'.
- Engages the community: 56% 'above average' or 'excellent'.

Urban CSBs reported a higher rating for engaging the community compared to rural CSBs (69% of urban said above avg or excellent; 45% of rural).

In addition to variation in CSB-coalition relationships, there is also variation in the focus areas of coalitions. Some are specific to substance prevention, or even prevention of a single substance, such as alcohol, tobacco, or opioids. Others are tackling broader community issues, such as youth development, and substance use prevention is addressed through a subcommittee.

In 2016 and 2018, CSBs administered coalition readiness assessments to their partner coalitions to determine the coalition's capacity to address substance use issues across five coalition domains: context, structure, members, processes, and results. Scores range from one to four for each domain and an average score is calculated summarizing all domains. Coalition readiness scores did not differ between urban and rural CSBs in the 2016 and 2018 assessments.

Coalition readiness is high across coalitions, with most scores above 3.5 out of 4.
Source: Coalition Readiness Assessments, SABG Evaluation data



*There was a significant change from 2016 to 2018 on the mean scores for coalition structure (p=.005). This may indicate that the investments through prevention grants to build coalition capacity and engage coalitions has been effective at formalizing the structure of coalitions.

What prevention programs are provided?

There are several characteristics that can be used to describe and categorize the suite of prevention programs offered across CSBs. Below, information on programs provided is presented across several characteristics.

Center for Substance Abuse Prevention (CSAP) Strategy

SAMHSA's CSAP has identified six main types of prevention strategies, and all prevention activities are reported to SAMHSA under the umbrella of one of the six strategies. Best practices in prevention science recommend the implementation of a mix of strategy types, such as individual-level education sessions that target a few people paired with environmental-level strategies that impact communities as a whole. In SABG FY19, CSBs implemented an average of four different CSAP strategy types.

Over the last few years, as Virginia has moved toward a data-driven system, there has been a push to shift from a prevention system heavily dominated by direct education strategies to more environmental strategies that reach entire populations. In SABG FY19, 36 CSBs were implementing environmental strategies, and 31 were implementing education strategies.

52% of CSB staff felt that their agency implements environmental-level strategies 'above average' or 'excellent'.

CSAP Strategy	Definition[3]	Example Activities	Number of CSBs Implementing (SABG FY19)	SABG FY19 Highlights (PBPS data)
Community-Based Processes	Strengthen resources such as community coalitions to prevent substance use and misuse. Organizing, planning, and networking are included in this strategy to increase the community's ability to deliver effective prevention and treatment services.	Coalition collaboration or management, community trainings (e.g., ACEs, ASIST, Mental Health First Aid, Naloxone Training)	39	• CSBs provided 45 Naloxone Trainings to 525 individuals. • CSB staff engaged with over 1,300 coalition members across their communities.
Information Dissemination	Increase knowledge and change attitudes through communications. This method of learning is mainly one-way, such as classroom speakers or media campaigns.	Media Campaigns, Health Fairs, Resource Directories, Speaking Engagements, Radio and TV PSAs	37	• 356 media campaigns reached 1.7 million Virginians. • CSB staff spoke at 237 gatherings reaching over 14,400 individuals.
Environmental Strategies	Aimed at the settings and conditions in which people live, work, and socialize. These strategies call for change in policies — to reduce risk factors and increase protective factors —for example, tighter zoning restrictions on alcohol outlets or stronger enforcement to prevent underage purchases of alcohol and tobacco products. As these changes are carried out at the community level, they can have a sweeping impact.	Counter Tools merchant education, distribution of prescription drug supply reduction materials (deactivation packets, locks, etc.), social marketing campaigns	36	• CSB staff distributed 14,973 drug deactivation packets. • 47 social marketing campaigns reached over 752,000 Virginians.

[3] Substance Abuse and Mental Health Services Administration, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

Education	A two-way approach to teaching participants important skills. These skills can include resisting pressure to use drugs, looking at the intent behind advertising, or developing other skills used in making healthy choices.	Youth Education Programs (e.g., Al's Pals, Life Skills, Too Good for Drugs); Parenting and Family Management Programs (e.g., Active Parenting, Children of Divorce Intervention Program)	31	• Over 300 small group substance use prevention and mental health programs reached 12,425 youth. • Over 1,300 individuals participated in parenting and family management classes.
Alternative Activities	Provide fun, challenging, and structured activities with supervision so people have constructive and healthy ways to enjoy free time and learn skills. These alcohol- and drug-free activities help people —particularly young people — stay away from situations that encourage use of alcohol, tobacco, or illegal drugs.	Drug-Free Recreation Activities, Parties, and Dances	14	• 7,252 youth participated in recreation activities instead of using substances.
Problem Identification and Referral to Services	This process includes determining when the behavior of people who are at high risk or who are using alcohol, tobacco, and other drugs requires education or other intensive interventions.	Student Assistance Programs	1	• 2,172 students were provided with resources and referrals to services.

Source: PBPS evaluation data system

Evidence-Based Programs, Practices, and Policies

Across Virginia, CSBs utilize needs assessment data and the strategic planning process to select evidence-based strategies that fit the substances, populations, and risk and protective factors they are targeting.

75% of CSB staff felt that their agency implements evidence-based practices 'above average' or 'excellent'.

Evidence-based strategies have been shown through research and evaluation to produce the results intended. Utilizing evidence-based strategies maximizes the chances that a prevention initiative will be effective. While an evidence-based strategy might be proven to impact an issue a community wants to target, that does not mean it will work perfectly in that community. All evidence-based practices may require adaptation to meet the local needs and context.[4]

Historically, evidence-based strategies typically only included programs, but prevention science now supports the use of evidence-based practices and policies in addition to programs. CSBs are implementing a mix of evidence-based programs, practices, and policies.

Types of Evidence-Based Strategies	Example CSB Strategies
Program A program is a set of predetermined, structured, and coordinated activities. A program should have specified goals, objectives, and structured components (e.g., a defined curriculum, an explicit number of hours) to ensure the program is implemented with fidelity to its model.[5]	Active Parenting; Al's Pals; All Stars; Children of Divorce Intervention Program; Life Skills; Second Step; Too Good for Drugs; ACEs Trainings; ASIST; Mental Health First Aid
Practice A practice is a type of approach, technique, or strategy.[5]	Utilizing the SPF through prevention programming; facilitating active coalitions to address community issues; implementing environmental strategies such as merchant education to support enforcement of tobacco laws

[4] Substance Abuse and Mental Health Services Administration, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

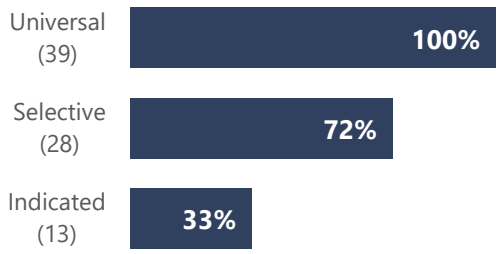
[5] Substance Abuse and Mental Health Services Administration. (September 2018). *Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners*. Retrieved from https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

Types of Evidence-Based Strategies	Example CSB Strategies
Policy A law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions (e.g. tobacco control policies and school nutrition policies for healthier meals in schools).[6]	Hosting legislative roundtables for local legislators and community members to meet and discuss policy options to address substance use issues

Continuum of Prevention

All CSB prevention directors reported their CSB implements universal prevention programs and over 70% implement selective prevention programs. Harm reduction activities are also becoming more common prevention initiatives.

In general, prevention programs aim to reach individuals before substance use has begun. The continuum of prevention classifies prevention programs according to the audiences for which they are suited based on risks for substance use: [7]



- Universal programs reach the general population such as all students in a school or all parents in a community. These are the most common type of prevention programs implemented in Virginia, and all CSBs implement at least some programs that are considered universal.
- Selective programs target groups such as children of substance users or those who display problems at school and have an above-average risk of developing substance use issues. Over 70% of CSBs implement at least some selective programs.
- Indicated programs are for those whose actions — for example, antisocial or other risky behaviors such as truancy, academic failure, or hanging out with peers who misuse substances — put them at high risk for substance use issues. One-third of CSBs implement these types of programs.

In addition to the continuum above, a fourth type of activity has gained traction in the prevention field in recent years: harm reduction. Harm reduction activities are designed to mitigate the negative impacts of substance use after it has begun. A common example of a harm reduction activity is syringe exchanges which provide sterile needles to individuals who are injection drug users. While this strategy does not necessarily reduce the prevalence of injection

[6] Centers for Disease Control and Prevention. (September 26, 2017). *State, tribal, local & territorial public health professionals gateway*. Retrieved from https://www.cdc.gov/stltpublichealth/policy/

[7] Substance Abuse and Mental Health Services Administration, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

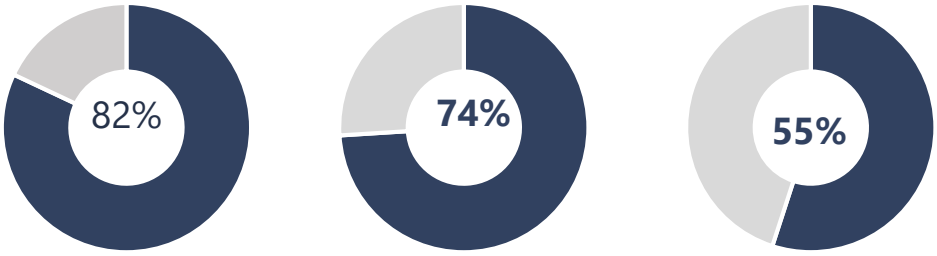
drug use, it is a form of prevention against the potential negative impacts of using unsterile needles, such as transmission of hepatitis C and HIV.

Harm reduction activities have increased particularly in light of the opioid epidemic and the associated consequences. Two-thirds of CSB prevention directors reported their CSB is implementing harm reduction strategies (26 CSBs; 67%).

Prevention Programming Focus Areas

Primary prevention that covers all populations, topics, and substances is a hallmark of prevention work. This remains a key component of CSBs' prevention efforts which all CSBs engage in, but it is not the only approach that CSBs are taking. As CSBs have shifted to a data-driven model, they have been able to identify areas that need particular attention in their communities, and some have implemented targeted programs accordingly.

A larger proportion of prevention directors reported that they target specific community risk or protective factors vs. specific substances or individual-level risk factors.



of CSB prevention directors report they target specific **community risk or protective factors.**

of CSB prevention directors report they target specific **substances**.

of CSB prevention directors report they target specific **behavioral health disorders or individual risk factors**.

Source: Prevention Director Survey

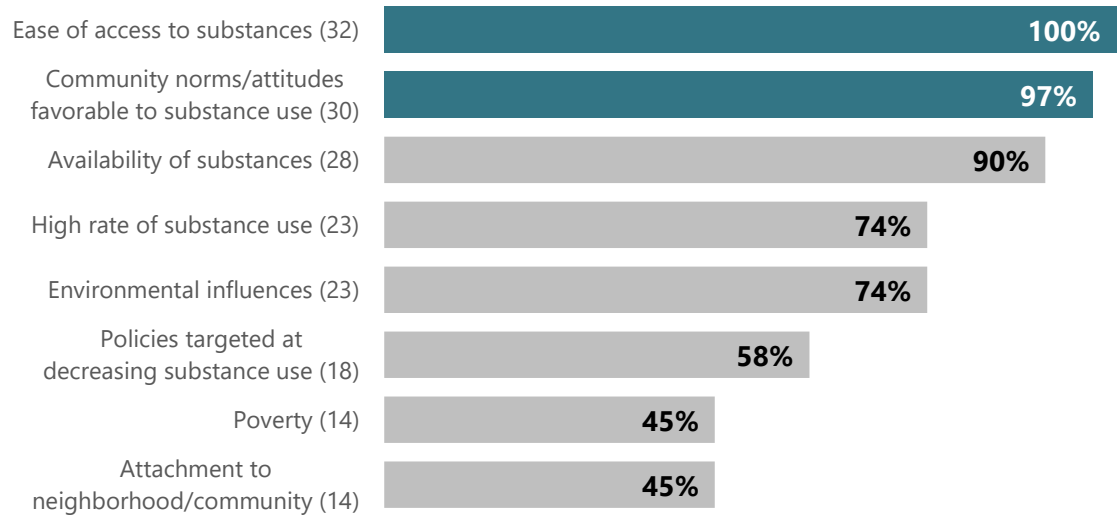
The following sections detail how CSBs are targeting these areas and the differences in targets across rural and urban CSBs.

Risk and Protective Factors

Risk and protective factors are conditions in people's lives that make them more or less likely to use alcohol, tobacco, or illicit drugs.[8] Effective prevention interventions aim to reduce risks and/or boost protective factors. Thirty-one of the 39 CSB prevention directors who completed the survey reported their services target specific community risk or protective factors.

75% of CSB staff felt that their agency identifies risk and protective factors 'above average' or 'excellent'.

All 31 of the CSBs targeting specific risk and protective factors have targeted ease of access to substances and 97% have targeted community norms/attitudes favorable to substance use.



Source: Prevention Director Survey

Other community risk or protective factors identified by prevention directors include adverse childhood experiences, perception of harm/perception of parental disapproval, unlocked gun in the home, and social determinants of health.

[8] Substance Abuse and Mental Health Services Administration, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Revised 2017. Accessed from: https://store.samhsa.gov/system/files/sma10-4120.pdf

Targeting specific risk and protective factors was more common among rural CSBs (86%) than urban (71%) overall. In addition, rural and urban CSBs targeted specific factors at different rates.

Factors more commonly targeted in rural CSBs:

- High rate of substance use
- Poverty
- Attachment to neighborhood/community

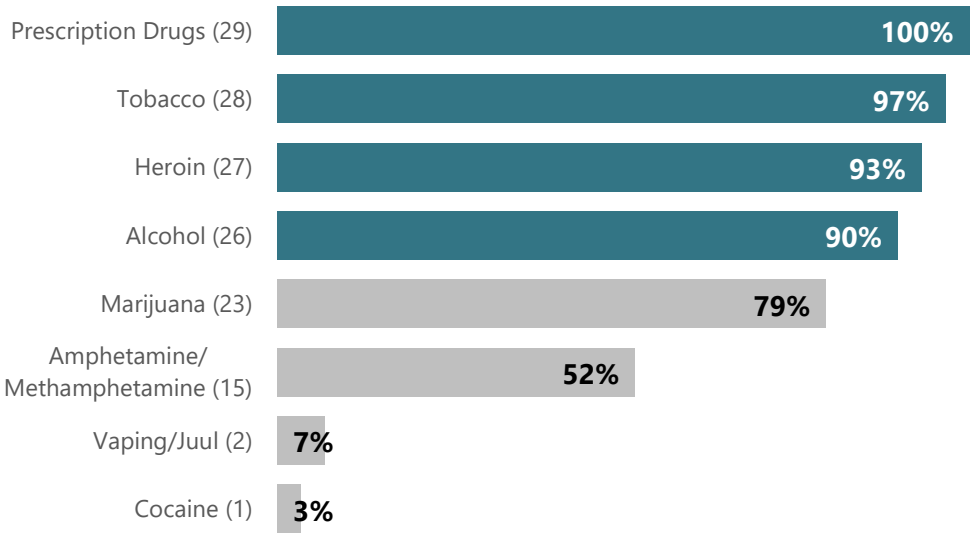
Factors more commonly targeted in urban CSBs:

- Policies targeted at decreasing substance use
- Environmental influences

Substances

The majority of prevention directors reported their CSB targeted specific substances with prevention strategies (74%).

The 29 CSB prevention directors who report they are targeting specific substances identified prescription drugs, tobacco, heroin, and alcohol as the most commonly targeted substances.



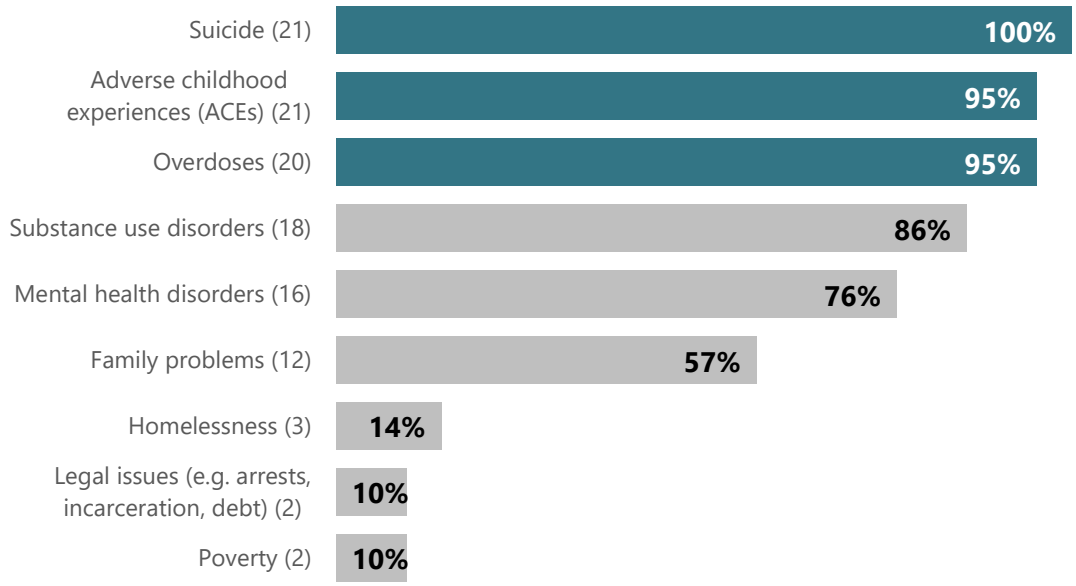
Source: Prevention Director Survey

Targeting specific substances was more common among rural CSBs (86%) than urban (59%).
A greater proportion of urban CSBs targeted alcohol and marijuana than rural CSBs. Conversely, rural CSBs targeted methamphetamine more frequently than urban CSBs.

Behavioral Health Disorders and Individual Risk Factors

Behavioral health and substance use are inter-related and complex issues. Because of the relationship between the two, substance prevention work often targets behavioral health disorders or other individual risk factors for substance use. Over half of prevention directors reported the prevention services they provide targeted specific behavioral health disorders or individuals risk factors (55%).

Among the 21 CSBs who are targeting behavioral health disorders, suicide, ACEs, and overdoses are the most common targets.
Source: Prevention Director Survey



64% of rural CSBs and 41% of urban CSBs reported targeting specific behavioral health disorders.
86% of the rural CSBs who are targeting specific disorders reported targeting mental health disorders, compared to 57% of the urban CSBs. Rural and urban CSBs were targeting other disorders at similar rates.

Who receives prevention programs?

Identifying and calculating the reach of prevention programs is challenging and varies greatly depending on the type of intervention. For example, environmental strategies are typically designed to impact the entire population of a given county or catchment area, so the reach of these types of interventions is quite large. Policy changes impact the entire population of a community and social marketing campaigns are distributed through mass media channels, reaching hundreds of thousands of individuals. The demographics of who is reached by these types of strategies are usually estimates based on population census data since it is not possible to identify each individual person who sees a media campaign or who is impacted by a policy change.

In contrast, education or training programs reach a much smaller group of individuals in a more direct and intensive fashion. In these cases, it is possible to track individuals who receive services and the demographic data on participants is more accurate. Because of these fundamental differences in the nature of prevention strategies, it is not possible to make comparisons across certain types of strategies to identify which ones are achieving "better" reach.

Another important consideration when reviewing prevention reach data is that the recipients of some prevention strategies aren't always the individuals in the target population that stands to benefit from the strategy. For example, attendees at Youth Mental Health First Aid trainings are typically adults who are parents or who work with youth. By completing this training, the adults are positioned to recognize and respond to mental health issues that may arise in the lives of the youth with whom they interact. Coalitions are another common prevention strategy in which the coalition membership and meeting attendees are not necessarily the target audience for the coalition's initiatives and impact.

This type of indirect programming has two implications for the prevention data that is collected:

1. The number of individuals who will ultimately benefit from the prevention strategy is underestimated in reach data. In the case of trainings like Youth Mental Health First Aid, a training group of 15 adults may interact with dozens of youth on a regular basis, and all those youth stand to benefit from the adults' training.
2. The demographics of those who participate in the prevention programming are not reflective of the ultimate target audience. Records of a Youth Mental Health First Aid training will include the adults in attendance, not the youth that benefit from their learnings.

For these reasons, interpreting data on who receives prevention programs is a nuanced exercise with many considerations.

Prevention Programming Reach

In SABG FY19, CSBs implemented a diverse mix of strategies, some of which reached the full population (e.g., environmental strategies work) and some of which was directly delivered to individuals. The table below displays reach data from selected direct programming strategies that were commonly implemented across the state in FY19.

In SABG FY 19, CSBs disseminated prevention information to more than 100,000 youth and adults, provided direct education to more than 13,000 people, trained over 13,000 community members in prevention skills, and engaged more than 1,300 coalition members across the state.

Most prevention strategies engaged both youth and adults. Youth (ages 0-17 years) represented 97% of the individuals reached by direct education programs, while training participants and coalition members were primarily adults (99% and 94% adults, respectively). However, much of the content of trainings and coalition work is designed to promote youth prevention, so youth are a significant secondary target audience for those activities.

Strategy Type	Activity	Youth Reached	Adults Reached	Total Reached (SABG FY19)
Information Dissemination	Speaking engagements	7,808	6,114	13,922
	Health fairs	23,821	69,442	93,263
Education	Parenting and family management programs	265	1,075	1,340
	Education programs	11,903	329	12,232
Community Trainings	Adverse Childhood Experiences Training	51	6,647	6,698
	Applied Suicide Intervention Skills Training (ASIST)	0	707	707
	Mental Health First Aid (MHFA) and Youth MHFA	3	5,563	5,566
	REVIVE! Naloxone Training	129	396	525
Coalitions	Coalition participants	83	1,228	1,311

Source: PBPS SABG FY19 Evaluation Data

Characteristics of Populations Served

The majority of CSBs are reaching individuals across the span from early childhood to young adulthood.

In the prevention staff survey, staff reported on the primary populations served by their CSB services. Nearly all CSB staff report they serve adolescents, which is the age range when many youth experiment with substances or become regular users. Prevention geared toward this age group is essential to reduce risky behaviors. More than 85% of staff also reported working with

young adults. This group has unique prevention needs due to high rates of use and often risky forms of use in college settings, and the challenges presented by transitioning into adulthood. Children are served less frequently than adolescents and young adults, but primary prevention with this age range helps lay the groundwork for reducing risk factors and bolstering protective factors as children approach adolescence. Having that groundwork in place early is important, as approximately 10% of Virginia youth report drinking alcohol for the first time before age 11.[9]

Percentage of CSB staff who report they serve:

Children (0-11 years):
60%

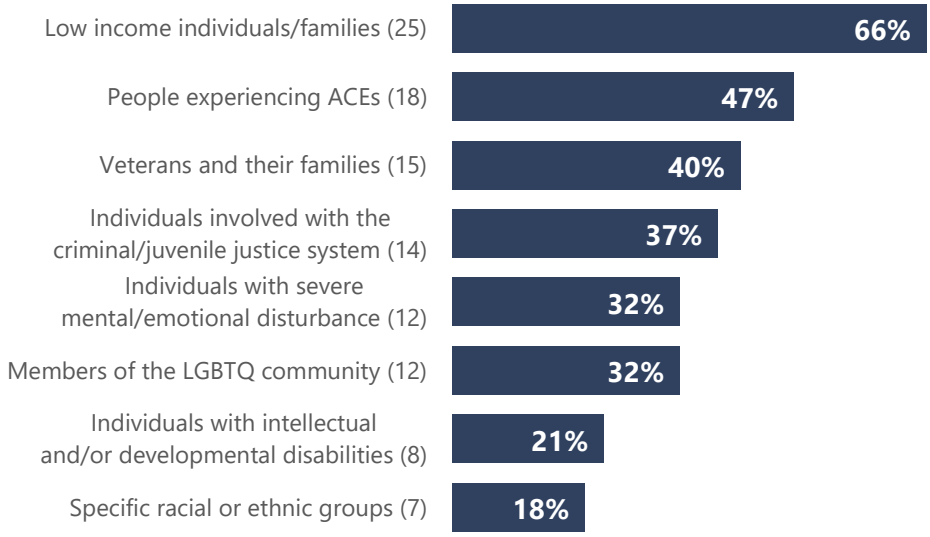
Adolescents (12-17 years):
97%

Young adults (18-24 years):
87%

The shift of prevention work to environmental strategies and to addressing social determinants of health is reflected in CSB staff responses to which populations are served. Low income individuals/families topped the list and people experiencing adverse child experiences (ACEs) was also a common population served.

Addressing ACEs has been a focus of SABG prevention work in the past few years. There have also been recent efforts to address racial and ethnic disparities in behavioral health and substance use, but this remains an area for growth in the prevention system, as only 18% of staff reported serving specific racial or ethnic groups.

Percentage of CSB staff who report their agency serves:



Source: Prevention Staff Survey

[9] Percentage of youth who reported drinking alcohol for the first time before age 11 on the 2017 Virginia Youth Survey of middle schoolers. Retrieved from the Virginia Social Indicator Dashboard: https://vasisdashboard.omni.org/rdPage.aspx?rdReport=Dashboard.VDH_VYS_MS

On the CSB staff survey, rural and urban staff reported some differences in the primary populations their CSBs serve.

Populations more commonly served in rural CSBs:

- Children 0-11 years old
- Young adults 18-24 years old
- Individuals in the criminal justice system

Populations more commonly served in urban CSBs:

- Low income individuals/families
- Specific racial or ethnic groups

Meeting Community Prevention Needs

Ensuring that prevention services are responsive to community needs and emerging trends is a constant challenge for CSBs.

The majority of prevention staff feel they are successfully reaching targeted populations, but a smaller proportion report being able to meet community needs in other ways.

Percentage of staff who reported:

76% Services offered by CSB **successfully reach targeted** individuals and/or populations

57% Individuals/populations targeted receive prevention services **when and where they need it**

57% CSB has resources to **help individuals access programming** (e.g., transportation, convenient hours)

49% Services are **available in the preferred language** of targeted individuals and/or populations

41% There are **adequate staff available** to implement prevention strategies

52% of CSB staff felt that their agency identifies gaps in prevention services 'above average' or 'excellent'

Urban CSB staff were more likely than rural CSB staff to report their CSB:

- Has resources to help individuals access prevention programming
- Has prevention services available in the preferred language of targeted populations
- Has adequate staff available to implement prevention strategies

The Prevention Workforce

Satisfaction with Prevention Work

Nearly all CSB staff who completed the survey are satisfied with the quality of prevention services their agency provides and their relationships with coworkers.

When asked about several aspects of their jobs, prevention staff generally reported being satisfied with their work. The lowest level of satisfaction was around compensation, but even on this item three-quarters of staff reported being satisfied.

Percentage of CSB staff who are satisfied with the following:

A greater proportion of rural CSB staff members report overall satisfaction with their job (100% of rural staff; 88% of urban staff).
In addition, a greater percentage of them reported it is likely or very likely they will continue to work at their agency in five years (76% of rural staff; 63% of urban staff). However, satisfaction with compensation is lower among rural staff (67% satisfied) than urban staff (88%).

Demographics

Among the 38 prevention staff who took the survey, the majority were female (87%), White (71%), and non-Hispanic/non-Latinx (100%). Nearly all have a bachelor's (45%) or master's (50%) degree. Half of the staff surveyed were 35-54 years old (53%) and 29% were 55 years or older. Almost two-thirds of staff had been in their role for 5 or more years (61%).

Urban CSB staff who completed the survey tended to be younger and more racially diverse than rural staff who completed the survey.
A greater proportion of urban CSB staff were black (35%) than rural CSB staff (19%). In addition, a greater proportion of urban CSB staff were 25-44 years old (59% of urban staff; 33% of rural staff). Rural staff tended to be slightly older (62% of rural staff were 45-64 years old, compared to 35% of urban staff) and a greater proportion were White (81% of rural staff; 59% of urban staff).

Appendix J.

Virginia Behavioral Health Needs Assessment: Focus Group and Survey Results from CSB Prevention Staff and Coalition Members

Virginia Behavioral Health Needs Assessment

Focus Group and Survey Results from CSB Prevention Staff and Coalition Members

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Virginia Behavioral Health Needs Assessment

Focus Group and Survey Results from CSB Prevention Staff and Coalition Members

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Introduction

To inform a larger assessment of behavioral health needs of Virginians, OMNI Institute (OMNI) was subcontracted by JBS International (JBS) in the fall of 2019 to conduct virtual focus groups with Community Service Board (CSB) prevention focused staff and CSB-related coalition members, along with analyzing results from two surveys sent to CSB Prevention Directors and staff members. This report presents findings from these efforts to inform a needs assessment for the Virginia Department of Health and Developmental Services (DBHDS), which evaluates the commonwealth's behavioral health needs and the capacity of CSBs to provide behavioral health services to the areas they serve.

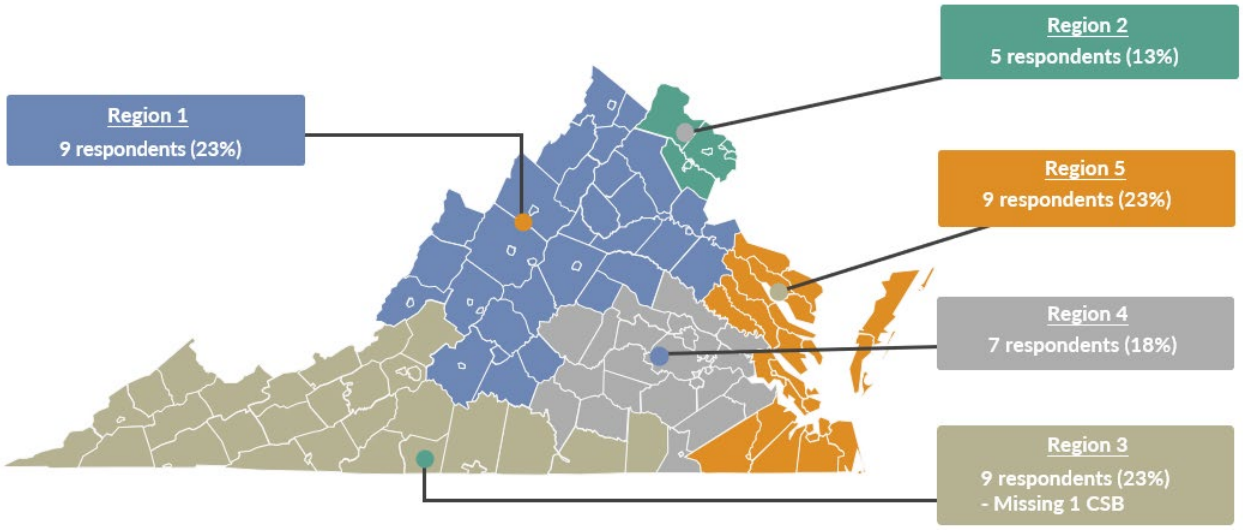
Methods

Surveys

Two surveys were developed in partnership with JBS International to assess the characteristics and experiences of CSB Directors and Staff members who engage in delivering, planning, and evaluating prevention services, including their perceptions of the effectiveness of their CSB to affect behavioral health in Virginia. CSB Directors were first surveyed and subsequently nominated staff members from their CSB to receive the second survey using a snowball sampling approach.

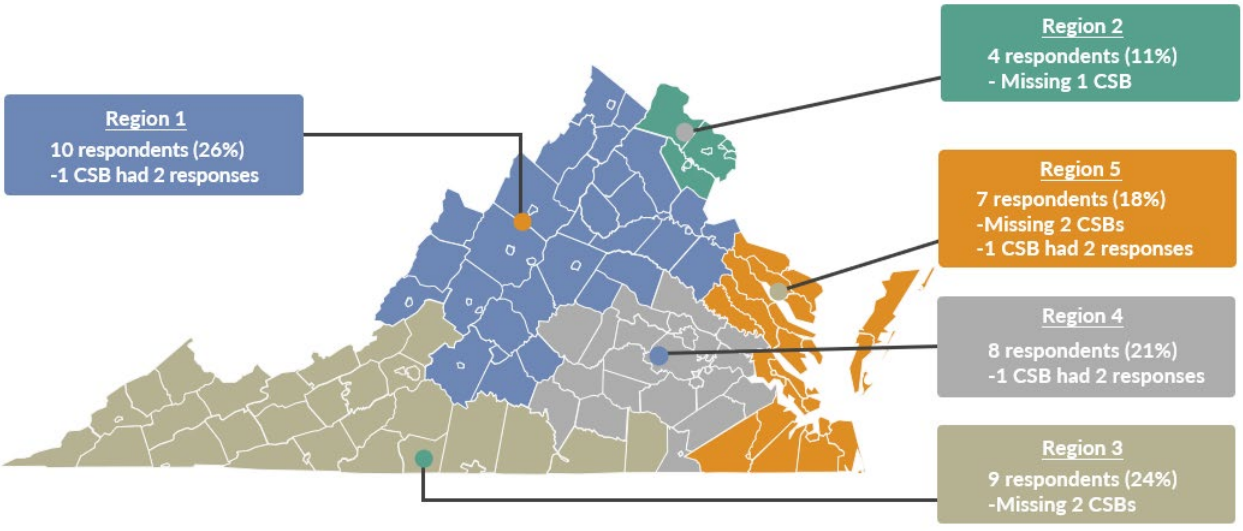
CSB Directors answered a 10-question online survey using the Survey Monkey data collection platform. The survey was sent to all 40 CSBs across the five regions in the Commonwealth of Virginia. A total of 39 of 40 CSBs (98%) were represented from across all regions. Figure 1 below shows the geographic distribution and responses to the survey among Prevention Directors.

PREVENTION DIRECTOR SURVEY DISTRIBUTION AND RESPONSE



Following the Director survey, 38 CSB prevention staff members representing 35 CSBs participated in the prevention staff survey[1]. This survey included 43 questions and was deployed online using Survey Monkey as the data collection platform. Please see Appendix B for additional demographic information on CSB prevention staff who participated. Figure 2 below shows the geographic distribution and responses to the survey among Prevention Staff.

FIGURE 2. PREVENTION STAFF SURVEY DISTRIBUTION AND RESPONSE



Survey data were cleaned and analyzed using SPSS software. CSBs were coded as representing primarily urban or rural areas, using the 2017 CSB population estimates from the Weldon

[1] 38 total staff members responded, three CSBs were represented by two staff members, and five CSBs were not represented.

Cooper Center for Public Service, UVA, which identified urban areas as having 200 or more people per square mile. Frequency level analyses were performed on all variables. Additional frequency level analyses were performed after splitting the data by urban/rural status in order to identify any key differences between CSBs serving these different types of geographic areas.

Focus Groups

Community Service Boards: Between late October and early December 2019, five 1.5-hour long virtual focus groups were conducted. Participants (n=35) were Community Service Board (CSB) directors, managers, and staff members from across all regions of Virginia whose role in their CSB pertained to prevention of behavioral health disorders. Participants' role in their CSB included prevention-related work such as planning, program implementation, community engagement, campaign or program development, supervisory positions, and others. The purpose of the focus group was to better understand the strengths, challenges, and capacity of CSB prevention staff to engage in prevention work. The focus group guide was developed in partnership with JBS International, and was adapted from a broad set of questions used to guide qualitative data collection at CSB site visits.

Participants were identified through a snowball sampling technique. In a preceding needs assessment survey, CSB Directors nominated at least one participant from their CSB (some nominated themselves) to participate in a focus group. OMNI researchers then recruited participants into focus groups stratified by position level, with 3 groups for CSB Directors, and two groups for CSB prevention staff. The focus groups were conducted virtually using Zoom teleconferencing platform (www.zoom.us/). One OMNI researcher moderated the focus group while another took notes and coordinated technical matters. Both researchers were visible via webcam in a conference-call style meeting. Participants were able to connect using either their computers or telephones and were encouraged to enable their cameras to better simulate an in-person focus group. Participants provided their verbal consent to having the focus group recorded for transcription purposes and were instructed that their participation in the focus group was voluntary and confidential; any identifying information provided in the focus group (e.g. staff and CSB names, locations) would not be included in any reports and responses would be aggregated.

Coalitions: Two additional focus groups were conducted in late November and early December 2019 using the same methodology for members from CSB-affiliated coalitions that engaged in community behavioral health prevention work. The participants (n= 11) were similarly identified, this time from nominations from a survey of the CSB prevention staff focus group participants. Some coalition members were also CSB Directors and staff, though there was no overlap in participants across the CSB prevention staff and coalition member focus groups. The coalition focus group question prompts were generated from the CSB prevention staff focus group protocols and were similar in nature (i.e. prevention-related), though tailored to assess the needs and dynamics of, and services provided from coalitions affiliated with a CSB.

Analysis: Focus groups were audio-recoded, transcribed, and formally coded using a qualitative analysis software (Dedoose). The coding schema was designed to capture themes and sub-themes related to question areas, in addition to any emergent themes. Because of the small number of total groups, all CSB focus groups were coded together for common themes. However, analyses focused attention on various possible key differences when relevant such as role within CSBs and coalitions, rural vs. urban issues, and specific sub-group examples (e.g., the challenge of delivering prevention services when a military base is part of a CSB's locality).

Coalition focus groups were coded using a similar coding schema as CSB focus groups, as questions that were asked overlapped (See Appendix A for focus group guides). Because of the similarity in themes in many cases, coalition focus group findings were integrated within the sections for themes raised by CSB focus group participants (headers and descriptive language are used to make it clear when themes were raised by CSB prevention staff and coalition members).

Findings

Prevention System Structure and Services

Community Service Boards (CSBs) provide a wide range of prevention services, and all target services to the general population. In the survey to CSB Directors, participants were asked about the types of prevention services offered at their CSB, classified by the Institute of Medicine Report (Haggerty & Mrazek, 1994)[2]: 'Universal' (services given to individuals in the general population, not directed at a specific group), 'Selective' (services given to individuals targeted as having high risk for a substance and/or behavioral health disorder), and 'Indicated' (services given to individuals already using substances or identified as having a behavioral health disorder). Directors were also asked if they provide harm reduction and other types of services. All CSB Directors reported offering 'Universal' services targeted to the general population and nearly three-quarters (71.8%) reported 'Selective' services for high risk populations. One-third (33.3%) of CSBs offer 'Indicated' services, and two-thirds (66.6%) engage in harm reduction strategies.

Examples of Prevention Focus Areas

- Academic failure
- Adverse childhood experiences (ACEs)
- Community health and wellbeing
- Domestic violence
- Homelessness
- Mental health promotion
- Overdose prevention
- Parent education & home visiting
- Poverty
- Risk and protective factors
- Social emotional and life skills
- Specific substance use prevention (alcohol, opioids, tobacco, vaping, prescription drug misuse, etc.)
- Substance use in schools & college campuses
- Suicide
- Teen pregnancy
- Trauma resiliency

Prevention services reach a wide range of individuals. CSB Directors also estimated the number of individuals their prevention services serve or reach in a month. Almost half of CSBs (43.6%) reported serving 100-1,000 individuals per month, while an additional 38.4% served 1,000-25,000 people per month. Approximately 18% reported serving more than 25,000 people in a given month. Due to the nature of prevention services, there is wide variability in the types of programs provided (e.g. individual education programs vs. population-based media campaigns) which may influence the estimated number of individuals reached across CSBs.

Most CSBs (75%) reported targeting specific substances in their work and identified prescription drugs, tobacco, heroin, and alcohol as the most commonly targeted substances for prevention services. In addition to specific substances, CSB Staff focus group participants listed a range of behavioral health areas targeted by their services. Some participants indicated health topics targeted by their CSB had changed over time due to funding

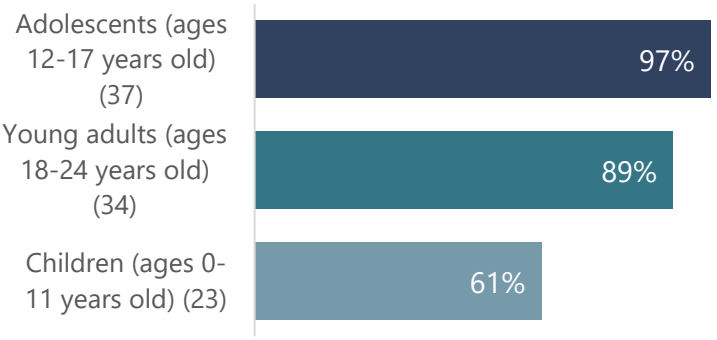
[2] Haggerty, R. J., & Mrazek, P. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. National Academies Press.

changes, or changes in the behavioral health needs of their communities. For example, several participants mentioned a shift from initially focusing on alcohol and tobacco use prevention to a focus on prescription drug and opioid misuse due to the growing opioid crisis in Virginia.

The types of prevention strategies being utilized has also changed over time. CSB Director/Staff focus group participants discussed that the types of prevention activity and/or delivery methods and locations where prevention services are implemented in the community have been changing. For example, one participant explained their CSB had moved away from implementing school-based prevention strategies to focusing on community collaborations, coalitions and environmental strategies. Most changes in prevention efforts were due to changes in funding and the development of collaborations with community agencies. CSB prevention staff described these changes occurring over a longer period of time (sometimes ten to thirty years), since the launch of the Virginia CSB initiative.

CSB prevention services mostly focus on youth and parent populations. CSB focus group participants most often cited school-aged youth, ranging from kindergarten to high school, as specific populations that are reached and/or targeted by their CSB services as shown below in Figure 1. Funding mechanisms often are set up explicitly to serve youth populations, and school systems are an ideal means for program delivery and assessment of youth and community health. Many participants spoke about the benefits and importance of "getting in," "partnering" and "working with" the school system. Services for youth populations seek to promote mental health and wellbeing, improve social skills and reduce aggressive behaviors, substance use, academic failure and suicide. Non-traditional school settings, such as "high need" or alternative schools were also included as sources for youth engagement.

Primary Age Populations for Prevention Services



Supporting youth coalitions is an important prevention strategy. In order to better reach youth populations, CSBs establish youth-led coalitions and school-based wellness groups, and recruit younger prevention planning group members because, as one participant said, "youth listen to youth." Multiple CSBs employ separate youth-based coalitions in addition to adult coalitions, some of which implement their own individual campaigns, data collection, and other prevention activities based on the unique health needs of youth. Sometimes youth are enlisted by CSBs to implement prevention activities in the community, which according to participants, fosters positive and collaborative relationships among community partners.

Participants indicated that it is more difficult to reach youth who are not in some type of school setting. Outside of schools, CSBs reach at-risk youth at community recreation centers,

and sometimes through home visiting programs. Social media is also used to reach youth (e.g. social marketing and messaging campaigns). Additionally, CSBs focus on young adults aged 18-25, mostly through community colleges and universities, but participants often characterized collaborations with higher education as nascent compared to those of school districts.

"Being able to work with kids, going into the schools and then being able to work with the adults in the community and meeting parents… It keeps me on my toes, but I do enjoy the variety of people that I get to work with."

Parent-focused prevention efforts often include parenting education programs and services either through classes conducted in schools and community centers, or home visiting programs. Parents can be difficult to reach compared to other stakeholders, and CSBs noted that successful recruitment depends upon ensuring parents are comfortable when engaging with services. Services are provided to high-risk parents to promote healthy attachment with children and healthy family functioning, and prevent child abuse, and substance use in the family. Some parents' participation in prevention services, namely child abuse prevention, is mandated by social services. Parents are also recruited by CSBs to promote or provide input on community initiatives.

Many CSBs seek to provide services to low-income families, and CSBs implement group-based or environmental programs in low-income neighborhoods. Participants described "diversity" and "cultural differences" in Virginia rural communities as not necessarily involving race and/or ethnicity as much as it involves "poverty and substance abuse." Latinx/Hispanic and Spanish-speaking communities, as well as refugee populations were the only racial/ethnic groups mentioned as a focus of prevention efforts. Participants also noted two historically overlooked and/or underserved groups as a focus of outreach efforts which included older adults (e.g. ages 65 and over, senior center residents, etc.), and visually impaired individuals.

The Role of Collaborations and Coalitions in CSB Efforts

Director/CSB prevention staff focus group participants were asked about the role of coalitions in their prevention work and specifically about their efforts to collaborate with these groups. Many shared they have established coalitions with representatives from multiple agencies/organizations in their catchment area to collaborate on a specific issue or topic, or to support existing groups. Smaller coalitions have also come together at times to streamline efforts. Most coalitions focus on substance use prevention and mental health, but also specific issues such as homelessness, trauma or general wellness.

"A lot of collaborative work that we've done with community coalitions has propelled us in a very positive direction."

Community partnerships are vital to a coalition's success. Participants agreed that coalitions are integral in the delivery of services or strategies that target specific issues in their communities: "you've got all of your other main players in the community at the table and it's not just coming through one main one voice." Key community partners described by participants were justice service agencies, non-profits, health districts, police, and departments of social services.

"It's more important for us to build relations and connections than it is just to throw out a couple of billboards to spend money down. So, we've spent a lot of time and energy just building relationships."

Relationships between community groups and coalitions were described as deep, collaborative, and reciprocal. Collaborations with community partners facilitate coalitions in achieving their strategic plans, agendas, and missions. They emphasized that developing and maintaining partnerships for their coalition are "key to effective prevention planning and implementation." The following are frequently mentioned benefits of collaborating with community partners for their coalitions:

- **Lived experiences shape coalition planning efforts.** Participants acknowledged the importance of passionate members to move efforts forward promptly and that this energy often stems from coalition members with lived experiences: "we have a lot of people in [our] coalition that have lost a loved one to suicide." Participants highlighted lived experiences have shaped efforts and added a sense of 'passion credibility' to their trainings and presentations.
- **Information exchange and networking opportunities are enhanced.** Participants agree that collaboration has increased their access to valuable knowledge and resources as well as networking opportunities. Coalition members now collaborate with organizations they were not previously aware of. One participant mentioned their coalition partnered with trauma services at a local pediatrician's office to provide resource documents for families facing food insecurity during welfare checks. Additionally, some coalitions provide training and professional development opportunities for their partners.
- **Prevention efforts are streamlined.** Coalitions have identified duplication in efforts such as organizations implementing similar services at the same time. Coalitions are working to ensure roles and communications are explicit, particularly if coordinating regional efforts.
- **Involvement from the faith community and youth has increased.** Many participants shared collaborating with the faith community to implement mental health trainings and community events, which has increased community engagement. Participants also shared youth are not only involved in their CSB youth coalitions, but also their substance use prevention and wellness coalitions. Youth are not only participating in meetings to share their perspectives, but also creating campaigns to shift substance use attitudes among youth and encouraging youth participation in CSB prevention efforts.

CSBs were also described as the "backbone" of coalitions. Coalition members unanimously agreed that CSBs were extremely instrumental in the success and expansion of their coalitions. In fact, multiple coalitions were initially formed through the efforts of CSB prevention staff. For example, due to the efforts of a CSB, three fragmented coalitions in one community were merged into a now larger coalition, and that coalition is now more able to apply for grant funding and sustain itself. CSBs are instrumental in the functioning of coalitions by spending a great deal of time and energy coordinating coalition efforts.

- **CSBs provide guidance in conducting meetings** such as planning meetings, following meeting protocols, and providing office space and materials.
- **CSBs assist with developing expectations** for coalitions and laying out plans for future years to ensure coalitions thrive.
- **CSBs help coalitions carry out their programming**, and conduct trainings in the coalition's community, especially trauma-informed trainings, Mental Health First Aid, and ACEs trainings.

Sometimes CSB prevention staff manage large aspects of coalition work; for example, CSB prevention staff act as fiscal agents and manage task groups for the coalition. Coalitions and CSBs sometimes engage in joint supervision as some coalition members are also staff at affiliated CSBs.

CSB-coalition collaboration allows coalitions to expand their services, increase their membership size, and strengthen their partnerships with community agencies. CSBs sometimes have better capacity than coalitions to make and share connections with community partners (e.g. school systems). Similarly, coalitions directly contract with CSBs to fulfill block grant requirements for prevention, treatment, and recovery work.

Community partnerships and coalitions also face challenges. Participants shared barriers for collaborative efforts which included the following:

- **Community engagement and involvement can be challenging.** It can be difficult to engage participation from the community when attendance is not required for their job or individuals do not have the time to participate. For example, parent coalition participation can be difficult when many have full-time jobs and responsibilities or transportation challenges.
- **Coalitions are typically led by CSB prevention staff.** Though there are coalitions that are led by community partners, most coalitions are led by CSB prevention staff and have been for many years. Some shared they are working to identify and support community members in this role. One participant shared they are meeting with interested members 1:1 to gauge interest and dedication to coalition efforts.

- **Running coalitions can be a time burden for prevention staff.** Participants shared they often have administrative and prevention work that can get in the way of overseeing coalitions. It takes time for prevention staff to develop and maintain relationships with organizations: "[Running coalitions] takes a lot of time and effort to develop the relationships and keep them, and that's just time that we don't have for all the different groups [coalitions] that we try to attend." This is especially difficult for CSBs with limited resources and capacity.
- **Coalitions vary widely in terms of prevention staff involvement, funding, and resources.** Some CSBs do not have the budget or resources to have a point person to work in all coalition-related efforts, particularly when there are multiple within a catchment area. Participants shared too many coalitions make it difficult to manage and streamline prevention-related efforts, which affects coalition sustainability. Participants agreed that having coalition dedicated staff is essential for coordination such as setting up the agenda, attending meetings, and maintaining collaborative partnerships.

"If we try to hold meetings in the evenings or weekends, that hasn't been successful for us. Without the CSB folks taking leadership of the coalitions, I'm afraid they would not exist."

Coalition Structure and Services

Coalitions represent an important part of the prevention system and expand the capacity of CSBs to plan for and implement prevention services. Because of this, coalition members were asked to participate in focus groups to better understand how they interface with CSBs, and where associated successes and challenges emerge in these partnerships. Coalition focus group participants were first asked how they would describe the structure and size of their coalition. Coalition size generally refers to how many active members are in the coalition. Structure involves how engaged members are, how often they meet, what decision making processes are like, and what different types of backgrounds, expertise, and experience members add to the coalition.

Coalition membership is diverse. Coalitions are comprised of three types of members: leadership (e.g. board members, directors), staff, and partnering community members and agencies. Two participants mentioned they were the only staff members at their coalition, while another said they managed nine staff members. Community members and agencies who have a partnership with the coalition however can range from 80-150 members. Partnering agencies include the CSB, school systems, universities, police departments, other coalitions, different types of non-profits, health departments, and departments of social services. One participant's coalition included a representative from each of the twelve sectors of their community. Participants noted some community partners were more involved than others, and that the size of coalitions can vary from month to month, "people come and go."

