



Virginia Department of  
Behavioral Health &  
Developmental Services

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

to  
**Members of the Virginia General Assembly**

**October 1, 2015**



# COMMONWEALTH of VIRGINIA

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October 1, 2015

To: Members, Virginia General Assembly

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

This report provides information on the public funds allocated to the Department of Behavioral Health and Developmental Services (DBHDS) for the treatment and prevention of substance abuse and epidemiological information about the incidence and prevalence of substance use disorders in the state, the resources available to address these needs, and highlights of the activities recently undertaken by DBHDS to provide services for prevention and treatment.

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

This report describes DBHDS' major substance use disorder prevention and treatment initiatives in the last two years. I hope you will find it useful.

Sincerely,

A handwritten signature in blue ink that reads "Jack Barber, M.D.".

Jack Barber, M.D.

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

**Table of Contents**

Overview..... 1

Nature, Scope and Degree of Substance Use Disorders in Virginia..... 2

Publicly Funded Substance Abuse Treatment Services..... 20

Major Substance Abuse Activities at the Department of Behavioral Health  
and Developmental Services ..... 23

Appendices

    A. Code of Virginia ..... 34

    B. Virginia Localities Sorted by National Survey of Drug Use and Health (NSDUH)  
        Region ..... 35

    C. Diagnostic Criteria for Substance Use Disorders ..... 36

    D. List of Cities and Counties Sorted by Regions used by the Virginia Department of  
        Health – Office of the Chief Medical Examiner ..... 37

    E. Services Definitions ..... 38

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Per Code of Virginia § 37.2-310  
to Members of the Virginia General Assembly**

## **OVERVIEW**

### ***Purpose***

This biennial report provides information about the extent to which Virginians are affected by substance use disorders and the activities supported by the Department of Behavioral Health and Developmental Services (DBHDS) to address these needs during the biennium (2012-2014). National statistical information analyzed at the state level and available state data were used to identify state, regional and age-related issues.

### ***The Department of Behavioral Health and Developmental Services***

Title 37.2 of the *Code of Virginia* establishes DBHDS as the state authority for alcoholism and drug abuse services. DBHDS works to make efficient, accountable and effective services available for citizens with substance use disorders. DBHDS is responsible for the administration, planning and regulation of services for substance use disorders in the state.

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

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

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

DBHDS supports substance use disorder prevention and treatment services provided in local communities through the allocation of state general fund (GF) dollars and federal Substance Abuse Prevention and Treatment Block Grant (SAPT block grant) funds to 40 community services boards and behavioral health authorities (collectively referenced as CSBs). These organizations are entities of local government. The Department's expectations for all CSBs is established in the annual community services performance contract. DBHDS funds, monitors, licenses, and regulates the CSBs which function as:

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

### ***Substance Related Disorders***

There are several sources of definitions for conditions considered to be substance use disorders. The *Code of Virginia* §37.2-100 defines substance abuse as "the use of drugs, enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.), without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care."

Clinical definitions usually refer to "substance use disorders," based on 11 criteria in the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (DSM-5). Both definitions include the nonmedical use of prescription drugs. Data reported in this document are based on DSM-5 criteria, unless otherwise stated.

## **NATURE, SCOPE AND DEGREE OF SUBSTANCE ABUSE IN VIRGINIA**

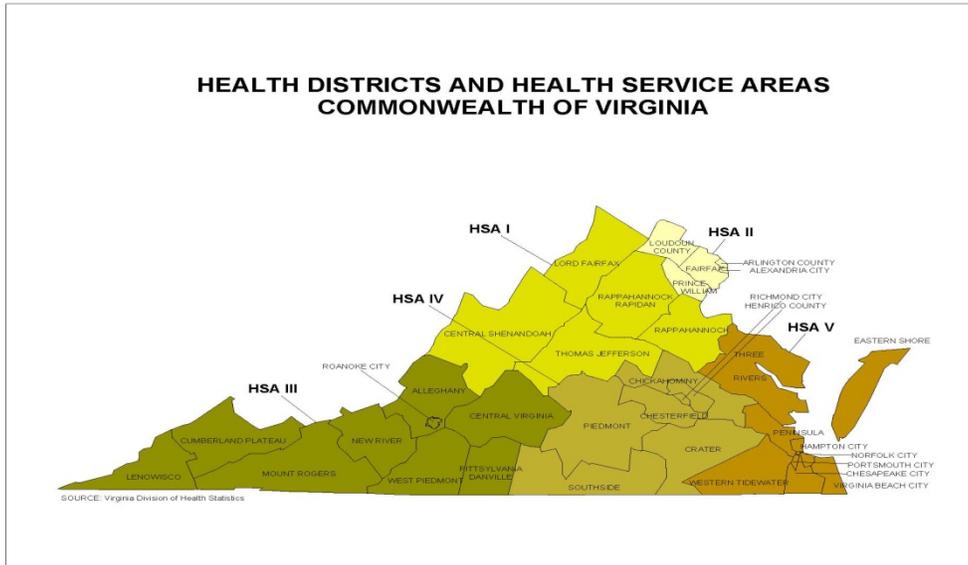
### ***Sources of Information***

Information about the types and extent of substance abuse in the state comes from several resources. A major source of epidemiological information (the measure of the occurrence of the disorder) is the National Survey on Drug Use and Health (NSDUH) conducted annually by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Another important source of information concerning causes of death related to substance abuse is provided by the Office of the Chief Medical Examiner (OCME) at the Virginia Department of Health (VDH). Additional data are collected by VDH through the Virginia Youth Survey, a voluntary survey of students in Virginia high schools.

### ***National Household Survey of Drug Use and Health***

The National Household Survey of Drug Use and Health is conducted annually by interviewing a statistically significant sample of individuals age 12 and older in the population to allow statistically valid inferences and conclusions to be drawn. In Virginia, a valid sample of individuals representing each of five regions of the state is interviewed. This is helpful in tracking regional trends to assist in planning and allocating resources. The five regions are shown below in Figure 1. A list of Virginia cities and counties grouped by these five regions is included as Appendix B.

Figure 1



In addition, valid samples are collected by age groups so that developmental trends can be identified. To strengthen the power of the data analysis of these smaller groups, SAMHSA combines two or three years of data for analysis when it issues its official reports. The NSDUH data that are reported in this document provides regional analysis of data collected in 2010, 2011 and 2012. The age-group data were collected in 2012 and 2013. The population figures for Virginia in 2014 are based on estimates provided by the Weldon Cooper Center for Public Service at the University of Virginia.

NSDUH collects data on the same issues each year. The charts in this report depict the responses to selected questions in three ways. The first chart shows the proportion of the population impacted by nation, state and region. The second chart shows the actual population impacted displayed by state region. The regions are not equal in population size, and in some instances a larger number of individuals may be affected by an issue even when the proportion of the population affected is smaller. The third chart displays the responses by percent of population divided by age groups of 12-17, 18-25, and 26 and older. Analysis by age helps to inform policy and practice for treatment and prevention.

**Alcohol** is both the most used and most abused drug in the nation and in the state. NSDUH data indicate that, nationally, 52.13 percent of the population older than 12 years used alcohol in the month prior to the survey. In Virginia, the rate of alcohol use, 55.15 percent, is slightly higher.

a. **Binge Drinking** - About half of those who use alcohol engaged in binge drinking (five or more drinks on one occasion) in the month prior to the survey. The national rate for binge drinking is 22.92 percent, and the rate in Virginia is slightly lower at 21.95 percent. Figure 2 below displays the percent of the population that engaged in binge drinking by region. The highest rate is in Region 5 (22.79 percent) and the lowest rate is in Region 2 (20.69 percent).