Example Prevention Health Areas Targeted by Coalitions
• Adverse childhood experiences • Developmental assets (life skills) • Human trafficking • Internet safety • Mental Health • Reducing stressors • Substance use including underage use: alcohol, illegal drugs, marijuana, opioids, prescription drugs, tobacco, vaping • Suicide • Trauma

Coalitions meet monthly or quarterly on various topics related to their mission. Often, coalitions have leadership meetings, subcommittee meetings, and meetings that involve general coalition members (i.e. community partnerships). Coalition subcommittees head up activities related to specific topics such as substance use prevention, mental health and wellbeing, kindergarten readiness, family engagement, etc. Additionally, multiple participants described youth coalitions that meet separately from, but are still considered members of, the larger coalition. Many coalitions are evolving and building capacity, including working with consultants and forming steering committees to define their purpose, and "revamping" their coalition to be more focused on their mission.

Coalitions focus mostly on spreading community awareness about health issues (i.e. information dissemination) and the coalition itself and its mission ("getting our name out there"). This is accomplished through such activities as speaking engagements, movie screenings, interactive presentations, speaking to county supervisors and school board members, and "advocacy days," which provide trainings on health topics for everyone in the community. Media campaigns are also employed (e.g. Twitter, Facebook, monthly newsletters). Coalitions aim to stimulate conversations among community members to make talking about sensitive health topics less awkward and more commonplace. Other prevention activities include coordinating drug collection days with police departments, working with retailers to reduce sales of alcohol and tobacco to minors, and distributing information cards to first responders, so that their patients can be informed about community resources available to them. Coalitions generally identified working with the same target populations as CSBs, and on similar prevention priorities.

Coalitions experience role ambiguity. A challenge that coalition members mentioned when engaging in prevention service implementation was role ambiguity. Coalition members discussed sometimes feeling unsure about where the coalition fit into the community. One participant summed it up by asking, "…are we a gathering, do we gather people together to network? Do we provide trainings? Do we provide screenings? Are we educators, are we advocates? Do we need to focus on certain things for a year?" The source of this ambiguity in part was due to the broad variety of activities coalitions engage in, and diverse community stakeholders they collaborate with. Also, coalition activities are contingent on funding that often dictate their efforts, requiring them to shift their role with changes in funding. This challenge was also surfaced by CSB Directors/Staff (see the Capacity section below).

Coalition members get satisfaction from their accomplishments. Participants described being passionate about their work, feeling "called to it," and that it was an honor to be involved with their coalition, with some participants noting 10 and 20 years of service. Participants were pleased with being able to connect with many people and organizations in their community. Participants were proud to leave a strong foundation, groundwork, and legacy of impact that would be carried on by someone else in the future. When discussing what was not satisfying with their coalition work, multiple participants characterized it in terms of what the coalition was not able accomplish in their community. For example, one participant said they would not be satisfied until their coalition successfully integrated their services into local schools. Another participant wished their coalition had more capacity to serve the needs of their community. Overall, however, most indicated they would not change anything about their experience.

"I think all of our coalitions are looking more at the resiliency factor and educating our community about ACEs and what that means and how we're all affected ...and how important it is to recognize the things that our kids might be going through, our teens or even young adults. It's the question of, 'What has happened? What have you experienced?' Instead of 'Why are you doing this?'"

Prevention Services Approach and Considerations

Identifying Root Causes to Guide Prevention Services

Understanding the reasons why substance misuse and other behavioral health issues occur, as well as the factors that facilitate or inhibit their progression, is important for effectively targeting prevention efforts. In the CSB Director survey, almost all participants (97%) reported focusing on specific community risk or protective factors in their prevention work. The most commonly reported risk and protective factors included easy access to substances, community norms and attitudes, and availability of substances.

CSBs reported a heavy focus on adverse childhood experiences (ACEs) as root causes of behavioral health issues. First, CSBs identify root causes using assessments (e.g., surveys), following the Strategic Prevention Framework and other risk and protective models, and partnering with health departments when creating community health improvement plans. Using these processes allow CSBs to "peel the onion", surfacing issues and enhancing understanding about root causes. Though multiple root causes of behavioral health issues were identified by participants, ACEs and other types of trauma were the causes most often cited. Specific traumas included childhood, teen and young adult traumas, family and domestic violence, and mental health-related trauma. Participants also mentioned root causes related to social determinants of

health such as poverty and homelessness; substance use in the family; and accessibility of and favorable attitudes toward substance use.

CSBs use multiple strategies to address root causes. Participants noted that understanding ACEs is a key framework for guiding prevention efforts, and several CSBs conduct ACEs trainings in their communities to increase awareness about the root cause dynamic. Some CSBs are also actively involved in the Trauma Informed Community Network which educates individuals, groups, and health professionals about the effects of trauma through presentations.

Participants emphasized that root causes are rarely addressed directly. Instead, once root causes have been identified, CSBs must integrate them as elements into programs that target specific health outcomes. For example, one CSB incorporates elements of ACEs trainings into existing adult programming, such as classes, programs in jails, and parenting groups, as well as the school system. In this way, CSBs can engage in prevention by "working within the system," where prevention may not always be a priority.

The integration of root causes into existing programming is beneficial for CSBs. Being able to "connects the dots" between root causes and substance use outcomes links community partners who may have been "scattered doing their own thing, or thought they were "the only one at the table" in their efforts. This can result in renewed engagement, greater collaboration, and reduced duplication of community initiatives and costs.

Targeting root causes appropriately can be inhibited by funding constraints. The main challenge mirror those experienced in selecting prevention topic areas: efforts are too often restricted by amount of funding, and the constraints of stipulations from funding sources. CSB prevention staff reported funding sources are "dictating what we can do." For example, regarding the Partnership for Success grant funding source, one participant said plainly, "if we could combine all of our funding sources and use them for root causes that aren't specific to one particular substance, that would make our lives easier, and our work more effective." This dynamic is especially detrimental for CSBs who want to move away from focusing on single risk or protective factors and follow established models or frameworks that address root causes, such as the Developmental Assets Framework or other strengths-based models, larger public health or community-wide models, and positive youth development.

Root causes are a newer focus for coalitions. Coalition members were also asked to what extent their coalition work targeted root causes of behavioral health issues. Some root causes commonly cited by participants were trauma, ACEs, and negative stigma surrounding ACEs, mental health, or substance use. Several participants described the history of their coalition work as not having targeted root causes from the beginning, and that only until more recently their coalition changed their focus, "revamped," or otherwise took steps to address them. As one participant shared, "…in the end, we are a substance abuse prevention coalition, but we've got to go to root causes." Difficulty in focusing on root causes lies in a lack of data in order to know what to effectively target. Otherwise the causes that are targeted are merely anecdotal. With the number of root causes and health issues to consider, coalitions may partner with other coalitions and organizations to more effectively address them.

Coalitions target protective factors. Rather than targeting root causes or risk factors directly, one participant explained their coalition had been shifting its work over the last couple of years to focus on positive developmental assets in youth. The coalition achieves this by teaming up with the local department of human services that runs campaigns that follow Search Institute's Developmental Assets Framework. This coalition plans in the next year to learn more about root causes such as ACEs and how a focus on them could fit into their current protective factor strategy.

Implementation of Evidence-Based Strategies

CSB prevention staff shared that their prevention efforts are grounded in evidence-based strategies and programs. Most commonly mentioned were those in the education realm such as after school programming in partnership with social workers and counselors, as well as specific programs such as "Too Good for Drugs", "Teen Intervene", "Safe Dates", and other ongoing education curricula. Participants also shared that efforts are shifting more to environmental strategies and community-level interventions, such as merchant education and media campaigns. Some CSBs receive smaller grants from the Virginia Foundation for Healthy Youth to implement evidence-based programming related to tobacco, substance use prevention, and childhood obesity.

Participants also stressed the importance of implementing evidence-based programming that have been evaluated to show change and replicated in various communities. This has become a criterion for the selection of their prevention strategies as well as ensuring risk and protective factors are considered: "the science-based approach has empowered my ability to say yes, there's poverty. Yes, there's drug addiction, but yes there's [also] protective factors." Identifying risk and protective factors in their community, implementing evidence-based strategies, and assessing outcomes have contributed to CSB ownership of the work and the larger belief in its value: "...and I think that's where prevention will become a value to the continuum of care rather than just some free thing that feels good." Participants emphasized that it is rewarding to identify positive outcomes and have evidence that can lead to additional funding opportunities. Further, 80% of CSBs felt confident that they implement prevention programming with fidelity.

Evidence-based practices are less a focus for coalitions than CSBs. Generally, coalitions make themselves aware of evidence-based practices and resources by attending conferences such as the Community Anti-Drug Coalitions of America (CADCA) and consulting national registries of evidence-based programming websites. Coalition members said they implement programs that are "well-known." At the same time, some participants seemed unsure when it comes to evidence-based work at their coalition, and a few mentioned this aspect was addressed by employing a coordinator or consultant to review their grant applications or otherwise ensure their work was evidence-based.

Coalitions may experience tensions between funding that requires use of evidence-based practices, and what they believe works best in their communities. Evidence-based practices

are commonly becoming a requirement for receiving funding for coalitions. However, difficulty in employing evidence-based prevention practices in coalition work lies in shifting from established practices with long-time histories of implementation in communities to newer evidence-based ones that may not be as familiar to the coalition or their community partners. Also, participants explained that what works in other localities doesn't necessarily work for their locality, and coalitions decide to implement what best serves local needs rather than what has been established as a best or promising practice.

Program Adaptations to Better Serve Specific Populations

CSBs adapt key elements of service provision to improve efforts, and strive to reach individuals in their own communities. Participants emphasized that the populations they serve have diverse characteristics and prevention needs. As one participant put it, "the unique thing about our CSB is we do serve nine localities, with nine different communities, who have nine different [needs]." CSB prevention staff travel to communities or plan for activities to be implemented in ways so that community members can participate for free and/or receive additional benefits of participation such as receiving a hot meal, etc.

"[Regarding language barriers], ...we've been able to get interpreters that will come in and work or be in the class with the parent and interpret for them as we go through the class. That's a success but it's also a challenge when you don't have the interpreter, if they can't be there every time."

The most commonly mentioned service adaptations were translating spoken language and printed materials to reflect the communities served by CSBs. Examples included hiring interpreters, employing bilingual staff, ensuring program materials are accessible and at appropriate reading levels, and connecting program participants to therapists or staff who are equipped to provide culturally responsive services. Service adaptions specific to youth include employing youth specialists to research effective youth engagement strategies, such as appropriate social media outlets for delivery of prevention messaging and outreach. Multiple participants emphasized the rapidly evolving social media landscape as a key variable in youth outreach.

CSBs foster representation of specific populations to improve efforts. CSBs also aim to better address the needs of unique populations by ensuring they are represented in different aspects of prevention work. In prevention planning and assessment stages, CSBs endeavor to involve and empower community members from diverse backgrounds at community meetings, local and regional trainings, and recruit them on various leadership panels that guide community efforts or goals. This includes employing CSB prevention staff that are representative of specific groups. When performing assessments, or other data collection efforts, multiple participants discussed paying special attention to disparities in behavioral health outcomes and risk factors present in their CSB localities. Further, in the dissemination of data or results of

program implementation, one participant also highlighting the importance of including individuals with lived experience with behavioral health disorders in data dissemination such as at the National Prevention Network or other conferences.

Funding to support program adaptations to serve populations with varied or non-traditional behavioral health needs was raised as a key challenge. Additionally, the historical lack of inclusion of underserved groups in behavioral health research leaves CSBs with minimal information about best practices in program adaptation. CSBs also noted challenges with getting individuals from specific communities to the table across significant distance, and with ensuring consistent translation for various reasons (e.g. translators only available at certain times). In the prevention staff survey, approximately 60% of CSBs said that their target populations receive prevention services when and where they need it, and 50% of CSBs said that their CSB prevention services are available in the preferred language(s) of target populations.

Coalition members also emphasized transportation and translation as key barriers that they face. With many individuals served relying on public transportation and from locations across a vast coverage area, getting individuals in need connected with services can be difficult. One participant described, "...we have very limited public transportation. We have one public transportation that has to be scheduled three days ahead of time, and people have to wait all day to be picked up...." Another challenge is that translating prevention materials into languages for different cultural groups is too slow, resulting in services that are not culturally competent.

Aspects of a Data Driven Prevention System

Utilizing Data to Inform Services

Focus group participants were asked about data or other evidence that is used to inform prevention services in their communities. Participants frequently emphasized that "data drives everything," in terms of identifying services and prevention approaches. Data are used not only to identify needs that align with CSB funding requirements, but also to request additional funding. CSBs noted commonly utilizing the following data sources:

CSB utilize a variety of survey data. Participants shared the importance of survey data such as the Virginia Youth Risk Behavior Survey (YRBS), PRIDE, and the Young Adult Survey (YAS) to understand health risk behaviors among youth/young adults. CSB prevention staff frequently reported that the YRBS data drives their prevention efforts at the community level, as it helps prioritize strategies for targeting specific risk behaviors among middle and high school students. CSBs have learned that although prescription drug usage is high, underage alcohol use is a signficant problem as well. All participants mentioned presenting YRBS data to school boards and local governments to highlight existing needs and request additional funding to address those needs.

Some CSBs also utilize local survey data from tools such as The Search Institute's Developmental Assets Survey and the Secondary School Climate Survey to inform their prevention work. One

participant shared that their School Climate Survey data revealed high academic failure and aggressive behavior in early childhood settings. These survey results supported a grant application to fund a school-based drug prevention service. CSBs that do not have access to local survey data utilize state-wide data from the Virginia Department of Health website to make data-driven decisions.

Community partner data is crucial and partnerships with community organizations have helped CSBs access unique local data sources. One participant shared they have obtained food insufficiency data indicating food deserts in certain areas. This deepened understanding of community mental health and substance use issues by highlighting related issues of health equity. Another participant shared that their partnership with law enforcement provided access to heat maps that highlight areas with high overdose rates, which has helped target areas for substance use prevention, outreach, and harm reduction efforts. Other community data sources included faith-based groups, Virginia Commonwealth University, and municipal data. These community partnerships are not only important sources of data, but also opportunities to collaborate on the analysis and reporting back to community partners, coalitions and local youth.

"It's constantly nurturing those relationships with towns and municipalities, and with state organizations, but also faith-based groups, recovery groups, looking for data everywhere and anywhere, and constantly going to the public and asking what is needed, holding focus groups, holding events for people to come and share with us as much as we share with them."

CSBs utilize needs assessment data. CSB prevention staff also utilize data and findings from their needs assessments[3] (e.g. Virginia Youth Survey data, young adult survey data, arrest rates, deaths, other consequences of use, etc.) to inform efforts. The needs assessment includes a wide range of data, including risk and protective factors as well as priority areas identified by CSBs. Participants noted that assessment data have been used to seek funding, identify priorities for prevention efforts, target areas and issues, and inform staffing patterns. On the prevention staff survey, over half of CSBs rated themselves as 'above average' or 'excellent' on conducting needs assessments and utilizing data to select strategies.

Similarly, coalition decisions are data driven. Coalition focus group participants also said their prevention efforts were data driven, and if not, they were seeking to understand how data could be used effectively by their coalition. Several coalitions employ an independent evaluator or consultant to provide them with and help them use data to make decisions and assess what their community's needs, and the impact the coalition's services are having. Additionally,

[3] Each CSB engaged in a needs assessment process in 2016 to drive prevention strategic planning, and updated needs assessment data in 2018 to ensure alignment with areas of need.

coalitions typically share data between their affiliated CSB, health department, and other community partners.

Challenges with Data Access and Reporting

Many participants shared CSB and coalition barriers to data collection, access, and reporting which included: 1) issues with accessing local-level data; 2) securing school support for data collection efforts; 3) obtaining adequate sample sizes; 4) ensuring consistent data collection methodologies; and 5) mitigating evaluation burdens on staff.

Accessing and utilizing locality level data can be challenging. Although some CSBs have access to local data, the majority need additional funding and resources to support data collection efforts in smaller, rural localities. Participants highlighted that these smaller rural communities can be overlooked or lumped into one larger region, which makes it difficult to identify and report local-level public health issues. As one participant shared: "the data we normally provide is either state data, tribal data, or whole county data. It is hard to drive data down to localities, very small localities. And that's for a variety of reasons." It is challenging for prevention staff to highlight specific issues in their communities (e.g., rising suicides) when they can only access statewide data and anecdotal reports. Obtaining funding and resources for focused efforts such as suicide prevention services can therefore be difficult.

CSBs and coalitions also highlighted the burden of gathering and synthesizing local level data from various community partners. Because of wide variation in data sources and collection methodologies, it can be challenging for CSBs and coalitions to effectively interpret findings. As one participant noted, "so the abundance of data that were gathering, you have to separate by locality, work with those coalitions, pull out what's important in one may not be the same in the other." Coalition participants also noted this same challenge, sharing that it was overwhelming to navigate data collected by multiple partner agencies that each collect data through different means and related to different outcomes, with many of the requirements dictated by several different grantors. Participants noted that evaluation services to conduct local needs assessments or track and report local data would be beneficial to understanding local needs and seeking additional funding.

Schools are sometimes reluctant to administer or share data from the Virginia YRBS. Participants raised the following barriers related to school administration of the YRBS:

- Some participants reported that a lack of YRBS data is due to a lack of relationships with the schools and/or losing relationships due to capacity changes in their CSBs: "…I think the root cause of that [lack of YRBS implementation] is that we don't have a relationship with them [schools]."
- Implementation of other surveys or standardized tests such as Standards of Learning tests are often prioritized over the YRBS and schools believe they do not have the time to administer another survey to students.
- School administrators are reluctant to utilize their staff time to administer the survey.

- Some schools are reluctant to collect or share health information about their students, for example substance use or suicide rates, for fear of appearing to "have a problem" in their school. Participants said schools tend to compete with one another, and that they may be afraid reporting student behavioral health information will affect property values in nearby residential areas.
- Parents sometimes disagree with substance use questions being included on the YRBS, and do not want their children or schools to participate.

Differences in school survey instruments and administration timelines are also barriers. Many participants shared that schools administer different versions of youth surveys—some schools administer the CDC version of the YRBS survey while others administer the PRIDE survey, which includes additional questions related to student behavior and perceptions. Some shared concerns about how survey questions on various versions are worded, either not including lingo commonly used by youth or using technical language that impacts participant comprehension (e.g., "prescription drug misuse" and "prevention strategies"). Another example included the PRIDE survey which includes language on cigarettes and vaping but not language specific to Juuls. Because students do not consider Juul a vaping tool (despite it being classified as such), some survey reports falsely indicated little to no vaping which contradicted anecdotal reports of high Juul use. Participants also reported difficulty tracking survey types, versions and administration timelines across their catchment areas which has led to confusion or lack of access to the most recently available data.

Survey samples for various populations can be limited due to outreach challenges. Some participants noted it is difficult to engage young adults to take the Young Adult Survey (YAS), despite staff visiting local college university campuses for student outreach. Some CSBs are now utilizing social media platforms to share an online version of the YAS. Participants also shared difficulties reaching the older adult population and understanding specific issues such as opioid misuse rates: "I feel like we're lacking in that area of what's best practice in reaching the elderly population." CSBs have also been unable to identify appropriate and reliable survey tools: "we've tried to go to the senior centers and come up with our own survey. But there's really nothing out there that we have found usable with some sort of fidelity and research behind it." Participants highlighted the importance of understanding prevention across the life span, gathering older adult perspectives and engaging them in prevention services such as community events. This is a gap that participants agreed on and expressed interest in better addressing.

Prevention staff experience fatigue from the range of grant requirements and evaluation demands. Participants shared that staff find it difficult to keep up with data entry and reporting, particularly across multiple grants with varying reporting requirements. Gathering data, tracking event efforts and distribution of information, and ensuring information is entered appropriately into the various systems for different grants were all challenges mentioned. Participants also noted that administrative tasks and completing evaluation requirements such as logic models can be burdensome. Staff often feel they are constantly being pulled into different directions by different grants, needing to prove the worth of their prevention efforts.

Outcomes of Prevention Efforts

CSBs have observed a range of positive changes in their communities. CSB focus group participants were also asked how their efforts were contributing to change in their communities and attribute the following outcomes to their prevention efforts:

Example Outcomes Tracked by Coalitions
• Arrests • Overdoses and overdose-related deaths • Public awareness of health problems • Public perceptions of harm of using substances • Substance use (alcohol, marijuana, opioids, tobacco, etc.) • Suicide

- **Increase in knowledge and awareness.** Participants reported information dissemination campaigns such as radio PSAs and billboards have increased awareness and knowledge of issues and priorities in their communities. Media campaign messaging through different platforms have allowed CSBs to reach more people in the community. Participants also shared that media campaigns are making an impact on perceptions of access to substances; young adults are reporting that alcohol and prescription drugs are harder to access in the YAS. Some participants also shared that their logos and branded materials are being recognized in the community, further increasing awareness of their work and offerings for the community.
- **Increased access to mental health education.** Mental health education and training efforts in CSB communities have increased in order to combat high rates of youth-reported depression, hopelessness and suicidal thoughts in the YRBS. The most commonly shared trainings were ACEs, Mental Health First Aid, and Lock and Talk.
- **Improved relationships with business/retail community.** Local merchants/businesses have reported looking forward to engaging with CSBs and are receptive to the education and materials provided. Many are making notable changes such as moving their larger advertisements and alcohol to less accessible places.
- **Healthier communities.** Changes in various community health indicators have also been observed. Data in some communities indicate decreases in tobacco use, underage drinking, and access to prescription drugs. One participant also shared their evidence-based preschool program has improved social skills and reduced aggression among preschoolers.

CSBs report various challenges related to tracking outcomes. Although CSBs reported a number of positive outcomes in their communities, participants more easily identified the barriers and challenges related to tracking outcomes over time.

"How do we know, longer term, if what we've done has really made the change? I don't know."

First, observing outcomes is challenging because of the time it takes to see impact: "It takes years and years to see some of those outcomes take place in the community." Both CSBs and coalitions agreed that shifting attitudes related to substance use and reducing stigma around mental health takes significant time, and some expressed that prevention work can seem like a gamble when striving to see meaningful change. Though participants have worked on logic models to identify short, intermediate, and long-term outcomes, staff are more interested in tangible indicators that directly relate to their prevention work. Many shared that it is much easier to identify and assess progress toward short-term outcomes than it is for long-term outcomes related to their prevention efforts.

Similarly, it can be more straightforward to track outputs than outcomes. "Our problem is tracking the data from what we actually do. it's a lot of outputs, and we're looking for outcomes. Everybody's looking for these sweeping changes, and all that we can provide is how many people attended a training," explained one participant.

"You can say how many people you're training. And we can believe that's making a difference. But we're not able to capture that true difference that is making in the community. "

This is particularly relevant as CSBs shift from implementing education-based strategies to strategies such as media campaigns. Participants shared they can easily track the number of people trained and gather pre/post survey data for education-based strategies. However, there are concerns about losing quantifiable data as they shift to implementing more media campaigns such as billboards, radio ads, or PSAs to increase awareness on opioids. They also fear losing funding opportunities because of the inability to report specific outcomes that show an increase in awareness or knowledge other than hearing community members seeing a media campaign anecdotally. Though CSBs track the number of people reached or impressions of from marketing companies, it is difficult for CSBs to use this information to explain the campaign's impact. Coalition participants echoed this challenge, specifically with not having outcome data directly tied to prevention activities, making it hard to determine if an outcome was due to their efforts or some other factor.

To address this, participants shared holding community meetings, focus groups, booths and other engagement strategies to gather perspectives on their efforts. For information dissemination strategies like health fairs or community events, some participants shared employing post-event evaluations to gather feedback that can be applied to future events: "we will ask individuals attending a conference, for example, what community events relevant to substance use or mental health will they like more information on, or even a presentation on."

Though these efforts do not assess change in knowledge over time, they provide CSBs with valuable information to inform ongoing strategies.

CSBs reported various additional challenges related to assessing progress toward intended outcomes:

- Difficulty administering surveys or other information gathering methods (e.g., interviews) to the same sample over time, limiting ability to track longitudinal change.
- Lack of timely access to local-level data.
- Challenges with collaborations and data-sharing agreements with key entities such as law enforcement and other local community organizations, as many groups are reluctant to share data outside of their organization.
- Community distrust and/or lack of buy in for survey efforts due to perceptions such as social desirability bias and collecting data that cannot be generalized to the larger community.
- Limited staff capacity to report progress or track outcomes, particularly when CSBs are completing their monitoring reports or evaluation tasks. Though some CSBs have more funding and resources to leverage for this purpose, others lack this capacity and are forced to limit the outcomes they can target and track.

Rural/Urban Contexts and Issues

Throughout the focus groups several participants discussed issues around prevention service delivery and unique needs for rural areas and/or populations. At least one participant in each focus group served individuals from rural communities in their CSB's catchment area.

Urban and rural CSBs have many commonalities, but also important differences in the structure and focus of prevention services. According to the surveys of prevention directors and staff, urban CSBs were more likely to report being supported by local level funding. Funding difference may drive differences in capacity; urban CSBs were also more likely to report having resources to help individuals access prevention programming, and to have prevention services in the preferred languages of target populations, though these were issues for many urban CSBs as well. Additionally, while the majority of CSBs did not feel like they had adequate staff available to implement prevention strategies, this was even more common in rural CSBs. Other differences emerged in the focus of prevention services. Urban CSBs were more likely to report targeting alcohol and marijuana prevention as compared to rural CSBs, and rural CSBs were more likely to report targeting methamphetamine prevention.

The geography of rural areas impedes prevention service delivery. The distance between communities in rural areas, and between service agencies and communities presents a challenge for CSB prevention staff and their community partners in delivering prevention services. Examples of these challenges include not being able to travel from a CSB office to a specific community within a day, and difficulty visiting retailers that are scattered across rural areas to

"Someone once told me [regarding substance use], at the opposite of addiction is connection. And that's what southwest Virginia had forever. You look at people piled up on a porch in Appalachia, they had each other…but the drug epidemic ticked away at that, it took that passion away… and that's why I came here rather than staying in northern Virginia… I wanted to be part of the fold."

provide merchant education. This problem is exacerbated for CSBs that have minimal staff (sometimes just a single staff member) responsible for engaging communities across rural areas. Geographic distance is not the only challenge. In the coastal areas, communities can be cut off from urban centers as a result of barrier islands or peninsular-shaped catchment areas that are only connected to other communities by a single bridge. Participants noted that the efforts CSBs make to interact with rural communities are crucial for establishing and mobilizing coalitions. If such initiatives are not part of their everyday job duties or schedule, it is difficult for rural community members to attend meetings or participate and slows prevention efforts on the whole.

The population dynamics of rural communities present unique data collection challenges. Using data to inform prevention strategies is a key goal for CSBs. A central issue with data collection in rural areas is the difference in population density compared to urban areas. One focus group participant stated that the assessments of health needs are informed by data from urban areas, and as a result the assessments do not accurately represent the health needs of rural Virginians. Related to this, assessments that do measure rural populations are not calculated or presented *per capita*, resulting in a situation where health problems in rural areas seem less prevalent than in urban areas. This is a significant issue when funding is driven by such assessments.

"…looking back over the years, I've had data and was ignored. Funding needs to be driven by need, not by population numbers. I like the per capita idea because 40 people dying in my community of 3,000 was huge."

An additional challenge with data collection in rural contexts is protecting confidentiality due to smaller population numbers or in cases where the data can only have come from one source. Examples of this are law enforcement agencies that are reluctant to share or provide data for fear of admitting their jurisdiction has a behavioral health problem, such as substance use. Schools may hold on to their youth health-related data and instead only provide data on standards of learning, which are not as valuable for informing prevention efforts. Other agencies are reluctant to give CSBs any type of data at all. Fewer people across larger geographic areas makes finding local health data difficult.

Rural communities have rich, diverse cultures and traditions that both aid and hinder prevention efforts. Participants talked about many aspects of rural Virginia that make it unique from the rest of the state. Rural communities have "long-term" coalitions that rely on cultural traditions to maintain cohesiveness and positively affect the problem of substance use, such as organizing around good food, valuing the importance of families, and loving each other. CSB prevention staff leverage these traditional cultural values to "find a way out of the problem."

At the same time rural communities were described as particularly heterogenous, with communities within one county that could range from resort, yacht, and country club types to an impoverished and poor neighborhood where some homes have dirt floors and limited access to water. Additionally, substances such as alcohol and tobacco were discussed as being traditionally easier for youth to access in rural areas. CSB prevention staff work hard to change the cultural health norms of people who live in "forgotten area that no one cares about."

Urban areas have unique context issues too, such as diversity in populations and diversity in need. Population dense, urban areas were also cited as having specific dynamics around prevention service delivery and health. In some of the larger catchment areas, CSB prevention staff mentioned barriers such as adequate translation for delivering services to diverse populations. Other communities have different prevention priorities across different localities. In one participant's experience, the substances targeted for prevention efforts differed between the city and the county, in their case in the city marijuana use is the most pressing issue, whereas in the county it's alcohol.

Capacity to Provide Prevention Services

Capacity Facilitators

Relationships with community stakeholders facilitate the delivery of prevention services. When asked what services are working well, all participants consistently spoke about the relationships their CSB/coalition maintains with community stakeholders as being integral to successes. Community partners include non-profits, coalitions, CSBs, schools, municipal leaders, law enforcement agencies, faith-based organizations and other entities. Relationships were described as beneficial, "not stepping on each other's toes," and not "duplicating [prevention] efforts."

Community stakeholder relationships facilitate delivery of prevention services by connecting CSBs with key populations of focus. For example, one participant talked about their CSB developing and maintaining relationships with community churches where people from "all walks of life and different age groups" gather all in one place. Community partner relationships also provide CSBs with important community context and information about community needs. In terms of capacity or readiness to engage in prevention services, these relationships enable CSBs to "meet [stakeholders] where they're at, not just expect them to show up where [CSBs are] at," which can offset participant burdens often experienced in prevention programming.

Community relationship dynamics like these require significant time and effort to develop, nurture, and maintain.

Participants also shared creative and innovative strategies for bolstering capacity:

- **Shifting to environmental strategies and media campaigns** as a result of not having enough capacity to cover a large geographic region with limited prevention staff. However, only utilizing these strategies can limit the ability to create real changes in communities, as staff are needed to make connections in the community.
- **Leveraging staff enuthusiasm and innovation**: "I would say we have tremendous capacity when it comes to innovation. We have great support in terms of 'Go, get them girl' kind of support. We develop services and deliver services with fervor and enthusiasm."
- **Investing in a dedicated grant writer** on staff to help secure grant funds, including local funds.
- **Employing train-the-trainer strategies** to broaden reach/capacity. For example, to address limited certified prevention specialists covering a large geographic area, one CSB trained teachers but encountered challenges such as turnover of teachers, fidelity to the content, and sustainability of efforts.
- **Utilizing interactive social media to access hard to reach groups.** Coalition members shared wanting to deliver prevention activities via platforms like Facebook Live in order to reach populations who have transportation/travel barriers or are too busy to attend in-person events.

"To serve three rural counties that cover six hours of driving time, I could have three more staff to do a good job. But instead, I've shifted to environmental, and we do the best we can."

Capacity Barriers

Lack of statewide funding for prevention. One main capacity constraint that participants across both urban and rural settings spoke about at length was the lack of statewide funds for prevention. Example quotes included, "We operate on a shoestring," and "All of us are grant writing like crazy trying to braid enough funding together to even do what we're mandated to do." The result according to participants is an unstable environment for delivering prevention services, particularly when compared to treatment services. "I just wish we would get the kind of attention and financial support that treatment services receives," was a common sentiment, as was a need to "prove prevention's worth." Funding limitations also emerged from coalition members, who shared that more funding is needed to expand services to meet new needs as well as sustain current service implementation.

Lack of funding is also experienced differently by CSB's. Depending on the locality, CSBs with similar population size or other characteristics can have different capacity. For example,

some CSB's only receive federal funds, while other CSBs with similar populations may have a robust prevention workforce because of local prevention funds. Rural CSBs were less likely to report receiving local funds, and feel the challenges of having limited funds and staffing to cover a large geographic region. "I'm one person covering a five county area... I want you to picture me trying to do all these five county area merchant education places, plus doing suicide prevention and opioid epidemic."

"We have knee-jerk reactions because of funding. We'll be out there going steady and strong addressing tobacco, and then funding will be dropped down for us to do something specific to opioids. And we'll be yanked in another direction. And then three months later, we're yanked in another funding direction. That stuff is fatiguing to me."

Efforts are directed by funds rather than local needs. Because there are no dedicated state funds towards prevention, efforts are directed or driven by grant funds, which can lead CSBs to feel "yanked" in different directions and like they have "knee-jerk" reactions to grants. This can also lead to feeling like the work continues to expand and CSBs are "trying to do it all" rather than have focused and targeted efforts. "Sometimes I feel like we try to do everything, and I'm not sure that we do everything well." explained one one participant, and the participant went on to explain how they are expected to work on suicide prevention, mental health, parenting classes, and all the substance abuse prevention work."Sometimes it's very overwhelming trying to keep up with everything. And some days I feel like I'm not doing the best job at everything."

Similarly, participants discussed how grants are designed to target specific issues (e.g., opioids, underage drinking), which does not always align with local community priorites and needs and CSBs and coalitions may be forced to work on priorities that are not areas of strength and knowledge. Local grant funds can also be for very localized, specific programs (e.g., school-based interventions), which can limit CSBs' ability to scale up efforts and expand capacity. Further, grant funds may need to be spent in a short amount of time depending on the funding stream, which can force CSBs to utilize funds in ways that do not support long-term needs and goals.

DBHDS was also described as becoming more "directive" with how funds are utilized and the focus has changed over time, which means needing to redirect resources. "The state has come up with these four group of services that our staff need to provide, so that has caused us to redirect our resources from ways we had used them traditionally," explained one participant.

Participants also surfaced a need for better compensation to retain staff. Although cost of living or other expenses rise (e.g., health care), salaries do not, which can make it difficult to retain staff. Lower salaries can also make retention of staff difficult, and CSBs may continuously hire and train people only for them to go elsewhere for better salaries. Results from the prevention staff surveys indicated that staff employed by urban CSBs were more likely to be satisfied with their compensation than staff at rural CSBs. Despite this, both urban and rural staff reported high levels of overall satisfaction with their jobs, and rural prevention staff were more likely to indicate that it was 'likely' or 'very likely' that they would still be working at their CSB in 5 years.

"It used to be nobody left prevention, it was like the job to have at the CSB. Once you got a prevention, you usually weren't going anywhere but over the last few years, because I think of the salary, people aren't staying because they can go to jobs where they're getting paid more money."

Prevention is understaffed and staff are over overallocated. Because funds are limited and evolving depending on the grant funds that become available, a challenge participants in all focus groups raised is that CSBs are understaffed and overallocated. One way this manifests was with CSB Directors wearing multiple "hats," typically in both treatment and prevention. "We're stretched in many directions that I don't think other directors normally have to be" and "I do two jobs. I'm a director of [therapy] because it was my passion, and I kept being a director of prevention." CSB Directors also discussed "working off the clock" or during evening hours and weekends to grant-write, enter data into databases, keep up social media campaigns, etc. Even larger CSBs that indicated having more staff than their peers said they still felt understaffed due to the need for community presentations, requests to go into communities and provide programming, etc. Less than half of CSBs who participated in the prevention survey indicated that there was adequate staff to implement prevention strategies.

By far the most frequently cited issue for coalitions was having limited staff, both at the coalition and at their affiliated CSB. Participants don't have enough time to carry out prevention activities without additional staff. Furthermore, coalitions also frequently utilize volunteers on their staff, which are somewhat limited in their capacity to provide services, such as managing a resource table at an event, or "really being out in the community doing things."

Collaboration can be limited. Working collaboratively with other organizations was surfaced as a capacity constraint in some cases. Several coalition members discussed schools as being more challenging to collaborate with (see Challenges with Data Access and Reporting above). They shared that some schools are reluctant to have to notify parents of their students' involvement in prevention activities. Coalition staff referred to this dynamic as "site-based management," where even when buy-in is established with school administration, each school principal is different and requires an additional level of connection for programming to be delivered in their school. This extra layer of buy-in needed is frustrating for coalitions. As one participant put it,

they have to go from the top down *and* the ground up. One way this relationship dynamic might be improved, one participant said, is to work with schools through new social workers who are being employed by school systems, and who are also recruited as members of the coalition.

Further, collaboration with other organizations can be surface level when organizations only do enough work to meet their funders' requirements for collaboration (e.g., reporting on shared outputs in collective impact processes). Effectively engaging volunteers can be challenging when participating in efforts is not directly tied to someone's job responsibilities and paid time. Finally, engaging the military base if in a CSB's catchment area can be difficult, as the base can be unresponsive even though CSBs have services and trainings that could be of benefit (e.g., mental health first aid specific for military personnel).

Recommendations to Address Capacity Issues

Participants surfaced various ways in which their capacity could be bolstered, including:

- **A need for prevention to be valued and funded**, "brought into the fold," and seen as "the foundation" for assessment and evaluation in the CSB system. This includes "an equitable shake at the resources."
- **More training and education** around prevention topics (e.g., opioids), as CSBs may be tasked to go into the community to promote different priorities without the training or education to do so effectively.
- **Better school engagment and buy-in** on data collection, which could be fostered if the groundwork came from "the top," such as the Department of Education "putting their stamp of approval" on data collection efforts.
- **Development of campaigns at the state-level** that local CSBs could implement. Although developing individual campaigns ensures that efforts are targeted for local needs, it can also lead to a lot of individual-level work that could be streamlined. "I would like to see statewide advertising that we can just go in and select what we want to use for our local community."
- **More effective collaboration at the state level** among offices such as health departments, education, and justice: "In order for us to collaborate on the local level, the state needs to start that collaboration."
- **Better utilization of local needs assessment data to inform the statewide efforts** so that what is developed at the state level is informed by the needs assessments and data that communities have already gathered.

Appendix A

Prevention Service Providers Focus Group

Date of Focus Group: **Start Time:** **End Time:**		
Participant Name	**CSB represented**	**Role at CSB**

For interviewer: Please rate your confidence level about the thoroughness of the information collected during this interview. ☐ Very Thorough ☐ Reasonably Thorough ☐ Missing Information

Zoom Logistics (Virtual FG Only) (5 minutes)

Start Zoom meeting 10 minutes prior to FG starting time. Take note of participant names, CSB they are representing, and role as they join (CSBs).

Welcome to the Prevention Service Providers Focus group. My name is Paola, and I'll be today's facilitator. This is [Jason/Julia] who will be helping with note-taking. Let's take a few moments to assure all participants have joined the meeting.

Wait a few minutes or until all are present.

Before we start the focus group, let's take a moment to ensure that everyone is ready and familiar with the Zoom teleconferencing software.

Let's take a moment to make sure everyone has connected properly and is able to see and hear.

- **Video and Gallery view:** Please turn on your video. There is an icon at the bottom of your screen for this. You also have a gallery or speaker view. These are different ways to view the other participants on the call. You can change the view by clicking on the gallery or speaker icon at the top-right of your screen.
- **Chat:** You may also use the chat function to send a message, though we prefer your focus group responses be audible. The chat function will also be recorded, so you are welcome to write something at the end if you would like for us to read after the focus group has ended. We will also be monitoring the chat for any questions or comments during the focus group.
- **Muting:** We also ask that you mute yourself when you are not talking to help reduce noise/interference. If you are joining from a computer, in the lower left corner of the Zoom meeting screen you will see a microphone icon that you can click to mute and unmute yourself. Everyone is currently muted now as we give out these instructions.

  Are there any participants joining only by phone? *IF YES*: If you are joining by phone, during the focus group please indicate your response to prompts by saying your name.

  In just a moment, we will unmute you on our end. When you wish to speak, please take yourself off mute, and remute yourself when you are finished. If joining by phone please say your name to indicate you have a response. 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.

Please let us know now if you are having audio or video issues or with anything we just covered.

Respond to any issues. Make sure everyone can hear the moderator by doing a roll call with participants who have joined.

Introduction (10 minutes)

Thank you for participating in today's prevention service provider focus group. My name is _____ and I will be facilitating our discussion. For the next 90 minutes, we are going to have a conversation around the successes, concerns, and needs you may have as a prevention service provider for your agency. It will also help us to understand, from your perspective, your role and your program's ability to serve your clients and meet their needs.

Background

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment. JBS has subcontracted with OMNI Institute, that's us, to support this assessment, specifically within the prevention arena. The purpose of this needs assessment is to 1) assess the needs of Virginians for publicly funded behavioral health services; and 2) assess the current capacity of the State of Virginia's behavioral health system to meet the behavioral health needs of Virginians. While the Virginia Needs Assessment is funded by DBHDS, we are not part of the DBHDS system. Findings from this needs assessment will be used to guide a series of recommendations to DBHDS that support system improvements and proactively prepare for future system change.

Purpose

Your opinions and experiences as Prevention Service Providers are very important to us. To help inform our needs assessment, we are conducting interviews and focus groups and distributing questionnaires (surveys) to service providers, administrators and clients across all 40 CSBs in Virginia. These focus groups will allow us to understand the context behind the answers provided in our interviews and written questionnaires and to explore topics in more detail. Our goal is to gather information that accurately reflects your experience so that we can help provide meaningful recommendations to Virginia DBHDS. That means there are no right or wrong answers and we appreciate your honest input. You are the experts here today, and I am here to learn from you.

Group Norms/Agreements

- Give and take with respect – Please express your thoughts and opinions openly but in a respectful manner, as there are always different histories, experiences, and beliefs to navigate in a group setting.
- Take space and make space – Some people are more talkative by nature and others more reserved. Because we want to hear from everyone, we ask that if you have responded to questions, please wait while others who haven't responded share their thoughts.
- Commit to keeping the comments expressed here today confidential, in order to encourage frank and full participation.
- Please turn your phone off or put it on vibrate and if possible please do not check your phone while we are having this group discussion.

Participation.

Participation in today's focus group is completely voluntary. You are free to leave at any time. You do not have to answer any questions you feel uncomfortable answering.

Privacy

Information collected today will be compiled and aggregated with the information we collect from all the CSB interviews and focus groups hosted across Virginia. Names and identities, including CSB names, will not be used in any published reports. Only combined results will be presented in reports.

We also want to acknowledge that you may recognize other individuals on this call. We ask that all information shared on this call stays 'on this call' and that participants do not discuss any information shared as a part of this focus group after the group has concluded.

At this time, do you have any questions about what I have explained?

Although we are taking detailed notes, we would also like to record the discussion to help verify our notes. Recordings will be kept confidential in a password protected computer, and only be heard by a trained researcher/transcriber not affiliated with Virginia DBHDS, for transcription purposes only.

Do we have your permission to record this focus group?

NOTE TO INTERVIEWER: Turn on recorder and verify that it is recording. For virtual groups, click the record button in the Zoom interface and select "Record to the cloud."

SERVICE DELIVERY (20 minutes)

First, we'd like to take time to understand your experience delivering prevention services to clients. As I ask the following questions, please think about what works, what is challenging, and any aspects about service delivery that you would change.

1. I want to start by hearing about the prevention services that your CSB provides. How would you describe the breadth of this work, and where are your efforts most strongly focused?

   Facilitator to probe:
   - *How would you describe the populations for which your CSB provides prevention services (e.g., geographic, racial/ethnic, or cultural characteristics of populations targeted by CSBs)?*
   - *What are the types of prevention services that your CSB provides (e.g., are services provided for individuals, groups, or are they environmental/population level in nature? Do CSBs implement programs or campaigns? Education? Information dissemination?)?*

- *What services work well?*
- *What services are challenging?*

2. **To what extent do prevention services in your CSB target root causes of behavioral health issues (such as adverse childhood experiences [ACES], exposure to risk factors, social health conditions)?**

    - *Facilitator to probe: What are the root causes targeted? How might your CSB better target issues like these?*

3. **How are prevention programs, campaigns, or services adapted to better serve populations in need in your CSB?**

    Facilitator to probe:
    - *What are the unique prevention needs of individuals in your CSB?*
    - *How are efforts tailored to address local customs/norms?*
    - *What specific sub-populations, if any, are you targeting?*
    - *How does your CSB identify which populations have the highest need for prevention services?*
    - *What populations do you want to target, but aren't having success with? Why are you not having success? What are the challenges?*

USING DATA TO INFORM SERVICES (20 minutes)

Next, we'd like to get a sense of how data or other evidence is used to inform the prevention services in your CSB. Again, we are looking to hear from you on what works, what is challenging, and any aspects related to accessing services that you would change.

4. **To what extent does your CSB use data to drive prevention efforts? And how?**

    Facilitator to probe:
    - *Do you utilize needs assessment data in identifying what services to offer? What surveys do you use? What partner data?*
    - *Is data tracked and how?*
    - *How does data inform practices?*
    - *What additional data is needed or what barriers exist in accessing data valuable to CSB prevention efforts?*

5. How does your CSB implement the use of evidence-based or "best" practices?

    Facilitator to probe:
    - *How are best practices identified? What are the criteria for evidence your CSB takes into consideration?*
    - *What support is needed in this area?*

6. **To what extent do you feel that the prevention efforts implemented in your CSB are leading to changes in outcomes (for example, reduced substance use)?**

   Facilitator to probe:
   - *How does your CSB track outcomes?*
   - *What are you tracking?*
   - *What works? What is challenging?*
   - *What are barriers in the system to improving services?*

CAPACITY TO PROVIDE PREVENTION SERVICES (20 minutes)

Now I'm going to ask a few questions about the capacity of your CSB to provide prevention services. Again, please think about what works, what is a challenge, and what elements related to your CSB's capacity to deliver prevention services you would change.

7. **How would you describe your CSB's capacity to provide prevention services?**

   Facilitator to probe:
   - *Are there sufficient resources to support prevention efforts (e.g. time, personnel, funding, management), why or why not? What else is needed, if anything?*
   - *What works/what's challenging/what would you change?*
   - *What does your CSB need to further maximize the impact of its prevention services on mental, behavioral, or substance use disorders in the community?*
     - *What resources are lacking?*
     - *What are the most frequently cited issues that impede efforts?*

8. What role do coalitions play or how does your CSB work or collaborate with any community coalitions? If so, how would you describe the nature of your relationships with coalitions?

   Facilitator to probe:
   - *How does working with coalitions benefit prevention service delivery?*
   - *What are any challenges in collaborating with coalitions?*

9. What procedures does your CSB have in place to ensure sustainability of prevention efforts?
   Consider the following:
   - Funding
   - Staffing
   - Planning

PROVIDER EXPERIENCE (10 minutes)
Finally, we'd like to hear about your experience as a prevention service provider at your CSB.

10. Given everything we've talked about, how would you describe your satisfaction with your work experience? This can be personal satisfaction with your position or more broadly. Consider the following:
    - Communication
    - Relationships
    - Time allocation for different tasks
    - Compensation, benefits and job security, and professional growth

    Facilitator to probe:

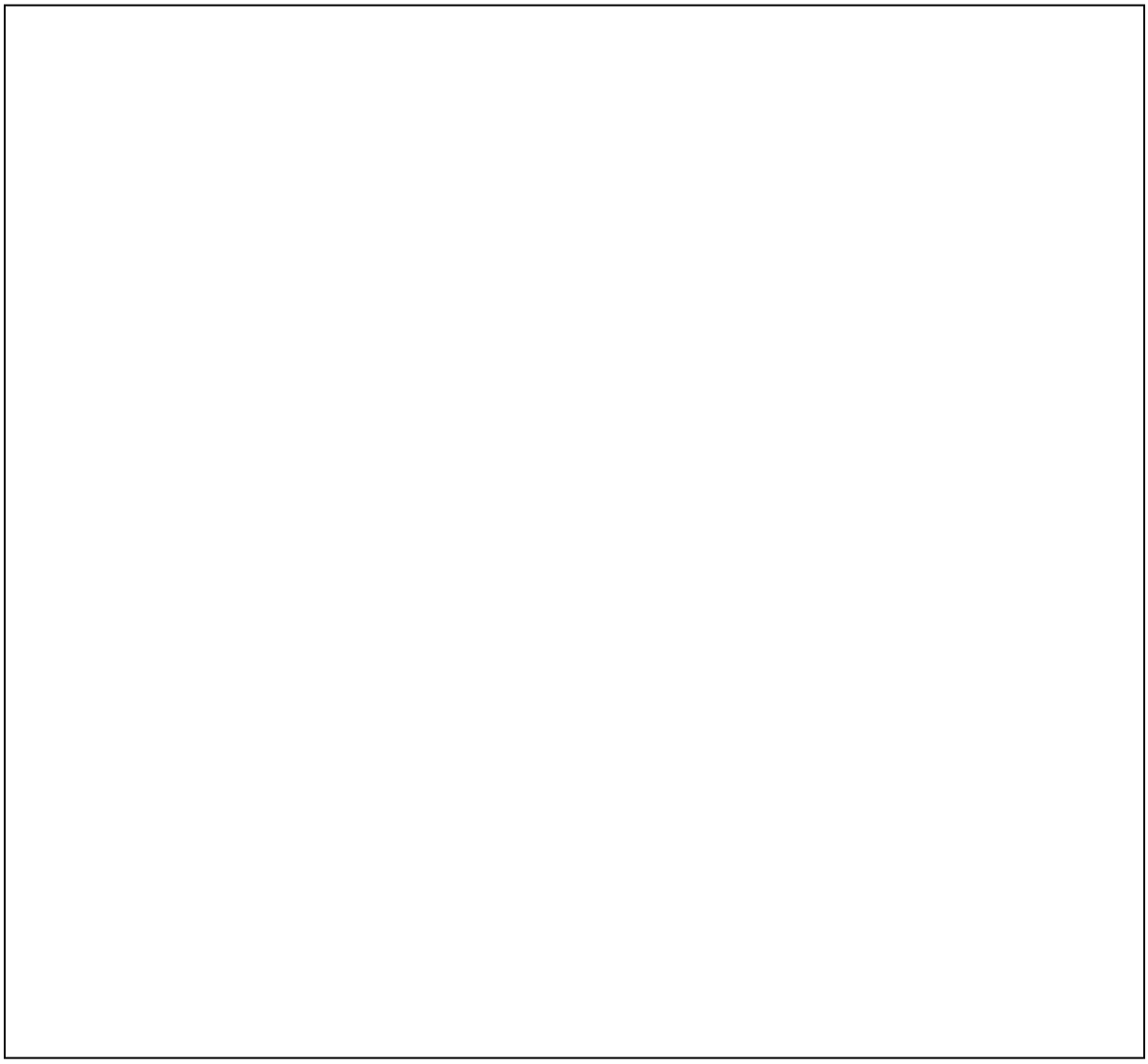
    - *What works?*
    - *What is challenging?*
    - *What is one thing you would change?*
    - *What aspects of the work experience does your CSB excel at?*

ADDITIONAL QUESTIONS IF TIME PERMITS (5 minutes)

11. **If you could improve one thing about clients' experiences with prevention services from this agency, what would that be?**
12. **(See below)** ~~**Describe a program/campaign where your CSB excels? What is leading to success in this prevention work?**~~
13. Is there anything else that you think we should have asked about?