**Figure 2**

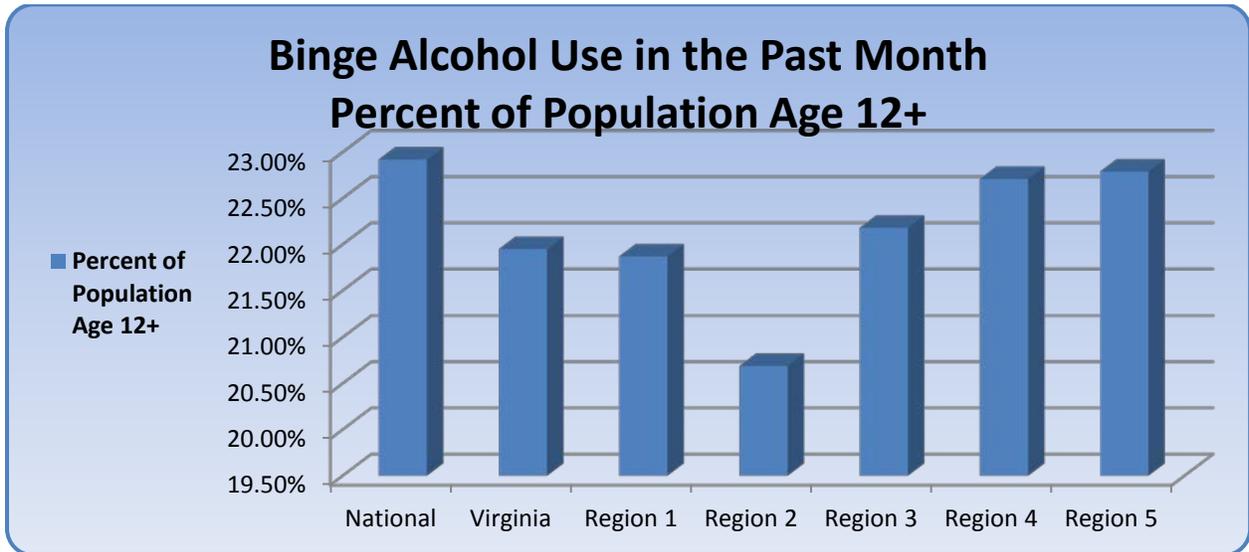


Figure 3 below displays estimates of the actual number of people who engaged in binge drinking by region. Although the proportion of binge drinkers is highest in Region 5, the actual numbers of people who engaged in binge drinking was the highest in Region 2, followed by Region 5.

**Figure 3**

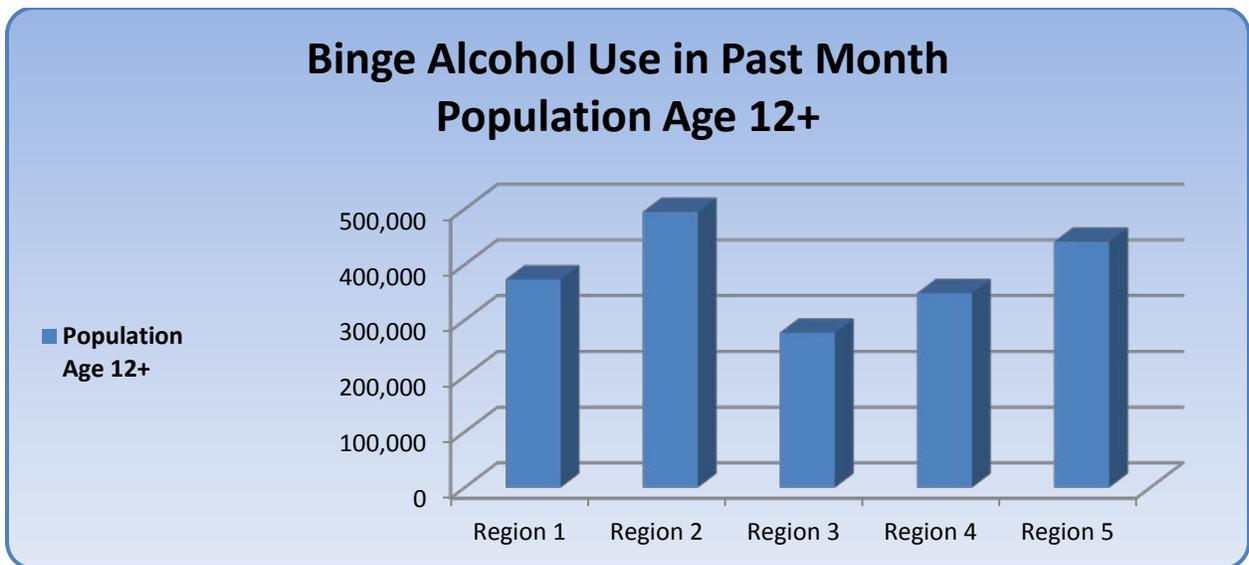
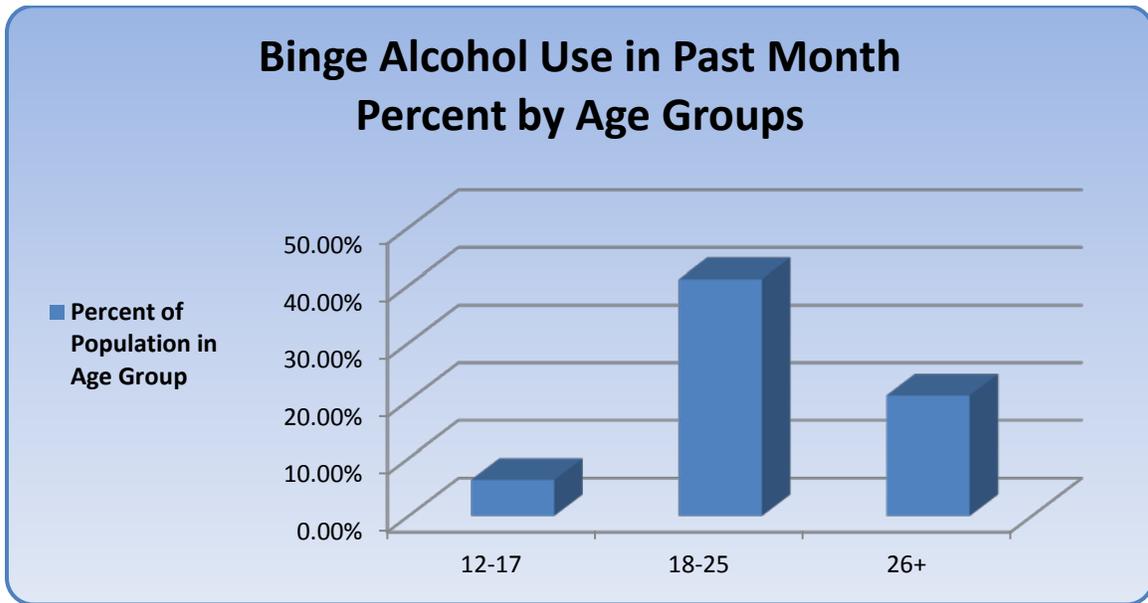