As a final exercise before we end the focus group, we would love to hear from you via the chat box about **a program/campaign where you CS excels and what is leading to success in this prevention work.** This can be a private message in Zoom, which will be archived for later analysis.

THANK YOU FOR YOUR TIME!



Notes:

Prevention Coalition Focus Group

Date of Focus Group: **Start Time:** **End Time:**		
Participant Name	**Coalition represented**	**Role at coalition**
For interviewer: Please rate your confidence level about the thoroughness of the information collected during this interview. ☐ Very Thorough ☐ Reasonably Thorough ☐ Missing Information		

Zoom Logistics (Virtual FG Only)

Start Zoom meeting 10 minutes prior to FG starting time. Take note of participant names, coalition they are representing, and role as they join (coalitions).

Welcome to the Prevention Coalition Focus group. Let's take a few moments to assure all participants have joined the meeting.

Wait a few minutes or until all are present.

Before we start the focus group, let's take a moment to ensure that everyone is ready and familiar with the Zoom teleconferencing software.

Let's take a moment to make sure everyone has connected properly and is able to see and hear.

- **Video and Gallery view:** Please turn on your video. There is an icon at the bottom of your screen for this. You also have a gallery or speaker view. These are different ways to view the other participants on the call. You can change the view by clicking on the gallery or speaker icon at the top-right of your screen.
- **Chat:** You may also use the chat function to send a message, though we prefer your focus group responses be audible. The chat function will also be recorded, so you are welcome to write something at the end if you would like for us to read after the focus group has ended. We will also be monitoring the chat for any questions or comments during the focus group.
- **Muting:** We also ask that you mute yourself when you are not talking to help reduce noise/interference. If you are joining from a computer, in the lower left corner of the Zoom meeting screen you will see a microphone icon that you can click to mute and unmute yourself. Everyone is currently muted now as we give out these instructions.

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Please let us know now if you are having audio or video issues or with anything we just covered.

Respond to any issues. Make sure everyone can hear the moderator by doing a roll call with participants who have joined.

Introduction

Thank you for participating in today's prevention coalition focus group. My name is _____ and I will be facilitating our discussion. For the next 90 minutes, we will engage in a conversation with you to gain an understanding of the values, successes, concerns, and needs you may have as a prevention coalition working in partnership with a Community Service Board (CSB). It will also help us to understand, from your perspective, your role and your coalition's ability to lead and support prevention efforts within your community.

Background

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has funded JBS International to conduct a statewide needs assessment. JBS has subcontracted with OMNI Institute, that's us, to support this assessment, specifically within the prevention arena. OMNI Institute is a non-profit Colorado-based social science research consultancy that supports social change through research and evaluation and other services.

Purpose

The purpose of this needs assessment is to assess the needs of Virginians for publicly funded behavioral health services; and assess the current capacity of the State of Virginia's behavioral health system including coalition partnerships to meet the behavioral health needs of Virginians. While the Virginia Needs Assessment is funded by DBHDS, we are not part of the DBHDS system. Findings from this needs assessment will be used to guide a series of recommendations to DBHDS that support system improvements and proactively prepare for future system change.

Your opinions and experiences as Prevention Coalition members are very important to us. To help inform our needs assessment, we are conducting interviews and focus groups and distributing questionnaires (surveys) to service providers, administrators and clients across all 40 Community Service Boards in Virginia. You were identified as being a member of coalition who collaborates with a CSB. Our goal is to gather information that accurately reflects your experience so that we can help provide meaningful recommendations to Virginia DBHDS. That means there are no right or wrong answers and we appreciate your honest input. You are the experts here today, and I am here to learn from you.

Group Norms/Agreements

- Give and take with respect – Please express your thoughts and opinions openly but in a respectful manner, as there are always different histories, experiences, and beliefs to navigate in a group setting.
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Do we have your permission to record this focus group?

NOTE TO INTERVIEWER: Turn on recorder and verify that it is recording. For virtual groups, click the record button in the Zoom interface and select "Record to the cloud."

INTRODUCTIONS- *OK- keeping in mind your responses are confidential and your identities will remain anonymous, we'd like to get a sense for which coalitions are being represented in the group. I'd like each person to say their role in your coalition, the Community Service Board they are affiliated with, or if you like the main geographic area in Virginia you serve.* ***I can repeat these for you, or the questions are in the chat window. Who would like to go first?***

Great! Nice to get acquainted with everyone.

COALITION STRUCTURE AND FUNCTIONING

First, we'd like to take time to understand the structure and functioning of coalitions, and your experience supporting the prevention strategies in your catchment area. As I ask the following questions, please think about what works, what is challenging, and any aspects about your coalition that you would change.

1. **Describe the structure and size of your coalition.** *Facilitator to probe: How many members, and how consistent is membership? What different types of backgrounds, expertise, and/or lived experience do members have? How engaged are members?*

    - How often do you meet? What are decision-making processes like (formalized/not? Shared with CSB or independent?)?

2. **Describe the relationship, and resource support from the Community Service Board in your area?** *Facilitator to probe: What staff, funding, guidance or other resources do you receive from the CSB?*

3. **What are the key prevention priority areas that your coalition is working toward?** ***Facilitator to probe: Do you focus on a particular aspect of behavioral health such as substance use or mental health?*** *Is your coalition work provided for individuals, groups, or are they environmental/population level in nature? What do the main activities include?*

    - What works well?
    - What is challenging?
    - What do you wish you could change?

4. **[OK TO SKIP FOR TIME**] How would you describe the populations for that your coalition works with most? *Facilitator to probe: For example, what are the geographic, racial/ethnic, or cultural characteristics of populations targeted by your coalition?*

    - What are the distinguishing or unique characteristics about the population that you serve?
    - What groups or stakeholders are you trying to engage with but haven't had success with yet? Are you engaged in recruitment efforts, and what are they?

5. **[OK TO SKIP FOR TIME**] To what extent does your coalition work target root causes of behavioral health issues (such as adverse childhood experiences [ACES], exposure to risk factors, social health conditions)? *Facilitator to probe: What are the root causes targeted? How might your coalition better target issues like these?*

6. **[OK TO SKIP FOR TIME**] How are your coalition's activities or services adapted to better serve populations in need in the area your coalition serves? *Facilitator to probe:*
    - *What are the unique prevention needs of individuals targeted by your coalition?*
    - *How are efforts tailored to address local customs/norms?*
    - *What specific sub-populations, if any, are you targeting?*
    - *How does your coalition identify which populations have the highest need for prevention strategies?*

USING DATA TO INFORM SERVICES

Next, we'd like to get a sense of how data or other evidence is used to inform the work at your coalition. Data can be from surveys, your affiliated Community Service Board other organizations, or maybe you collect your own. Again, we are looking to hear from you on what

works, what is challenging, and any aspects related to people interacting with your coalition that you would change.

7. **To what extent does your coalition use data to drive prevention efforts? And how?** *Facilitator to probe:*
   - *Did you use data to identify the primary issues your coalition targets? If so, how? Where was the data collected from? What partner data?*
   - *Is data tracked and how?*
   - *How does data inform practices?*
   - *Tell me about data efforts that involve your affiliated CSB*
   - *What additional data are needed or what barriers exist in accessing data valuable to coalition efforts?*
8. How does your coalition implement the use of evidence-based or "best" practices? *Facilitator to probe:*
   - *How are best practices identified? What are the criteria for evidence your coalition takes into consideration?*
   - *What support is needed in this area?*

9. To what extent do you feel that the prevention efforts implemented in your coalition are leading to changes in outcomes (for example, reduced substance use)? *Facilitator to probe*:
   - *How does your coalition track outcomes?*
   - *What are you tracking?*
   - *What works? What is challenging?*
   - *What are barriers in the system to improving services?*
   - *What kind of support do you receive from your affiliated CSB?*

CAPACITY TO PROVIDE PREVENTION SERVICES

Now I'm going to ask a few questions about the capacity of coalitions to do prevention or other work in your community. Again, please think about what works, what is a challenge, and what elements related to your coalition's capacity to engage in prevention-related activities you would change.

10. **How would you describe your coalition's capacity to impact mental, behavioral, or substance use disorders in the community?** *Facilitator to probe:*
    - *Are there sufficient resources to support prevention efforts (e.g. time, personnel, funding, management), why or why not? What else is needed, if anything?*
    - *What works/what's challenging/what would you change?*
    - *What are the most frequently cited issues that impede efforts?*
    - *What resources are lacking?*

11. Does your coalition work or collaborate with any other key community groups? If so, how would you describe the nature of your relationships with them? What do typical interactions consist of? *Facilitator to probe:*
    - *How does working with these groups benefit your coalition's work?*
    - *What are any challenges in collaborating with community stakeholders or other groups?*

12. What procedures does your coalition have in place to ensure sustainability of its efforts? *Consider the following:*
    - Funding
    - Staffing
    - Planning

PROVIDER EXPERIENCE

Finally, we'd like to hear from you about your experience as a member of your coalition.

13. **Given everything we discussed, how would you describe your overall satisfaction with your coalition involvement?**

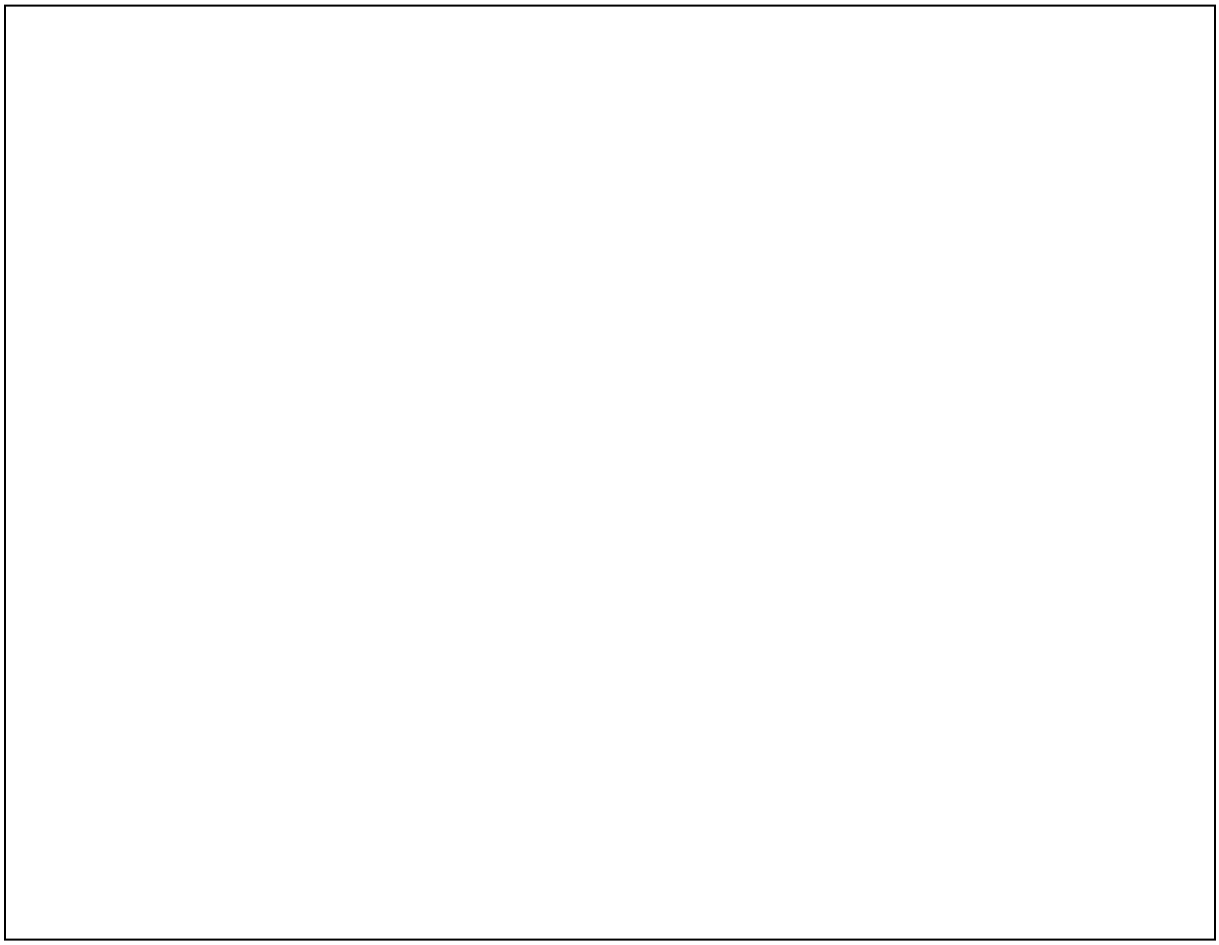
    Consider the following:
    - Communication
    - Relationships
    - Time allocation for different tasks

Facilitator to probe: What works? What is challenging? What is one thing you would change? What aspects of the work experience does your coalition excel at?

ADDITIONAL QUESTIONS IF TIME PERMITS

14. If you could improve one thing about the efforts of your coalition, what would that be?
15. Describe an area where your coalition excels? What is leading to success in this work? Is there anything else that you think we should have asked about?

THANK YOU!

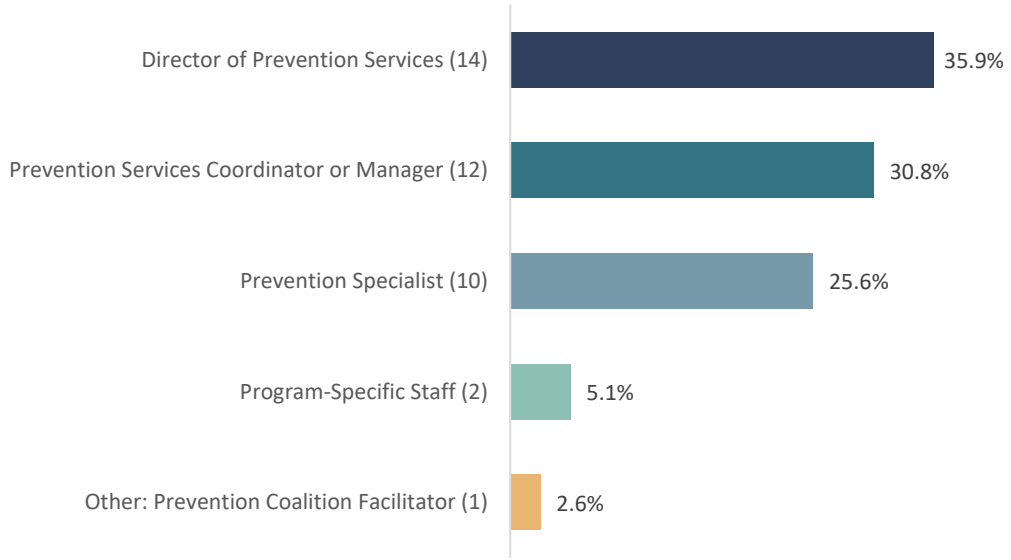


Notes:

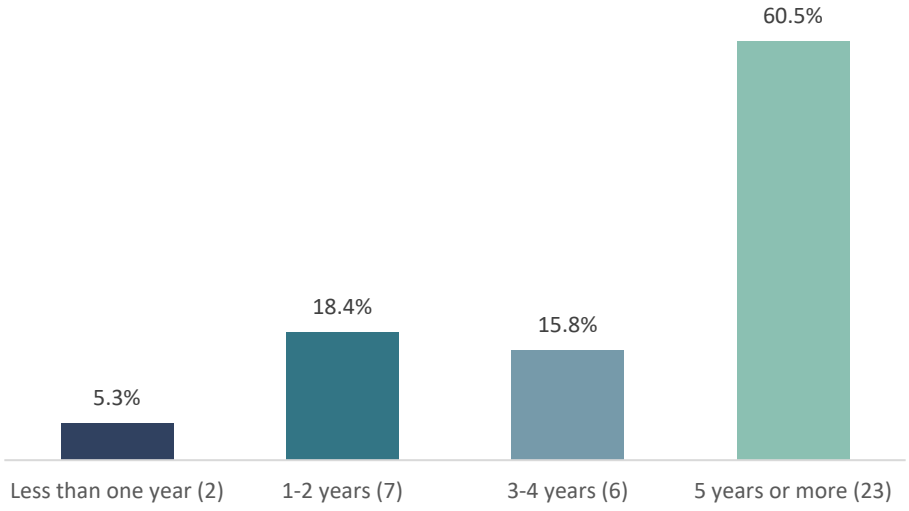
Appendix B:

Additional Survey Results

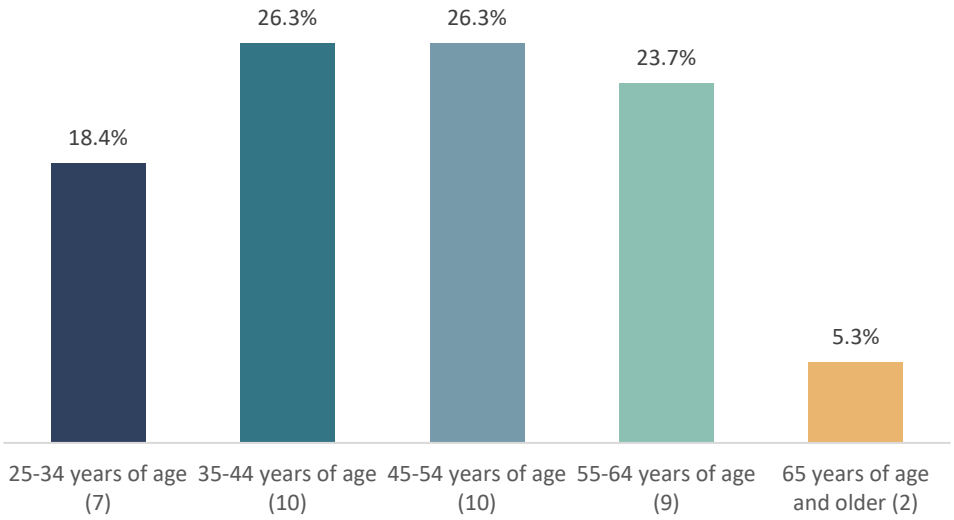
Staff were asked to identify the role(s) they held at their CSB. Most staff identified their role(s) as a Director of Prevention Services, followed by Prevention Services Coordinator/Manager.



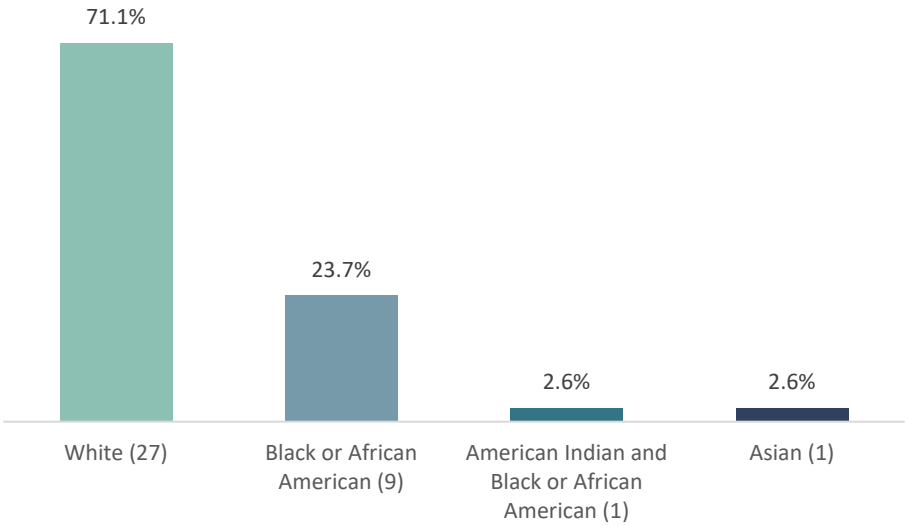
The majority of respondents had a tenure of 5 or more years in their role. The majority also indicated that it was 'likely' or 'very likely' that they would remain at their agency for the next five years. This was more commonly reported from rural CSB staff (76%) than urban (63%).



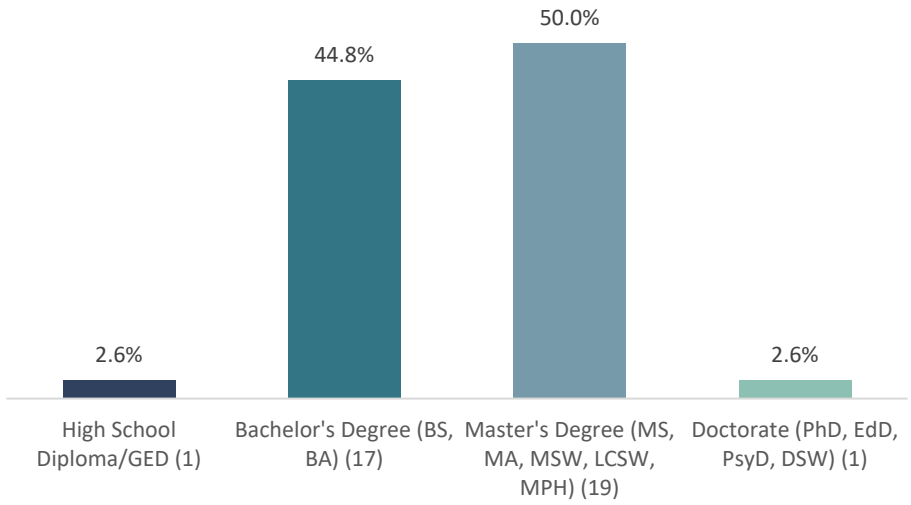
CSB staff were mostly female (87%), between 35 and 54 years of age. Staff at urban CSBs were more likely to report being younger: 59% were between ages 25-44 years compared to 33% of rural staff, while 62% of rural staff were between ages 45-64 years compared to 35% of urban staff.



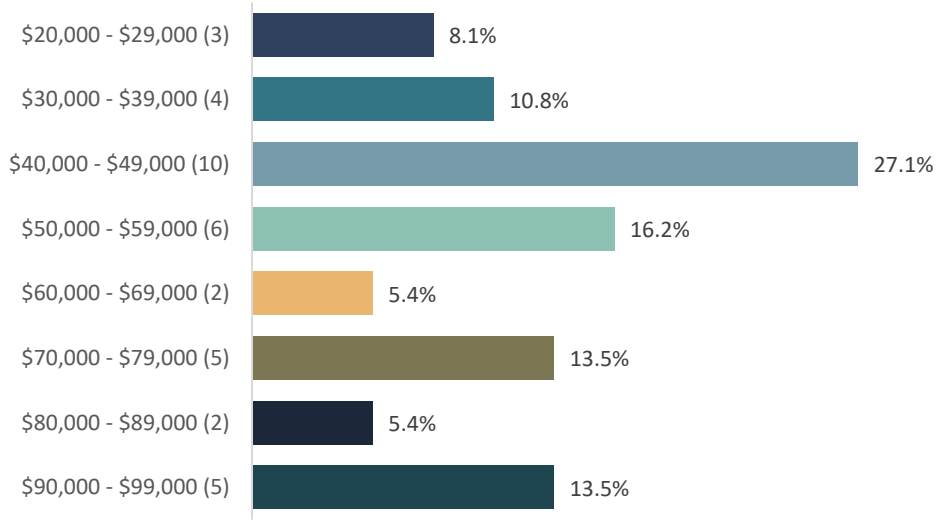
The majority of respondents were White. There were no respondents of Hispanic or Spanish origin. Rural CSBs had a larger proportion of staff who identified as White (81% compared to 59% in urban CSBs), and urban CSBs had a larger proportion of staff who identified as Black or African American (35% compared to 19% in rural CSBs).



CSB staff are highly educated with most reporting bachelor's or master's level of degree completion.



The majority of staff reported earning between $40,000-$49,000 yearly.



Appendix K.

Prevalence Estimates and Need for Behavioral Health Services in Virginia

Prevalence Estimates and Need for Behavioral Health Services in Virginia

303-839-9422

omni.org

899 Logan St, St 600
Denver, CO 80203

OMNI

Table of Contents

Virginia Population Demographics

This section describes the demographic characteristics of Virginia's general population and populations of interest including children (under 5 years), youth and young adults (under 21 years), and adults 18 years and over. Based on 2019 US census bureau estimates, the general population of Virginia is 8,517,685 people with a median household income of $71,564 and poverty rate of 10.7%. Virginia comprises 2.6% of the US general population, and in comparison, the US has a median household income of $57,652 and poverty rate of 11.8%.

Virginia's population has increased approximately by 6% since the 2010 Census. While the population growth is continuous, the annual growth rate has been slower particularly in the last 5 years as shown in Figure 1. According to the University of Virginia Weldon Cooper Center for Public Service[1], annual population growth in Virginia this decade is the lowest since 1920, with the past five years growth rate slower than the US overall.

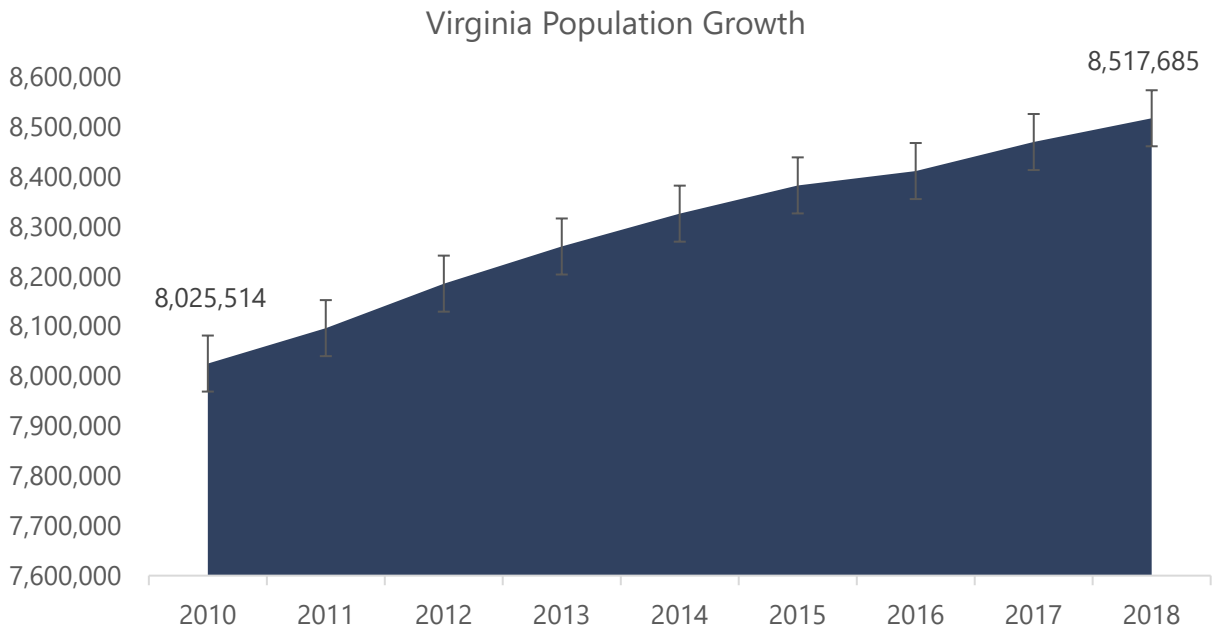


Figure 1: Virginia population growth trend

Table 1 compares the gender, age, race and ethnicity of Virginia and the US populations. Virginia and the US have a similar gender and age composition. However, the distribution of race and ethnicity in Virginia is significantly different from the general US population. Notably, Virginia has a larger proportion of the population who identify as Black or African American and Asian, and a smaller proportion who identify as White, American Indian or Alaska Native, or Hispanic/Latino compared to the general US population.

[1] University of Virginia Weldon Cooper Center, Demographics Research Group. (2019). Virginia Population Estimates. Retrieved from https://demographics.coopercenter.org/virginia-population-estimates

Table 1: Demographic Characteristics of Virginia versus US (2018)

Demographic	Virginia (%, n)	United States (%, n)
Gender		
Male	**49.2%** (4,190,738)	**49.2%** (161,118,151)
Female	**50.8%** (4,326,947)	**50.8%** (166,049,288)
Age (years)		
Under 5 years	**5.9%** (502,102)	**6.0%** (19,646,315)
Under 21 years	**26.3%** (2,239,654)	**26.5%** (86,814,784)
18+ years	**78.0%** (6,648,045)	**77.6%** (253,815,197)
Race		
One race	**95.9%** (8,168,181)	**96.6%** (315,887,408)
Two or more races	**4.1%** (349,504)	**3.4%** (11,280,031)
Black or African American	**19.2%** (1,631,512)	**12.7%** (41,617,764)
American Indian and Alaska Native	**0.3%** (22,265)	**0.9%** (2,801,587)
Asian	**6.5%** (555,422)	**5.6%** (18,415,198)
White	**67.4%** (5,737,580)	**72.7%** (236,173,020)
Native Hawaiian and Other Pacific Islander	**0.1%** (5,659)	**0.2%** (626,054)
Ethnicity		
Hispanic or Latino	**9.5%** (812,810)	**18.3%** (59,763,631)
Not Hispanic or Latino	**90.5%** (7,704,875)	**81.7%** (267,403,808)

Key Findings

This section summarizes key findings in behavioral health trends from a select set of secondary indicator data that are commonly used to monitor the prevalence of substance use, mental health, and the factors known to influence the development of behavioral health disorders. Throughout this report, data from national surveillance systems such as the Youth Risk Behavior Survey, the Behavioral Risk Factor Surveillance Survey, the National Survey on Drug Use and Health, and the National Survey on Child Health are presented. Importantly, most data sources do not present data at the county level. Crude estimates of county level prevalence for a select set of behavioral health indicators are presented in Appendix XX.

Overall, the prevalence for substance use disorder (SUD) has shown a downward trend across age groups from 2009-10 to 2016-17. In contrast, the prevalence for several mental health conditions has shown an increase over this same time period. By the age of 18, over half of the population in Virginia has experienced one or more adverse childhood experiences (ACEs).

Table 2 below summarizes relative prevalence of key conditions and associated trends over time.

Table 2. Summary of Behavioral Health Indicator Prevalence and Trends

Indicator*	Age Group	Estimated Prevalence	Estimated # of People	Significant Trend Over Time***
Substance Use Disorder				
Substance Use Disorder (SUD)	12-17[a]	**3.7%**	23,000	↓ 2009-10 to 2016-17
	18-25[a]	**16.1%**	141,000	↓ 2009-10 to 2016-17
	26+[a]	**6.5%**	354,000	NS, 2009-10 to 2016-17
Unmet need for SUD treatment	12-17[a]	**3.6%**	23,000	↓ 2009-10 to 2016-17
	18-25[a]	**15.4%**	135,000	NS, 2009-10 to 2016-17
	26+[a]	**6.1%**	336,000	NS, 2009-10 to 2016-17
Mental Health				
Major depressive episode	12-17[a]	**13.2%**	83,000	↑ 2009-10 to 2016-17
	18-25[a]	**12.3%**	108,000	↑ 2009-10 to 2016-17
	26+[a]	**5.9%**	323,000	NS, 2009-10 to 2016-17
Serious thoughts of suicide	*Middle School*[b,**]	***21.4%***	--	↑ *2013 to 2017*
	High School[b]	**15.7%**	--	NS, 2013 to 2017
	18-25[a]	**9.3%**	81,000	↑ 2009-10 to 2016-17
	26+[a]	**3.4%**	186,000	NS, 2009-10 to 2016-17
Any mental illness	18-25[a]	**25.4%**	223,999	↑ 2009-10 to 2016-17
	26+[a]	**17.7%**	972,000	NS, 2009-10 to 2016-17
Received mental health services	18-25[a]	**14.3%**	125,000	NS, 2010-11 to 2016-17
	26+[a]	**15.7%**	862,000	NS, 2010-11 to 2016-17
Adverse Childhood Experiences (ACEs)				
Experienced 1+ ACE	0-5[c,**]	**28.7%**	168,936	--
	6-11[c,**]	**43.9%**	243,232	--
	12-17[c,**]	**53.7%**	363,946	--
	18+[d,**]	**61%**	--	--

[*] All indicators reflect past year prevalence with the exception of Middle School Serious Thoughts of Suicide (lifetime) and Experienced 1+ ACE (lifetime).
[**] Reflects lifetime prevalence instead of past year
[***] Arrows reflect statistically significant change over years noted. NS = no significant change.
[a] NSDUH, [b] YRBS, [c] NSCH, [d] BRFSS

Substance Use

Prevalence of Substance Use Disorder

Source: National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), and is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population aged 12 years or older. NSDUH data is available at both state and sub-state (regional) levels, as well as for

certain age groups (12-17, 18-25, 26+ years). Throughout this report, the most recent year(s) of available data are presented[2].

In 2016-17, an estimated 575,000 individuals (8.2%) aged 12+ engaged in past month illicit drug use[3] and an estimated 518,000 (7.4%) met the criteria for substance use disorder (SUD), including alcohol use disorder. SUD occurs when recurrent substance abuse and dependence results in significant impairment including health problems, disability, and failure to meet major responsibility at work, school, or home.[4] An estimated 3.7% of Virginia's youth (approximately 23,000 individuals) aged 12-17 years met the criteria for SUD in the past year (2016-17). The SUD prevalence among Virginia young adults aged 18-25 years was 16.1% (141,000), and among adults aged 26+ years SUD prevalence was 6.5% (354,000).

Regional Differences and Trends of SUD

The NSDUH provides prevalence estimates for 5 geographic regions of Virginia: Northwestern Virginia (Region 1), Northern Virginia (Region 2), Southwestern Virginia (Region 3), Central Virginia (Region 4), and Eastern Virginia (Region 5). Figure 2a shows the SUD prevalence among Virginia youth aged 12-17 years within each region. Youth in all regions showed a nonsignificant[5] downward trend in SUD prevalence from 2008-10 to 2012-14, as well as nonsignificant differences between regions.

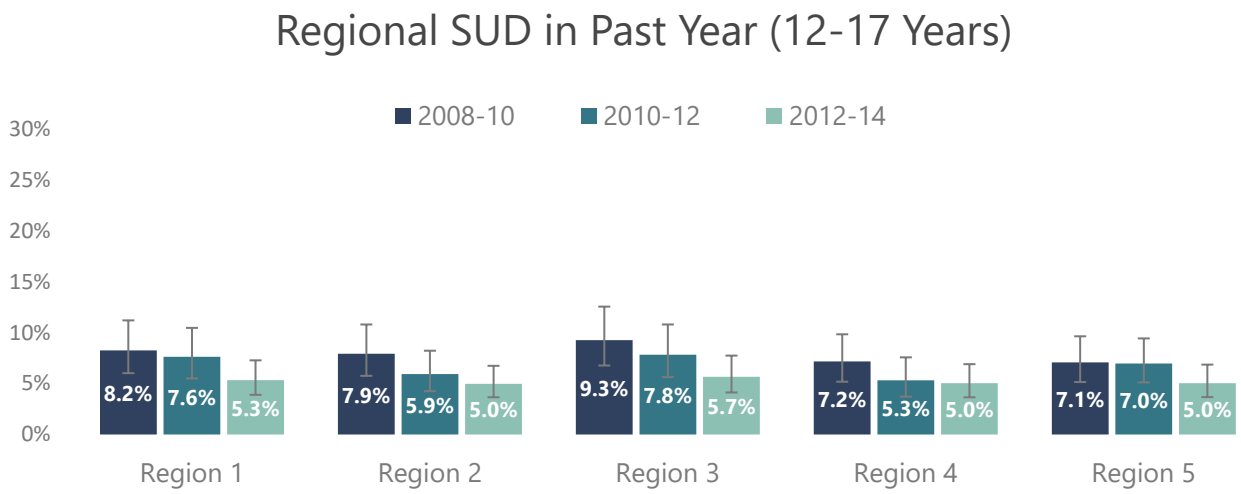


Figure 2a: Regional differences in SUD prevalence over time among Virginia's general population aged 12-17 years (source: NSDUH). Trend over time within region, as well as differences between regions were non-significant.

[2] Most estimates represent combined years of data. The most recent year of available data varies depending on the indicator and sub-population presented. The most recent state level data are annual averages from 2016-17 NSDUHs. Regional data depends on the indicator, with some data available through 2014-2016. See https://www.samhsa.gov/data/report/2014-2016-nsduh-overview-and-summary-substate-region-estimation-methodology for details.

[3] Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) The CBHSQ Report: Trends in substance use disorders among adults aged 18 and older (2017). Accessed on 1/18/2020 at https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.html

[5] Estimates between two groups are considered to be significantly different If confidence intervals (CI) do not overlap. The CI reflects the range of values within which NSDUH estimates a 95% chance that the accurate prevalence value falls within.

Figure 2b highlights regional differences in SUD prevalence among Virginia adults aged 18-25 years. The SUD prevalence in this group was significantly higher than for youth aged 12-17 for all regions for any year. All regions showed a nonsignificant downward trend in SUD among youth adults aged 18-25 years from 2008-10 to 2012-14, though patterns in year to year changes were inconsistent across regions.

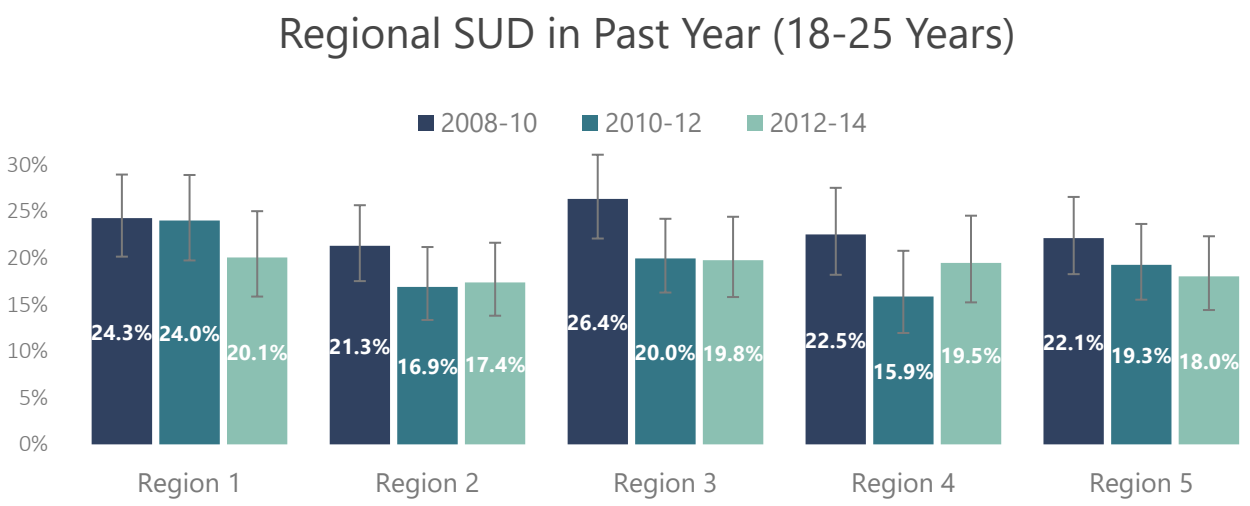


Figure 2b: Regional differences in SUD prevalence over time among Virginia's general population aged 18-25 years (source: NSDUH). Trend over time within region, as well as differences between regions were non-significant. Prevalence of SUD for young adults (aged 18-25) was significantly higher than for youth (12-17) and adults (26+).

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Patterns in SUD prevalence among Virginia adults aged 26+ (Figure 2c) years were significantly lower than young adults aged 18-25 years in all regions for any year. Differences in year to year SUD prevalence were not statistically significant. SUD prevalence trended downward in all regions between 2008-10 to 2010-12 and slightly increased from 2010-12 to 2012-14 in all but Region 1.

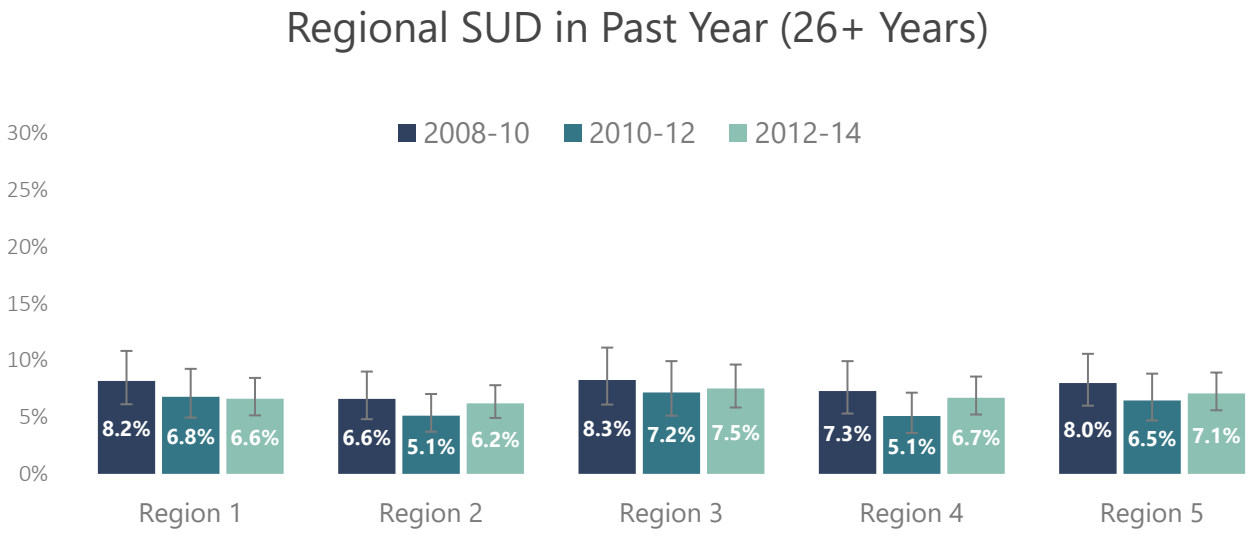


Figure 2c: Regional differences in SUD prevalence over time among Virginia's general population aged 26+ years (source: NSDUH). Trend over time within region, as well as differences between regions were non-significant.

Comparison of Virginia to National SUD Trends[6]

Figure 3a shows that SUD prevalence among Virginia youth aged 12-17 years has had a significant and steady decline from 2009-10 to 2016-17, from 7.7% to 3.6%. This decline mirrors the national trend, which declined from 7.2% to 4.1% over the same period.

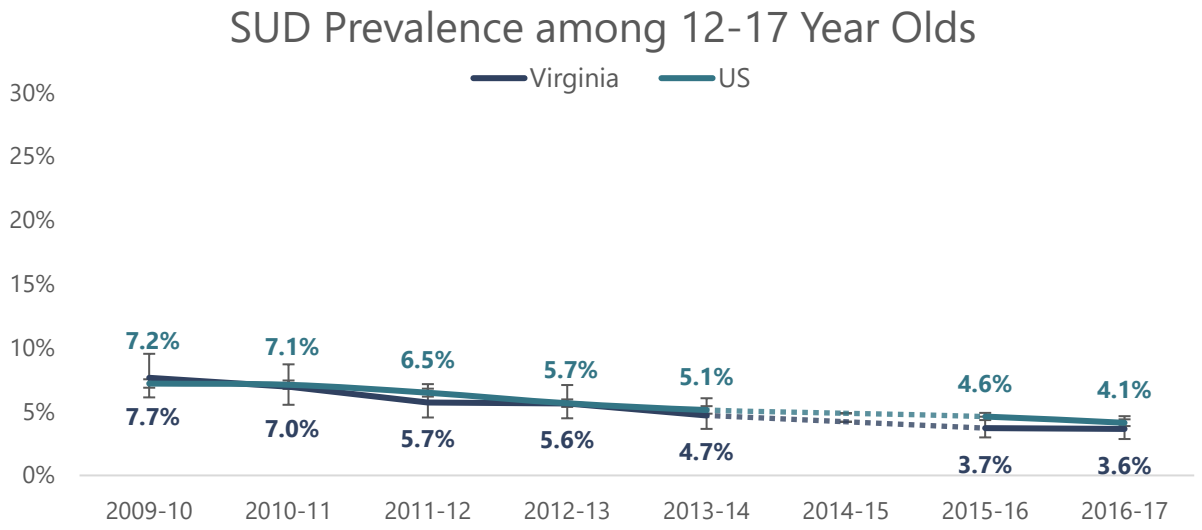
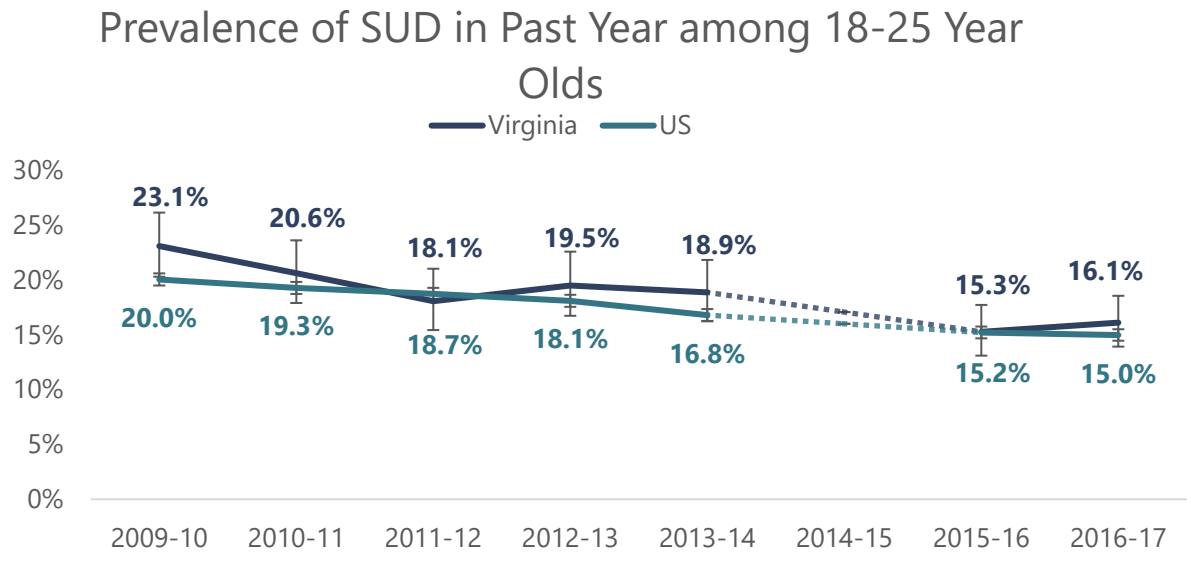


Figure 3a: Comparison between SUD prevalence trends in US and Virginia population aged 12-17 years between 2009-10 and 2016-17 (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

The prevalence of SUD among young adults has also shown a significant decline from 2009-10 to 2016-17 for both Virginia and the US. Unlike the national SUD prevalence among young adults aged 18-25 years which has been steadily declining since 2009-10, Figure 3b shows that the decline in SUD prevalence among Virginia young adults has been more inconsistent over time.



[6] SUD prevalence was extrapolated for both US and Virginia between 2013-14 and 2015-16 due to missing data (indicated with dotted lines).

Figure 3b: Comparison between SUD prevalence trends in US and Virginia population aged 18-25 years between 2009 and 2017(source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

The prevalence of SUD among adults aged 26+ years is similar between Virginia and the US (Figure 3c). While the US has seen a significant decline from 2009-10 to 2016-17, the decline for Virginia adults was not statistically significant.

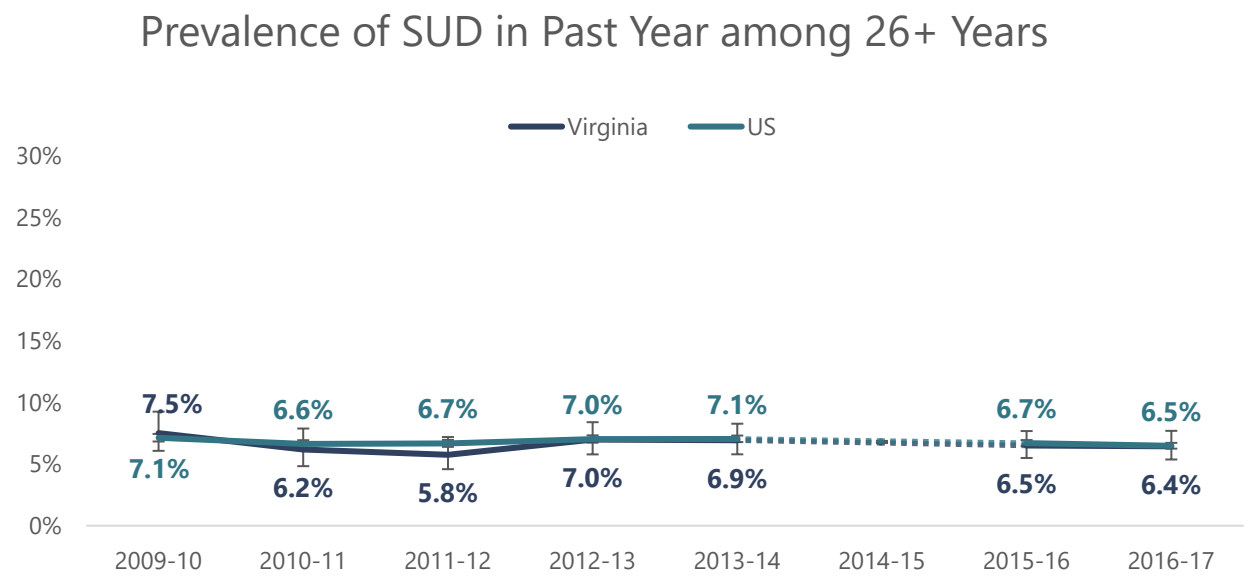


Figure 3c: Comparison between SUD prevalence trends in US and Virginia population aged 26+ years between 2009 and 2017 (source: NSDUH). While the US had a significant decline from 2009-10 to 2016-17, Virginia's decline was non-significant.

Prevalence of SUD in Past Year by Substance Category

Figure 4 shows that an estimated 7.4% of Virginia's population aged 12+ years (approximately 518,000 people) were affected by SUD in the past year (2016-17). Young adults aged 18-25 years had the highest prevalence of SUD, with approximately 16.1% or 141,000 people meeting the criteria. Of youth aged 12-17 years, 3.6% met the criteria for SUD (23,000 people affected), and an estimated 6.4% or 354,000 adults aged 26+ years were affected by SUD in 2016-17.

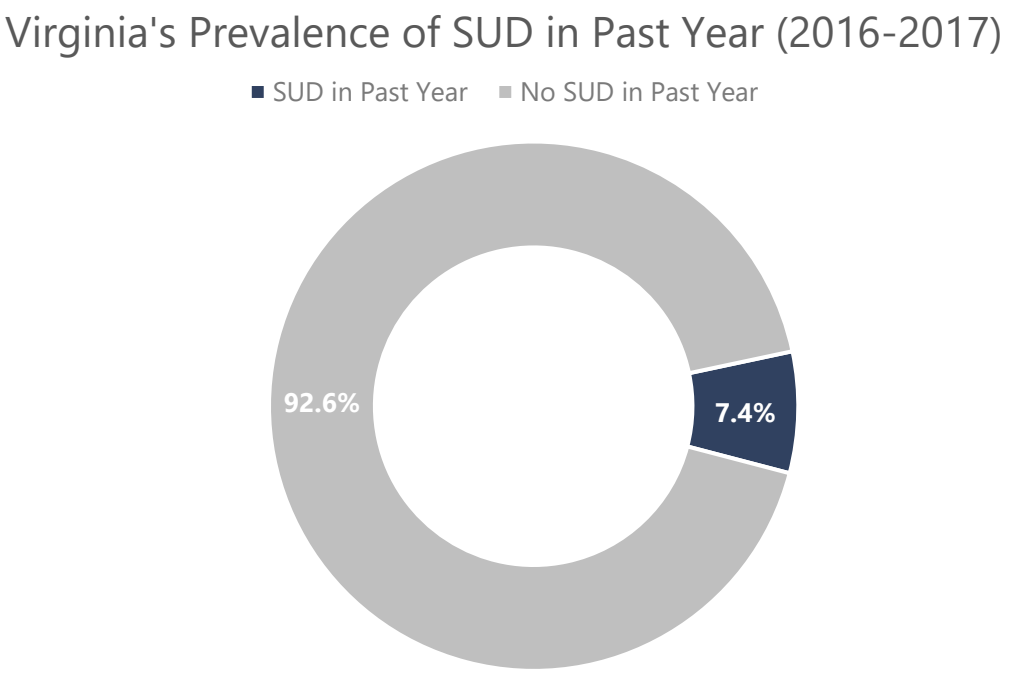


Figure 4: Prevalence of SUD among Virginia's population aged 12+ years for 2016-17 (source: NSDUH).

Figure 5 shows a breakdown of SUD in Virginia by substance categories among youth aged 12-17 years, young adults aged 18-25 and adults aged 26+ years who are affected by alcohol, illicit drug and pain reliever use disorders. Young adults had the highest prevalence of each disorder while youth 12-17 years had the lowest prevalence of each. Alcohol use disorder was the most prevalent for adults and young adults, while illicit drug use disorder was the most prevalent among youth. The prevalence of alcohol and illicit drug use disorders were significantly higher in Virginia compared to pain reliever use disorder.

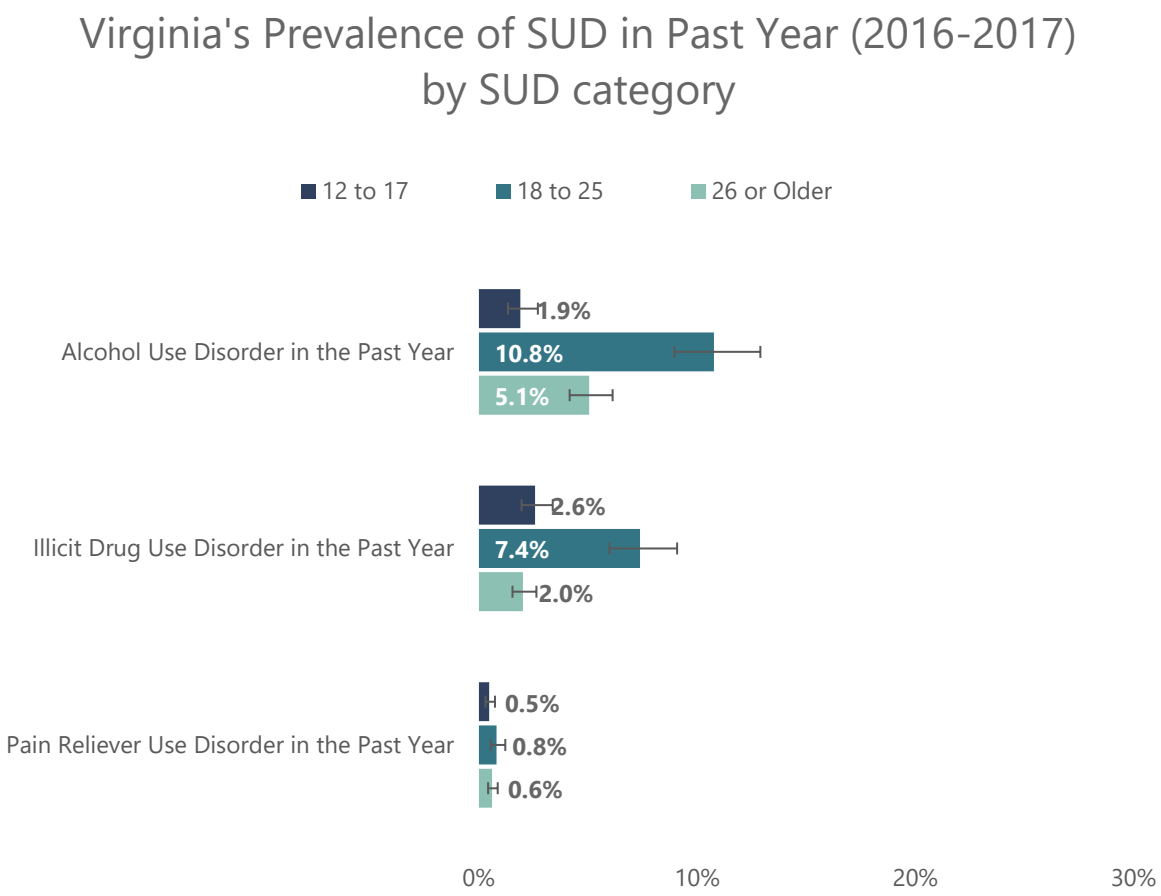


Figure 5: Prevalence of SUD among Virginia's population aged 12+ years by substance category (alcohol, illicit drug, and pain reliever use disorders) for 2016-17 (source: NSDUH). Young adults aged 18-25 had a significantly higher prevalence of alcohol use disorder and illicit drug use disorder compared to youth (12-17) and adults (26+).

Trend of Alcohol Use Disorder in Past Year

An estimated 384,000 individuals aged 12+ met the criteria for alcohol use disorder[7] in 2016-17. Figure 6a shows that the trend of alcohol use disorder in Virginia among youth aged 12-17 years was similar to the national trend, with a steady and significant decline observed between 2009-10 and 2016-17.

[7] Alcohol use disorder is defined as meeting DSM-IV criteria for either dependence or abuse for alcohol. On the NSDUH, an individual met this criteria if they reported use of alcohol on 6 or more days in the past 12 months **and** met three or more of the following seven dependence criteria: 1) spent a lot of time engaging in activities related to alcohol use; 2) used alcohol in greater quantities or for a longer time than intended; 3) developed tolerance; 4) made unsuccessful attempts to cut down on use; 5) continued use despite physical health or emotional problems associated with alcohol use; 6) reduced or eliminated participation in other activities because of alcohol use; 7) experienced withdrawal symptoms when cutting back or stopping use; **or** one or more of the following abuse criteria: 1) problems at work, home, or school because of alcohol use; 2) regularly using alcohol and then doing something physically dangerous; 3) repeated trouble with the law because of alcohol use; and 4) continued use of alcohol despite problems with family or friends. Accessed Feb 2020 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

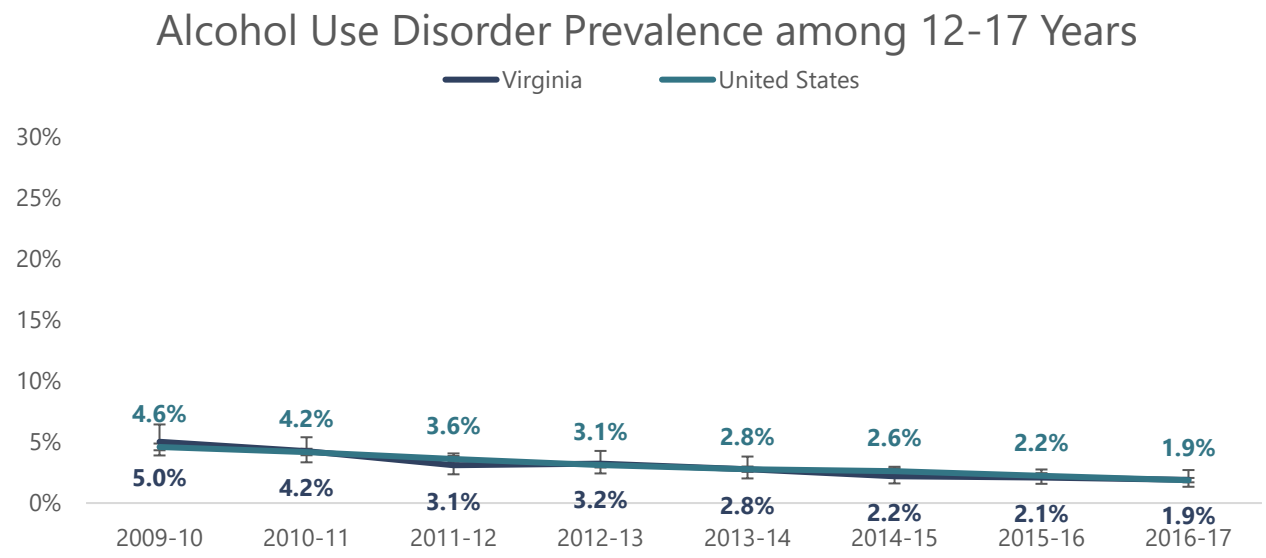


Figure 6a: Prevalence of alcohol use disorder among Virginia youth aged 12-17 years from 2009-10 to 2016-17in comparison to the US (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

Figure 6b shows that while alcohol use disorder prevalence among adults aged 18-25 years was on a national decline between 20019-10 and 2016-17, Virginia adults experienced an increase between 2011-12 and 2012-13. The overall decline from 2009-10 to 2016-17 was significant for both Virginia and the nation.

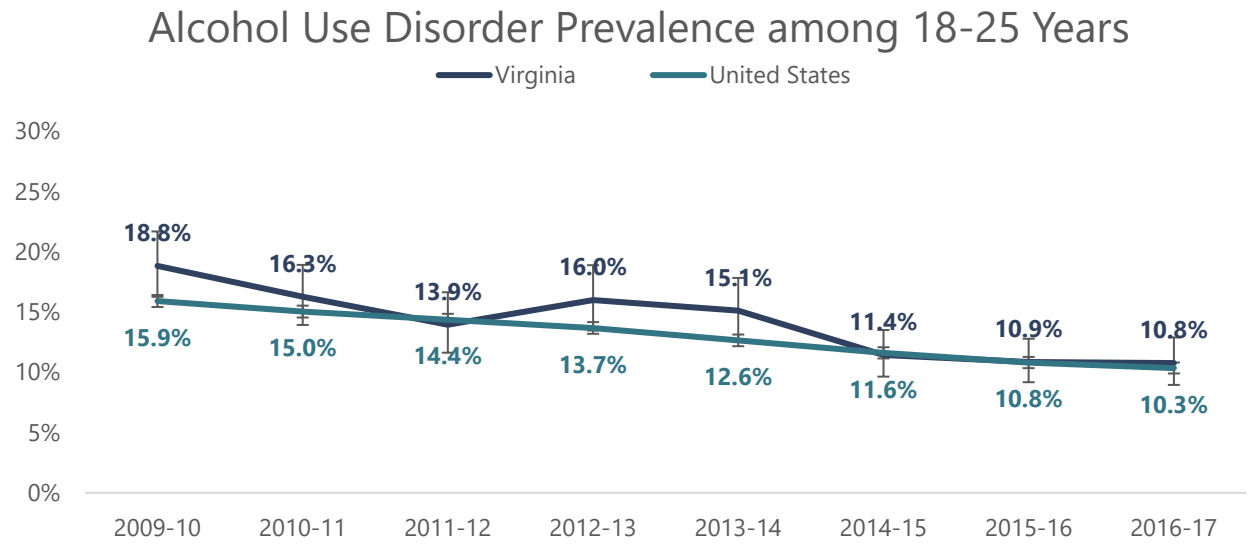


Figure 6b: Prevalence of alcohol use disorder among Virginia adults aged 18-25 years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

Figure 6c shows a similar prevalence trend of alcohol use disorder among adults in Virginia and the US between 2009-10 and 2016-17. The decline for the US was significant over time, while the decline for Virginia adults was nonsignificant.

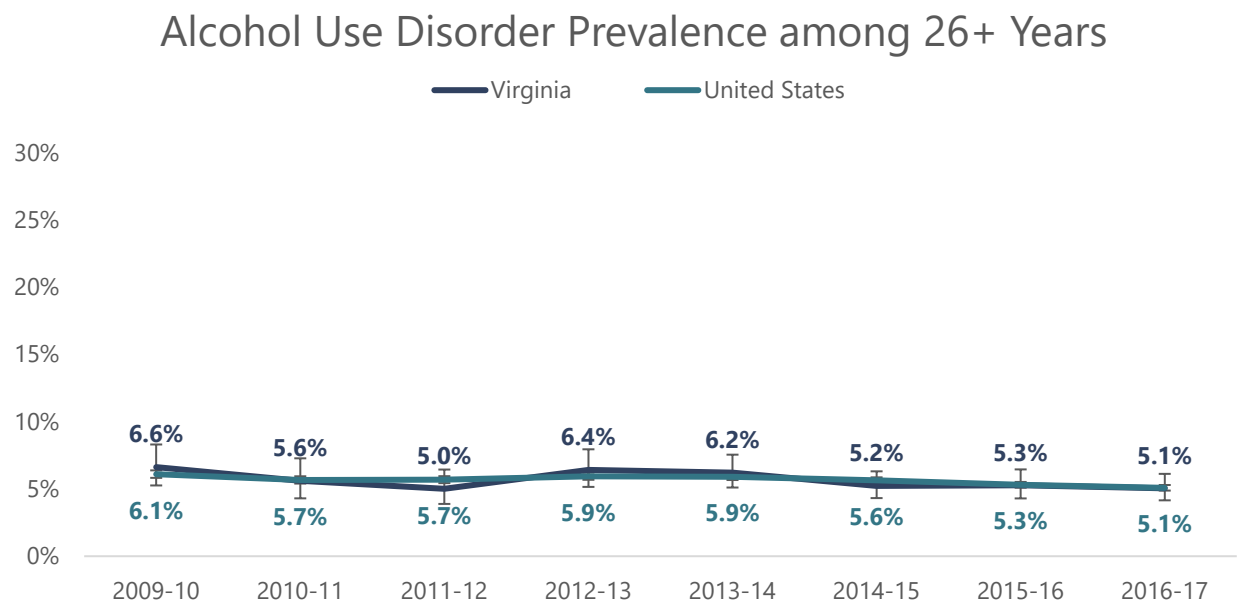


Figure 6c: Prevalence of alcohol use disorder among Virginia adults aged 26+ years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). While the US had a significant decline over time, the change for Virginia was nonsignificant.

Trend of Illicit Drug Use Disorder in Past Year

An estimated 192,000 individuals aged 12+ met the criteria for illicit drug use disorder[8] in 2016-17. The trend of illicit drug use disorder[9] in Virginia among youth aged 12-17 years and among adults aged 18-25 and 26+ years showed in Figures 7a, 7b, and 7c, respectively, were similar to national patterns between 2009-10 and 2016-2017. The decline for youth aged 12-17 was significant for both Virginia and the US

[8] Illicit drug use disorder is defined as meeting DSM-IV criteria for either dependence or abuse for one or more of the following illicit drugs: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutic drugs that were misused (i.e., stimulants, tranquilizers or sedatives, and pain relievers). On the NSDUH, the seven possible dependence criteria for specific illicit drugs include: 1) spent a lot of time engaging in activities related to use of the drug; 2) used the drug in greater quantities or for a longer time than intended; 3) developed tolerance to the drug; 4) made unsuccessful attempts to cut down on use of the drug; 5) continued to use the drug despite physical health or emotional problems associated with use; 6) reduced or eliminated participation in other activities because of use of the drug; and 7) experienced withdrawal symptoms when respondents cut back or stopped using the drug. For most illicit drugs, dependence is defined as meeting three or more of these seven criteria. However, experiencing withdrawal symptoms is not included as a criterion for some illicit drugs based on DSM-IV criteria. For these substances, dependence is defined as meeting three or more of the first six criteria. Individuals who used (or misused) a specific illicit drug in the past 12 months and did not meet the dependence criteria for that drug were defined as having abuse for that drug if they reported one or more of the following: 1) problems at work, home, or school because of use of the drug; 2) regularly using the drug and then doing something physically dangerous; 3) repeated trouble with the law because of use of the drug; and 4) continued use of the drug despite problems with family or friends. Accessed Feb 2020 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

[9] Estimates of illicit drug use disorder were extrapolated for both US and Virginia between 2013-14 and 2015-16 due to missing data (indicated with dotted lines).

but nonsignificant for young adults aged 18-25 years. Adults aged 26+ in Virginia and the US showed a nonsignificant upward trend in illicit drug use disorder over time.

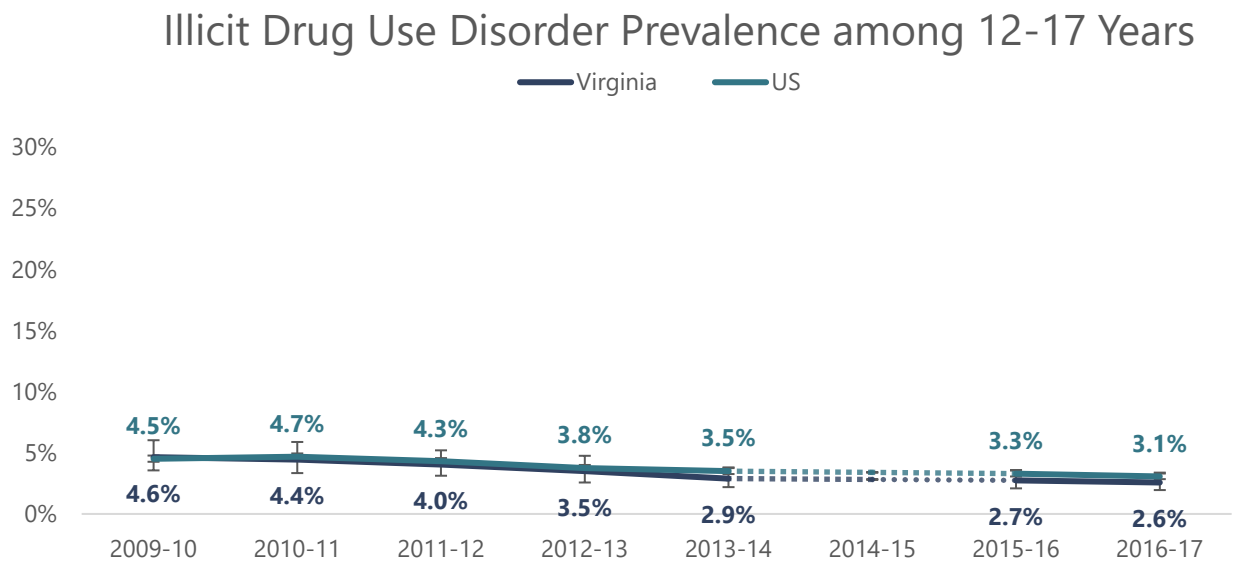


Figure 7a: Prevalence of illicit drug use disorder among Virginia youth aged 12-17 years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

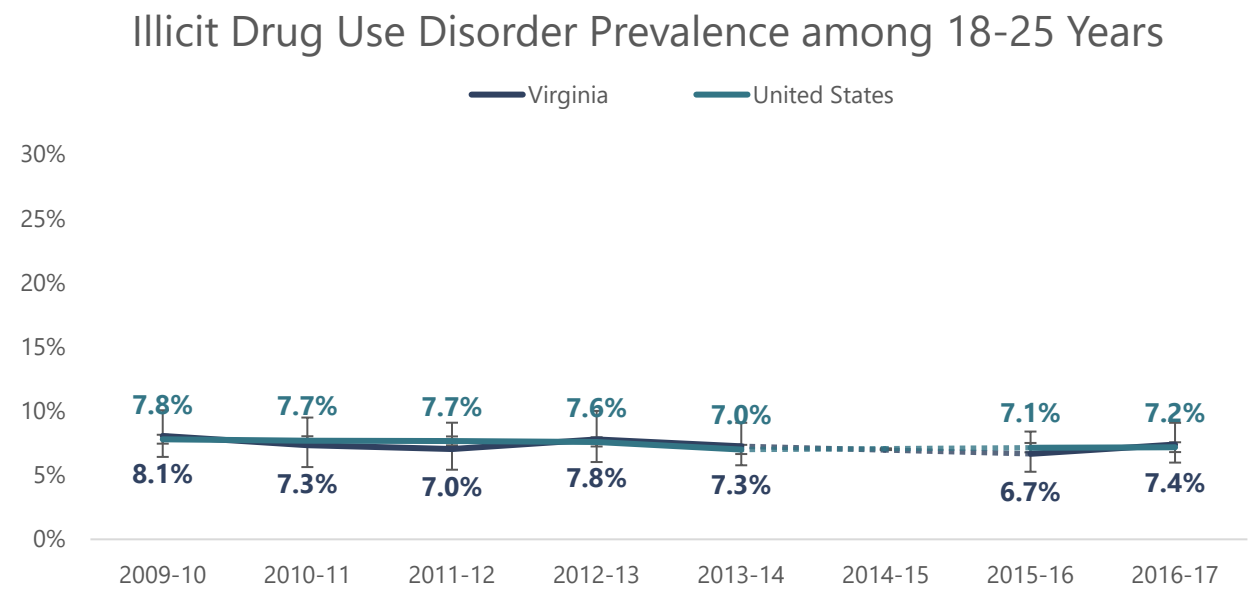


Figure 7b: Prevalence of illicit drug use among Virginia adults aged 18-25 years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). Both Virginia and the US had a non-significant decline from 2009-10 to 2016-17.

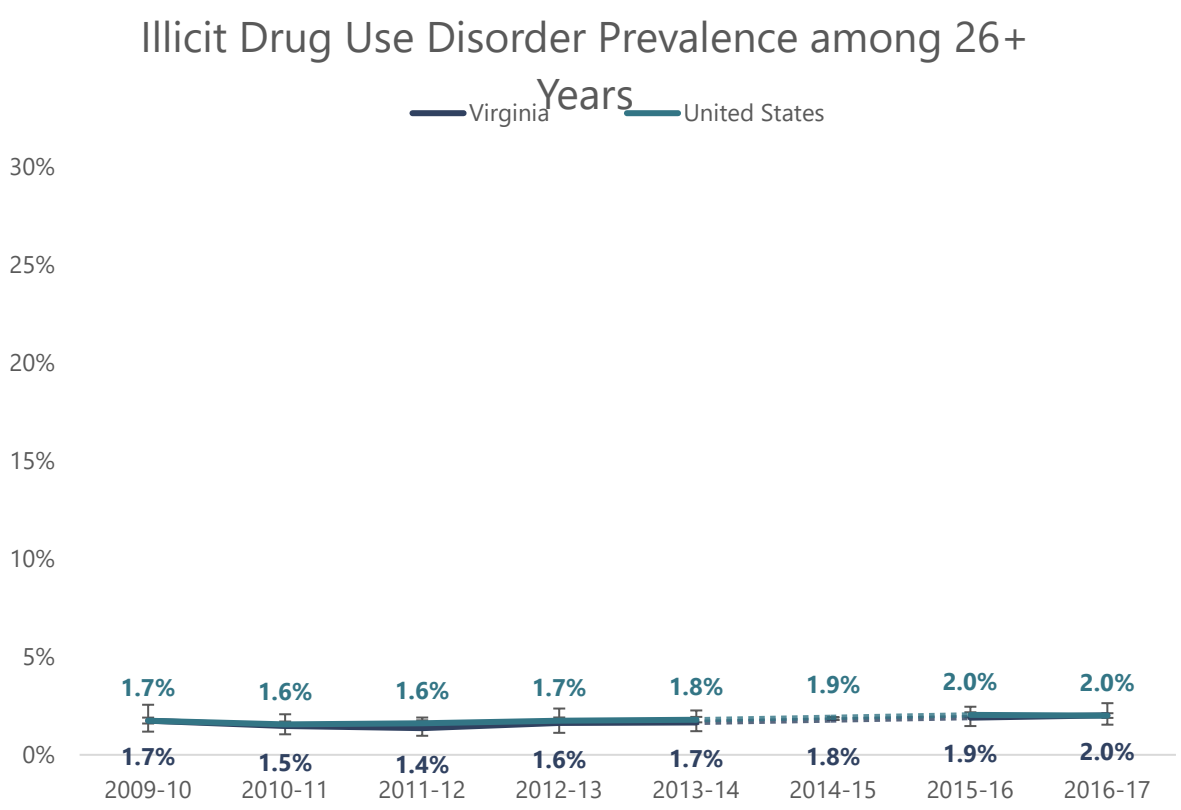


Figure 7c: Prevalence of illicit drug use among Virginia adults aged 26+ years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). Both Virginia and the US had a non-significant increase from 2009-10 to 2016-17

Trend of Pain Reliever Use Disorder in Past Year

An estimated 43,000 individuals aged 12+ met the criteria for pain reliever use disorder[10] in 2016-17. Pain reliever use disorder was similar across age groups and over time[11]. Figure 8a, 8b, and 8c show no significant differences over time or in the prevalence of pain reliever use disorder between Virginia and the US.

[10] Pain reliever use disorder occurs when someone experiences clinically significant impairment caused by the recurrent use of pain relievers, including health problems, physical withdrawal, persistent or increasing use, and failure to meet major responsibilities at work, school, or home. The NSDUH categorizes individuals who misused pain relievers in the past 12 months as having a pain reliever use disorder if they met the DSM-IV criteria for either dependence or abuse for pain relievers (see earlier definition for dependence and abuse criteria for illicit drugs including misused pain relievers). Accessed Feb 2020 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[11] Data on pain reliever use disorder is only available for 2015-16 and 2016-17.

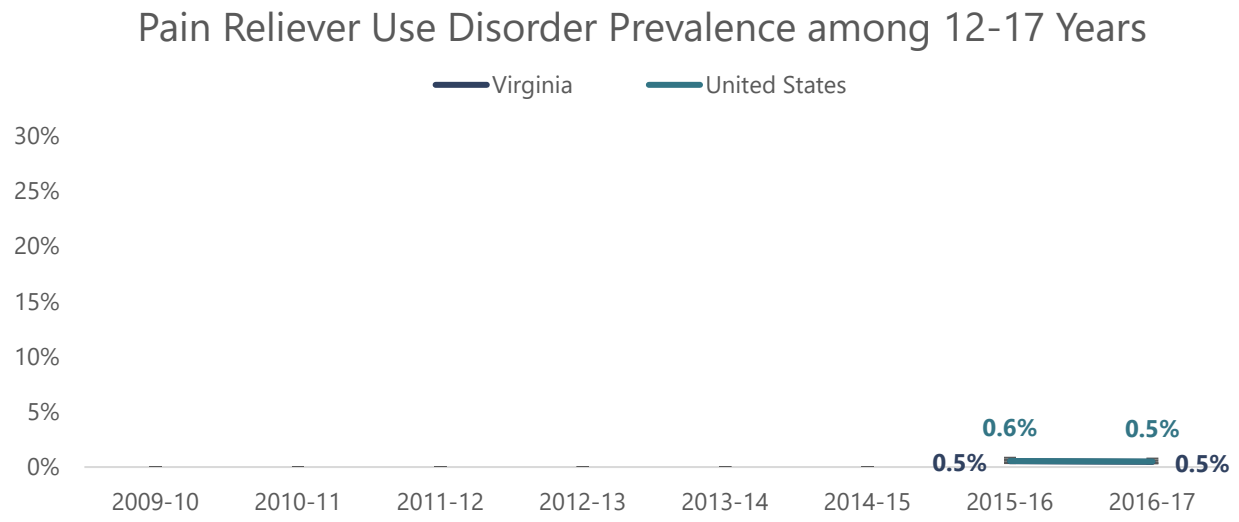


Figure 8a: Prevalence of pain reliever use disorder among Virginia youth aged 12-17 years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). There were no significant differences over time or between Virginia and the US.

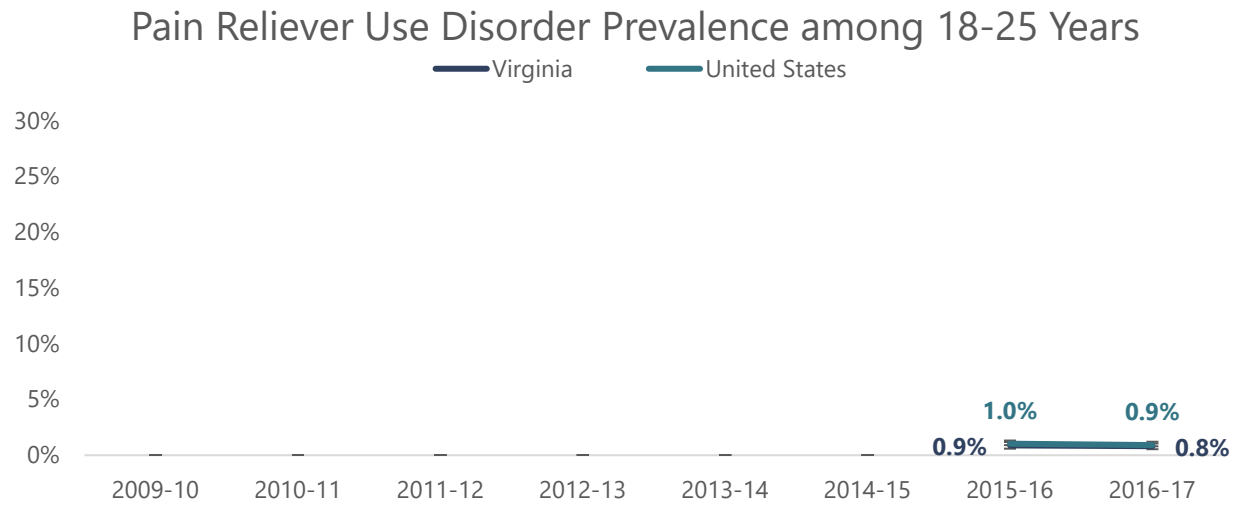


Figure 8b: Prevalence of pain reliever use disorder among Virginia adults aged 18-25 years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). There were no significant differences over time or between Virginia and the US.

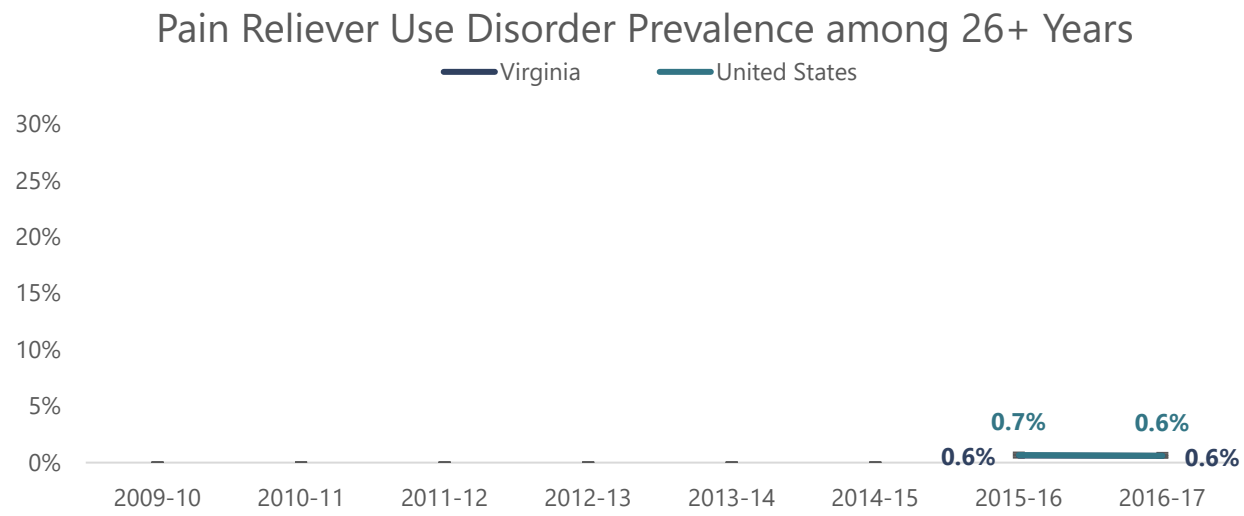


Figure 8c: Prevalence of pain reliever use disorder among Virginia adults aged 26+ years from 2009-10 to 2016-17 in comparison to the US (source: NSDUH). There were no significant differences over time or between Virginia and the US.

Need and Treatment of Substance Use

Source: National Survey on Drug Use and Health (NSDUH)

An estimated 494,000 individuals aged 12+ needed but did not receive treatment for substance use[12] in 2016-17. Figure 9a shows that the unmet need for treatment of substance use among Virginia youth aged 12-17 years closely mirrored the national trend, and significantly declined from 6.7% in 2010-11 to 3.6%, with an estimated 23,000 people who were affected in 2016-17.

[12] NSDUH classifies individuals as needing substance use treatment if they met the criteria for illicit drug or alcohol use disorder as defined in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol treatment, but who did not receive illicit drug or alcohol treatment at a specialty facility. Accessed at: https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables

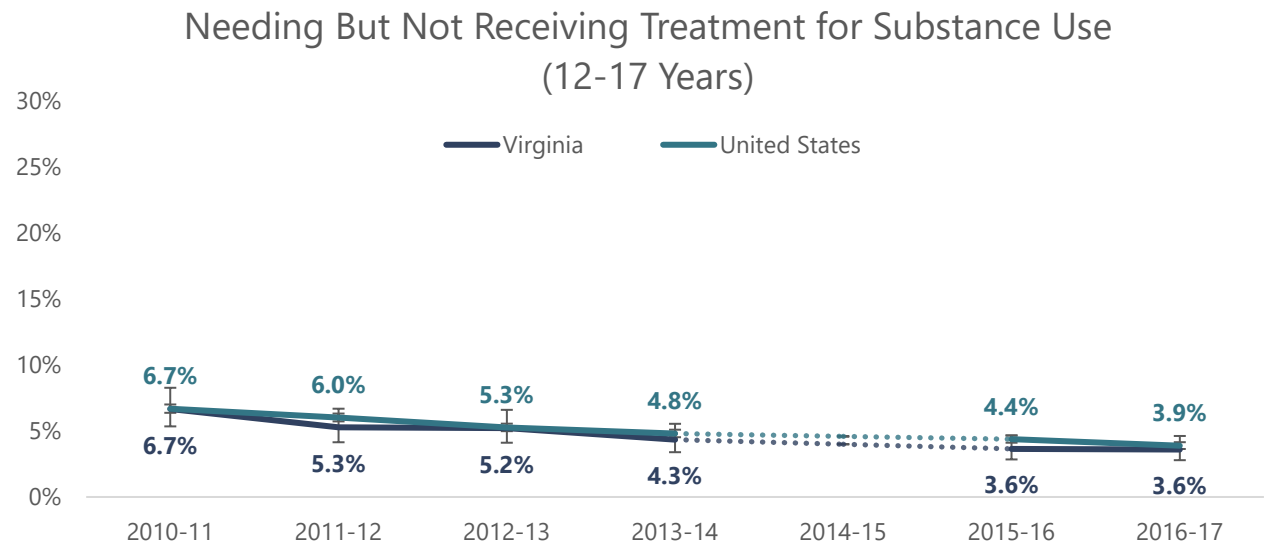


Figure 9a: Trend of Unmet Need for Treatment of Substance Use at a Specialty Facility in the Past Year among Virginia youth aged 12-17 years in comparison to US between 2010-11 and 2016-17 (source: NSDUH). Both Virginia and the US had a significant decline from 2010-11 to 2016-17.

While the national unmet need for substance use treatment among adults aged 18-25 years steadily and significantly declined between 2010-11 and 2016-17, Virginia experienced an increase from 2011-12 to 2013-14 and from 2015-16 to 2016-17 (Figure 9b). The overall change from 2010-11 to 2016-17 for Virginia was not significant.

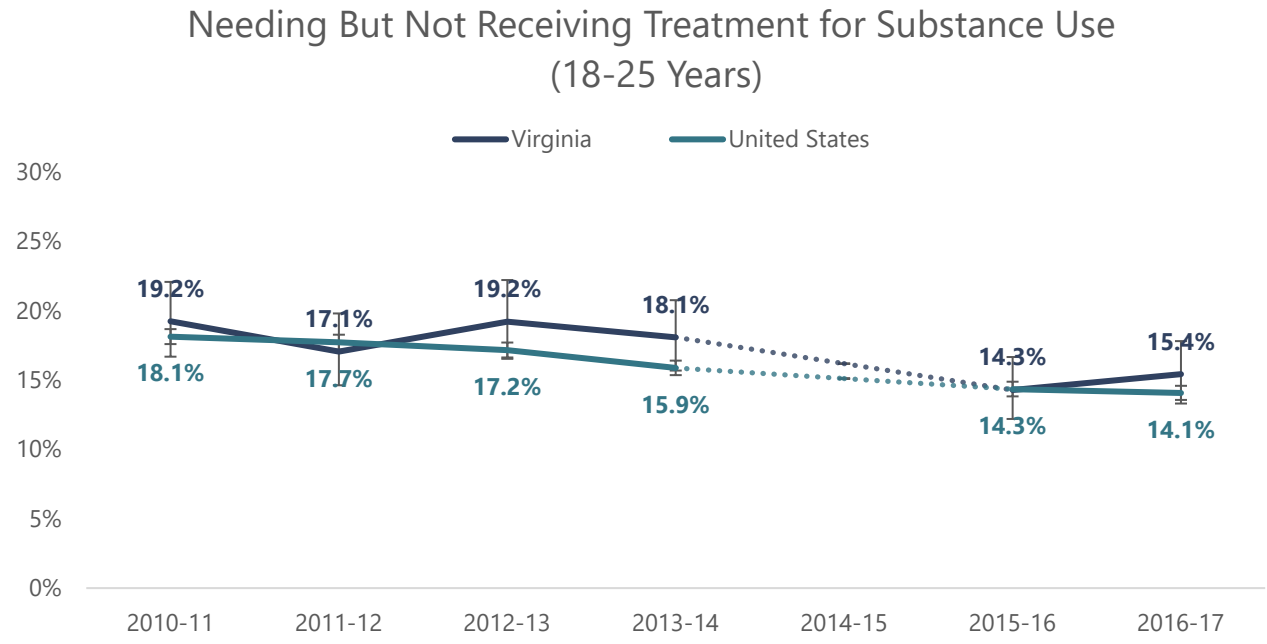


Figure 9b: Trend of Unmet Need for Treatment of Substance Use at a Specialty Facility in the Past Year among Virginia adults aged 18-25 years in comparison to US between 2010-11 and 2016-17 (source: NSDUH). The US had a significant decline from 2010-11 to 2016-17. The decline for Virginia was not significant during this time period.

Virginia's unmet need for substance use treatment among adults aged 26+ years closely mirrored the national trend which has remained consistent over time (Figure 9c).

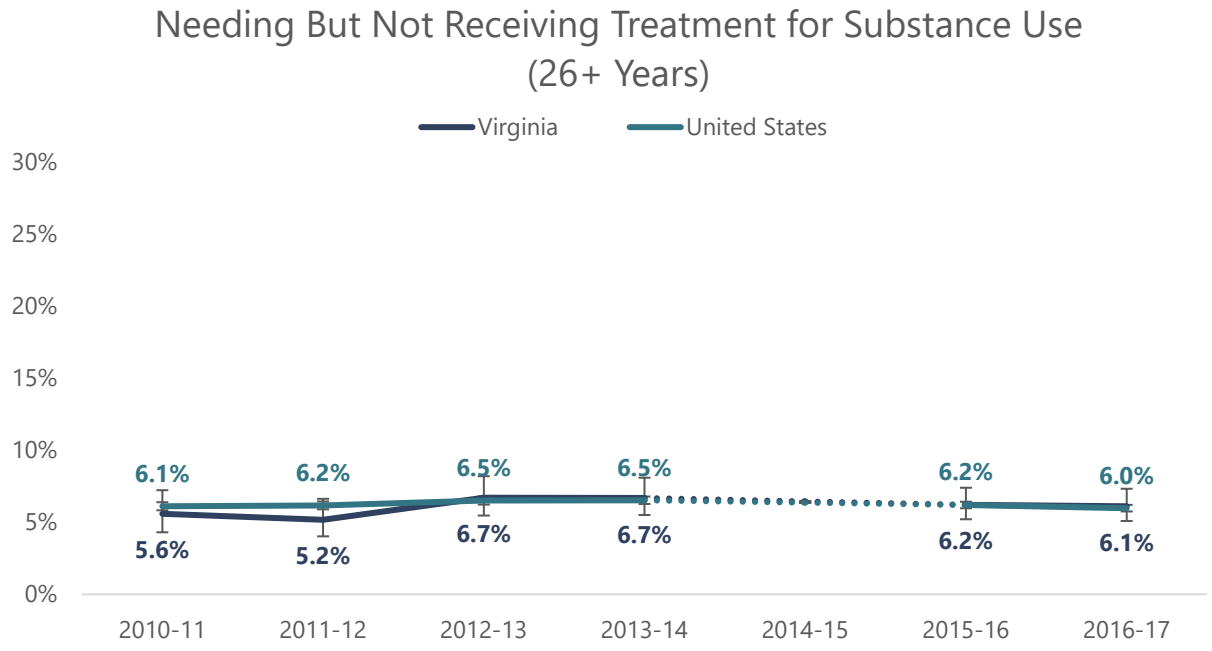


Figure 9c: Trend of Unmet Need for Treatment of substance use at a Specialty Facility in the Past Year among Virginia adults aged 26+ years in comparison to US between 2010-11 and 2016-17 (source: NSDUH). There was no significant change over time for Virginia or the US.

Need and Treatment for Substance Use by Category

Need and Treatment for Alcohol Use[13]

An estimated 381,000 individuals aged 12+ needed but did not receive treatment for alcohol use in 2016-17. The unmet need for alcohol use treatment among Virginia youth 12-17 years (Figure 10a) closely mirrored the national trend and consistently and significantly declined between 2009-10 and 2016-17.

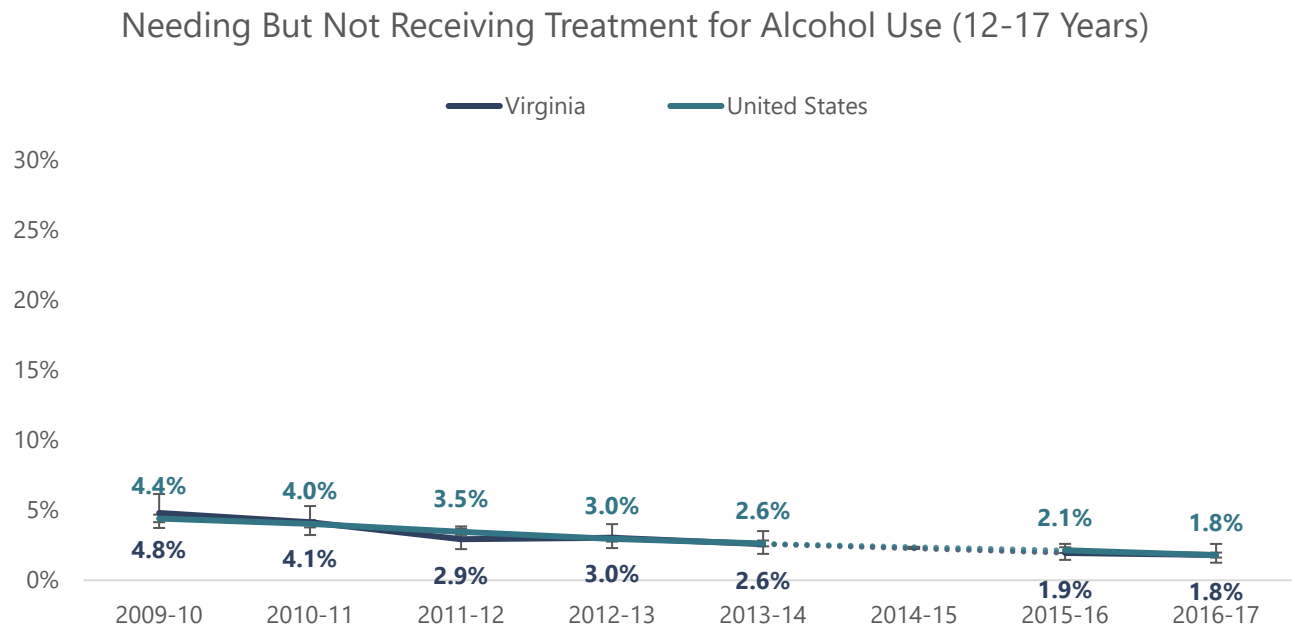


Figure 10a: Trend of Virginia youth aged 12-17 years Needing but Not Receiving Treatment for Alcohol Use at a Specialty Facility in the Past Year in comparison to US between 2009-10 and 2016-17 (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

Among young adults aged 18-25 years (Figure 10b), the national unmet need for alcohol use treatment steadily and significantly declined from 15.3% to 10.0% between 2009-10 and 2016-17. Overall, Virginia also had a significant decrease between 2009-10 and 2016-17, despite small year to year increases from 2011-12 to 2012-13 and from 2015-16 and 2016-17.

[13] Unreported data for unmet need for alcohol use treatment in year 2014-2015 period is indicated by extrapolated dotted lines.

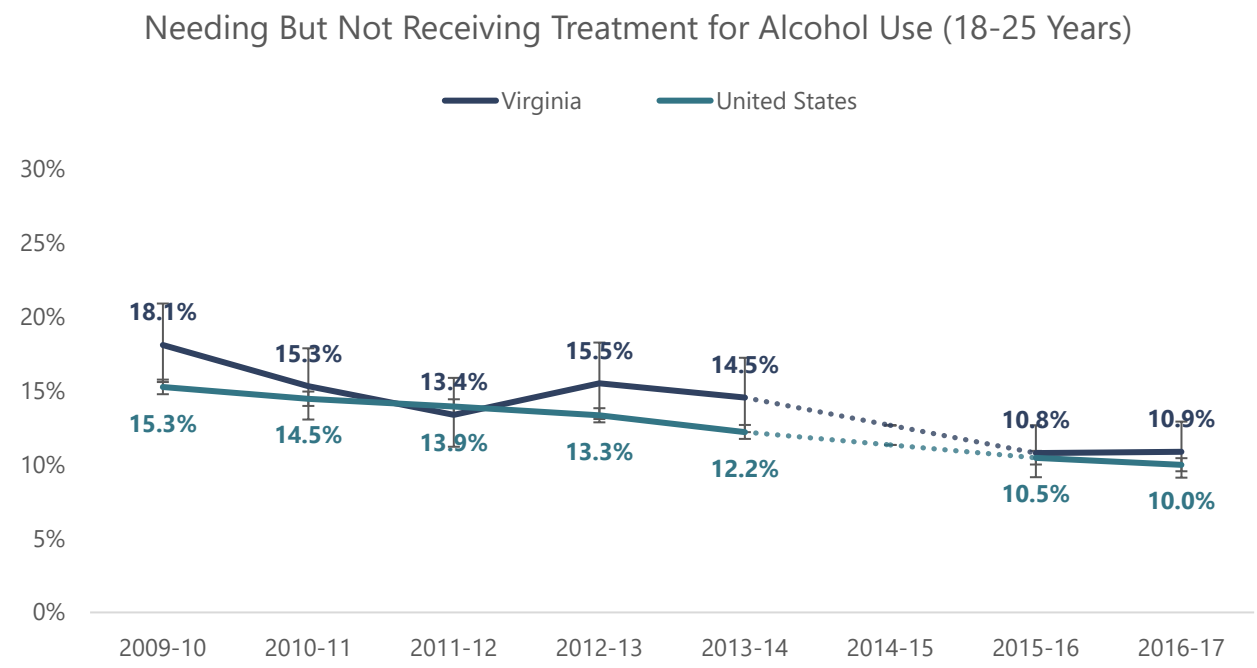


Figure 10b: Trend of Virginia adults aged 18-25 years Needing but Not Receiving Treatment for Alcohol Use at a Specialty Facility in the Past Year in comparison to US between 2009-10 and 2016-17 (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

Unmet need for alcohol use disorder treatment among Virginia adults aged 26+ (Figure 10c) was similar to the national trend between 2009-10 and 2016-17. While both Virginia and the US experienced a small decrease in prevalence over time, only the change at the national level was significantly different.