Figure 4



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
<b>Percent of Population Age 12+</b>	22.92%	21.95%	21.87%	20.69%	22.18%	22.71%	22.79%
<b>Population Age 12+</b>	73,424,494	1,941,689	373,279	494,952	277,543	348,654	441,434

	12+	12-17	18-25	26+
Percent of Population	22.19%	6.26%	41.03%	20.86%
Population Figure	1,557,158	39,709	382,978	1,136,797

Figure 4 above displays an alarming trend among Virginia youth. Although possession of alcohol is illegal for those under 21, more than six percent of Virginia’s youth engaged in binge drinking the month prior to the survey, and more than 40 percent of those between 18 and 25 drank to this excess. For those who are 26 and older, more than one in five engaged in binge drinking in the month prior to the survey.

b. Alcohol Dependence or Abuse - Figure 5 below indicates that nationally, 6.7 percent of Americans met criteria for one of these disorders, while a slightly lower proportion of Virginians

(6.49 percent) met criteria for either abuse of or dependence on alcohol. Regions 1 and 3 had the greatest proportion while Region 4 had the lowest. In raw numbers shown in Figure 6, however, Region 2 had the greatest number of people who met one of these clinical criteria, while Region 5 had the second most. (*Alcohol Dependence and Abuse as defined in American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV). American Psychiatric Association, Washington D.C., 1994*)