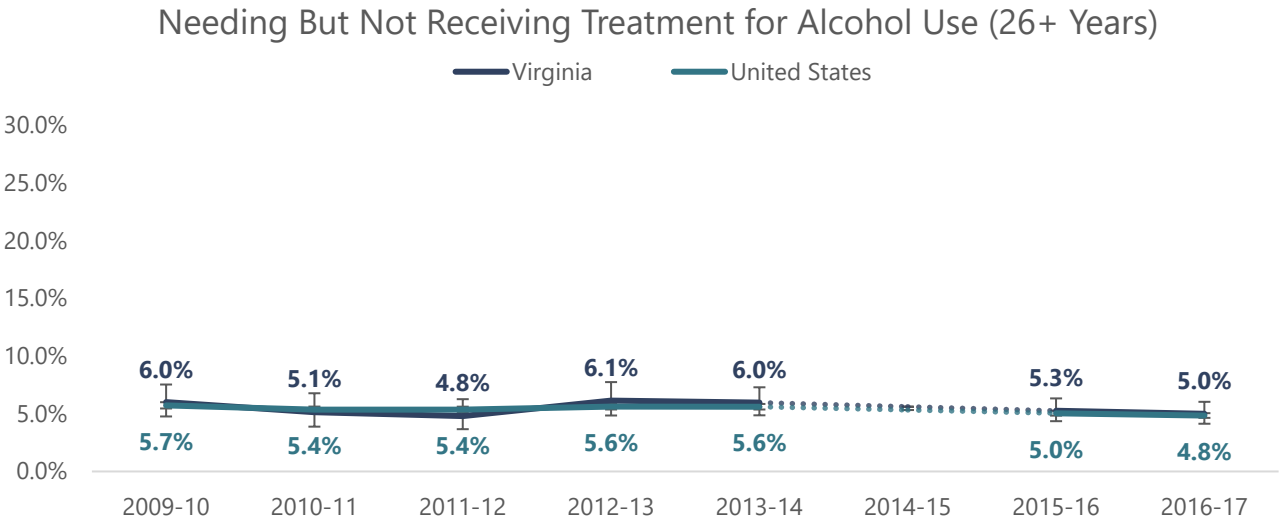


Figure 10c: Trend of Virginia adults aged 26+ years Needing but Not Receiving Treatment for Alcohol Use at a Specialty Facility in the Past Year in comparison to US between 2009-10 and 2016-17 (source: NSDUH). The decline from 2009-10 to 2016-17 was significant for the US but not for Virginia.

Need and Treatment for Illicit Drug Use[14]

An estimated 166,000 individuals aged 12+ needed but did not receive treatment for illicit drug use in 2016-17. The number of Virginia youth aged 12-17 years (Figure 11a) and young adults aged 18-25 years (Figure 11b) with unmet need for illicit drug use treatment declined from 2009-10 to 2016-17, similar to the national trends over the same period. The overall decline was statistically significant for youth aged 12-17 in Virginia and the US, but not for young adults aged 18-25 years. Adults aged 26+ years had a nonsignificant upward trend in the prevalence of needing but not receiving treatment for illicit drug use disorder (Figure 11c) both in Virginia and nationally.

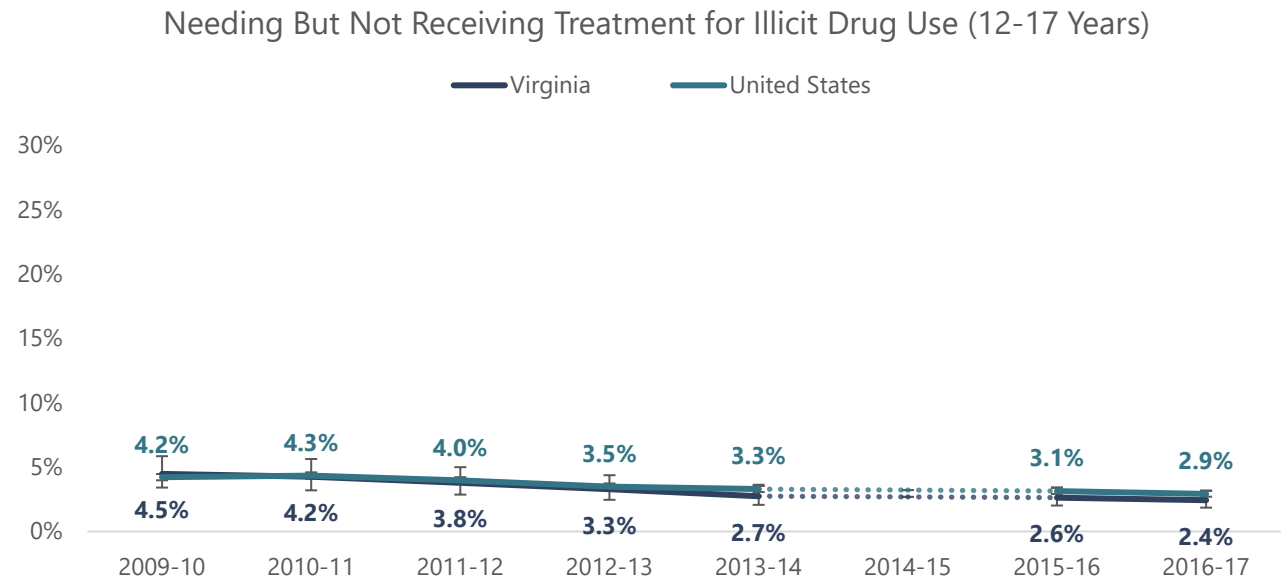


Figure 11a: Virginia youth aged 12-17 years Needing but Not Receiving Treatment for Illicit Drug Use at a Specialty Facility in the Past Year among in comparison to US between 2009-10 and 2016-17 (source: NSDUH). Both Virginia and the US had a significant decline from 2009-10 to 2016-17.

[14] Unreported data for unmet need for illicit drug use treatment in year 2014-2015 period is indicated by extrapolated dotted lines.

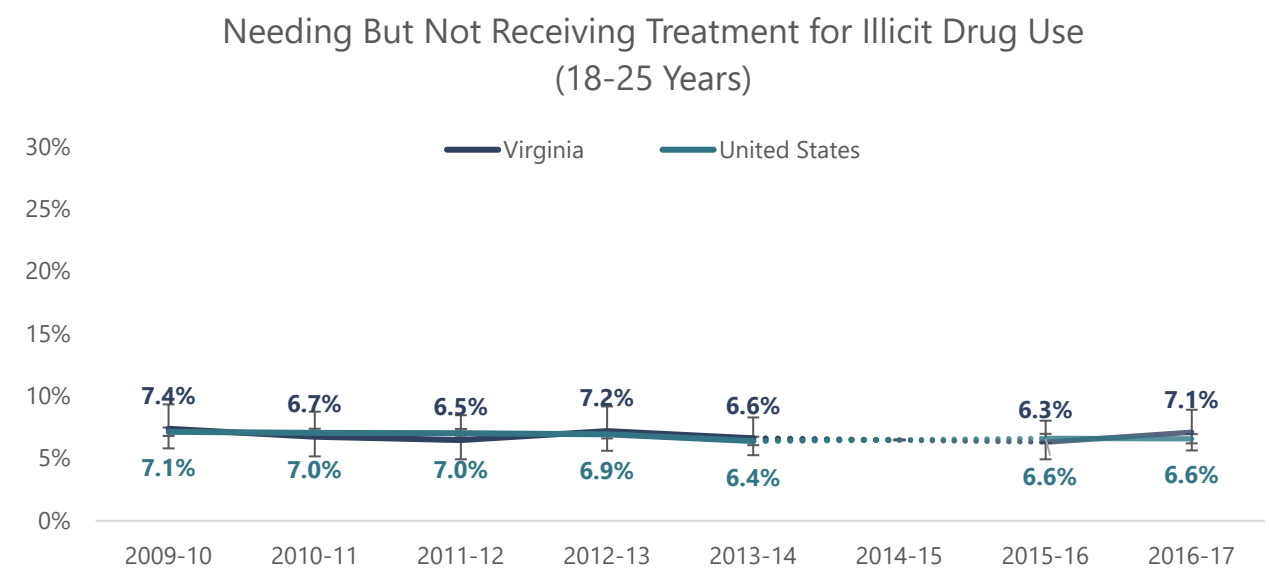


Figure 11b: Virginia adults aged 18-25 years Needing but Not Receiving Treatment for Illicit Drug Use at a Specialty Facility in the Past Year among in comparison to US between 2009-10 and 2016-17 (source: NSDUH). Neither Virginia nor the US had a significant change from 2009-10 to 2016-17.

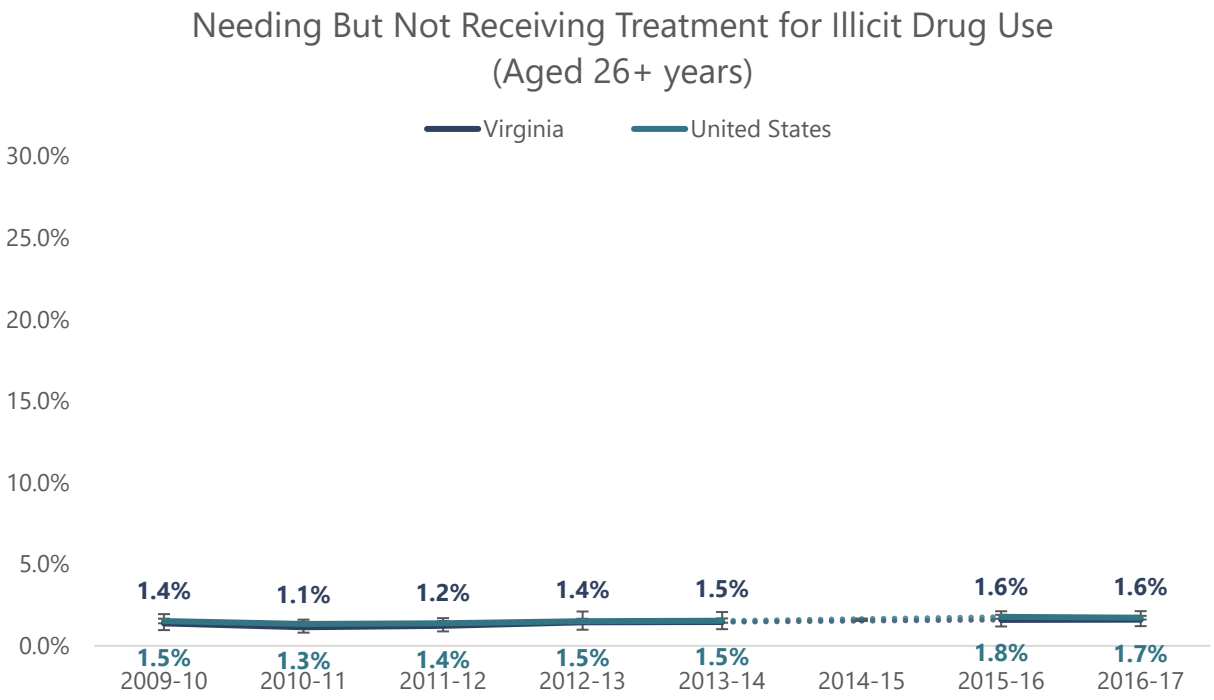


Figure 11c: Virginia adults aged 26+ years Needing but Not Receiving Treatment for Illicit Drug Use at a Specialty Facility in the Past Year in comparison to US between 2009-10 and 2016-17 (source: NSDUH). Neither Virginia nor the US had a significant change from 2009-10 to 2016-17.

Table 3 summarizes unmet need for the treatment of substance use, alcohol, and illicit drug use at a specialty facility in the past year for 2015-16 and 2016-17.

Table 3: Needing but Not Receiving Treatment at a Specialty Facility in Past Year (source: NSDUH)

	12-17 Years		18-25 Years		26+ Years	
Year	%	N	%	N	%	N
Substance Use						
2015-16	3.6%	23,000	14.3%	127,000	6.2%	338,000
2016-17	3.6%	23,000	15.4%	135,000	6.1%	336,000
Alcohol Use						
2015-16	1.9%	12,000	10.8%	96,000	5.3%	286,000
2016-17	1.8%	11,000	10.9%	96,000	5.0%	274,000
Illicit Drug Use						
2015-16	2.6%	16,000	6.3%	56,000	1.6%	86,000
2016-17	2.4%	15,000	7.1%	62,000	1.6%	88,000

Key Findings on Substance Use Disorder Prevalence

Data on substance use disorder prevalence comes from the National Survey on Drug Use and Health (NSDUH) which is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, and noninstitutionalized population aged 12 years or older. The key takeaways on the substance use prevalence in Virginia include:

- In 2016-17, an e**stimated 518,000 individuals (7.4%) aged 12+ met the criteria for substance use disorder (SUD)**, including alcohol use disorder. SUD did not significantly vary by region.
- **SUD in Virginia was most prevalent among young adults aged 18-25 years (16.1%),** and least prevalent among youth aged 12-17 years (3.6%) in 2016-17. Adults aged 26+ had a SUD prevalence of 6.4%.
- Alcohol use disorder was the most prevalent compared to illicit drug use and pain reliever use disorders for young adults (18-25) and adults (26+). **Illicit drug use disorder was the most prevalent for youth (12-17).**
- Similar to the national trends**, Virginia's SUD has declined from 2009-10 to 2016-17 among all age groups,** with statistically significant declines during this time period for youth (12-17) and young adults (18-25). Significant declines were also found during this time period for alcohol use disorder among youth (12-17) and young adults (18-25), and illicit drug use disorder among youth (12-17).
- An estimated **494,000 individuals (7.1%) aged 12+ needed but did not receive treatment for substance use** in 2016-17. Trends in needing but not receiving treatment largely mirrored trends in SUD described above. Significant declines between 2009-10 to 2016-17 In needing but not receiving treatment were found overall for substance use among youth (12-17), as well as for alcohol use among youth (12-17) and young adults (18-25), and for illicit drug use among youth (12-17).

Adverse Childhood Experiences (ACEs)

The 2013-2017 American Community Survey 5-year estimates indicate that Virginia's population under 18 years represented 1,866,274 individuals or 22.3% of the population. There were slightly more males (51% or 952,594) than females (49% or 913,680). Children under 5 years represented 6.1% of the population, or 509,922 individuals.[15]

Adverse childhood experiences (ACEs) are all types of abuse, neglect, and other potentially traumatic experiences that occur in childhood (under age 18), including household challenges in which a child observes violence or instability in the home.[16] Experiencing ACEs as a child has been linked to numerous physical and behavioral health consequences for both youth (medical issues, childhood obesity, behavioral problems, learning difficulties) and adults (substance misuse, cardiovascular disease, cancer, depression). Further, health risks increase as the number of ACEs increases. Given the link between ACEs and behavioral health outcomes, identifying opportunities to prevent and intervene with high risk populations is critical. Virginia collects information about ACEs through the National Survey of Children's Health (NSCH) and Behavioral Risk Factor Surveillance System (BRFSS).[17]

Populations Aged 17 Years or Younger at Risk due to ACEs

Source: National Survey of Children's Health (NSCH)

The NSCH is an annual survey that focuses on collecting data regarding physical and mental health, and access to quality health care along with other factors that may impact a child's life. NSCH data is available at the state and national level, as well as for different demographic sub-populations. In this report, the most recent year of NSCH data was utilized. Trends over time were not analyzed due to changes in survey methodology over time.

Figure 12 provides a snapshot of the prevalence of Virginia's overall ACE indicators among youth aged 17 years or younger, and by gender in 2016-2017. Parent/guardian divorce or separation was the most prevalent ACE. There were no significant differences between male and female children for any of the ACEs included.

[15] Accessed at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

[16] Centers for Disease Control and Prevention (CDC). (2019). About Adverse Childhood Experiences. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html

[17] CDC. (2019). Behavioral Risk Factor Surveillance System ACE data: ACEs definitions. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-brfss.html.

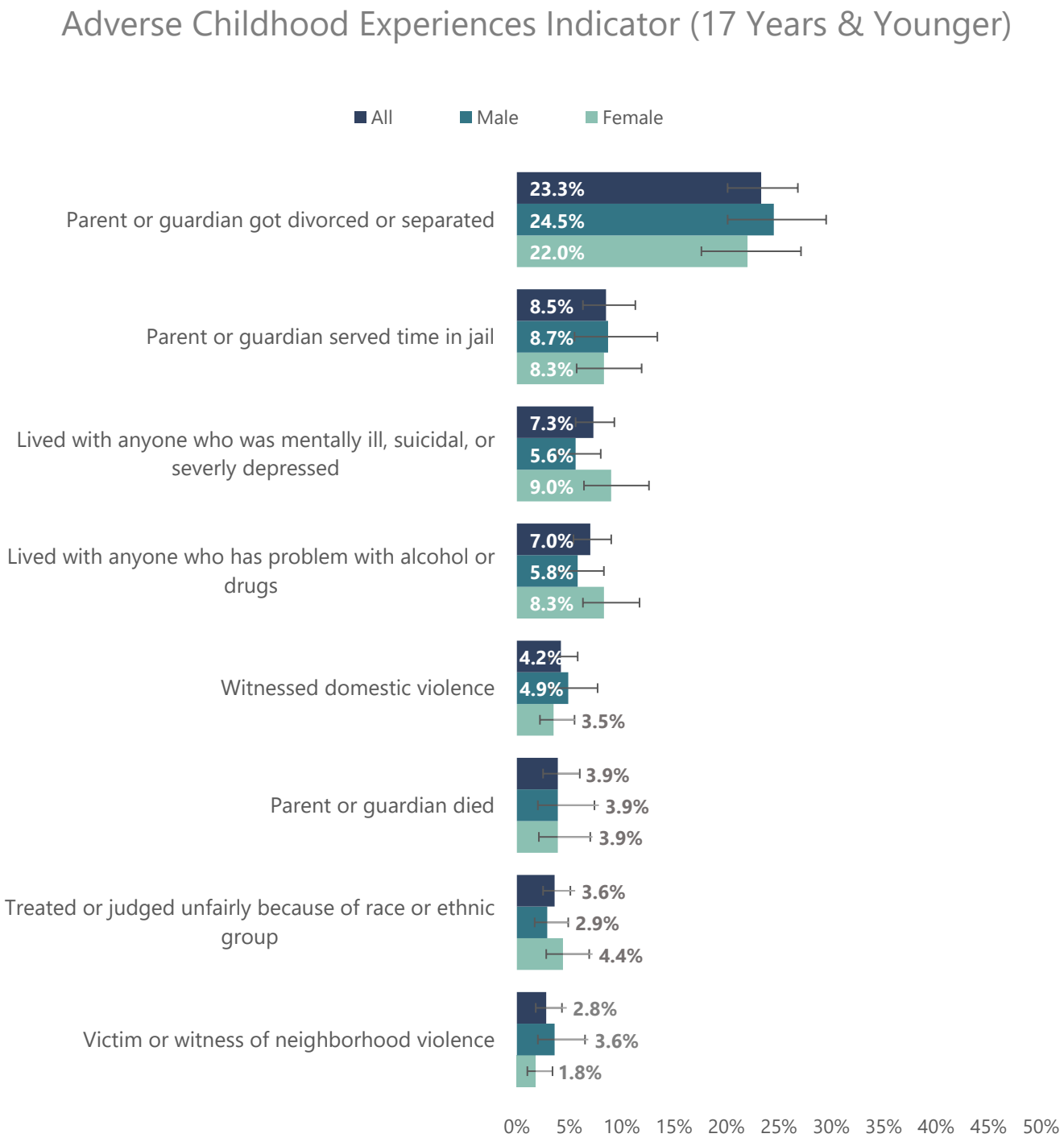


Figure 12: Prevalence of Virginia's overall Adverse Childhood Indicators among youth aged 17 years or younger, and by gender in 2016-2017 (source: NSCH). Parental divorce or separation was significantly more likely to be reported than any other ACE.

Figure 13 shows the difference in ACE indicators for Virginia's youth aged 17 years or younger and by gender and race/ethnicity in 2016-2017. Overall, 19.9% of youth had experienced 2 or more ACEs (approximately 362,353 children), 22.7% had experienced one ACE (approximately 413,760 children), and 57.4% had experienced zero ACEs (approximately 1,044,399 children). This distribution was similar across male and female children.

Differences were observed with race/ethnicity, where most of Virginia's youth who experienced zero ACEs were non-Hispanic Whites, followed by non-Hispanic Asians. Non-Hispanic Black children had the lowest prevalence of zero ACEs and the highest prevalence of two or more ACEs.

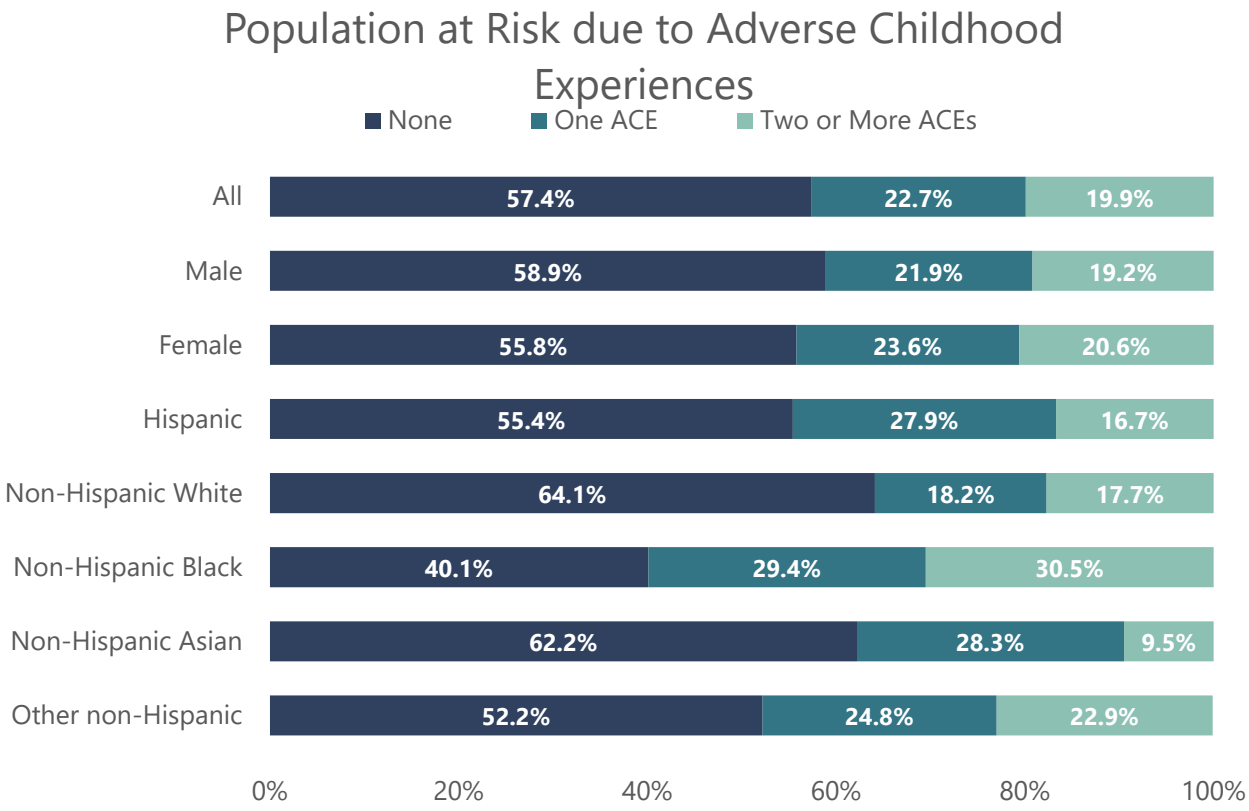


Figure 13: Virginia's youth aged 17 years or younger who are at risk due to Adverse Childhood Experiences, and by gender and race/ethnicity in 2016-2017 (source: NSCH). Non-Hispanic Black youth were significantly less likely to have an ACE score of 0 compared to Non-Hispanic White youth.

The prevalence of ACEs also varied by age. In general, older youth had a higher prevalence of ACEs compared to younger children (Table 4).

Table 4: Virginia's ACE Indicators by Age (Source: NSCH, 2016-17)

ACES	All	0 to 5 Years	6 to 11 Years	12 to 17 Years
	57.4%	71.3%	56.1%	46.3%
	42.6%	28.7%	43.9%	53.7%

Populations 18+ Years at Risk due to ACEs

Source: Behavioral Risk Factor Surveillance Survey (BRFSS)

The BRFSS, also known in Virginia as the Virginia Adult Health Survey, is an annual survey conducted by state health departments with support from the Centers for Disease Control and Prevention (CDC) to monitor prevalence data from adults aged 18+ about their risk behaviors and preventative health practices. Starting in 2016, The Virginia Department of Health (VDH) chose to include questions about Adverse Childhood Experiences (ACEs). For this report, ACEs data from the 2017 BRFSS was used to report on the number of adults 18 and older at risk due to ACEs.

In contrast to the NSCH, BRFSS data is self-reported data about the ACEs that an individual experienced as a child. Further, the BRFSS and NSCH ask about different ACEs; therefore the data presented in this section are not directly comparable to the data presented from the NSCH.

By age 18, 61% of Virginia adults experience at least one ACE, and 14% experience 4 or more ACEs. Figure 14 provides a snapshot of the prevalence of different ACEs among adults aged 18+ years in 2017. Approximately one-third of adults reported experiencing verbal abuse as a child (33.5%), followed by parental divorce (27.4%) and household substance abuse (25.4%).

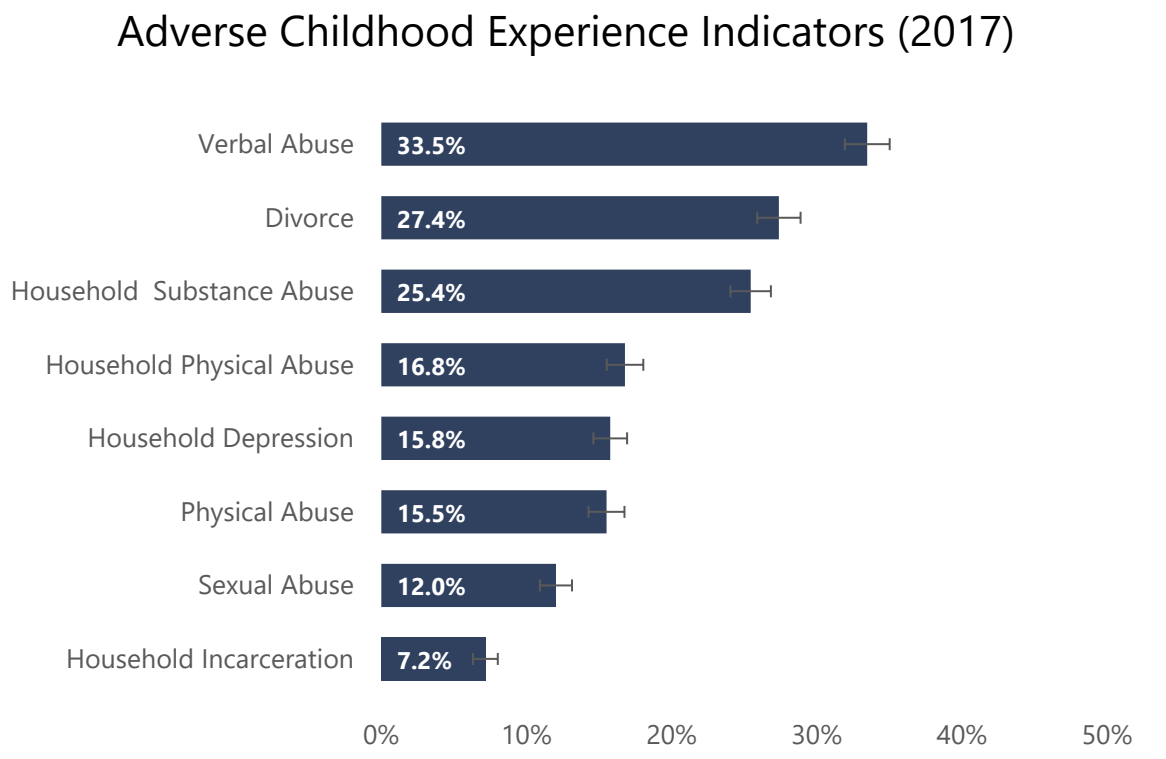


Figure 14: Prevalence of Virginia's overall Adverse Childhood Experiences Indicators among 18+ Years in 2017 (source: BRFSS). Verbal abuse was significantly more likely to be reported compared to any other ACE.

Figure 15 shows Virginia's ACE scores among adults aged 18+ years and by race/ethnicity. Overall, 38.8% had an ACE score of 0, and 14.4% had an ACE score of 4+. Virginia adults who experienced 4 or more ACEs are more likely to report that their health status was fair or poor compared to adults with fewer ACEs, and were 5.8 times more likely to engage in HIV risk behaviors, 4.2 times more likely to experience depression, 2.6 times more likely to have asthma, and 2.6 times more likely to have chronic obstructive pulmonary disease (COPD).

Other non-Hispanic and Non-Hispanic White adults were significantly more likely to have an ACE score of 0 compared to both Non-Hispanic Black and Hispanic adults. Hispanic adults had the highest proportion of 4+ ACEs (16.4%), though this was not significantly higher than any other race/ethnicity. Females were significantly more likely to report having experienced 4 or more ACEs compared to males.

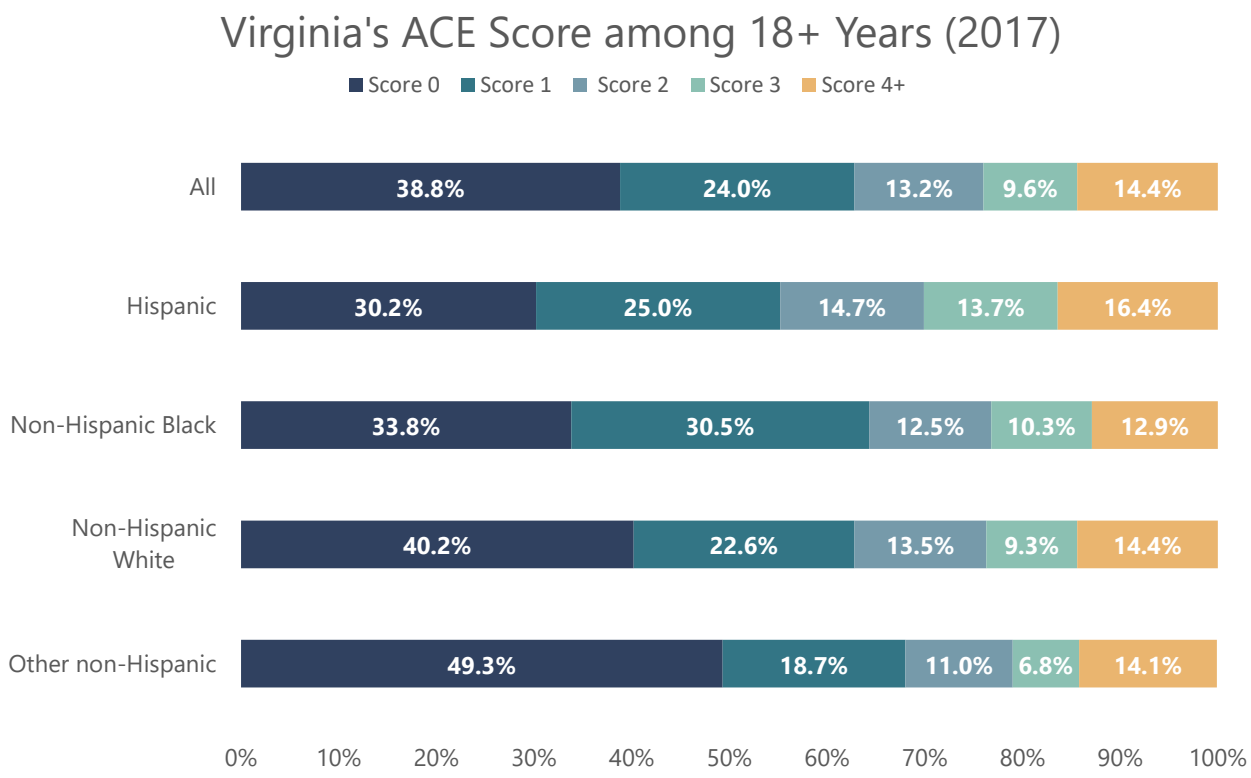


Figure 15: Prevalence of Virginia's overall Adverse Childhood scores among 18+ Years and by race/ethnicity differences in 2017 (source: BRFSS). Other non-Hispanic and Non-Hispanic White adults were significantly more likely to have an ACE score of 0 compared to both Non-Hispanic Black and Hispanic adults.

Key Findings on Adverse Childhood Experiences

Data on Adverse Childhood Experiences comes from two surveys; the NSCH which is completed about a child (aged 0-17) by an adult familiar with the child's health and health care, and the BRFSS which Is completed by individuals aged 18 and over and asks about their ACEs experiences from childhood.

- **Parental divorce or separation was a commonly reported ACE** across both surveys, with approximately one-quarter of Virginia youth and adults experiencing this ACE (23% of the NSCH population and 27% of the BRFSS).
- The **number of ACEs experienced increased with age**, and the number of ACEs experienced increases risk for other negative physical, mental, and behavioral health outcomes. Overall, the prevalence of ACEs was higher within the BRFSS dataset (individuals aged 18+)[18].
- There were few gender differences in the number of ACEs experienced across surveys, however **adult females were significantly more likely to report experiencing 4 or more ACEs**.
- **Other non-Hispanic and Non-Hispanic White adults were significantly more likely to have an ACE score of 0** compared to both Non-Hispanic Black and Hispanic adults. Similarly, in the NSCH dataset, Non-Hispanic Black youth were significantly less likely to have an ACE score of 0 compared to Non-Hispanic White youth.

Mental Health

Flourishing for Children and Adolescents

Source: National Survey of Children's Health (NSCH)

Flourishing mental health is defined as a combination of feeling good and functioning effectively resulting in high levels of mental well-being. Flourishing in infancy and toddlerhood is characterized by healthy attachment relationships, curiosity and interest in learning, and ability to regain equilibrium after an upset. Flourishing among older children reflect positive youth development and the capacity to recover from the impacts of adverse experiences.[19] Flourishing is conceived as the opposite of mental disorder rather than its mere absence.

Flourishing for children aged 6m-5 years is defined by four positive indicators[20] in the National Survey of Child Health (2016-2017). Figure 16a shows the overall prevalence of flourishing mental health among Virginia children aged 6m-5 years, and by gender and race/ethnicity in 2016-2017. Overall, 63.1% of children in Virginia (approximately 356,000 children) demonstrated all 4 positive indicators of flourishing with similar prevalence by gender, while 8.9% demonstrated 0-2 items (approximately 50,000 children).

[18] This could be due to the fact that the NSCH surveys youth aged 0-17, who may still experience additional ACEs, as well as differences in survey methodology.

[19] Kwong, TY and Hayes, D. Adverse family experiences and flourishing amongst children ages 6–17 years: 2011/12 National Survey of Children's Health (2018). *Child Abuse Negl.* 2017 Aug; 70: 240–246

[20] The four indicators include: 1) children bounce back quickly when things don't go their way; 2) children are affectionate and tender with parent; 3) children show interest and curiosity in learning new things; 4) children smile and laugh a lot.

Differences were observed across various race/ethnicities. Non-Hispanic White children had the highest prevalence of all 4 positive flourishing indicators (74.4%) while non-Hispanic Black children demonstrated the lowest prevalence (40.2%). Hispanic children demonstrated the highest prevalence of having 0-2 positive indicators of flourishing (26.2%).

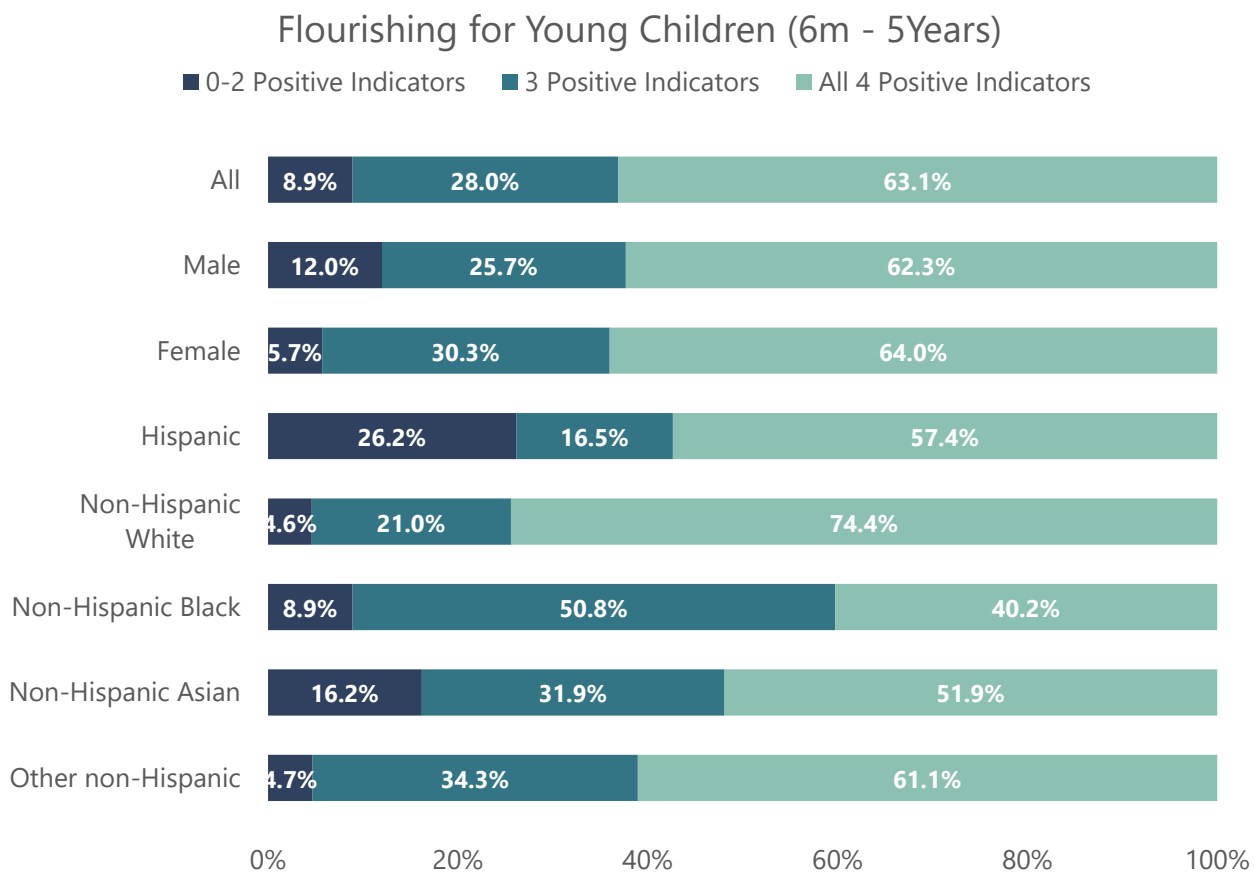


Figure 16a: Overall Flourishing[21] of Virginia children aged 6m-5 years, and by gender and race/ethnicity in 2016-2017 (source: NSCH). There were no significant differences by gender. Due to small sample sizes, significant differences between race/ethnicity were not calculated.

Flourishing for children aged 6-17 years is defined by three positive indicators[22] in the National Survey of Child Health (2016-2017). Among Virginia's children and adolescents aged 6-17 years, Figure 16b shows overall flourishing and by gender and race/ethnicity in 2016-2017. Compared to children under six, the prevalence of having all positive indicators was much lower. Overall, 39.4% demonstrated all 3 positive indicators of flourishing (approximately 495,000 youth) while 31.2% demonstrated 0-1 positive indicators (approximately 392,000 youth).

[21] The four indicators include: children bounce back quickly when things don't go their way; children are affectionate and tender with parent; children show interest and curiosity in learning new things; children smile and laugh a lot.

[22] The three indicators include: children show interest and curiosity in learning new things; children stay calm and in control when faced with a challenge; and children who work to finish the tasks they start.

A larger percentage of females displayed all 3 positive flourishing indicators compared to males (43.1% versus 35.9%). Non-Hispanic Asian children and adolescents most frequently demonstrated all 3 positive flourishing indicators (46.1%), followed by Other non-Hispanic children and adolescents (44.8%). Non-Hispanic Asian youth also had the lowest prevalence of only having 0-1 positive flourishing indicators.

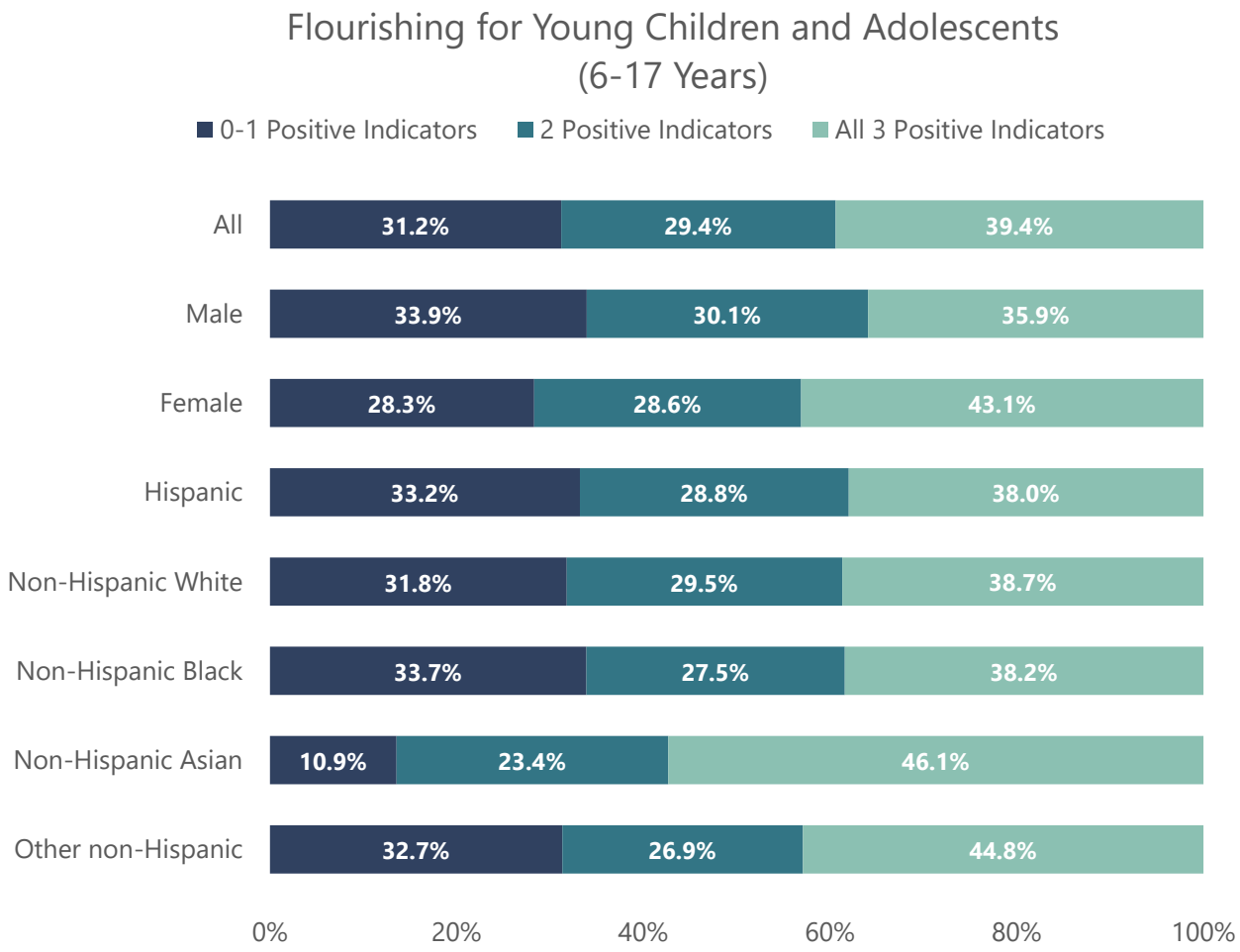


Figure 16b: Overall Flourishing of Virginia children aged 6-17 years, and by gender and race/ethnicity 2016-2017 (source: NSCH). There were no significant differences by gender. Due to small sample sizes, significant differences between race/ethnicity were not calculated.

Serious Emotional Disturbance

A child with serious emotional disturbance (SED) is defined as a child "from birth up to age 18 years who currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R; American Psychiatric Association, 1987) that resulted in functional impairment, which substantially interferes with or limits the child's role or

functioning in family, school, or community activities".[23] One of the common age-related diagnoses is attention deficit disorder and attention-deficit/hyperactivity disorder (ADD/ADHD).

Prevalence, Severity and Treatment of ADD/ADHD

Source: National Survey of Children's Health (NSCH)

ADD/ADHD is a chronic neurodevelopmental disorder that is characterized by a persistent and pervasive pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. An ADD/ADHD diagnosis requires symptoms to be present prior to the age of 12 years.[24]

Figure 17 highlights Virginia's prevalence, severity and treatment[25] of ADD/ADHD for 2016-2017 among youth aged 3-17 years. The overall prevalence of ADD/ADHD was 9.7% (approximately 153,338 children aged 3-17) in Virginia. Compared to the national estimates, Virginia was not significantly different in the prevalence of ADD/ADHD diagnosis, severity, and/or treatment.

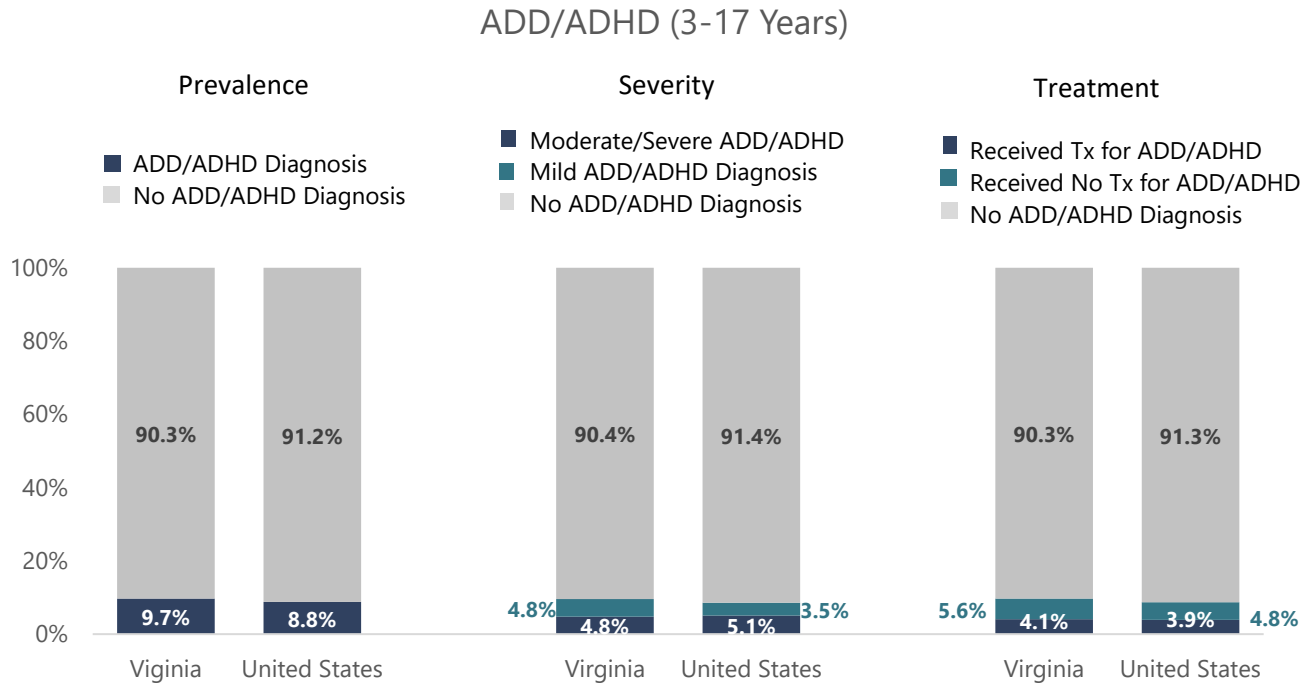


Figure 17: Prevalence, severity, and treatment of ADD/ADHD among Virginia youth aged 3-17 years in 2016-2017 (source: NSCH).

Figure 18 shows the gender differences in the prevalence, severity and treatment of ADD/ADHD In Virginia. Male youth had a significantly higher prevalence of ADD/ADHD diagnosis compared to female

[23] Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services. (1993). Defining serious emotional disturbance in children: Final notice. Federal Register, 58(96), 29422-29425.

[24] DSM-5 Changes: Implications for Child Serious Emotional Disturbance. Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (2016). Accessed on 2/25 at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf

[25] ADD/ADHD Diagnosis reflects children who currently have the condition. Severity reflects parent rating of mild or moderate. Treatment indicators reflect children who currently have ADD/ADHD and either did or did not receive treatment. All indicators are out of the total population, including the % of children who do not have ADD/ADHD.

youth (13.2 versus 6.0%). Likewise, significantly more male youth with an ADD/ADHD diagnosis did not receive treatment compared to female youth (8.3% versus 2.7%).

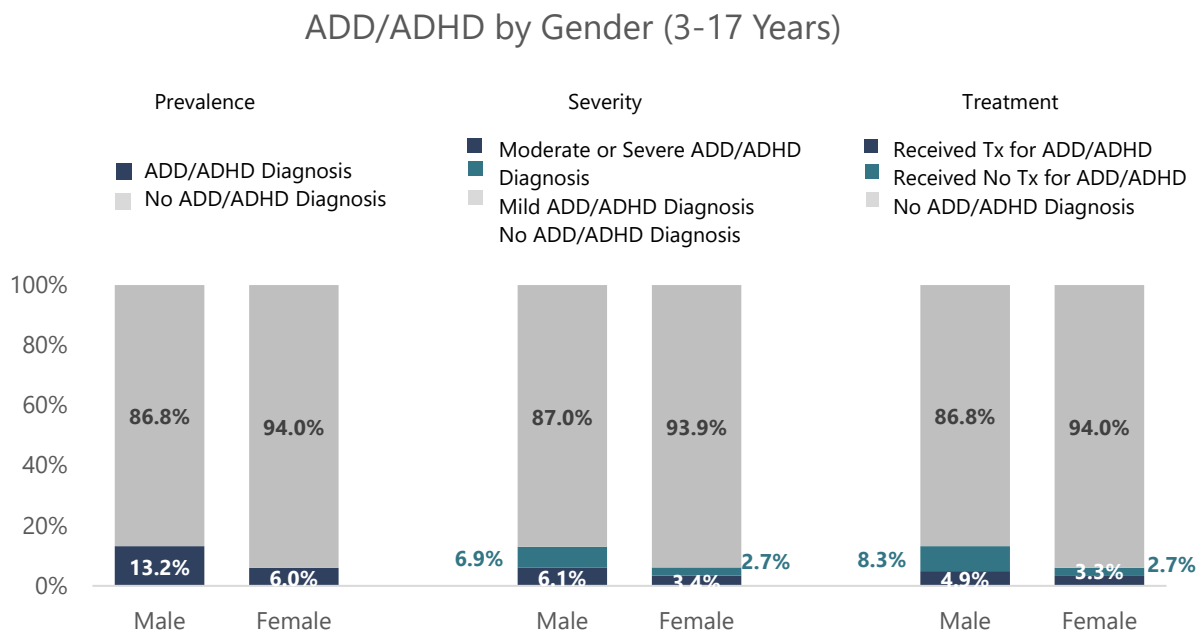


Figure 18: Gender differences in the prevalence, severity, and treatment of ADD/ADHD among Virginia youth aged 3-17 years in 2016-2017 (source: NSCH). Males were significantly more likely than females to have an ADD/ADHD diagnosis, and to report not receiving treatment.

Figures 19a, 19b, and 19c highlight the prevalence, severity and treatment of ADD/ADHD in Virginia among youth aged 3-17 years by race/ethnicity. Given small population sizes, the confidence intervals around the estimates were large, and few differences were statistically significant. Non-Hispanic Asian youth had the lowest prevalence of ADD/ADHD diagnosis while Other non-Hispanic youth had the highest prevalence.

Treatment indicators show that non-Hispanic White youth had the highest prevalence of treatment for ADD/ADHD followed by Other non-Hispanic youth. Non-Hispanic Black youth were the most likely to have not received treatment, followed by Hispanic and Other non-Hispanic youth.

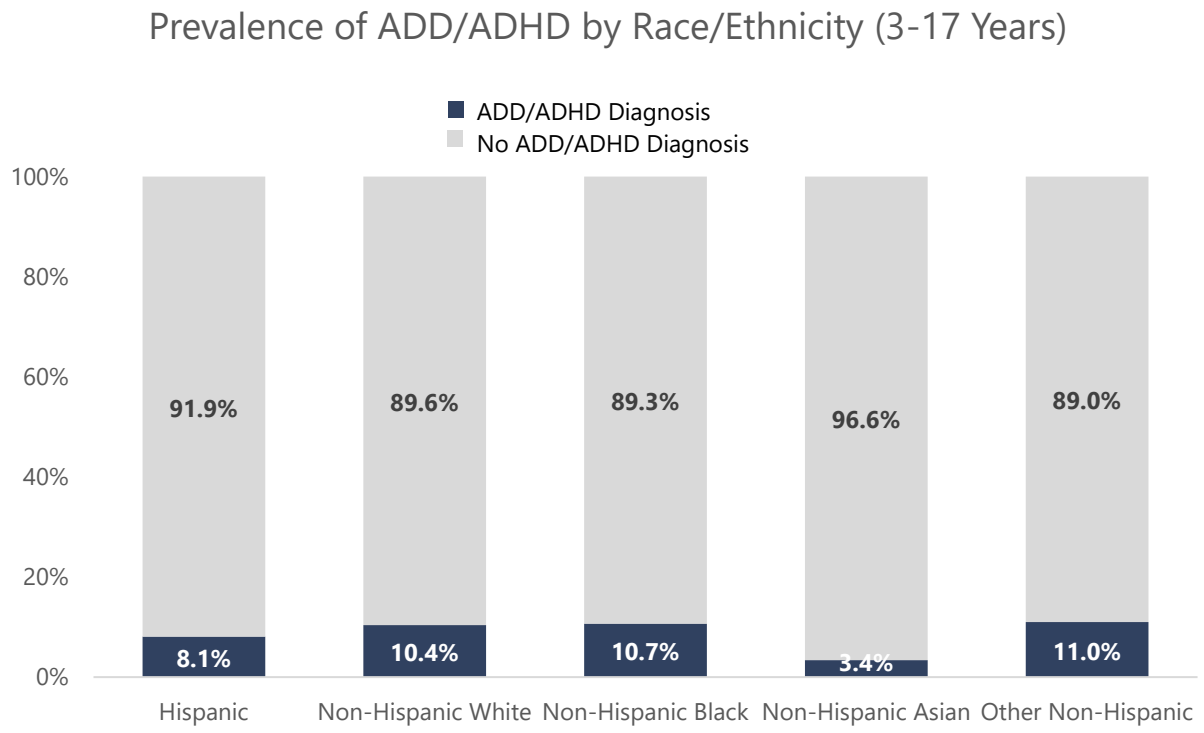


Figure 19a: Race/ethnicity differences in the prevalence of ADD/ADHD among Virginia youth aged 3-17 years in 2016-2017 (source: NSCH). Due to small sample sizes, significant differences were not calculated.

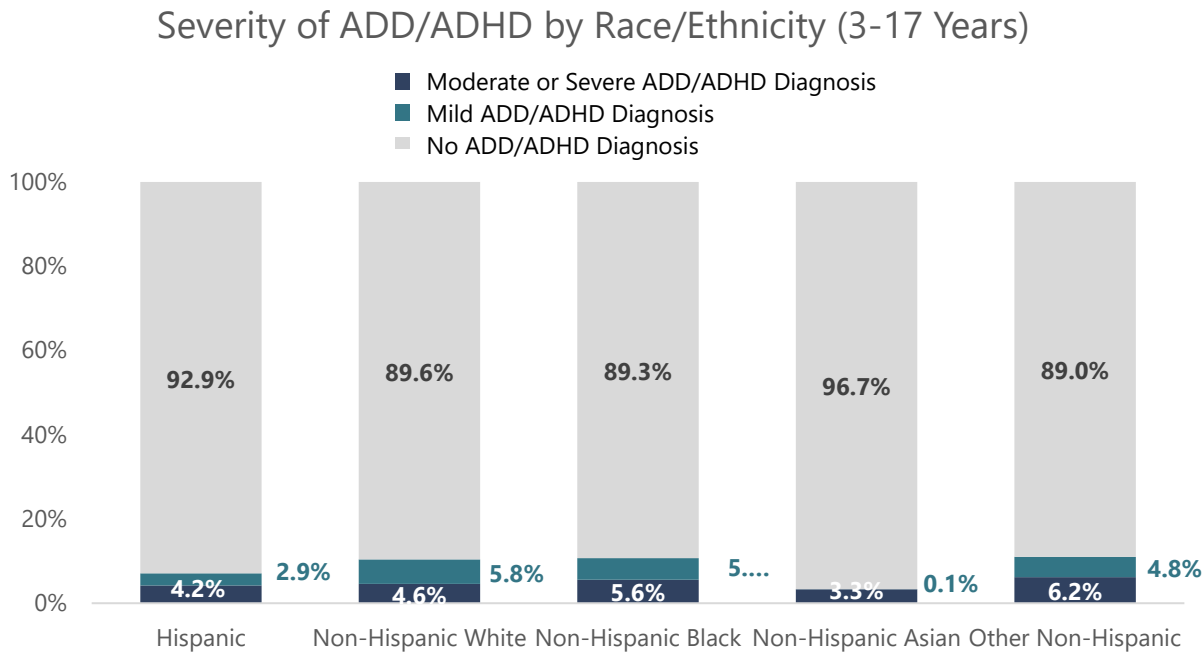


Figure 19b: Race/ethnicity differences in the severity of ADD/ADHD among Virginia youth aged 3-17 years in 2016-2017 (source: NSCH). Due to small sample sizes, significant differences were not calculated.

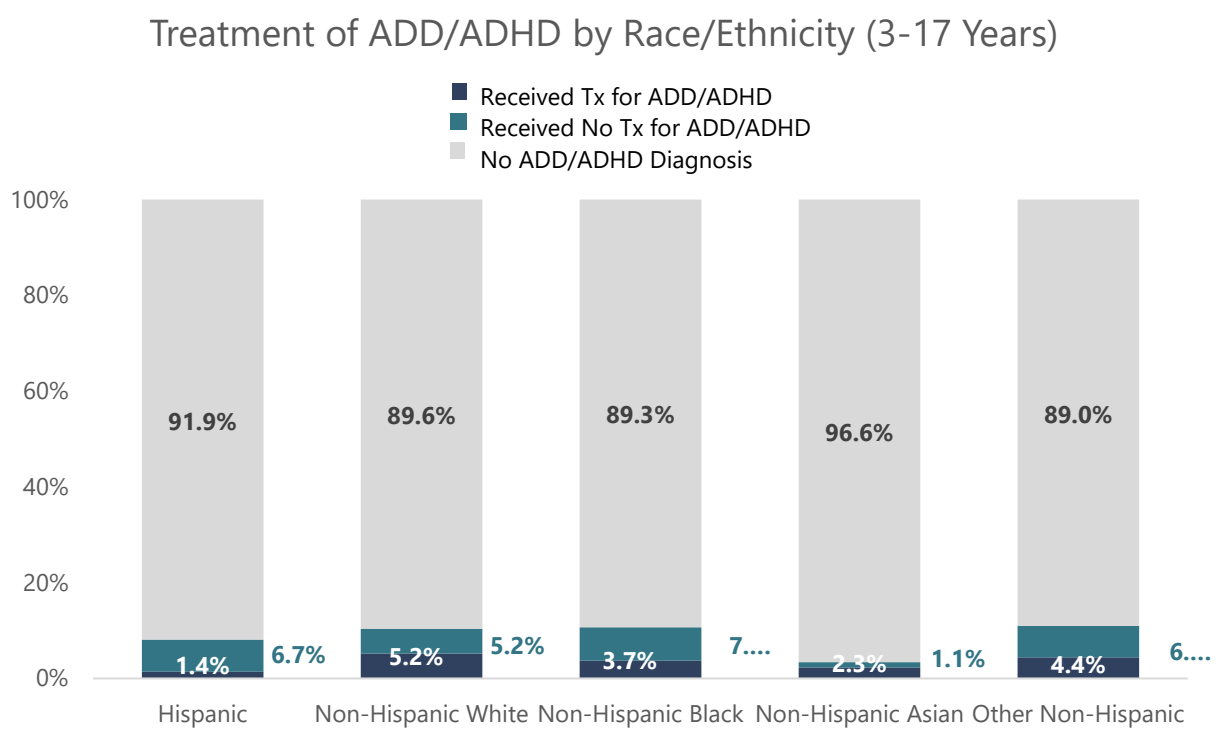


Figure 19c: Race/ethnicity differences in the treatment of ADD/ADHD among Virginia youth aged 3-17 years in 2016-2017 (source: NSCH). Due to small sample sizes, significant differences were not calculated.

Prevalence of Any Mental Illness[26]

Source: National Survey on Drug Use and Health (NSDUH)

For adults 18+, NSDUH defines any mental illness as any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.[27] An estimated 1,195,000 individuals aged 18+ met the criteria for any mental illness in the past year in 2016-17 (223,000 individuals aged 18-25 and 972,000 individuals aged 26+).

Among Virginia young adults aged 18-25 years, Figure 20a shows the trend of any mental illness from 2009-10 to 2016-17, compared to the US. Both the US and Virginia experienced a significant increase in any mental illness from 2009-10 to 2016-17.

[26] Data for any mental illness is not available for youth under 18 years old.
[27] SAMHSA (2016). Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Accessed at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

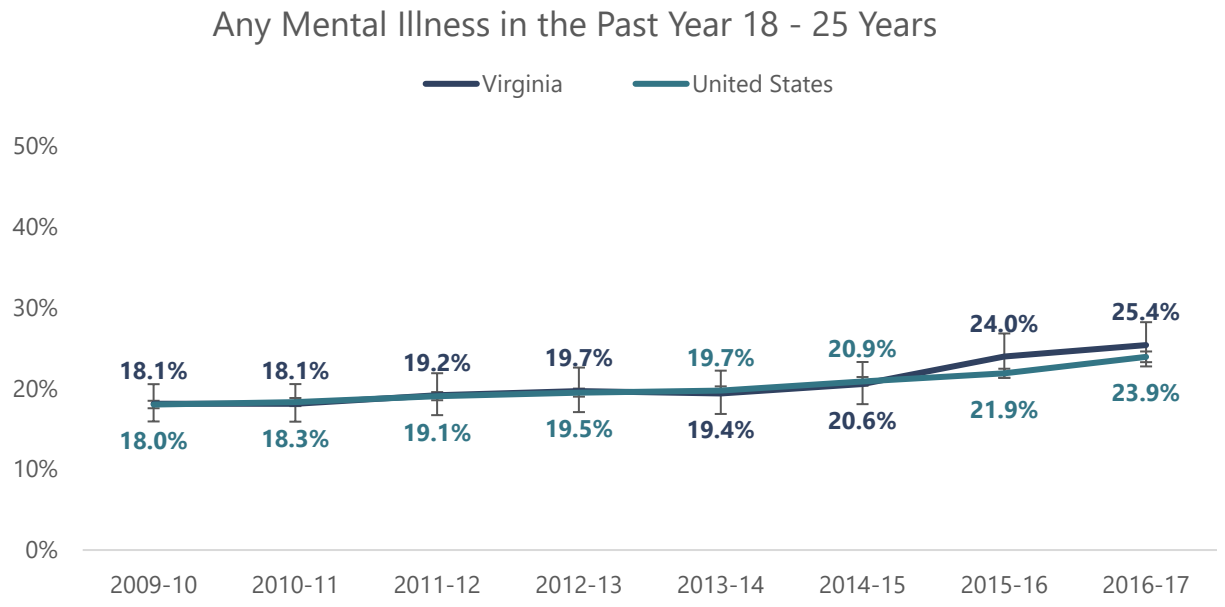


Figure 20a: Prevalence of Any Mental Illness among Virginia adults aged 18-25 years compared to the US from 2009-10 to 2016-17 (source: NSDUH). Both the US and Virginia experienced a significant increase from 2009-10 to 2016-17.

The prevalence of any mental illness among Virginia adults aged 26+ years (Figure 20b) has been stable over time and similar to the national trend.

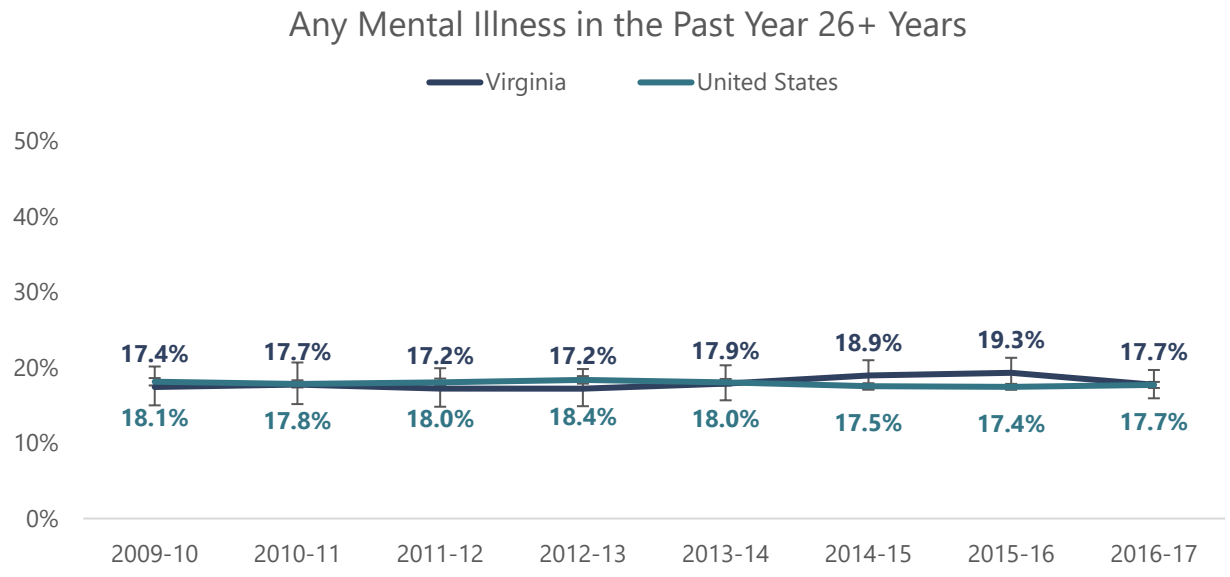


Figure 20b: Prevalence of Any Mental Illness among Virginia adults aged 26+ years compared to the US from 2009-10 to 2016-17 (source: NSDUH). There was no significant difference over time for Virginia or the US.

Prevalence of Serious Mental Illness[28]

Source: National Survey on Drug Use and Health (NSDUH)

Adults were defined as having serious mental illness (SMI) if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.[29] Any mental illness and SMI are not mutually exclusive categories; adults with SMI are included in estimates of adults with any mental illness. Overall, an estimated 255,000 individuals aged 18+ met the criteria for serious mental illness in the past year in 2016-17.

Figures 21a and 21b show similar trends in the prevalence of SMI among Virginia adults aged 18-25 and 26+ years, respectively, with no significant differences in the prevalence of SMI between Virginia and the US within the same age group. The prevalence of SMI among Virginia young adults aged 18-25 years has shown a nonsignificant increase between 2009-10 and 2016-17, while the prevalence among adults aged 26+ years has stayed the same over the same period.

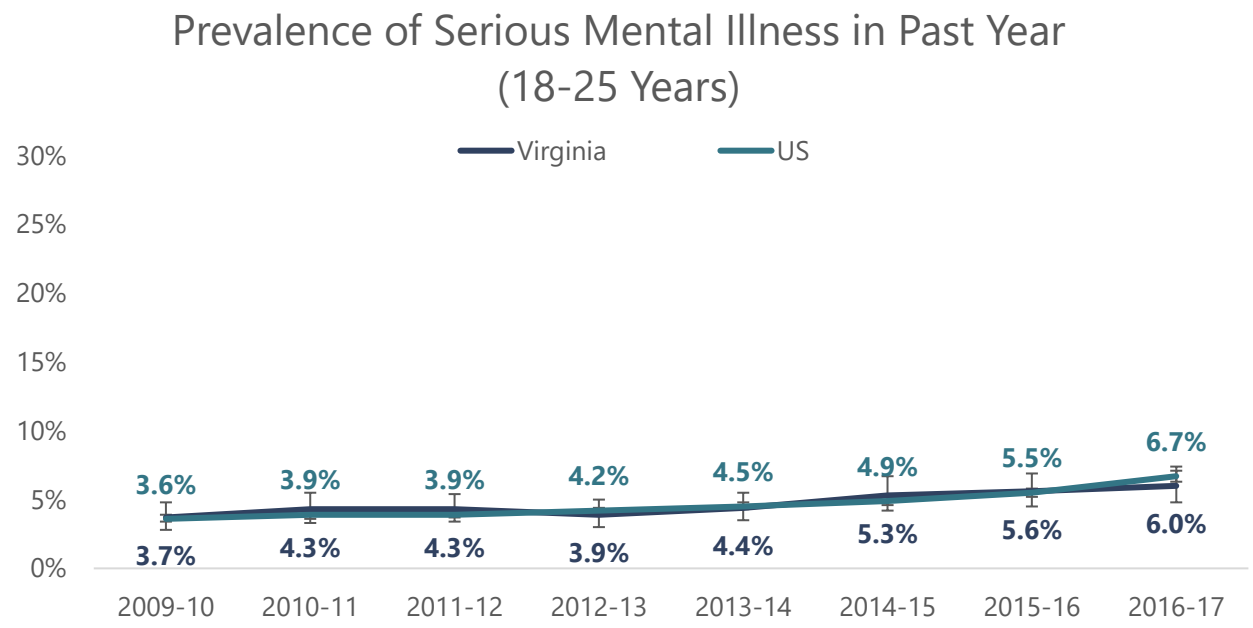


Figure 21a: Prevalence of SMI In Past Year among Virginia's adults aged 18-25 years in comparison to US from 2008-10 to 2014-16 (source: NSDUH). While the increase for the US was significant over time, the increase for Virginia was nonsignificant.

[28] SMI prevalence data is not available for youth under 18 years.

[29] SAMHSA (2016). Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Accessed at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

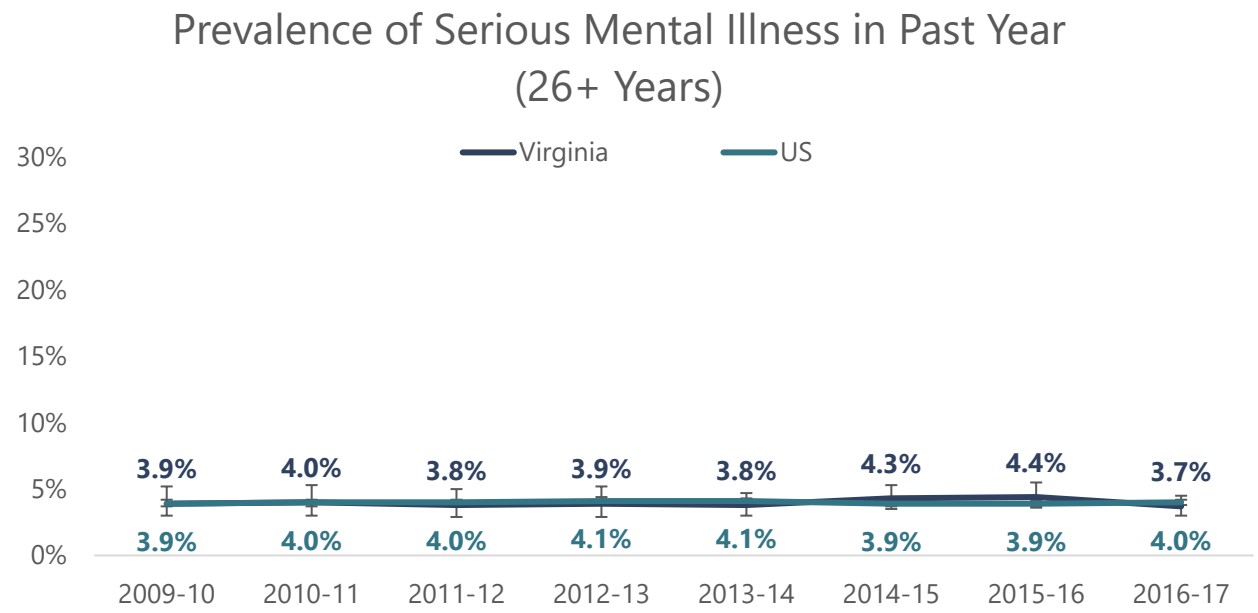


Figure 21b: Prevalence of SMI In Past Year among Virginia's adults aged 26+ years in comparison to US from 2008-10 to 2014-16 (source: NSDUH). There was no significant change over time for Virginia or the US.

There were no significant differences in the prevalence of serious mental illness by region, though Region 3 had the highest prevalence at any given time (Figure 22). There were no significant changes over time for any region.

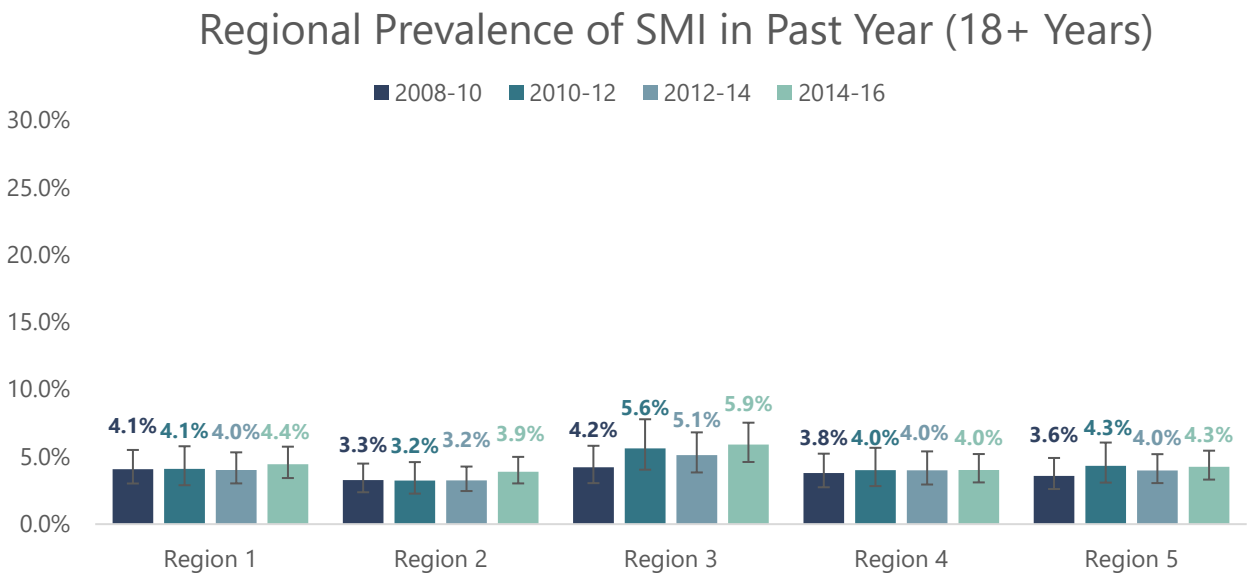


Figure 22: Regional Prevalence of SMI In Past Year among Virginia's adults aged 18+ years from 2008-10 to 2014-16 (source: NSDUH). There were no significant differences between regions or over time.

Sadness, Depression, and Suicide Related Indicators

Sad or Hopeless Almost Every Day for Two Weeks or More in a Row in Past Year

Source: Youth Risk Behavior Surveillance System (YRBSS)

The Youth Risk Behavioral Surveillance System (YRBSS) consists of surveys administered to high school and middle school students across the United States as a part of a CDC funded initiative to monitor the prevalence of health and risk behaviors of students[30]. In Virginia, the YRBS instrument is also known as the Virginia Youth Survey and is administered in odd years to a randomly selected sample of students in Virginia public schools[31]. The YRBS collects information across a number of behavioral health related areas, including mental health and substance use.

Figure 23 shows the prevalence of feeling sad or hopeless every day for two weeks or more in a row among Virginia high school students[32] between 2013 and 2017, as well as by gender. Overall, there has been a significant increase in the number of Virginia high school students who have had a prolonged period of feeling sad or hopeless since 2013, reaching a high of 29.5% in 2017. Female students have a significantly higher prevalence compared to males in all years.

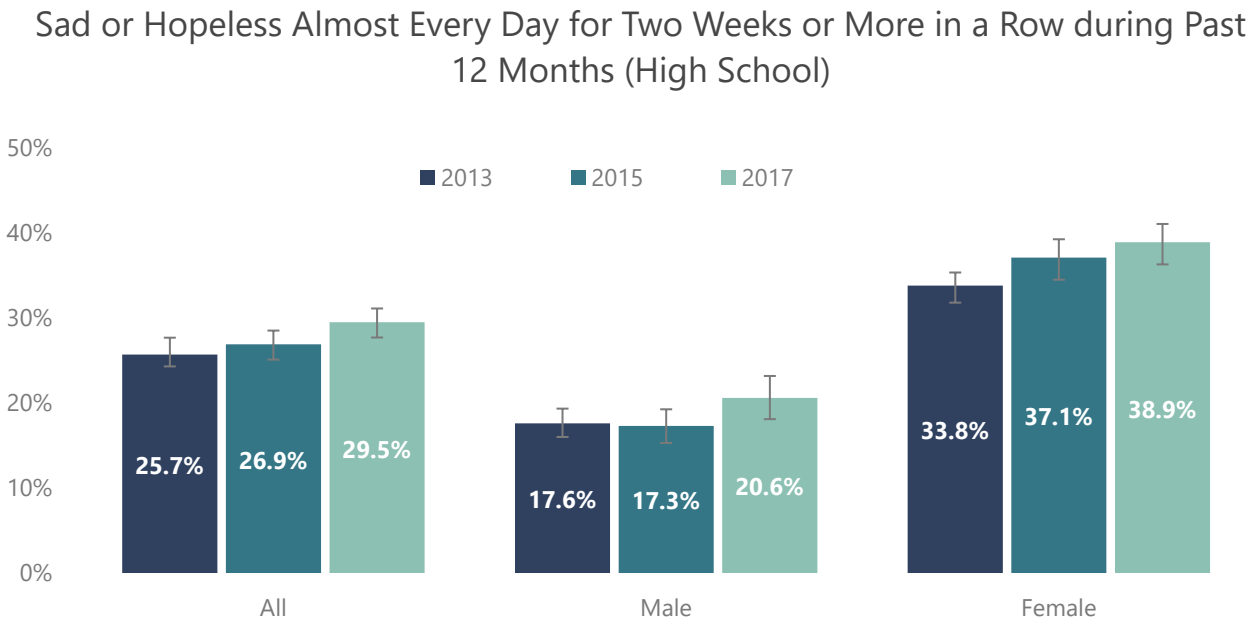


Figure 23: Overall and by gender prevalence of feeling sad or hopeless for two or more weeks in a row among Virginia high school students from 2013-2017 (source: YRBSS). Female students had a significantly higher prevalence compared to males.

[30] https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
[31] http://www.vdh.virginia.gov/virginia-youth-survey/
[32] The middle school version of the YRBS does not ask this question.

Major Depressive Episode

Source: National Survey on Drug Use and Health (NSDUH)

The NSDUH also asks about feeling sad or depressed for a period of 2 weeks or more in the past 12 months and categorizes this as a major depressive episode[33]. Overall, an estimated 431,000 individuals over aged 18 met the criteria for major depressive episode within the past year.

Figure 24a and 24b show the prevalence of major depressive episode among Virginia youth aged 12-17 years and adults aged 18-25 years, respectively, between 2009-10 and 2016-17. The prevalence trend in Virginia mirrors the national prevalence for each age group with each showing a significant increase from 2009-10 to 2016-17.

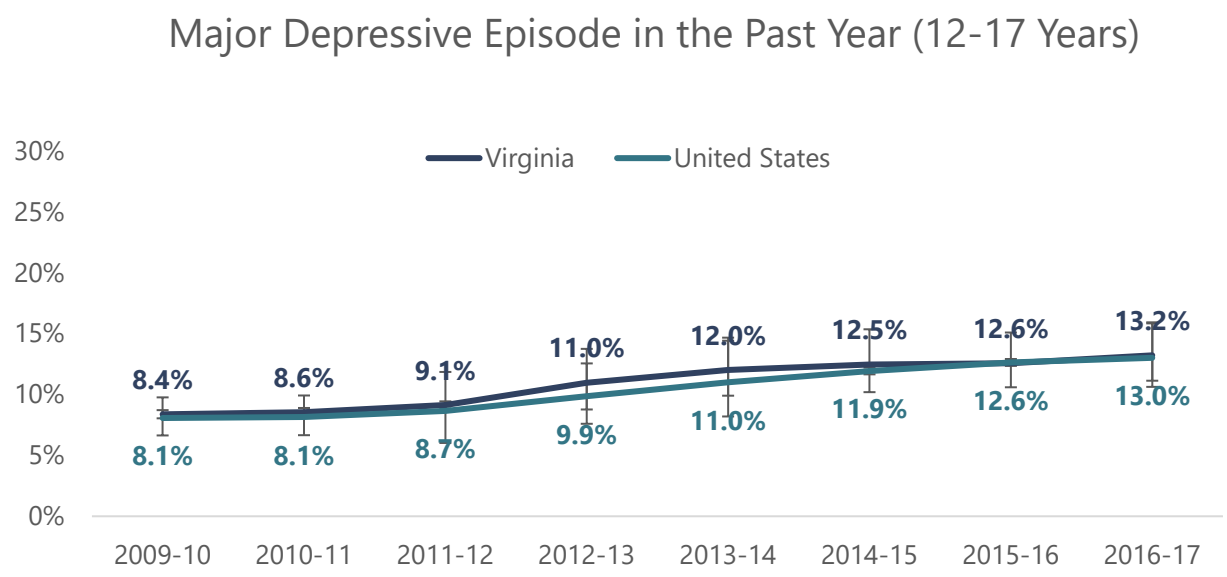


Figure 24a: Prevalence of Major Depressive Episode among Virginia youth aged 12-17 years compared to the US from 2009-10 to 2016-17 (source: NSDUH). Both Virginia and the US had a significant increase from 2009-10 to 2016-17.

[33] A major depressive episode is characterized by NSDUH as a period of 2 weeks or longer in the past 12 months where an individual experienced a depressed mood or loss of interest or pleasure in daily activities, and had at least some additional symptoms, such as problems with sleep, eating, energy, concentration, and self-worth. DSM-5 Changes: Implications for Child Serious Emotional Disturbance. Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (2016). Accessed on 2/25 at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf

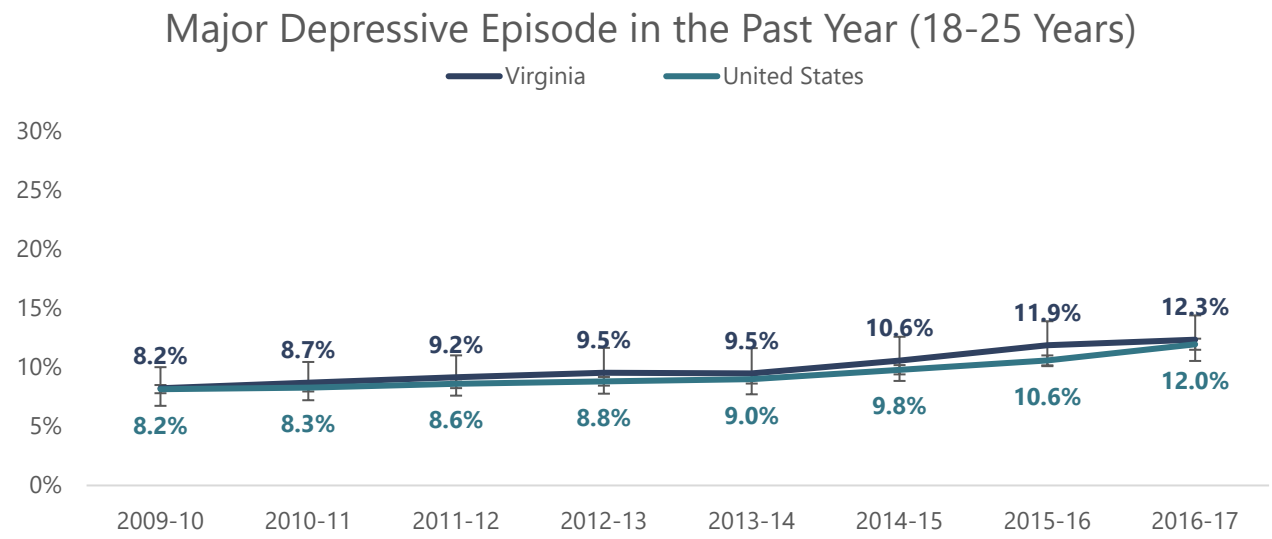


Figure 24b: Prevalence of Major Depressive Episode among Virginia adult 18-25 years compared to the US from 2009-10 to 2016-17 (source: NSDUH). Both Virginia and the US had a significant increase from 2009-10 to 2016-17.

The prevalence of major depressive episode among adults aged 26+ (Figure 24c) stayed relatively stable in Virginia and nationally between 20019-10 and 2016-17, with no significant change over time. The prevalence among adults aged 26+ was significantly lower than both youth aged 12-17 years and young adults aged 18-25 years.

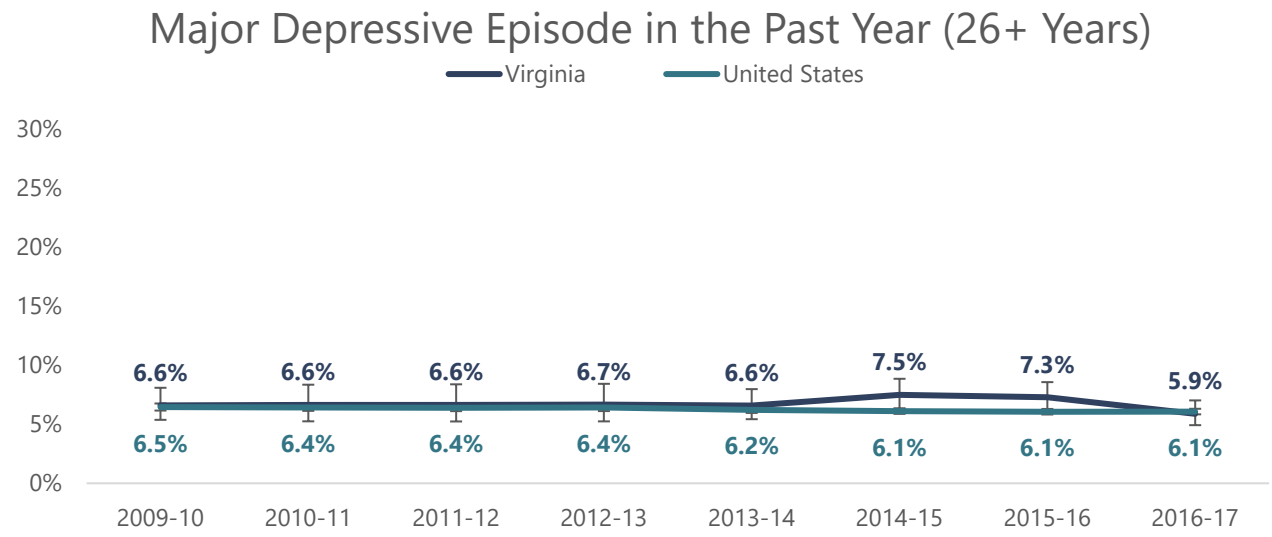


Figure 24c: Prevalence of Major Depressive Episode among Virginia adults aged 26+ years compared to the US from 2009-10 to 2016-17 (source: NSDUH). Neither Virginia nor the US had any significant change from 2009-10 to 2016-17.

Serious Thoughts of Suicide

Sources: Youth Risk Behavior Surveillance System (YRBSS) and National Survey on Drug Use and Health (NSDUH)

Figures 25a and 25b show the prevalence of Virginia's middle school students who ever had serious thoughts of suicide. There was a significant increase in the overall prevalence from 2013 to 2017, as well as the prevalence for male students. Female students had a significant increase from 2015 to 2017 and were also significantly more likely to have suicidal thoughts compared to males.

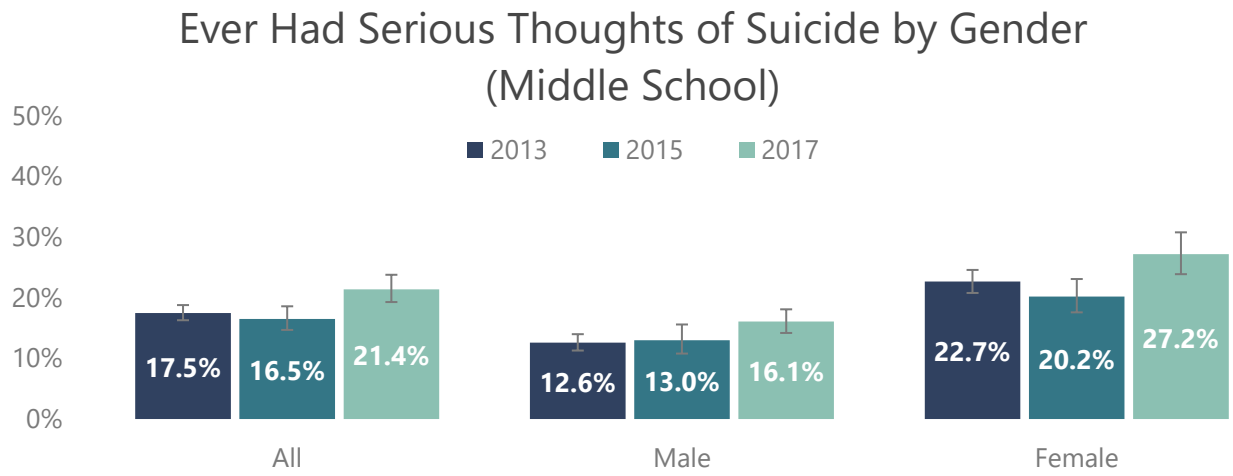


Figure 25a: Overall and gender differences in the prevalence of serious thoughts of suicide among Virginia middle school students from 2013-2017(source: YRBSS). Significant increase from 2013-2017 overall and for males. Female students had a significant increase from 2015-2017 and were significantly more likely to have suicidal thoughts compared to males.

The prevalence of serious thoughts of suicide was similar by race/ethnicity, with no significant differences between sub-groups. Hispanic middle school students had the highest prevalence of serious suicidal thoughts in 2017 (25.6%) and experienced a significant increase in prevalence between 2015 and 2017.

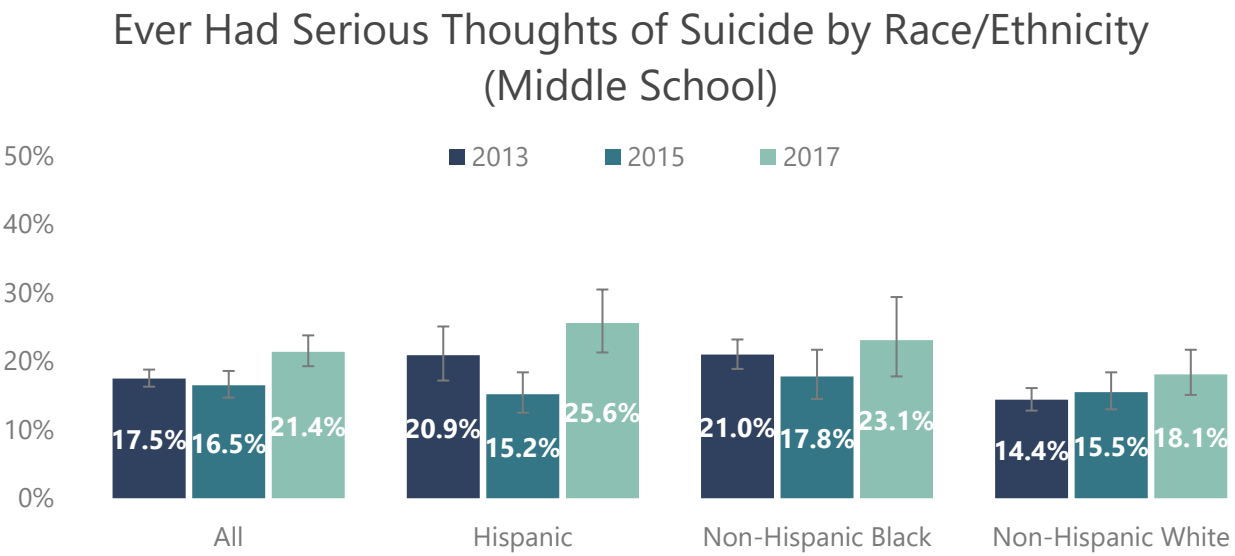


Figure 25b: Overall and race/ethnicity differences in the prevalence of serious thoughts of suicide among Virginia middle school students from 2013-2017 (source: YRBSS). There were no significant differences between race/ethnicity. Hispanic students had a significant increase between 2015-2017.

Figure 26a shows the overall and gender differences in the prevalence of suicidal thoughts among high school students during the past 12 months. There were no significant changes over time from 2013 to 2017. The prevalence of suicidal thoughts among female students in the past 12 months was significantly higher compared to male students at any time.

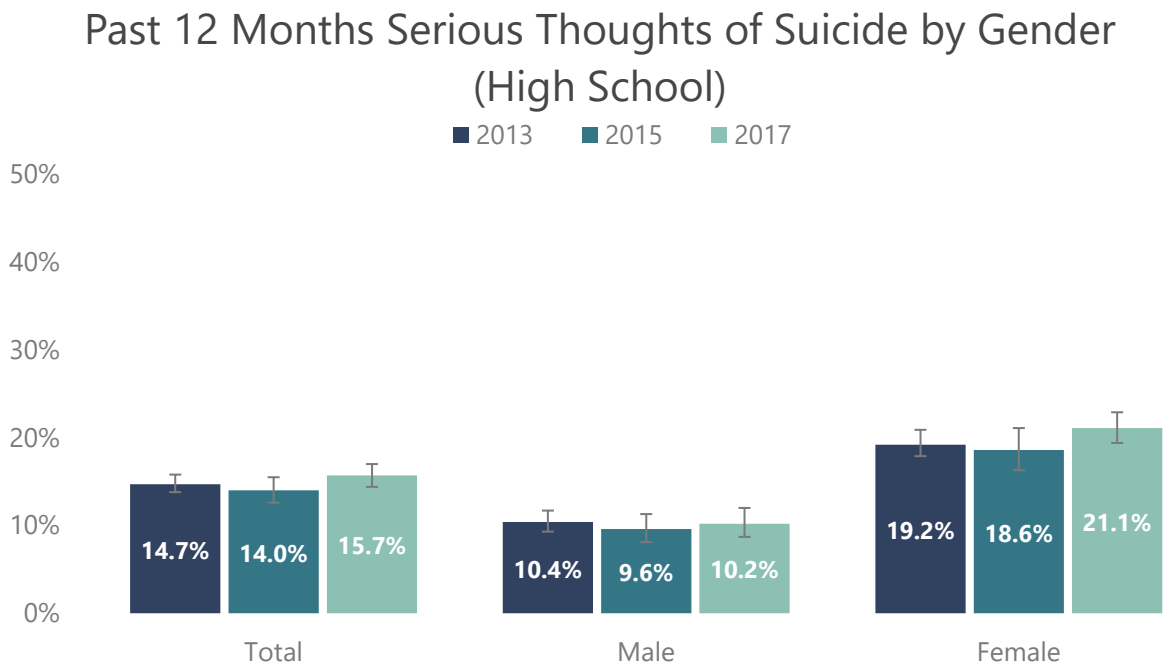


Figure 26a: Overall and gender differences in the prevalence of past year serious thoughts of suicide among Virginia high school students from 2013-2017(source: YRBSS). Female students had a significantly higher prevalence compared to males.

Figure 26b shows no significant difference in the prevalence of serious thoughts of suicide by race/ethnicity among high school students. All sub-populations experienced a nonsignificant increase in prevalence between 2015 and 2017.

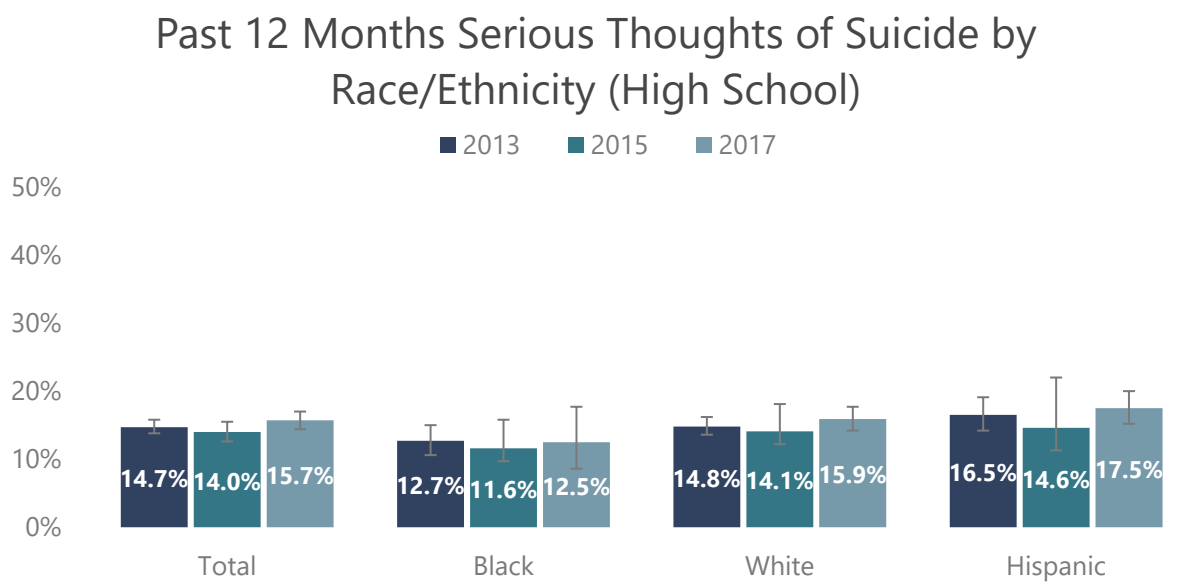


Figure 26b: Overall and race/ethnicity differences in the prevalence of past year serious thoughts of suicide among Virginia high school students from 2013-2017 (source: YRBSS). There were no significant differences between groups or over time.

The NSDUH also asks about having had serious thoughts of suicide in the past year. Overall, an estimated 268,000 individuals aged 18 or older had serious thoughts of suicide in the past year. Figure 27a shows a significant upward trend of Virginia young adults aged 18-25 years who had serious thoughts of suicide in the past year between 2009-10 and 2016-17. Virginia's prevalence mirrored the national trend.

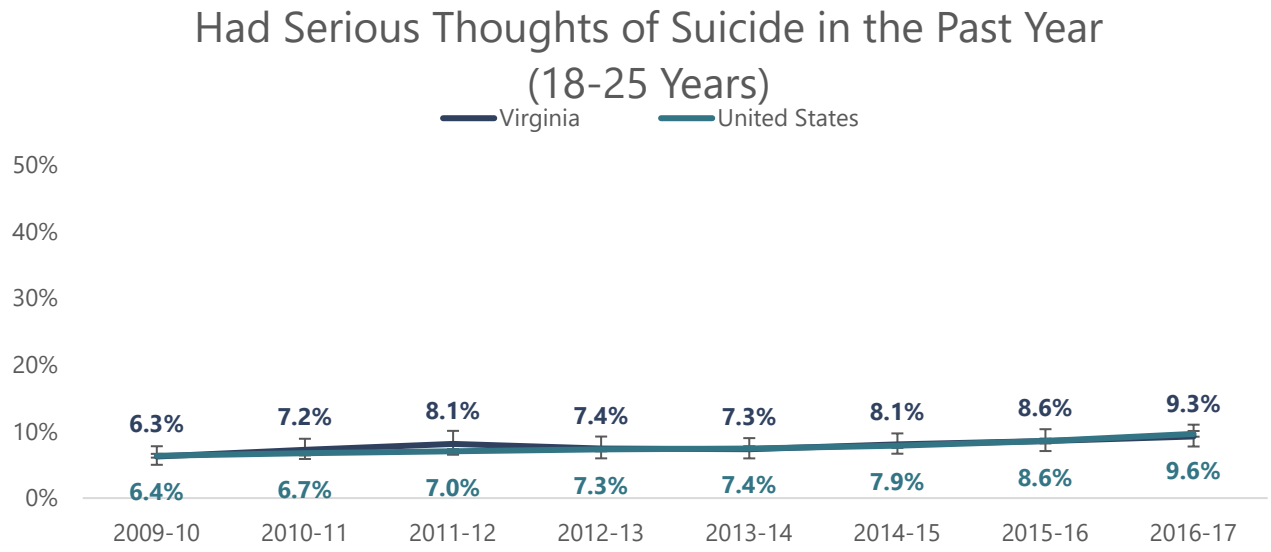


Figure 27a: Prevalence trend of serious thoughts of suicide among Virginia adults aged 18-25 years from 2013-2017 (source: NSDUH). Both Virginia and the US showed a significant increase from 2009-10 to 2016-17.

The prevalence of suicidal thoughts among Virginia adults aged 26+ years generally remained stable between 2009-10 and 2016-17, similar to the national trend (Figure 27b). There were no significant changes during this time period.

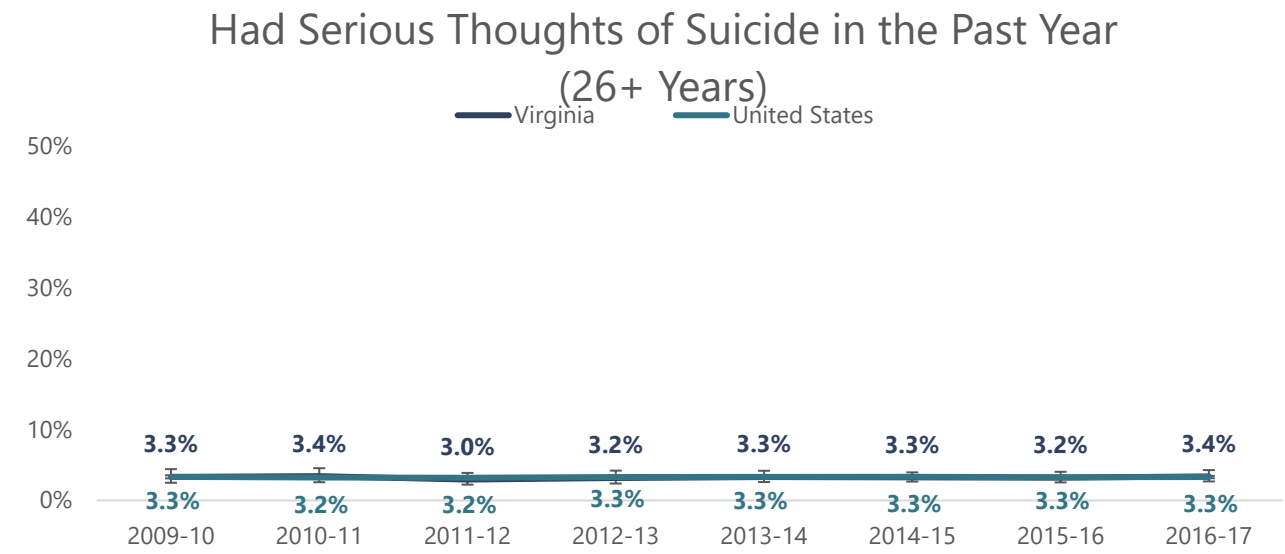


Figure 27b: Prevalence trend of serious thoughts of suicide among Virginia adults aged 26+ years from 2013-2017 (source: NSDUH). Neither Virginia nor the US showed significant change over time.

Ever Attempted Suicide

Source: Youth Risk Behavior Surveillance System (YRBSS)

Figure 28a shows the prevalence of suicide attempts among Virginia's middle school students. There was a nonsignificant upward trend in the prevalence of suicide attempts between 2013 and 2017, and the prevalence was significantly higher for females compared to males in all years.

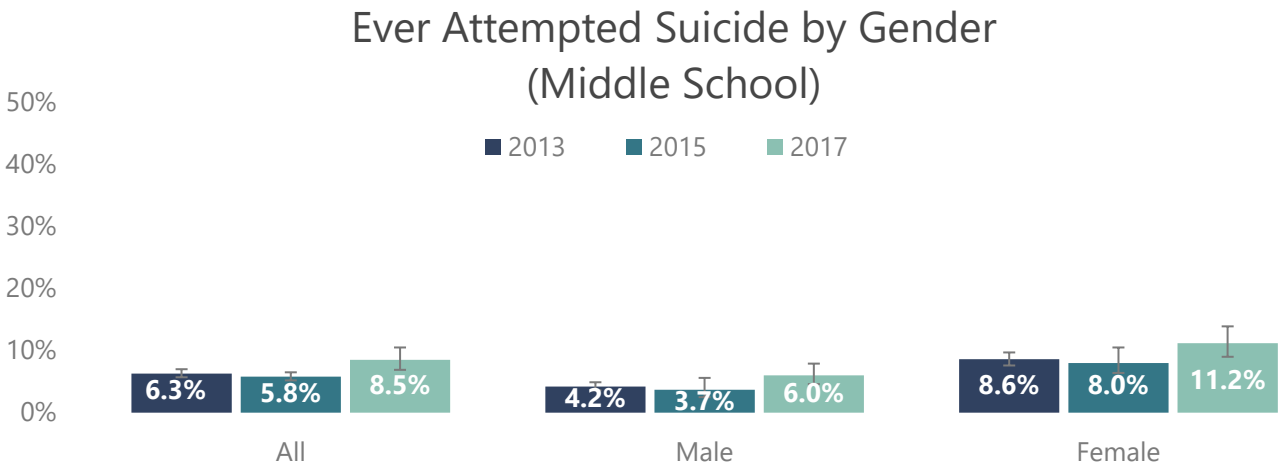


Figure 28a: Overall and gender differences in the prevalence of suicide attempts among Virginia middle school students from 2013-2017 (source: YRBSS). Females were significantly more likely to report attempting suicide compared to males.

Figure 28b shows racial/ethnic differences in the prevalence of Virginia's middle school students who ever attempted suicide between 2013 and 2017. All racial/ethnic groups showed a nonsignificant increase in the prevalence of suicide attempts between 2015 and 2017. There were no significant differences between racial/ethnic groups in any year.

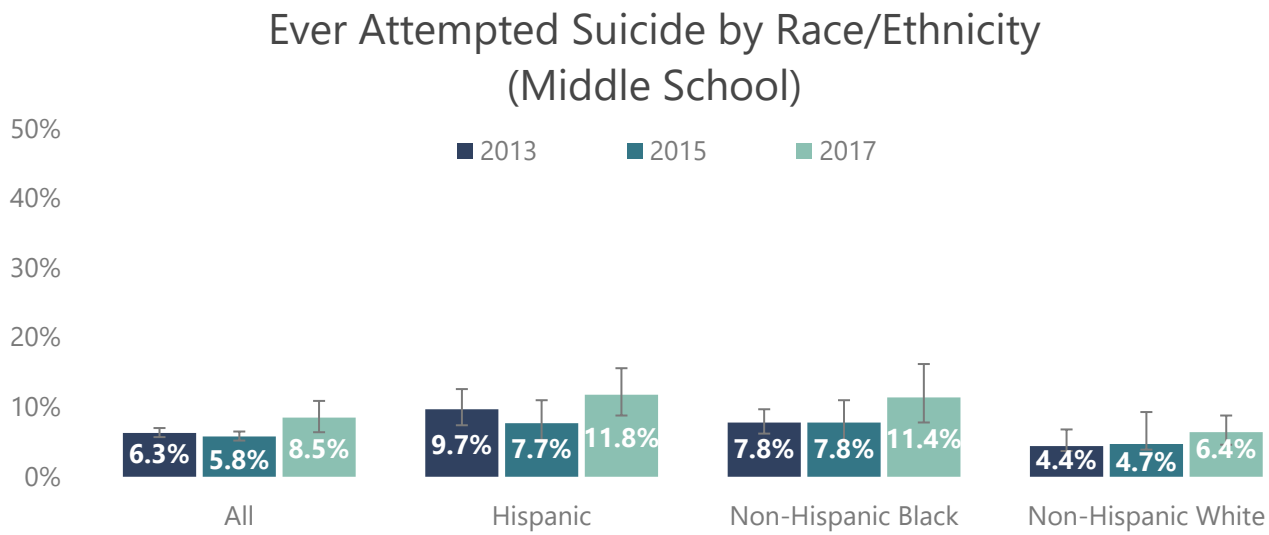


Figure 28b: Overall and race/ethnicity differences in the prevalence of ever attempted suicide among Virginia middle school students from 2013-2017 (source: YRBSS). There were no significant differences between groups or over time.

The prevalence of attempting suicide in the past year among Virginia high school students showed a different trend compared to other suicide indicators, with a statistically significant decrease over time (2013-2017) overall and for male students (Figure 29a). While there were no significant gender differences in 2013, female students were more likely to report attempting suicide in the past year compared to male students in 2015 and 2017.

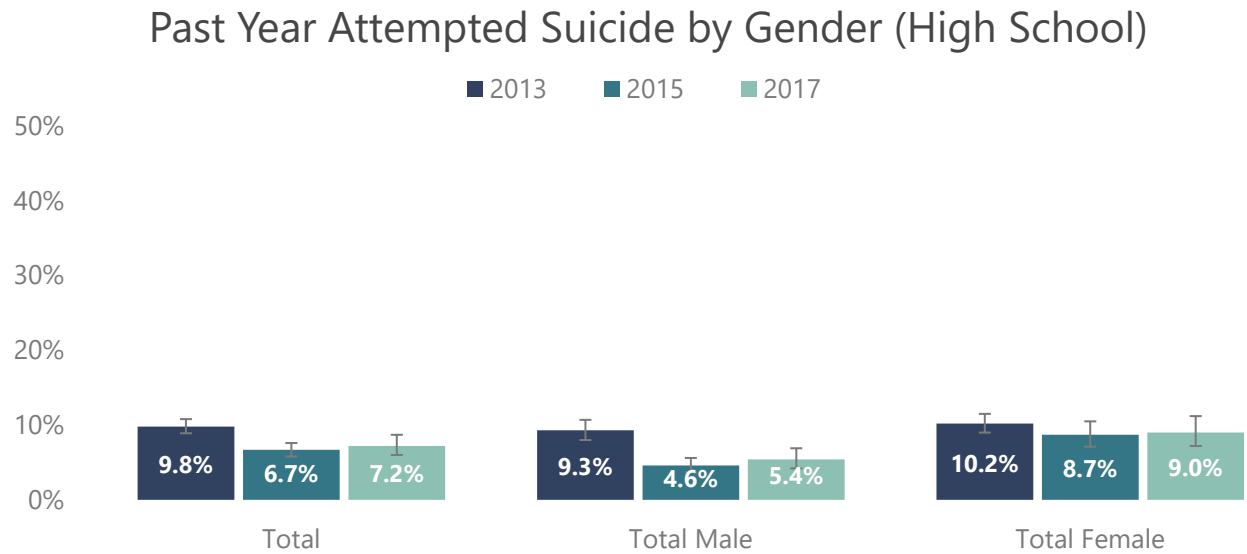


Figure 29a: Overall and gender differences in the prevalence of past year suicide attempts among Virginia high school students from 2013-2017 (source: YRBSS). There was a significant decrease from 2013-2017 overall and for males. Female students had a significantly higher prevalence compared to males in 2015 and 2017.

Figure 29b shows that high school students experienced a downward trend in past year attempted suicide from 2013 to 2017, and Hispanic high school students had a significant decrease from 2013 to 2017. There were no significant differences by race/ethnicity in 2017.

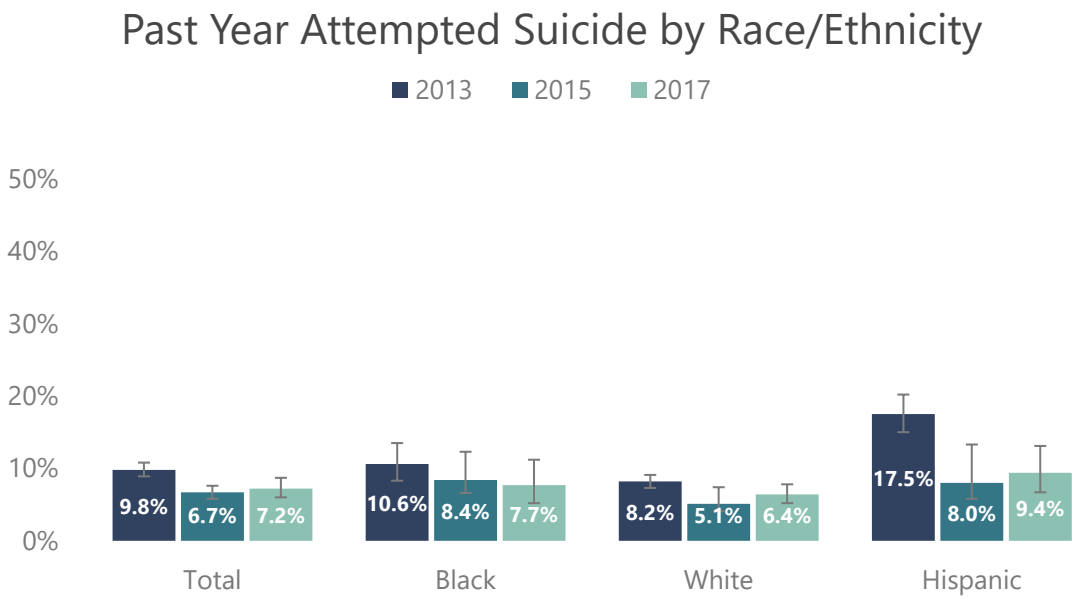


Figure 29b: Overall and race/ethnicity differences in the prevalence of past year attempted suicide among Virginia high school students from 2013-2017 (source: YRBSS). Hispanic students showed a significant decrease from 2013 to 2017.

Utilization of Mental Health Services[34]

Source: National Survey on Drug Use and Health (NSDUH)

An estimated 987,000 individuals aged 18+ (15.5%) received mental health services in the past year in 2016-17. The prevalence was similar for young adults aged 18-25 (14.3%, 125,000) and for adults aged 26+ (15.7%, 862,000). Figure 30a shows the utilization trend of mental health services among Virginia young adults aged 18-25 years. The prevalence of mental health services utilization has been increasing over time in both Virginia and US. The change from 2010-11 to 2016-17 was significant for the US population, but nonsignificant for Virginia young adults.

[34] Data for utilization of mental health services is not available for youth under 18 years.

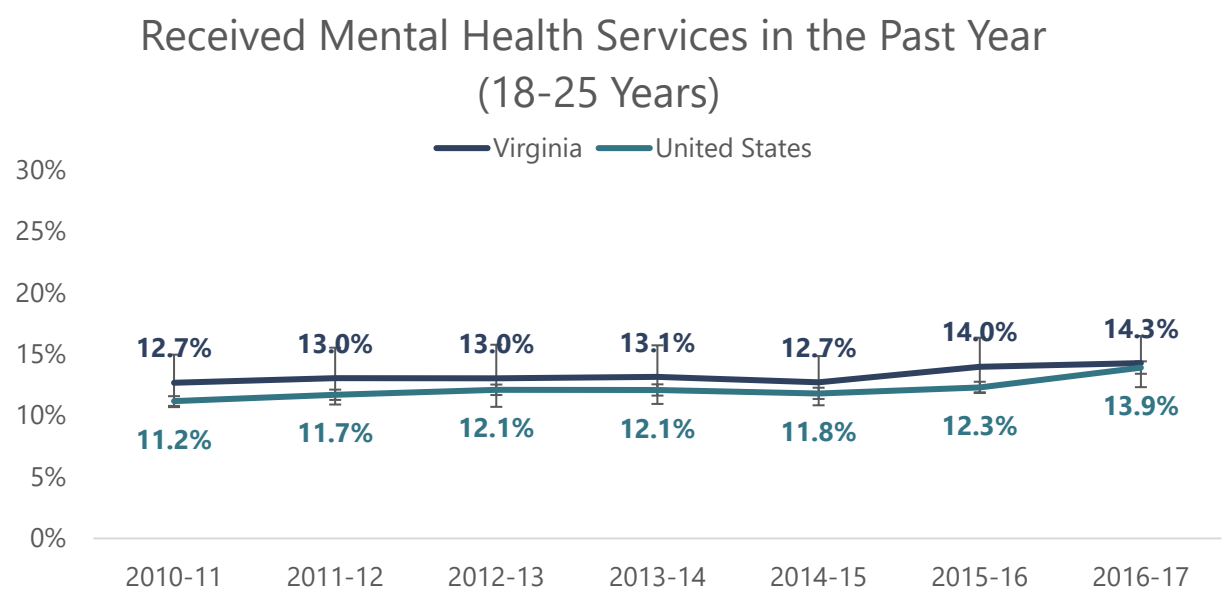


Figure 30a: Utilization of mental health services among Virginia adults aged 18-25 years compared to the US from 2010-11 to 2016-17 (source: NSDUH). The US showed a significant increase from 2010-11 to 2016-17, while the increase for Virginia was nonsignificant.

For adults aged 26+ years, mental health service utilization in Virginia and nationally has shown no significant change over time (Fig 30b). In 2016-17, there was no significant difference between utilization for young adults aged 18-25 and adults aged 26+.

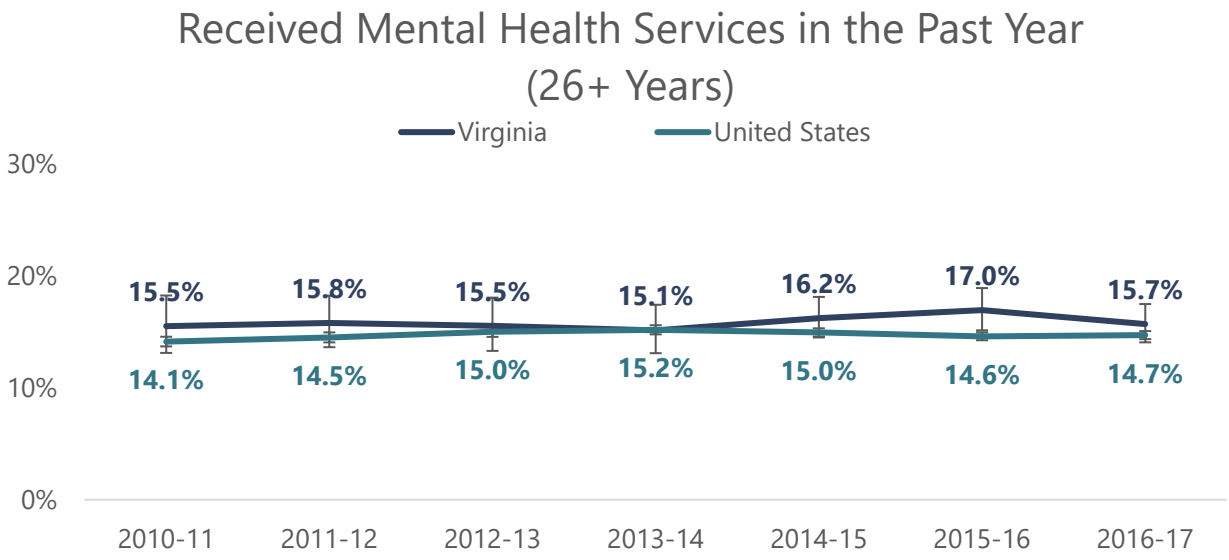


Figure 30b: Utilization of mental health services among Virginia adults aged 26+ years compared to the US from 2009-10 to 2016-17 (source: NSDUH). Neither Virginia nor the US showed significant change over time.

Key Findings on Mental Health

Data on mental health indicators from multiple national surveillance surveys: the NSCH which reflects children aged 0-17; the YRBS which reflects middle and high school aged students; the BRFSS which reflects adults aged 18 and over; and the NSDUH, which includes data for populations aged 12 and older. Key findings related to mental health In Virginia:

- Overall, **63% of Virginia children aged 6m-5years (approximately 356,000 children) demonstrated all positive indicators of flourishing** (mental wellness and functioning) compared to 39% of children aged 6-17 years.
- **Several mental health indicators showed an upward trend over time, particularly for youth and young adults.** Significant trends included increases in:
    - Major depressive episode for youth (12-17) and young adults (18-25) between 2009-10 to 2016-17;
    - Serious thoughts of suicide for middle school youth in their lifetime (2013-2017), and for young adults aged 18-25 In the past year (2009-10 to 2016-17);
    - Any mental Illness for young adults (18-25) between 2009-10 to 2016-17.
- Middle school students also showed a nonsignificant upward trend in ever attempting suicide between 2013 and 2017. In contrast, **high school students showed an overall decrease in past year suicide attempts** between 2013 and 2017.
- **Female middle and high school students were more likely than male students to report feeling sad for a period of two weeks or more, seriously thinking about suicide, or attempting suicide.**
- An estimated **987,000 individuals aged 18+ (15.5%) received mental health services** in the past year (2016-17).

Regional Estimates

CENTRAL: MIDDLE SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
6th grade	100.0%	2017	16,628
7th grade	100.0%	2017	16,273
8th grade	100.0%	2017	16,290
Has at least one adult they can talk to about their problems*			
6th grade	83.9%	2017	13,951
7th grade	84.3%	2017	13,718
8th grade	78.5%	2017	12,788
Ever thought about suicide*			
6th grade	17.5%	2017	2,910
7th grade	20.8%	2017	3,385
8th grade	26.2%	2017	4,268
Ever attempted suicide*			
6th grade	7.9%	2017	1,314
7th grade	6.4%	2017	1,041
8th grade	11.3%	2017	1,841
Ever used marijuana*			
6th grade	2.4%	2017	399
7th grade	5.4%	2017	879
8th grade	12.7%	2017	2,069
Ever used heroin*			
6th grade	1.3%	2017	216
7th grade	0.7%	2017	114
8th grade	2.2%	2017	358
Ever misused prescription pain medication*			
6th grade	3.7%	2017	615
7th grade	3.1%	2017	504
8th grade	7.4%	2017	1,205

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

CENTRAL: HIGH SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
9th grade	100.0%	2017	17,367
10th grade	100.0%	2017	16,396
11th grade	100.0%	2017	15,686
12th grade	100.0%	2017	15,535
Has at least one adult they can talk to about their problems*			
9th grade	77.4%	2017	13,442
10th grade	78.1%	2017	12,805
11th grade	78.8%	2017	12,361
12th grade	76.0%	2017	11,807
Sad or hopeless every day for two weeks in a row during the past 12 months*			
9th grade	25.7%	2017	4,463
10th grade	29.3%	2017	4,804
11th grade	34.1%	2017	5,349
12th grade	30.0%	2017	4,661
Attempted suicide at least once in the past 12 months*			
9th grade	8.1%	2017	1,407
10th grade	6.2%	2017	1,017
11th grade	7.8%	2017	1,224
12th grade	6.4%	2017	994
Smoked marijuana at least once in the past 30 days*			
9th grade	7.7%	2017	1,337
10th grade	13.9%	2017	2,279
11th grade	21.1%	2017	3,310
12th grade	23.7%	2017	3,682
Used heroin at least once in the past 30 days*			
9th grade	1.5%	2017	261
10th grade	1.8%	2017	295
11th grade	0.9%	2017	141
12th grade	1.1%	2017	171
Misused prescription pain medicine at least once in the past 30 days*			
9th grade	5.0%	2017	868
10th grade	4.3%	2017	705
11th grade	5.5%	2017	863
12th grade	6.8%	2017	1,056
Binge drank at least one day or more during the past 30 days*			
9th grade	5.3%	2017	920
10th grade	8.5%	2017	1,394
11th grade	15.5%	2017	2,431
12th grade	20.5%	2017	3,185

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

EASTERN: MIDDLE SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
6th grade	100.0%	2017	20,801
7th grade	100.0%	2017	20,738
8th grade	100.0%	2017	20,591
Has at least one adult they can talk to about their problems*			
6th grade	83.9%	2017	17,452
7th grade	84.3%	2017	17,482
8th grade	78.5%	2017	16,164
Ever thought about suicide*			
6th grade	17.5%	2017	3,640
7th grade	20.8%	2017	4,314
8th grade	26.2%	2017	5,395
Ever attempted suicide*			
6th grade	7.9%	2017	1,643
7th grade	6.4%	2017	1,327
8th grade	11.3%	2017	2,327
Ever used marijuana*			
6th grade	2.4%	2017	499
7th grade	5.4%	2017	1,120
8th grade	12.7%	2017	2,615
Ever used heroin*			
6th grade	1.3%	2017	270
7th grade	0.7%	2017	145
8th grade	2.2%	2017	453
Ever misused prescription pain medication*			
6th grade	3.7%	2017	770
7th grade	3.1%	2017	643
8th grade	7.4%	2017	1,524

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

EASTERN: HIGH SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
9th grade	100.0%	2017	23,102
10th grade	100.0%	2017	21,026
11th grade	100.0%	2017	18,898
12th grade	100.0%	2017	18,768
Has at least one adult they can talk to about their problems*			
9th grade	77.4%	2017	17,881
10th grade	78.1%	2017	16,421
11th grade	78.8%	2017	14,892
12th grade	76.0%	2017	14,264
Sad or hopeless every day for two weeks in a row during the past 12 months*			
9th grade	25.7%	2017	5,937
10th grade	29.3%	2017	6,161
11th grade	34.1%	2017	6,444
12th grade	30.0%	2017	5,630
Attempted suicide at least once in the past 12 months*			
9th grade	8.1%	2017	1,871
10th grade	6.2%	2017	1,304
11th grade	7.8%	2017	1,474
12th grade	6.4%	2017	1,201
Smoked marijuana at least once in the past 30 days*			
9th grade	7.7%	2017	1,779
10th grade	13.9%	2017	2,923
11th grade	21.1%	2017	3,987
12th grade	23.7%	2017	4,448
Used heroin at least once in the past 30 days*			
9th grade	1.5%	2017	347
10th grade	1.8%	2017	378
11th grade	0.9%	2017	170
12th grade	1.1%	2017	206
Misused prescription pain medicine at least once in the past 30 days*			
9th grade	5.0%	2017	1,155
10th grade	4.3%	2017	904
11th grade	5.5%	2017	1,039
12th grade	6.8%	2017	1,276
Binge drank at least one day or more during the past 30 days*			
9th grade	5.3%	2017	1,224
10th grade	8.5%	2017	1,787
11th grade	15.5%	2017	2,929
12th grade	20.5%	2017	3,847

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

NORTHERN: MIDDLE SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
6th grade	100.0%	2017	31,803
7th grade	100.0%	2017	31,233
8th grade	100.0%	2017	31,247
Has at least one adult they can talk to about their problems*			
6th grade	83.9%	2017	26,683
7th grade	84.3%	2017	26,329
8th grade	78.5%	2017	24,529
Ever thought about suicide*			
6th grade	17.5%	2017	5,566
7th grade	20.8%	2017	6,496
8th grade	26.2%	2017	8,187
Ever attempted suicide*			
6th grade	7.9%	2017	2,512
7th grade	6.4%	2017	1,999
8th grade	11.3%	2017	3,531
Ever used marijuana*			
6th grade	2.4%	2017	763
7th grade	5.4%	2017	1,687
8th grade	12.7%	2017	3,968
Ever used heroin*			
6th grade	1.3%	2017	413
7th grade	0.7%	2017	219
8th grade	2.2%	2017	687
Ever misused prescription pain medication*			
6th grade	3.7%	2017	1,177
7th grade	3.1%	2017	968
8th grade	7.4%	2017	2,312

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

NORTHERN: HIGH SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
9th grade	100.0%	2017	32,616
10th grade	100.0%	2017	32,390
11th grade	100.0%	2017	31,708
12th grade	100.0%	2017	30,095
Has at least one adult they can talk to about their problems*			
9th grade	77.4%	2017	25,245
10th grade	78.1%	2017	25,297
11th grade	78.8%	2017	24,986
12th grade	76.0%	2017	22,872
Sad or hopeless every day for two weeks in a row during the past 12 months*			
9th grade	25.7%	2017	8,382
10th grade	29.3%	2017	9,490
11th grade	34.1%	2017	10,812
12th grade	30.0%	2017	9,029
Attempted suicide at least once in the past 12 months*			
9th grade	8.1%	2017	2,642
10th grade	6.2%	2017	2,008
11th grade	7.8%	2017	2,473
12th grade	6.4%	2017	1,926
Smoked marijuana at least once in the past 30 days*			
9th grade	7.7%	2017	2,511
10th grade	13.9%	2017	4,502
11th grade	21.1%	2017	6,690
12th grade	23.7%	2017	7,133
Used heroin at least once in the past 30 days*			
9th grade	1.5%	2017	489
10th grade	1.8%	2017	583
11th grade	0.9%	2017	285
12th grade	1.1%	2017	331
Misused prescription pain medicine at least once in the past 30 days*			
9th grade	5.0%	2017	1,631
10th grade	4.3%	2017	1,393
11th grade	5.5%	2017	1,744
12th grade	6.8%	2017	2,046
Binge drank at least one day or more during the past 30 days*			
9th grade	5.3%	2017	1,729
10th grade	8.5%	2017	2,753
11th grade	15.5%	2017	4,915
12th grade	20.5%	2017	6,169

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

NORTHWESTERN: MIDDLE SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
6th grade	100.0%	2017	14,948
7th grade	100.0%	2017	14,880
8th grade	100.0%	2017	15,327
Has at least one adult they can talk to about their problems*			
6th grade	83.9%	2017	12,541
7th grade	84.3%	2017	12,544
8th grade	78.5%	2017	12,032
Ever thought about suicide*			
6th grade	17.5%	2017	2,616
7th grade	20.8%	2017	3,095
8th grade	26.2%	2017	4,016
Ever attempted suicide*			
6th grade	7.9%	2017	1,181
7th grade	6.4%	2017	952
8th grade	11.3%	2017	1,732
Ever used marijuana*			
6th grade	2.4%	2017	359
7th grade	5.4%	2017	804
8th grade	12.7%	2017	1,947
Ever used heroin*			
6th grade	1.3%	2017	194
7th grade	0.7%	2017	104
8th grade	2.2%	2017	337
Ever misused prescription pain medication*			
6th grade	3.7%	2017	553
7th grade	3.1%	2017	461
8th grade	7.4%	2017	1,134

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

NORTHWESTERN: HIGH SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
9th grade	100.0%	2017	16,064
10th grade	100.0%	2017	15,449
11th grade	100.0%	2017	14,925
12th grade	100.0%	2017	15,229
Has at least one adult they can talk to about their problems*			
9th grade	77.4%	2017	12,434
10th grade	78.1%	2017	12,066
11th grade	78.8%	2017	11,761
12th grade	76.0%	2017	11,574
Sad or hopeless every day for two weeks in a row during the past 12 months*			
9th grade	25.7%	2017	4,128
10th grade	29.3%	2017	4,527
11th grade	34.1%	2017	5,089
12th grade	30.0%	2017	4,569
Attempted suicide at least once in the past 12 months*			
9th grade	8.1%	2017	1,301
10th grade	6.2%	2017	958
11th grade	7.8%	2017	1,164
12th grade	6.4%	2017	975
Smoked marijuana at least once in the past 30 days*			
9th grade	7.7%	2017	1,237
10th grade	13.9%	2017	2,147
11th grade	21.1%	2017	3,149
12th grade	23.7%	2017	3,609
Used heroin at least once in the past 30 days*			
9th grade	1.5%	2017	241
10th grade	1.8%	2017	278
11th grade	0.9%	2017	134
12th grade	1.1%	2017	168
Misused prescription pain medicine at least once in the past 30 days*			
9th grade	5.0%	2017	803
10th grade	4.3%	2017	664
11th grade	5.5%	2017	821
12th grade	6.8%	2017	1,036
Binge drank at least one day or more during the past 30 days*			
9th grade	5.3%	2017	851
10th grade	8.5%	2017	1,313
11th grade	15.5%	2017	2,313
12th grade	20.5%	2017	3,122

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

SOUTHWEST: MIDDLE SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
6th grade	100.0%	2017	13,437
7th grade	100.0%	2017	13,509
8th grade	100.0%	2017	13,426
Has at least one adult they can talk to about their problems*			
6th grade	83.9%	2017	11,274
7th grade	84.3%	2017	11,388
8th grade	78.5%	2017	10,539
Ever thought about suicide*			
6th grade	17.5%	2017	2,351
7th grade	20.8%	2017	2,810
8th grade	26.2%	2017	3,518
Ever attempted suicide*			
6th grade	7.9%	2017	1,062
7th grade	6.4%	2017	865
8th grade	11.3%	2017	1,517
Ever used marijuana*			
6th grade	2.4%	2017	322
7th grade	5.4%	2017	729
8th grade	12.7%	2017	1,705
Ever used heroin*			
6th grade	1.3%	2017	175
7th grade	0.7%	2017	95
8th grade	2.2%	2017	295
Ever misused prescription pain medication*			
6th grade	3.7%	2017	497
7th grade	3.1%	2017	419
8th grade	7.4%	2017	994

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

SOUTHWEST: HIGH SCHOOL ESTIMATES

Health Behavior	Prevalence	Year	Estimated Number of Students
Region enrollment			
9th grade	100.0%	2017	14,387
10th grade	100.0%	2017	13,876
11th grade	100.0%	2017	13,324
12th grade	100.0%	2017	13,176
Has at least one adult they can talk to about their problems*			
9th grade	77.4%	2017	11,136
10th grade	78.1%	2017	10,837
11th grade	78.8%	2017	10,499
12th grade	76.0%	2017	10,014
Sad or hopeless every day for two weeks in a row during the past 12 months*			
9th grade	25.7%	2017	3,697
10th grade	29.3%	2017	4,066
11th grade	34.1%	2017	4,543
12th grade	30.0%	2017	3,953
Attempted suicide at least once in the past 12 months*			
9th grade	8.1%	2017	1,165
10th grade	6.2%	2017	860
11th grade	7.8%	2017	1,039
12th grade	6.4%	2017	843
Smoked marijuana at least once in the past 30 days*			
9th grade	7.7%	2017	1,108
10th grade	13.9%	2017	1,929
11th grade	21.1%	2017	2,811
12th grade	23.7%	2017	3,123
Used heroin at least once in the past 30 days*			
9th grade	1.5%	2017	216
10th grade	1.8%	2017	250
11th grade	0.9%	2017	120
12th grade	1.1%	2017	145
Misused prescription pain medicine at least once in the past 30 days*			
9th grade	5.0%	2017	719
10th grade	4.3%	2017	597
11th grade	5.5%	2017	733
12th grade	6.8%	2017	896
Binge drank at least one day or more during the past 30 days*			
9th grade	5.3%	2017	763
10th grade	8.5%	2017	1,179
11th grade	15.5%	2017	2,065
12th grade	20.5%	2017	2,701

* indicates that state prevalence estimates were used to generate the number of students by health behavior.

Community Estimates

ALEXANDRIA COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	6,966
ages 18 to 25	100.0%	2017	12,029
ages 26 and older	100.0%	2017	119,140
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	146
ages 18 to 25	10.3%	2014-16	1,241
ages 26 and older	5.1%	2014-16	6,018
Any Mental Illness in the past year			
ages 18 to 25	22.8%	2014-16	2,743
ages 26 and older	18.9%	2014-16	22,533
Had serious thoughts of suicide			
ages 18 to 25	8.3%	2014-16	1,002
ages 26 and older	3.0%	2014-16	3,541
Major Depressive Episode in past year			
ages 12 to 17	12.2%	2014-16	853
ages 18 to 25	12.0%	2014-16	1,448
ages 26 and older	7.2%	2014-16	8,530
Serious Mental Illness in the past year			
ages 18 to 25	5.7%	2014-16	682
ages 26 and older	3.7%	2014-16	4,354
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	179
ages 18 to 25	7.4%	2016-17	888
ages 26 and older	2.0%	2016-17	2,400
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	251
ages 18 to 25	15.4%	2016-17	1,855
ages 26 and older	6.1%	2016-17	7,288
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	254
ages 18 to 25	16.1%	2016-17	1,937
ages 26 and older	6.4%	2016-17	7,680

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

ALLEGHANY HIGHLANDS COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	1,507
ages 18 to 25	100.0%	2017	1,753
ages 26 and older	100.0%	2017	14,995
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	32
ages 18 to 25	10.2%	2014-16	179
ages 26 and older	5.1%	2014-16	767
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	414
ages 26 and older	19.6%	2014-16	2,945
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	160
ages 26 and older	3.7%	2014-16	548
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	194
ages 18 to 25	11.6%	2014-16	204
ages 26 and older	6.7%	2014-16	1,008
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	102
ages 26 and older	4.2%	2014-16	628
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	39
ages 18 to 25	7.4%	2016-17	129
ages 26 and older	2.0%	2016-17	302
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	54
ages 18 to 25	15.4%	2016-17	270
ages 26 and older	6.1%	2016-17	917
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	55
ages 18 to 25	16.1%	2016-17	282
ages 26 and older	6.4%	2016-17	967

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

ARLINGTON COUNTY COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	11,742
ages 18 to 25	100.0%	2017	24,712
ages 26 and older	100.0%	2017	168,277
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	246
ages 18 to 25	10.3%	2014-16	2,549
ages 26 and older	5.1%	2014-16	8,501
Any Mental Illness in the past year			
ages 18 to 25	22.8%	2014-16	5,636
ages 26 and older	18.9%	2014-16	31,826
Had serious thoughts of suicide			
ages 18 to 25	8.3%	2014-16	2,059
ages 26 and older	3.0%	2014-16	5,002
Major Depressive Episode in past year			
ages 12 to 17	12.2%	2014-16	1,438
ages 18 to 25	12.0%	2014-16	2,975
ages 26 and older	7.2%	2014-16	12,048
Serious Mental Illness in the past year			
ages 18 to 25	5.7%	2014-16	1,402
ages 26 and older	3.7%	2014-16	6,150
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	302
ages 18 to 25	7.4%	2016-17	1,824
ages 26 and older	2.0%	2016-17	3,390
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	422
ages 18 to 25	15.4%	2016-17	3,811
ages 26 and older	6.1%	2016-17	10,294
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	428
ages 18 to 25	16.1%	2016-17	3,979
ages 26 and older	6.4%	2016-17	10,847

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

BLUE RIDGE BEHAVIORAL HEALTHCARE

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	18,319
ages 18 to 25	100.0%	2017	24,191
ages 26 and older	100.0%	2017	179,718
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	417
ages 18 to 25	11.4%	2014-16	2,765
ages 26 and older	4.8%	2014-16	8,643
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	5,548
ages 26 and older	22.1%	2014-16	39,768
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	2,129
ages 26 and older	3.9%	2014-16	7,064
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	2,481
ages 18 to 25	11.7%	2014-16	2,834
ages 26 and older	8.6%	2014-16	15,470
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	1,512
ages 26 and older	5.8%	2014-16	10,512
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	471
ages 18 to 25	7.4%	2016-17	1,786
ages 26 and older	2.0%	2016-17	3,621
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	659
ages 18 to 25	15.4%	2016-17	3,731
ages 26 and older	6.1%	2016-17	10,994
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	668
ages 18 to 25	16.1%	2016-17	3,895
ages 26 and older	6.4%	2016-17	11,584

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

CHESAPEAKE INTEGRATED BEHAVIORAL HEALTHCARE

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	20,621
ages 18 to 25	100.0%	2017	23,983
ages 26 and older	100.0%	2017	157,960
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	383
ages 18 to 25	12.2%	2014-16	2,937
ages 26 and older	5.9%	2014-16	9,301
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	5,090
ages 26 and older	17.9%	2014-16	28,280
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	2,117
ages 26 and older	3.2%	2014-16	5,042
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	2,533
ages 18 to 25	9.4%	2014-16	2,266
ages 26 and older	6.9%	2014-16	10,960
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	1,161
ages 26 and older	4.1%	2014-16	6,548
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	531
ages 18 to 25	7.4%	2016-17	1,770
ages 26 and older	2.0%	2016-17	3,182
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	742
ages 18 to 25	15.4%	2016-17	3,699
ages 26 and older	6.1%	2016-17	9,663
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	752
ages 18 to 25	16.1%	2016-17	3,861
ages 26 and older	6.4%	2016-17	10,182

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

CHESTERFIELD COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	29,743
ages 18 to 25	100.0%	2017	34,410
ages 26 and older	100.0%	2017	227,294
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	599
ages 18 to 25	11.8%	2014-16	4,055
ages 26 and older	5.2%	2014-16	11,839
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	7,399
ages 26 and older	17.9%	2014-16	40,655
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	2,520
ages 26 and older	3.0%	2014-16	6,895
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	3,402
ages 18 to 25	11.2%	2014-16	3,863
ages 26 and older	6.7%	2014-16	15,312
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	1,699
ages 26 and older	3.9%	2014-16	8,791
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	766
ages 18 to 25	7.4%	2016-17	2,540
ages 26 and older	2.0%	2016-17	4,579
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	1,070
ages 18 to 25	15.4%	2016-17	5,307
ages 26 and older	6.1%	2016-17	13,904
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	1,084
ages 18 to 25	16.1%	2016-17	5,540
ages 26 and older	6.4%	2016-17	14,651

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

COLONIAL BEHAVIORAL HEALTH

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	13,266
ages 18 to 25	100.0%	2017	19,544
ages 26 and older	100.0%	2017	115,149
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	246
ages 18 to 25	12.2%	2014-16	2,393
ages 26 and older	5.9%	2014-16	6,780
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	4,148
ages 26 and older	17.9%	2014-16	20,615
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	1,725
ages 26 and older	3.2%	2014-16	3,675
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	1,630
ages 18 to 25	9.4%	2014-16	1,847
ages 26 and older	6.9%	2014-16	7,989
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	946
ages 26 and older	4.1%	2014-16	4,773
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	341
ages 18 to 25	7.4%	2016-17	1,443
ages 26 and older	2.0%	2016-17	2,320
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	477
ages 18 to 25	15.4%	2016-17	3,014
ages 26 and older	6.1%	2016-17	7,044
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	484
ages 18 to 25	16.1%	2016-17	3,147
ages 26 and older	6.4%	2016-17	7,422

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

CROSSROADS COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	6,725
ages 18 to 25	100.0%	2017	13,065
ages 26 and older	100.0%	2017	69,937
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	135
ages 18 to 25	11.8%	2014-16	1,540
ages 26 and older	5.2%	2014-16	3,643
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	2,809
ages 26 and older	17.9%	2014-16	12,509
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	957
ages 26 and older	3.0%	2014-16	2,121
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	769
ages 18 to 25	11.2%	2014-16	1,467
ages 26 and older	6.7%	2014-16	4,711
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	645
ages 26 and older	3.9%	2014-16	2,705
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	173
ages 18 to 25	7.4%	2016-17	964
ages 26 and older	2.0%	2016-17	1,409
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	242
ages 18 to 25	15.4%	2016-17	2,015
ages 26 and older	6.1%	2016-17	4,278
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	245
ages 18 to 25	16.1%	2016-17	2,104
ages 26 and older	6.4%	2016-17	4,508

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

CUMBERLAND MOUNTAIN COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	6,108
ages 18 to 25	100.0%	2017	7,217
ages 26 and older	100.0%	2017	65,557
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	139
ages 18 to 25	11.4%	2014-16	825
ages 26 and older	4.8%	2014-16	3,153
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	1,655
ages 26 and older	22.1%	2014-16	14,507
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	635
ages 26 and older	3.9%	2014-16	2,577
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	827
ages 18 to 25	11.7%	2014-16	845
ages 26 and older	8.6%	2014-16	5,643
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	451
ages 26 and older	5.8%	2014-16	3,834
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	157
ages 18 to 25	7.4%	2016-17	533
ages 26 and older	2.0%	2016-17	1,321
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	220
ages 18 to 25	15.4%	2016-17	1,113
ages 26 and older	6.1%	2016-17	4,010
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	223
ages 18 to 25	16.1%	2016-17	1,162
ages 26 and older	6.4%	2016-17	4,226

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

DANVILLE-PITTSYLVANIA COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	7,532
ages 18 to 25	100.0%	2017	9,047
ages 26 and older	100.0%	2017	72,470
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	172
ages 18 to 25	11.4%	2014-16	1,034
ages 26 and older	4.8%	2014-16	3,485
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	2,075
ages 26 and older	22.1%	2014-16	16,036
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	796
ages 26 and older	3.9%	2014-16	2,849
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	1,020
ages 18 to 25	11.7%	2014-16	1,060
ages 26 and older	8.6%	2014-16	6,238
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	565
ages 26 and older	5.8%	2014-16	4,239
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	194
ages 18 to 25	7.4%	2016-17	668
ages 26 and older	2.0%	2016-17	1,460
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	271
ages 18 to 25	15.4%	2016-17	1,395
ages 26 and older	6.1%	2016-17	4,433
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	275
ages 18 to 25	16.1%	2016-17	1,457
ages 26 and older	6.4%	2016-17	4,671

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

DICKENSON COUNTY BEHAVIORAL HEALTH SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	1,022
ages 18 to 25	100.0%	2017	1,131
ages 26 and older	100.0%	2017	10,694
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	23
ages 18 to 25	11.4%	2014-16	129
ages 26 and older	4.8%	2014-16	514
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	259
ages 26 and older	22.1%	2014-16	2,366
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	100
ages 26 and older	3.9%	2014-16	420
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	138
ages 18 to 25	11.7%	2014-16	132
ages 26 and older	8.6%	2014-16	921
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	71
ages 26 and older	5.8%	2014-16	625
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	26
ages 18 to 25	7.4%	2016-17	83
ages 26 and older	2.0%	2016-17	215
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	37
ages 18 to 25	15.4%	2016-17	174
ages 26 and older	6.1%	2016-17	654
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	37
ages 18 to 25	16.1%	2016-17	182
ages 26 and older	6.4%	2016-17	689

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

DISTRICT 19 COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	12,209
ages 18 to 25	100.0%	2017	17,641
ages 26 and older	100.0%	2017	118,468
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	246
ages 18 to 25	11.8%	2014-16	2,079
ages 26 and older	5.2%	2014-16	6,170
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	3,793
ages 26 and older	17.9%	2014-16	21,190
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	1,292
ages 26 and older	3.0%	2014-16	3,594
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	1,396
ages 18 to 25	11.2%	2014-16	1,980
ages 26 and older	6.7%	2014-16	7,981
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	871
ages 26 and older	3.9%	2014-16	4,582
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	314
ages 18 to 25	7.4%	2016-17	1,302
ages 26 and older	2.0%	2016-17	2,387
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	439
ages 18 to 25	15.4%	2016-17	2,721
ages 26 and older	6.1%	2016-17	7,247
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	445
ages 18 to 25	16.1%	2016-17	2,840
ages 26 and older	6.4%	2016-17	7,636

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

EASTERN SHORE COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	2,998
ages 18 to 25	100.0%	2017	3,318
ages 26 and older	100.0%	2017	31,977
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	56
ages 18 to 25	12.2%	2014-16	406
ages 26 and older	5.9%	2014-16	1,883
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	704
ages 26 and older	17.9%	2014-16	5,725
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	293
ages 26 and older	3.2%	2014-16	1,021
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	368
ages 18 to 25	9.4%	2014-16	314
ages 26 and older	6.9%	2014-16	2,219
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	161
ages 26 and older	4.1%	2014-16	1,326
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	77
ages 18 to 25	7.4%	2016-17	245
ages 26 and older	2.0%	2016-17	644
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	108
ages 18 to 25	15.4%	2016-17	512
ages 26 and older	6.1%	2016-17	1,956
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	109
ages 18 to 25	16.1%	2016-17	534
ages 26 and older	6.4%	2016-17	2,061

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

FAIRFAX- FALLS CHURCH COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	94,144
ages 18 to 25	100.0%	2017	114,028
ages 26 and older	100.0%	2017	794,640
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	1,970
ages 18 to 25	10.3%	2014-16	11,764
ages 26 and older	5.1%	2014-16	40,142
Any Mental Illness in the past year			
ages 18 to 25	22.8%	2014-16	26,007
ages 26 and older	18.9%	2014-16	150,290
Had serious thoughts of suicide			
ages 18 to 25	8.3%	2014-16	9,499
ages 26 and older	3.0%	2014-16	23,620
Major Depressive Episode in past year			
ages 12 to 17	12.2%	2014-16	11,528
ages 18 to 25	12.0%	2014-16	13,726
ages 26 and older	7.2%	2014-16	56,891
Serious Mental Illness in the past year			
ages 18 to 25	5.7%	2014-16	6,468
ages 26 and older	3.7%	2014-16	29,040
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	2,423
ages 18 to 25	7.4%	2016-17	8,417
ages 26 and older	2.0%	2016-17	16,009
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	3,386
ages 18 to 25	15.4%	2016-17	17,586
ages 26 and older	6.1%	2016-17	48,611
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	3,432
ages 18 to 25	16.1%	2016-17	18,360
ages 26 and older	6.4%	2016-17	51,221

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

GOOCHLAND-POWHATAN COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	3,630
ages 18 to 25	100.0%	2017	4,279
ages 26 and older	100.0%	2017	37,672
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	73
ages 18 to 25	11.8%	2014-16	504
ages 26 and older	5.2%	2014-16	1,962
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	920
ages 26 and older	17.9%	2014-16	6,738
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	313
ages 26 and older	3.0%	2014-16	1,143
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	415
ages 18 to 25	11.2%	2014-16	480
ages 26 and older	6.7%	2014-16	2,538
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	211
ages 26 and older	3.9%	2014-16	1,457
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	93
ages 18 to 25	7.4%	2016-17	316
ages 26 and older	2.0%	2016-17	759
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	131
ages 18 to 25	15.4%	2016-17	660
ages 26 and older	6.1%	2016-17	2,305
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	132
ages 18 to 25	16.1%	2016-17	689
ages 26 and older	6.4%	2016-17	2,428

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

HAMPTON-NEWPORT NEWS COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	21,761
ages 18 to 25	100.0%	2017	43,096
ages 26 and older	100.0%	2017	200,992
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	404
ages 18 to 25	12.2%	2014-16	5,277
ages 26 and older	5.9%	2014-16	11,834
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	9,147
ages 26 and older	17.9%	2014-16	35,984
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	3,804
ages 26 and older	3.2%	2014-16	6,415
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	2,673
ages 18 to 25	9.4%	2014-16	4,072
ages 26 and older	6.9%	2014-16	13,945
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	2,086
ages 26 and older	4.1%	2014-16	8,332
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	560
ages 18 to 25	7.4%	2016-17	3,181
ages 26 and older	2.0%	2016-17	4,049
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	783
ages 18 to 25	15.4%	2016-17	6,646
ages 26 and older	6.1%	2016-17	12,295
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	793
ages 18 to 25	16.1%	2016-17	6,939
ages 26 and older	6.4%	2016-17	12,956

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

HANOVER COUNTY COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	9,064
ages 18 to 25	100.0%	2017	10,337
ages 26 and older	100.0%	2017	72,026
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	183
ages 18 to 25	11.8%	2014-16	1,218
ages 26 and older	5.2%	2014-16	3,751
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	2,223
ages 26 and older	17.9%	2014-16	12,883
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	757
ages 26 and older	3.0%	2014-16	2,185
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	1,037
ages 18 to 25	11.2%	2014-16	1,160
ages 26 and older	6.7%	2014-16	4,852
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	510
ages 26 and older	3.9%	2014-16	2,786
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	233
ages 18 to 25	7.4%	2016-17	763
ages 26 and older	2.0%	2016-17	1,451
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	326
ages 18 to 25	15.4%	2016-17	1,594
ages 26 and older	6.1%	2016-17	4,406
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	330
ages 18 to 25	16.1%	2016-17	1,664
ages 26 and older	6.4%	2016-17	4,643

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

HARRISONBURG-ROCKINGHAM COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	9,023
ages 18 to 25	100.0%	2017	26,385
ages 26 and older	100.0%	2017	81,275
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	189
ages 18 to 25	10.2%	2014-16	2,693
ages 26 and older	5.1%	2014-16	4,160
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	6,225
ages 26 and older	19.6%	2014-16	15,963
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	2,406
ages 26 and older	3.7%	2014-16	2,970
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	1,163
ages 18 to 25	11.6%	2014-16	3,067
ages 26 and older	6.7%	2014-16	5,462
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	1,531
ages 26 and older	4.2%	2014-16	3,406
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	232
ages 18 to 25	7.4%	2016-17	1,948
ages 26 and older	2.0%	2016-17	1,637
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	325
ages 18 to 25	15.4%	2016-17	4,069
ages 26 and older	6.1%	2016-17	4,972
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	329
ages 18 to 25	16.1%	2016-17	4,248
ages 26 and older	6.4%	2016-17	5,239

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

HENRICO AREA MENTAL HEALTH AND DEVELOPMENTAL SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	28,132
ages 18 to 25	100.0%	2017	32,494
ages 26 and older	100.0%	2017	243,603
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	567
ages 18 to 25	11.8%	2014-16	3,829
ages 26 and older	5.2%	2014-16	12,688
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	6,987
ages 26 and older	17.9%	2014-16	43,572
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	2,380
ages 26 and older	3.0%	2014-16	7,389
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	3,218
ages 18 to 25	11.2%	2014-16	3,648
ages 26 and older	6.7%	2014-16	16,410
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	1,604
ages 26 and older	3.9%	2014-16	9,422
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	724
ages 18 to 25	7.4%	2016-17	2,399
ages 26 and older	2.0%	2016-17	4,908
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	1,012
ages 18 to 25	15.4%	2016-17	5,011
ages 26 and older	6.1%	2016-17	14,902
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	1,025
ages 18 to 25	16.1%	2016-17	5,232
ages 26 and older	6.4%	2016-17	15,702

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

HIGHLANDS COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	4,946
ages 18 to 25	100.0%	2017	6,382
ages 26 and older	100.0%	2017	51,242
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	113
ages 18 to 25	11.4%	2014-16	729
ages 26 and older	4.8%	2014-16	2,464
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	1,464
ages 26 and older	22.1%	2014-16	11,339
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	562
ages 26 and older	3.9%	2014-16	2,014
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	670
ages 18 to 25	11.7%	2014-16	748
ages 26 and older	8.6%	2014-16	4,411
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	399
ages 26 and older	5.8%	2014-16	2,997
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	127
ages 18 to 25	7.4%	2016-17	471
ages 26 and older	2.0%	2016-17	1,032
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	178
ages 18 to 25	15.4%	2016-17	984
ages 26 and older	6.1%	2016-17	3,135
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	180
ages 18 to 25	16.1%	2016-17	1,028
ages 26 and older	6.4%	2016-17	3,303

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

HORIZON BEHAVIORAL HEALTH

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	18,115
ages 18 to 25	100.0%	2017	37,923
ages 26 and older	100.0%	2017	171,482
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	379
ages 18 to 25	10.2%	2014-16	3,871
ages 26 and older	5.1%	2014-16	8,777
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	8,947
ages 26 and older	19.6%	2014-16	33,681
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	3,458
ages 26 and older	3.7%	2014-16	6,266
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	2,334
ages 18 to 25	11.6%	2014-16	4,408
ages 26 and older	6.7%	2014-16	11,524
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	2,201
ages 26 and older	4.2%	2014-16	7,187
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	466
ages 18 to 25	7.4%	2016-17	2,799
ages 26 and older	2.0%	2016-17	3,455
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	652
ages 18 to 25	15.4%	2016-17	5,849
ages 26 and older	6.1%	2016-17	10,490
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	660
ages 18 to 25	16.1%	2016-17	6,106
ages 26 and older	6.4%	2016-17	11,053

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

LOUDOUN COUNTY MH, SA AND DEVELOPMENTAL SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	38,640
ages 18 to 25	100.0%	2017	32,662
ages 26 and older	100.0%	2017	252,106
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	809
ages 18 to 25	10.3%	2014-16	3,370
ages 26 and older	5.1%	2014-16	12,735
Any Mental Illness in the past year			
ages 18 to 25	22.8%	2014-16	7,449
ages 26 and older	18.9%	2014-16	47,681
Had serious thoughts of suicide			
ages 18 to 25	8.3%	2014-16	2,721
ages 26 and older	3.0%	2014-16	7,494
Major Depressive Episode in past year			
ages 12 to 17	12.2%	2014-16	4,731
ages 18 to 25	12.0%	2014-16	3,932
ages 26 and older	7.2%	2014-16	18,049
Serious Mental Illness in the past year			
ages 18 to 25	5.7%	2014-16	1,853
ages 26 and older	3.7%	2014-16	9,213
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	995
ages 18 to 25	7.4%	2016-17	2,411
ages 26 and older	2.0%	2016-17	5,079
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	1,390
ages 18 to 25	15.4%	2016-17	5,037
ages 26 and older	6.1%	2016-17	15,422
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	1,408
ages 18 to 25	16.1%	2016-17	5,259
ages 26 and older	6.4%	2016-17	16,250

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

MIDDLE PENINSULA-NORTHERN NECK COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	9,382
ages 18 to 25	100.0%	2017	11,012
ages 26 and older	100.0%	2017	104,008
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	174
ages 18 to 25	12.2%	2014-16	1,348
ages 26 and older	5.9%	2014-16	6,124
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	2,337
ages 26 and older	17.9%	2014-16	18,621
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	972
ages 26 and older	3.2%	2014-16	3,320
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	1,152
ages 18 to 25	9.4%	2014-16	1,041
ages 26 and older	6.9%	2014-16	7,216
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	533
ages 26 and older	4.1%	2014-16	4,312
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	241
ages 18 to 25	7.4%	2016-17	813
ages 26 and older	2.0%	2016-17	2,095
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	337
ages 18 to 25	15.4%	2016-17	1,698
ages 26 and older	6.1%	2016-17	6,363
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	342
ages 18 to 25	16.1%	2016-17	1,773
ages 26 and older	6.4%	2016-17	6,704

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

MOUNT ROGERS COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	8,155
ages 18 to 25	100.0%	2017	9,499
ages 26 and older	100.0%	2017	86,030
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	186
ages 18 to 25	11.4%	2014-16	1,086
ages 26 and older	4.8%	2014-16	4,138
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	2,179
ages 26 and older	22.1%	2014-16	19,037
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	836
ages 26 and older	3.9%	2014-16	3,382
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	1,104
ages 18 to 25	11.7%	2014-16	1,113
ages 26 and older	8.6%	2014-16	7,405
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	594
ages 26 and older	5.8%	2014-16	5,032
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	210
ages 18 to 25	7.4%	2016-17	701
ages 26 and older	2.0%	2016-17	1,733
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	293
ages 18 to 25	15.4%	2016-17	1,465
ages 26 and older	6.1%	2016-17	5,263
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	297
ages 18 to 25	16.1%	2016-17	1,529
ages 26 and older	6.4%	2016-17	5,545

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

NEW RIVER VALLEY COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	10,586
ages 18 to 25	100.0%	2017	40,856
ages 26 and older	100.0%	2017	111,769
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	241
ages 18 to 25	11.4%	2014-16	4,670
ages 26 and older	4.8%	2014-16	5,375
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	9,371
ages 26 and older	22.1%	2014-16	24,732
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	3,596
ages 26 and older	3.9%	2014-16	4,393
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	1,434
ages 18 to 25	11.7%	2014-16	4,786
ages 26 and older	8.6%	2014-16	9,621
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	2,553
ages 26 and older	5.8%	2014-16	6,537
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	272
ages 18 to 25	7.4%	2016-17	3,016
ages 26 and older	2.0%	2016-17	2,252
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	381
ages 18 to 25	15.4%	2016-17	6,301
ages 26 and older	6.1%	2016-17	6,837
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	386
ages 18 to 25	16.1%	2016-17	6,578
ages 26 and older	6.4%	2016-17	7,204

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

NORFOLK COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	13,445
ages 18 to 25	100.0%	2017	49,540
ages 26 and older	100.0%	2017	146,680
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	250
ages 18 to 25	12.2%	2014-16	6,066
ages 26 and older	5.9%	2014-16	8,636
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	10,515
ages 26 and older	17.9%	2014-16	26,260
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	4,373
ages 26 and older	3.2%	2014-16	4,682
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	1,652
ages 18 to 25	9.4%	2014-16	4,681
ages 26 and older	6.9%	2014-16	10,177
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	2,398
ages 26 and older	4.1%	2014-16	6,080
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	346
ages 18 to 25	7.4%	2016-17	3,657
ages 26 and older	2.0%	2016-17	2,955
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	484
ages 18 to 25	15.4%	2016-17	7,640
ages 26 and older	6.1%	2016-17	8,973
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	490
ages 18 to 25	16.1%	2016-17	7,976
ages 26 and older	6.4%	2016-17	9,455

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

NORTHWESTERN COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	18,225
ages 18 to 25	100.0%	2017	21,686
ages 26 and older	100.0%	2017	161,706
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	382
ages 18 to 25	10.2%	2014-16	2,214
ages 26 and older	5.1%	2014-16	8,276
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	5,116
ages 26 and older	19.6%	2014-16	31,761
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	1,978
ages 26 and older	3.7%	2014-16	5,909
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	2,348
ages 18 to 25	11.6%	2014-16	2,521
ages 26 and older	6.7%	2014-16	10,867
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	1,258
ages 26 and older	4.2%	2014-16	6,777
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	469
ages 18 to 25	7.4%	2016-17	1,601
ages 26 and older	2.0%	2016-17	3,258
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	656
ages 18 to 25	15.4%	2016-17	3,344
ages 26 and older	6.1%	2016-17	9,892
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	664
ages 18 to 25	16.1%	2016-17	3,492
ages 26 and older	6.4%	2016-17	10,423

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

PIEDMONT COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	9,614
ages 18 to 25	100.0%	2017	11,522
ages 26 and older	100.0%	2017	99,759
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	219
ages 18 to 25	11.4%	2014-16	1,317
ages 26 and older	4.8%	2014-16	4,798
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	2,643
ages 26 and older	22.1%	2014-16	22,075
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	1,014
ages 26 and older	3.9%	2014-16	3,921
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	1,302
ages 18 to 25	11.7%	2014-16	1,350
ages 26 and older	8.6%	2014-16	8,587
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	720
ages 26 and older	5.8%	2014-16	5,835
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	247
ages 18 to 25	7.4%	2016-17	851
ages 26 and older	2.0%	2016-17	2,010
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	346
ages 18 to 25	15.4%	2016-17	1,777
ages 26 and older	6.1%	2016-17	6,103
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	350
ages 18 to 25	16.1%	2016-17	1,855
ages 26 and older	6.4%	2016-17	6,430

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

PLANNING DISTRICT ONE BEHAVIORAL HEALTH SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	5,964
ages 18 to 25	100.0%	2017	8,179
ages 26 and older	100.0%	2017	63,131
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	136
ages 18 to 25	11.4%	2014-16	935
ages 26 and older	4.8%	2014-16	3,036
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	1,876
ages 26 and older	22.1%	2014-16	13,970
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	720
ages 26 and older	3.9%	2014-16	2,481
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	808
ages 18 to 25	11.7%	2014-16	958
ages 26 and older	8.6%	2014-16	5,434
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	511
ages 26 and older	5.8%	2014-16	3,693
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	154
ages 18 to 25	7.4%	2016-17	604
ages 26 and older	2.0%	2016-17	1,272
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	215
ages 18 to 25	15.4%	2016-17	1,261
ages 26 and older	6.1%	2016-17	3,862
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	217
ages 18 to 25	16.1%	2016-17	1,317
ages 26 and older	6.4%	2016-17	4,069

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

PORTSMOUTH DEPARTMENT OF BEHAVIORAL HEALTHCARE SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	6,509
ages 18 to 25	100.0%	2017	10,146
ages 26 and older	100.0%	2017	62,232
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	121
ages 18 to 25	12.2%	2014-16	1,242
ages 26 and older	5.9%	2014-16	3,664
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	2,154
ages 26 and older	17.9%	2014-16	11,142
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	896
ages 26 and older	3.2%	2014-16	1,986
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	800
ages 18 to 25	9.4%	2014-16	959
ages 26 and older	6.9%	2014-16	4,318
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	491
ages 26 and older	4.1%	2014-16	2,580
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	168
ages 18 to 25	7.4%	2016-17	749
ages 26 and older	2.0%	2016-17	1,254
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	234
ages 18 to 25	15.4%	2016-17	1,565
ages 26 and older	6.1%	2016-17	3,807
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	237
ages 18 to 25	16.1%	2016-17	1,634
ages 26 and older	6.4%	2016-17	4,011

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

PRINCE WILLIAM COUNTY COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	46,721
ages 18 to 25	100.0%	2017	52,479
ages 26 and older	100.0%	2017	327,159
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	978
ages 18 to 25	10.3%	2014-16	5,414
ages 26 and older	5.1%	2014-16	16,527
Any Mental Illness in the past year			
ages 18 to 25	22.8%	2014-16	11,969
ages 26 and older	18.9%	2014-16	61,875
Had serious thoughts of suicide			
ages 18 to 25	8.3%	2014-16	4,372
ages 26 and older	3.0%	2014-16	9,725
Major Depressive Episode in past year			
ages 12 to 17	12.2%	2014-16	5,721
ages 18 to 25	12.0%	2014-16	6,317
ages 26 and older	7.2%	2014-16	23,422
Serious Mental Illness in the past year			
ages 18 to 25	5.7%	2014-16	2,977
ages 26 and older	3.7%	2014-16	11,956
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	1,203
ages 18 to 25	7.4%	2016-17	3,874
ages 26 and older	2.0%	2016-17	6,591
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	1,681
ages 18 to 25	15.4%	2016-17	8,093
ages 26 and older	6.1%	2016-17	20,014
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	1,703
ages 18 to 25	16.1%	2016-17	8,450
ages 26 and older	6.4%	2016-17	21,088

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

RAPPAHANNOCK-RAPIDAN COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	14,587
ages 18 to 25	100.0%	2017	15,384
ages 26 and older	100.0%	2017	121,289
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	306
ages 18 to 25	10.2%	2014-16	1,570
ages 26 and older	5.1%	2014-16	6,208
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	3,629
ages 26 and older	19.6%	2014-16	23,822
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	1,403
ages 26 and older	3.7%	2014-16	4,432
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	1,880
ages 18 to 25	11.6%	2014-16	1,788
ages 26 and older	6.7%	2014-16	8,151
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	893
ages 26 and older	4.2%	2014-16	5,083
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	375
ages 18 to 25	7.4%	2016-17	1,136
ages 26 and older	2.0%	2016-17	2,443
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	525
ages 18 to 25	15.4%	2016-17	2,373
ages 26 and older	6.1%	2016-17	7,420
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	532
ages 18 to 25	16.1%	2016-17	2,477
ages 26 and older	6.4%	2016-17	7,818

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	32,486
ages 18 to 25	100.0%	2017	40,667
ages 26 and older	100.0%	2017	232,857
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	680
ages 18 to 25	10.2%	2014-16	4,151
ages 26 and older	5.1%	2014-16	11,918
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	9,594
ages 26 and older	19.6%	2014-16	45,736
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	3,709
ages 26 and older	3.7%	2014-16	8,509
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	4,186
ages 18 to 25	11.6%	2014-16	4,727
ages 26 and older	6.7%	2014-16	15,649
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	2,360
ages 26 and older	4.2%	2014-16	9,759
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	836
ages 18 to 25	7.4%	2016-17	3,002
ages 26 and older	2.0%	2016-17	4,691
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	1,169
ages 18 to 25	15.4%	2016-17	6,272
ages 26 and older	6.1%	2016-17	14,245
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	1,184
ages 18 to 25	16.1%	2016-17	6,548
ages 26 and older	6.4%	2016-17	15,009

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

REGION TEN COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	16,810
ages 18 to 25	100.0%	2017	32,539
ages 26 and older	100.0%	2017	170,622
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	352
ages 18 to 25	10.2%	2014-16	3,322
ages 26 and older	5.1%	2014-16	8,733
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	7,677
ages 26 and older	19.6%	2014-16	33,512
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	2,967
ages 26 and older	3.7%	2014-16	6,235
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	2,166
ages 18 to 25	11.6%	2014-16	3,782
ages 26 and older	6.7%	2014-16	11,466
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	1,888
ages 26 and older	4.2%	2014-16	7,150
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	433
ages 18 to 25	7.4%	2016-17	2,402
ages 26 and older	2.0%	2016-17	3,437
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	605
ages 18 to 25	15.4%	2016-17	5,018
ages 26 and older	6.1%	2016-17	10,438
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	613
ages 18 to 25	16.1%	2016-17	5,239
ages 26 and older	6.4%	2016-17	10,998

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

RICHMOND BEHAVIORAL HEALTH AUTHORITY

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	11,213
ages 18 to 25	100.0%	2017	33,244
ages 26 and older	100.0%	2017	153,460
Alcohol Use Disorder in the past year			
ages 12 to 17	2.0%	2014-16	226
ages 18 to 25	11.8%	2014-16	3,918
ages 26 and older	5.2%	2014-16	7,993
Any Mental Illness in the past year			
ages 18 to 25	21.5%	2014-16	7,149
ages 26 and older	17.9%	2014-16	27,448
Had serious thoughts of suicide			
ages 18 to 25	7.3%	2014-16	2,435
ages 26 and older	3.0%	2014-16	4,655
Major Depressive Episode in past year			
ages 12 to 17	11.4%	2014-16	1,283
ages 18 to 25	11.2%	2014-16	3,732
ages 26 and older	6.7%	2014-16	10,338
Serious Mental Illness in the past year			
ages 18 to 25	4.9%	2014-16	1,641
ages 26 and older	3.9%	2014-16	5,936
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	289
ages 18 to 25	7.4%	2016-17	2,454
ages 26 and older	2.0%	2016-17	3,092
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	403
ages 18 to 25	15.4%	2016-17	5,127
ages 26 and older	6.1%	2016-17	9,388
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	409
ages 18 to 25	16.1%	2016-17	5,353
ages 26 and older	6.4%	2016-17	9,892

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

ROCKBRIDGE AREA COMMUNITY SERVICES

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	2,374
ages 18 to 25	100.0%	2017	6,651
ages 26 and older	100.0%	2017	27,273
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	50
ages 18 to 25	10.2%	2014-16	679
ages 26 and older	5.1%	2014-16	1,396
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	1,569
ages 26 and older	19.6%	2014-16	5,357
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	607
ages 26 and older	3.7%	2014-16	997
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	306
ages 18 to 25	11.6%	2014-16	773
ages 26 and older	6.7%	2014-16	1,833
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	386
ages 26 and older	4.2%	2014-16	1,143
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	61
ages 18 to 25	7.4%	2016-17	491
ages 26 and older	2.0%	2016-17	549
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	85
ages 18 to 25	15.4%	2016-17	1,026
ages 26 and older	6.1%	2016-17	1,668
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	87
ages 18 to 25	16.1%	2016-17	1,071
ages 26 and older	6.4%	2016-17	1,758

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

SOUTHSIDE COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	5,679
ages 18 to 25	100.0%	2017	7,180
ages 26 and older	100.0%	2017	58,658
Alcohol Use Disorder in the past year			
ages 12 to 17	2.3%	2014-16	129
ages 18 to 25	11.4%	2014-16	821
ages 26 and older	4.8%	2014-16	2,821
Any Mental Illness in the past year			
ages 18 to 25	22.9%	2014-16	1,647
ages 26 and older	22.1%	2014-16	12,980
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	632
ages 26 and older	3.9%	2014-16	2,306
Major Depressive Episode in past year			
ages 12 to 17	13.5%	2014-16	769
ages 18 to 25	11.7%	2014-16	841
ages 26 and older	8.6%	2014-16	5,049
Serious Mental Illness in the past year			
ages 18 to 25	6.2%	2014-16	449
ages 26 and older	5.8%	2014-16	3,431
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	146
ages 18 to 25	7.4%	2016-17	530
ages 26 and older	2.0%	2016-17	1,182
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	204
ages 18 to 25	15.4%	2016-17	1,107
ages 26 and older	6.1%	2016-17	3,588
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	207
ages 18 to 25	16.1%	2016-17	1,156
ages 26 and older	6.4%	2016-17	3,781

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

VALLEY COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	8,518
ages 18 to 25	100.0%	2017	11,103
ages 26 and older	100.0%	2017	88,358
Alcohol Use Disorder in the past year			
ages 12 to 17	2.1%	2014-16	178
ages 18 to 25	10.2%	2014-16	1,133
ages 26 and older	5.1%	2014-16	4,522
Any Mental Illness in the past year			
ages 18 to 25	23.6%	2014-16	2,619
ages 26 and older	19.6%	2014-16	17,354
Had serious thoughts of suicide			
ages 18 to 25	9.1%	2014-16	1,013
ages 26 and older	3.7%	2014-16	3,229
Major Depressive Episode in past year			
ages 12 to 17	12.9%	2014-16	1,098
ages 18 to 25	11.6%	2014-16	1,291
ages 26 and older	6.7%	2014-16	5,938
Serious Mental Illness in the past year			
ages 18 to 25	5.8%	2014-16	644
ages 26 and older	4.2%	2014-16	3,703
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	219
ages 18 to 25	7.4%	2016-17	820
ages 26 and older	2.0%	2016-17	1,780
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	306
ages 18 to 25	15.4%	2016-17	1,712
ages 26 and older	6.1%	2016-17	5,405
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	310
ages 18 to 25	16.1%	2016-17	1,788
ages 26 and older	6.4%	2016-17	5,695

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

VIRGINIA BEACH COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	32,951
ages 18 to 25	100.0%	2017	50,291
ages 26 and older	100.0%	2017	300,008
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	612
ages 18 to 25	12.2%	2014-16	6,158
ages 26 and older	5.9%	2014-16	17,664
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	10,674
ages 26 and older	17.9%	2014-16	53,711
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	4,439
ages 26 and older	3.2%	2014-16	9,575
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	4,048
ages 18 to 25	9.4%	2014-16	4,752
ages 26 and older	6.9%	2014-16	20,815
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	2,434
ages 26 and older	4.1%	2014-16	12,436
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	848
ages 18 to 25	7.4%	2016-17	3,712
ages 26 and older	2.0%	2016-17	6,044
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	1,185
ages 18 to 25	15.4%	2016-17	7,756
ages 26 and older	6.1%	2016-17	18,353
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	1,201
ages 18 to 25	16.1%	2016-17	8,097
ages 26 and older	6.4%	2016-17	19,338

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

WESTERN TIDEWATER COMMUNITY SERVICES BOARD

Health Outcome and Behavior	Prevalence	Year	Estimated Number of People
General population in community			
ages 12 to 17	100.0%	2017	12,098
ages 18 to 25	100.0%	2017	13,501
ages 26 and older	100.0%	2017	104,065
Alcohol Use Disorder in the past year			
ages 12 to 17	1.9%	2014-16	225
ages 18 to 25	12.2%	2014-16	1,653
ages 26 and older	5.9%	2014-16	6,127
Any Mental Illness in the past year			
ages 18 to 25	21.2%	2014-16	2,866
ages 26 and older	17.9%	2014-16	18,631
Had serious thoughts of suicide			
ages 18 to 25	8.8%	2014-16	1,192
ages 26 and older	3.2%	2014-16	3,321
Major Depressive Episode in past year			
ages 12 to 17	12.3%	2014-16	1,486
ages 18 to 25	9.4%	2014-16	1,276
ages 26 and older	6.9%	2014-16	7,220
Serious Mental Illness in the past year			
ages 18 to 25	4.8%	2014-16	654
ages 26 and older	4.1%	2014-16	4,314
Illicit Drug Use Disorder in the past year*			
ages 12 to 17	2.6%	2016-17	311
ages 18 to 25	7.4%	2016-17	997
ages 26 and older	2.0%	2016-17	2,096
Needing but not receiving treatment for substance use at a specialty facility in the past year*			
ages 12 to 17	3.6%	2016-17	435
ages 18 to 25	15.4%	2016-17	2,082
ages 26 and older	6.1%	2016-17	6,366
Substance Use Disorder in the past year*			
ages 12 to 17	3.6%	2016-17	441
ages 18 to 25	16.1%	2016-17	2,174
ages 26 and older	6.4%	2016-17	6,708

* indicates that state prevalence estimates were used to generate the number of people by a health outcome or behavior.

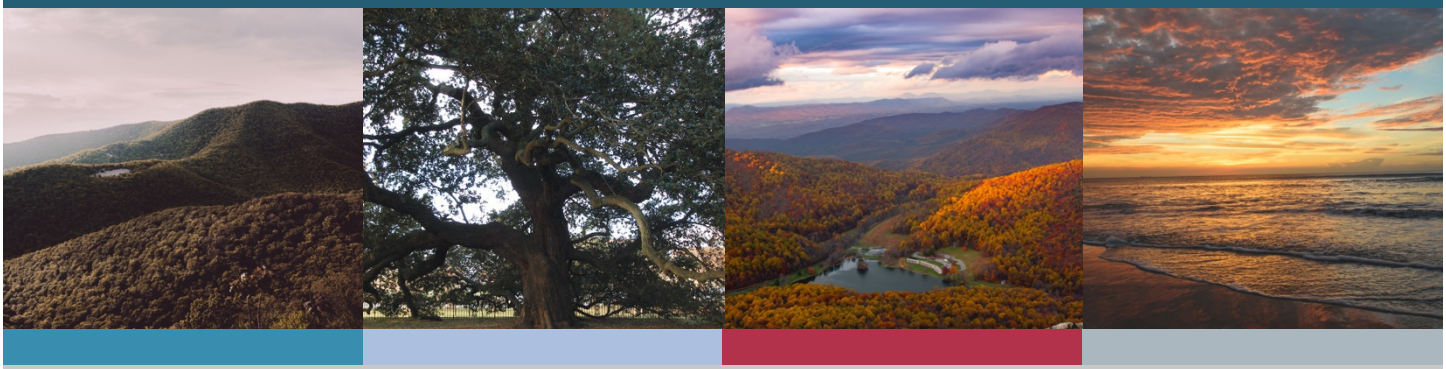
Appendix L.

Sample CSB Site Visit Report

Community Service Board Site Visit Report

CSB Name

City, Virginia



<Placeholder>

Dates of Site Visit: Month, Days, 2019

Prepared by JBS International, Inc., for conducting the Virginia Public Behavioral Health System Needs Assessment, under Planning District One Behavioral Health Services (PD1BHS) in partnership with the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Virginia Behavioral Health System Assessment Contract No. 05120190235.

Table of Contents

Site Visit Information

Table 1: CSB Site Visit and Contact Information

CSB Name	
CSB Address	
Site Visit Date(s)	
Contact Person	
Site Visit Team Members	

Table 2: CSB Site Visit Participants

Site Visit Participants	
Name	Title
Name	Title
Name	Title
Name	Title
Name	Title
Name	Title
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Site Visit Background

The State of Virginia Department of Behavioral Health and Developmental Services (DBHDS), in partnership with JBS International, Inc., is conducting an extensive needs assessment process to better understand the current Virginia public behavioral health statewide system strengths, needs, and capacity across the continuum of community behavioral health services, including provision of prevention, treatment, and recovery services. As part of this process, JBS International, Inc., is collecting data from a variety of resources. CSBs are an essential part of the behavioral health service delivery system and as such are a key part of the needs assessment. Over the course of the summer and early fall 2019, all 40 CSBs took part in an onsite visit that included key informant interviews and focus groups with consumers as well as key staff members who are knowledgeable of the clinical and administrative practices being conducted at each CSB. In addition, each CSB completed a survey prior to the site visit to report on specific information about the numbers of persons being served, the types of services being offered, the capacity of the system to meet the needs of Virginians, and funding sources. A special emphasis of the needs assessment process is understanding each CSB's progress in implementation of Virginia Behavioral Health System's System Transformation Excellence and Performance (STEP-VA).

This report is a brief synopsis of key information gathered during the site visit process. The report is intended to assist each CSB in understanding strengths, challenges, and action steps that will further the work of the CSB.

CSB Snapshot

221,045

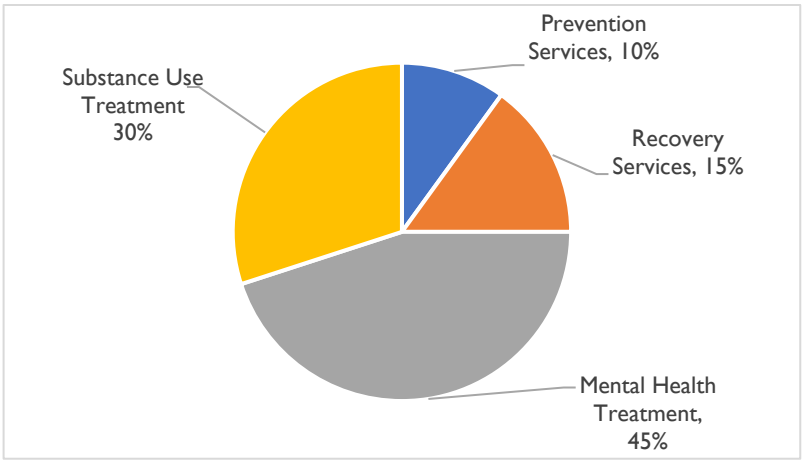
The number of residents living in [Name of Location] to whom the CSB is responsible for providing mental health and substance use services.

The CSB operates out of [XX] locations. Most services are operated in the [Location Name] location.

Location	Services Provided

$XX million

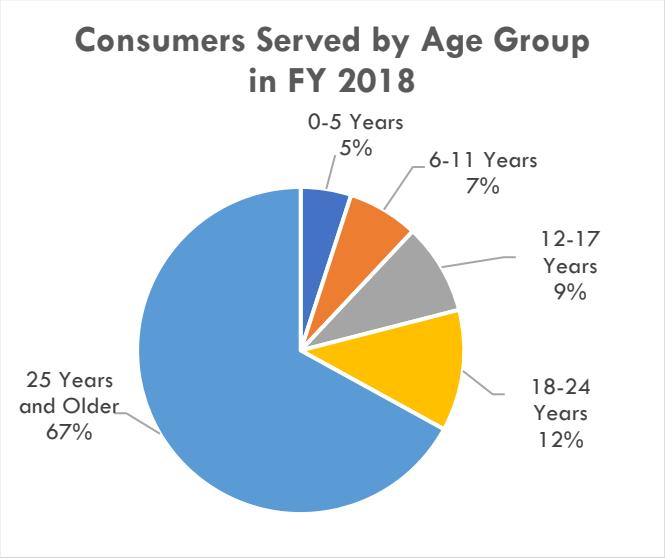
[Name of CSB] Annual Budget

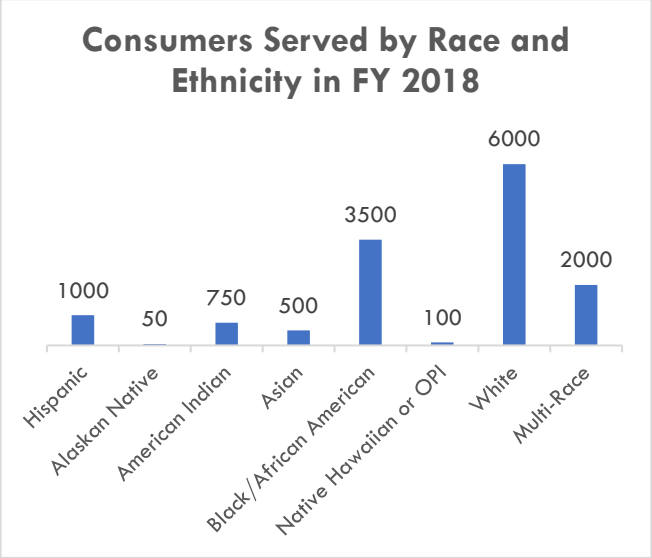


10,000

consumers were served in FY 2018 by the [Name of CSB].

Populations of Focus





At-Risk Population	Total Number Served in FY 2018
Pregnant women with substance use issues	
Individuals involved with the criminal justice system (e.g., prisons, jails, juvenile justice system) as perpetrators or victims of crime	
Individuals at risk due to environmental and adverse childhood experiences	
Returning veterans and their family members	
Children with or at risk of developmental disabilities (DD)	
Individuals with intellectual disabilities and/or DD with co-occurring conditions	
Children (ages 6–11 years) experiencing serious emotional disturbance (SED)	
Adolescents (ages 12–17 years) experiencing SED	
Populations experiencing serious mental illness (SMI) • Young adults (ages 18–24 years) and adults	
Populations experiencing SUDs • Adolescents (ages 12–17 years) • Young adults (ages 18–24 years) and adults	
Populations experiencing co-occurring mental health and substance use disorders • Adolescents (ages 12–17 years) • Young adults (ages 18-24 years) and adults	

- General paragraph: Brief contextual information from interview i.e., changes in population served, Interview (I), focus groups (FG)
- May pull information from:
- Key Informant Interviews:
  - Are there certain client groups that you think you have reasonable capacity to serve and do a good job of serving?
  - Are there certain client groups for which you think you need to build capacity to better serve?
  - If you could improve one thing about client's experience when seeking mental health and/or substance use disorder services, what would that be?

Service Provision

The manner in which CSBs provide prevention, treatment and recovery services is crucial to success. This section will review CSBs ability to provide quality services as demonstrated by their use of evidence-based practices or practices that have been tested and shown to be effective in demonstrating outcomes. CSBs also must be mindful of their capacity to provide services to all who need them in a timely manner. Consumers must be able to access quality services when they are ready to begin the change process. Thus, this section will also explore whether enough services are provided to meet the community's needs by looking at whether a service is over utilized, underutilized, or utilized at the right rate as well as the time it takes a consumer to receive services after being requested.

Evidence Based Practices Being Implemented		
Substance Use and/or Mental Health Treatment Evidence Based Practices	**Substance Use Prevention and Mental Health Promotion Evidence Based Practices**	**Recovery Support Services**
•	•	•

Service Capacity		
Service Overutilized	**Service Utilized Appropriately**	**Service Underutilized**
•	•	•

Service Availability (Average time for consumers to receive services after they are requested)				
Same Day	**1-7 Days**	**8-14 Days**	**15-21 Days**	**22-30 Days**
•	•	•	•	•

Summary of Service Provision

Provide a summary of the way services are provided including notable practices being used and the availability of staff and services. May pull from the following Key Informant/ Direct Service Provider Focus Group Questions:

- Can you describe the intake process for new persons seeking service?
- Describe the available clinical practices being utilized at this CSB?
- How do your clients access pharmacotherapy evaluation and medication management?
- How accessible are your services for clients? Consider the following:
  - Scheduling, waitlists
  - Adequate staff
  - Availability of client services

- Client services available within a reasonable time frame
- Client services are in accessible location
- Collaboration with key community stakeholders to advance program efforts
- Services are available in clients spoken languages

CSB Workforce and Professional Development

CSBs are dependent on a qualified workforce to provide behavioral health services. A qualified workforce is one that has service providers who have the educational and experiential background necessary for specific certifications and licensure categories that are pertinent to their specialty area. A qualified workforce also receives continuous training and professional development about the latest research so it can be applied in the field and provides knowledge refreshers to ensure the most important information is regularly reinforced. This section describes staff qualifications as well as the CSB's approach to continued professional development.

Staff Certification/ Licensure	
Total Number of Direct Service Staff	
Total Number of Licensed/ Certified Direct Service Staff	
Percent (%) of Direct Service Staff that are Certified and/or Licensed	
Total Number of Peer Staff	
Total Number of Certified Peer Staff	
Percent (%) of Peer Staff that are Certified	

Training

Brief paragraph with contextual Information about training and professional development

May pull from the following CSB Key Informant Interview Questions:

- Do you have a workforce development plan for your staff?
- Describe your training methodology.

May pull from the following Direct Service Provider Focus Group Question:

- Career development opportunities for learning and professional growth.

Direct Service Outcomes

All CSBs provide essential behavioral health services to consumers living in their area. In order to understand the benefits of those services on consumers being served, CSBs must: 1) Collect data; 2) Review/ analyze the data; 3) Use the data to improve services. Ultimately CSBs must ask themselves if consumers are "getting better" because of the services provided. This section describes the CSBs efforts to collect, analyze and use the data as well as the benefits consumers receive as a result of service delivery.

Collecting Data

Paragraph that describes data collection methods

Review/ Analyze the data

Paragraph that describes the quality assurance processes

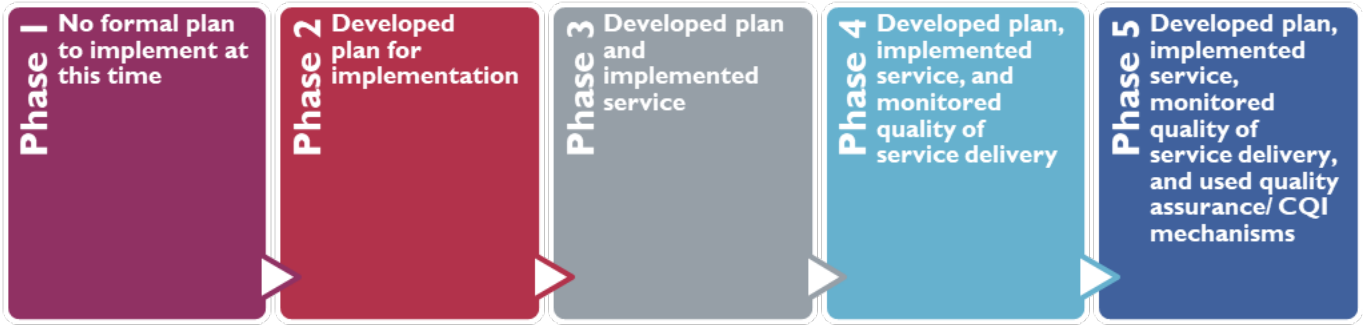
Outcomes

Paragraph that describes services that have good outcomes that were mentioned during the key informant interviews and also includes consumer perceived benefits and satisfaction with services provided.

STEP-VA Implementation

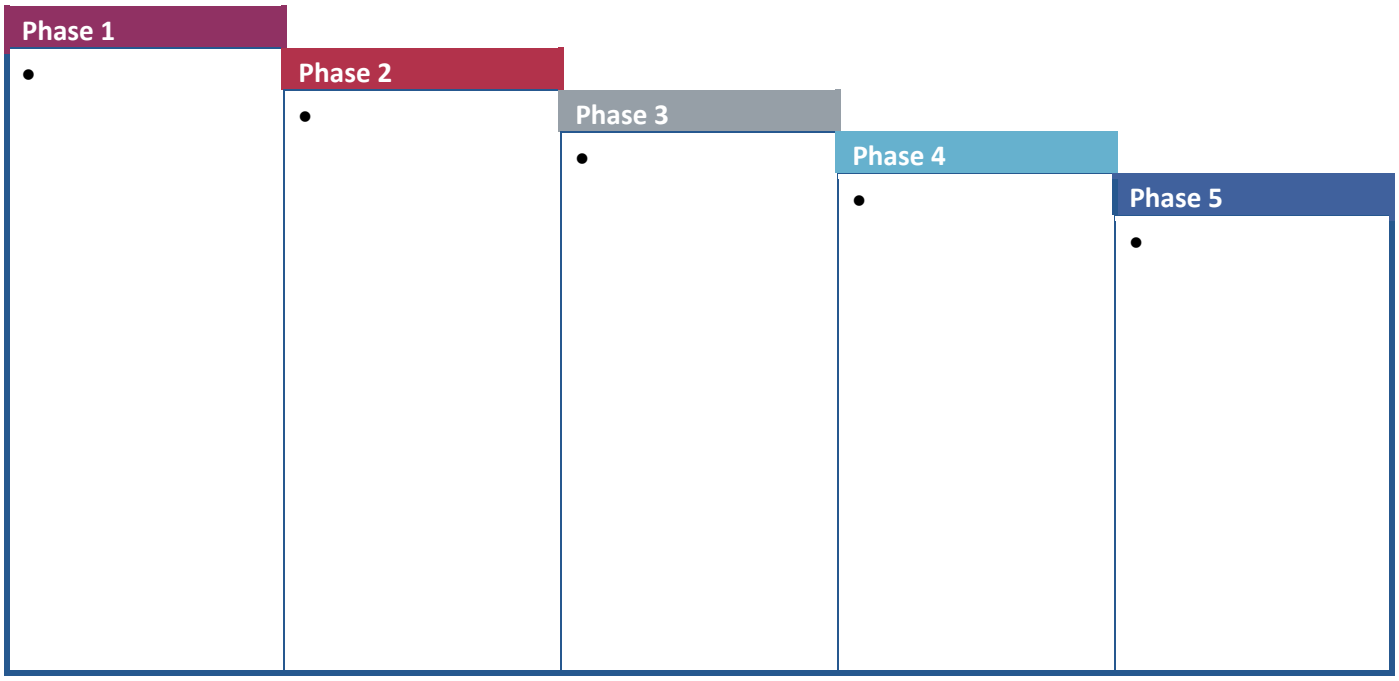
STEP-VA is an innovative initiative for individuals with behavioral health disorders featuring a uniform set of required services, consistent quality measures, and improved oversight. STEP-VA is based on a national best-practice model that requires the development of a set array of deliberately chosen services that make up a comprehensive, accessible system for those with serious behavioral disorders. Each CSB is working toward full implementation of each of the STEP-VA services. The table below describes the [Name of CSB]'s progress in implementing the STEP-VA services. Progress is defined using the following five phases as noted below.

Phases of Progress with Implementing STEP-VA

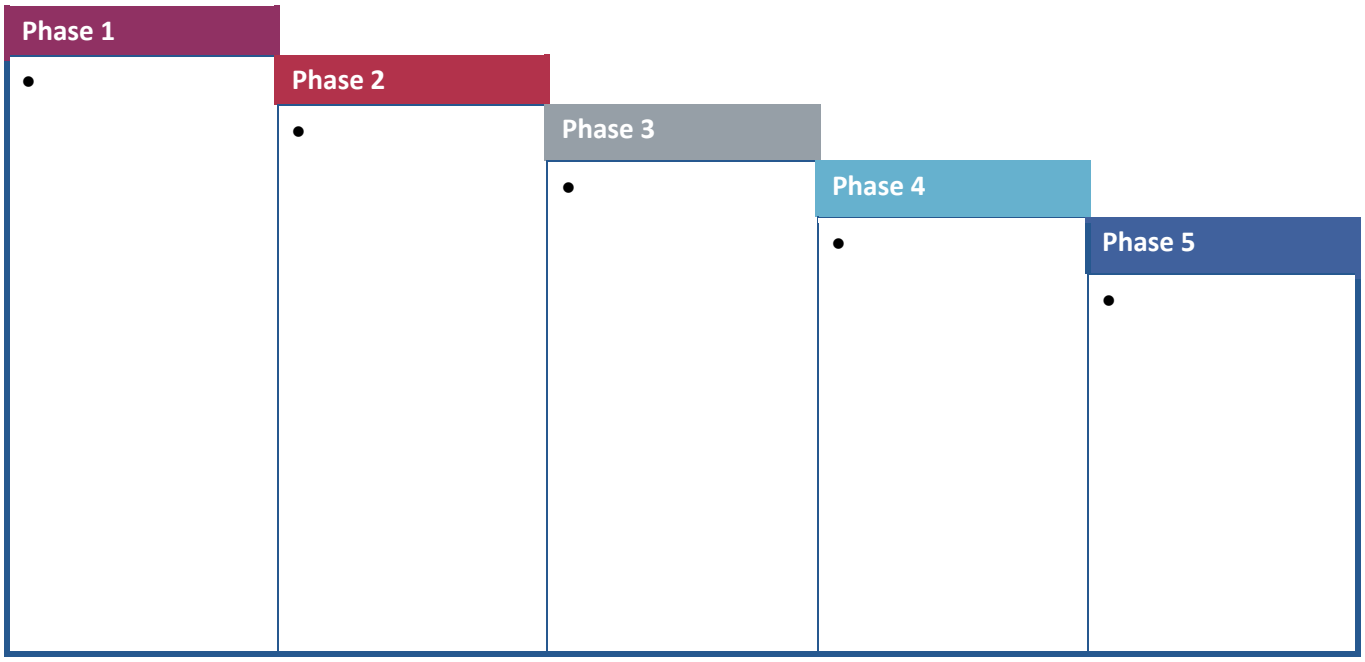


The graphics below summarize the progress with implementing STEP-VA services and evidence-based practices, respectively, at this CSB.

CSB STEP VA Progress by Service Type



CSB STEP VA Progress by Evidence Based Practice



Overall Progress Implementing STEP VA

Pull from Key Informant Interview Questions:

- Does your CSB have a strategy in place for STEP-VA Implementation?
- If yes, what do you know about the plan? If no, what additional factors need to be in place for you to implement STEP VA
- Is there a team or an individual at your agency who is leading up the STEP VA efforts?
- Can you describe your CSB's current capacity to provide STEP-VA programs and evidence-based practices?
- Does your CSB have a plan or strategy in place for STEP-VA Implementation?
- If yes, what have you accomplished and what still needs to be accomplished?
- If no, what additional factors need to be in place for you to implement STEP VA?
- Have you collected any outcomes related to STEP-VA implementation? If yes, please describe?
- What additional capacity needs to be in place for you to implement STEP-VA?
- Please describe any facilitators you have found to be helpful related to STEP-VA implementation in your CSB?
- Please describe any concerns or potential barriers you have experienced related to STEP-VA implementation in your CSB?

Medicaid

Pull from Key Informant Interview Questions:

- As the State moves forward with Medicaid Expansion, what kind of changes do you anticipate Medicaid Expansion will make to your CSB?
- Changes or impact to your treatment program(s)?
- Changes or impact to the BH system in Virginia?

- Are current Medicaid reimbursement rates adequate to cover the true costs of services provided? If no, please explain.
- If not, what are the barriers?
- Do you have the infrastructure to calculate costs by services or conduct cost modeling?
- What are the biggest challenges or areas of concern with Medicaid Expansion?
- Working with managed care organizations or other third-party payers?
- Contracting, reporting, billing, denials, eligibility, credentialing?
- Workforce development?

Summary of Findings

Summary of Findings	
Summary: Population served, capacity, services provided, workforce, direct service outcomes **Strengths:** **Challenges:**	
Next Steps	
1	
2	
3	
4	
5	

Abbreviations/Terminology

CIT	Crisis Intervention Teams
CM	Case management
CSB	Community services board
DBHDS	Virginia Department of Behavioral Health and Developmental Services
DD	Developmental disabilities
DLA-20	Daily Living Activities 20
DMAS	Department of Medical Assistance Services
EBP	Evidence-based practice
EHR	Electronic health record
HIT	Health information technology
IOP	Intensive outpatient
MAT	Medication-assisted treatment
MCO	Managed care organization
MH	Mental health
MTM	Medication therapy management
OP	Outpatient
PSR	Psychosocial rehabilitation
QA	Quality assurance
SED	Serious emotional disturbance
SDA	Same-day access
SMI	Serious mental illness
SPQM	Service Process Quality Management
STEP-VA	System Transformation Excellence and Performance – Virginia
SUD	Substance use disorder

Appendix 1: CSB Organizational Chart

[INSERT organizational chart provided by the CSB]

Appendix 2: Final Completed Agenda

SITE VISIT AGENDA
[NAME OF CSB] Site Visit
[SITE VISIT ADDRESS]
[SITE VISIT DATES]

Day 1: Day, Month XX, 2019			
Time	**Activity**	**Location**	**Participants**
8:30 – 9:00 A.M.	Entrance Meeting		• CSB Administrators and JBS Site Visit Team
9:00 – 9:15 A.M.	**BREAK & TRANSITION**		
9:15 – 10:15 A.M.	Interview #1: Board President		•
9:15 – 10:15 A.M.	Interview #2: Executive Director		•
10:15 – 10:30 AM	**BREAK**		
10:30 – 11:30 A.M.	Interview #3: Clinical Director		•
10:30 – 11:30 A.M.	Interview #4: Prevention Director		•
11:30 – 12:00 P.M.	**BREAK & TRANSITION**		
12:00 P.M. – 1:30 P.M.	**Client Focus Group and lunch**		• Up to 10 CSB clients or former clients • JBS Site Visit Team
1:30 – 2:00 P.M.	**BREAK & TRANSITION**		
2:00 – 3:00 P.M.	Interview #5: Recovery Director		•
2:00 – 3:00 P.M.	Interview #6: Housing Director		•
3:00 – 3:15 P.M.	**BREAK**		
3:15 – 4:15 P.M.	Interview #7: Women's Services		•
3:15 – 4:15 P.M.	Interview #8: IT Director		•
4:15 – 5:00 P.M.	**JBS staff meet and discuss before leaving for the day. End of day one site visit.**		

Day 2: Day, Month XX, 2019			
Time	**Activity**	**Location**	**Participants**
9:00 A.M. – 9:30 A.M.	Set up for interviews		• CSB POC and JBS Site Visit Team
9:30 – 10:30 A.M.	Interview #9: Children's Services		•
9:30 – 10:30 A.M.	Interview #10:		•

	Fiscal Director		
10:30 – 10:45 AM	**BREAK**		
10:45 – 11:45 A.M.	Interview #11: Medical Director		•
10:45 – 11:45 A.M.	Interview #11:		•
11:45 A.M. – 12:00 P.M.	**BREAK & TRANSITION**		
12:00 – 1:30 P.M.	**Direct Service Provider Focus Group and LUNCH** - For Providers of treatment SUD & MH (60-90 minutes)		• Up to 10 CSB direct service providers • JBS Site Visit Team
1:30 – 2:30 PM	**BREAK & TRANSITION**		
2:30 – 3:30 PM	Wrap up and Report Out: Next Steps		CSB Administrators, Board Chair/President, CSB Staff, and JBS Site Visit Team