**Figure 5**

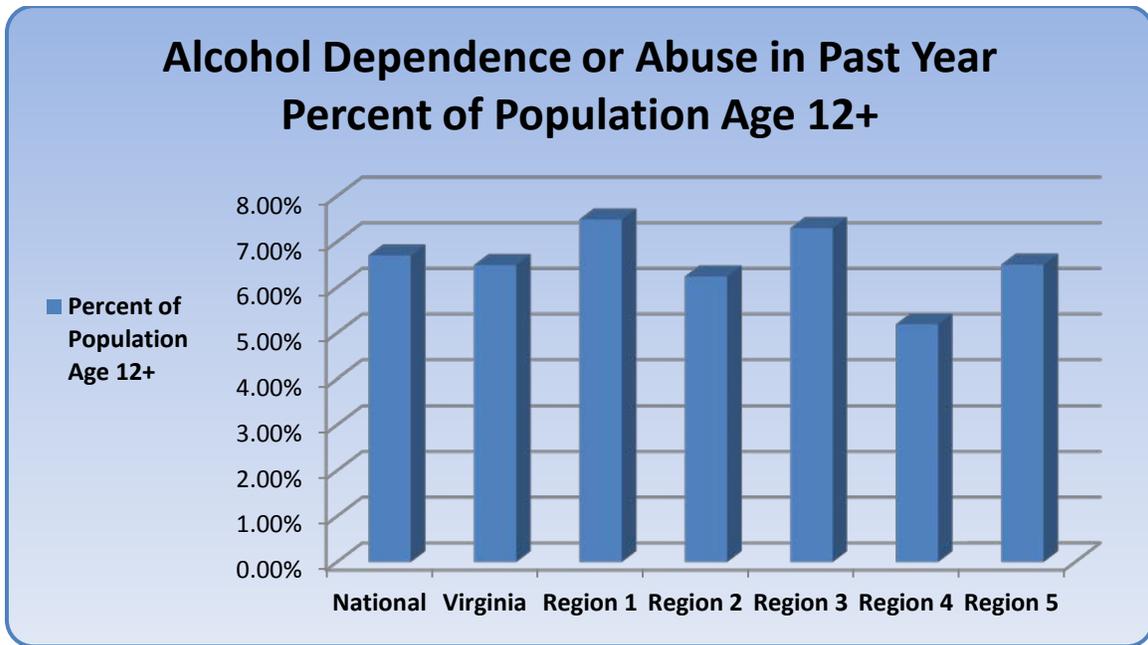
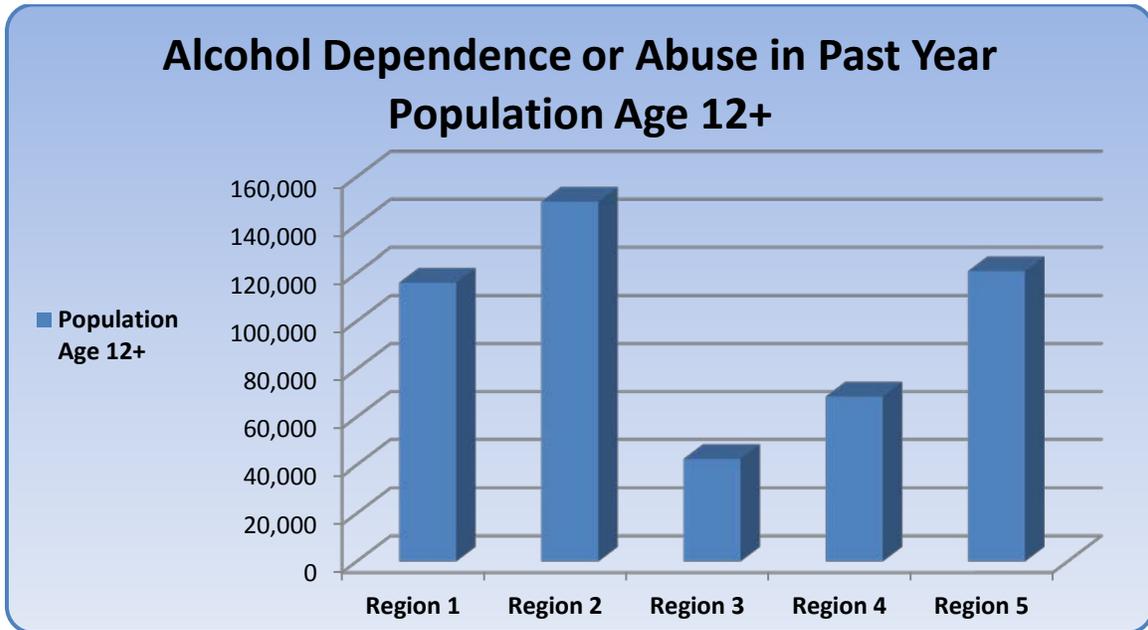
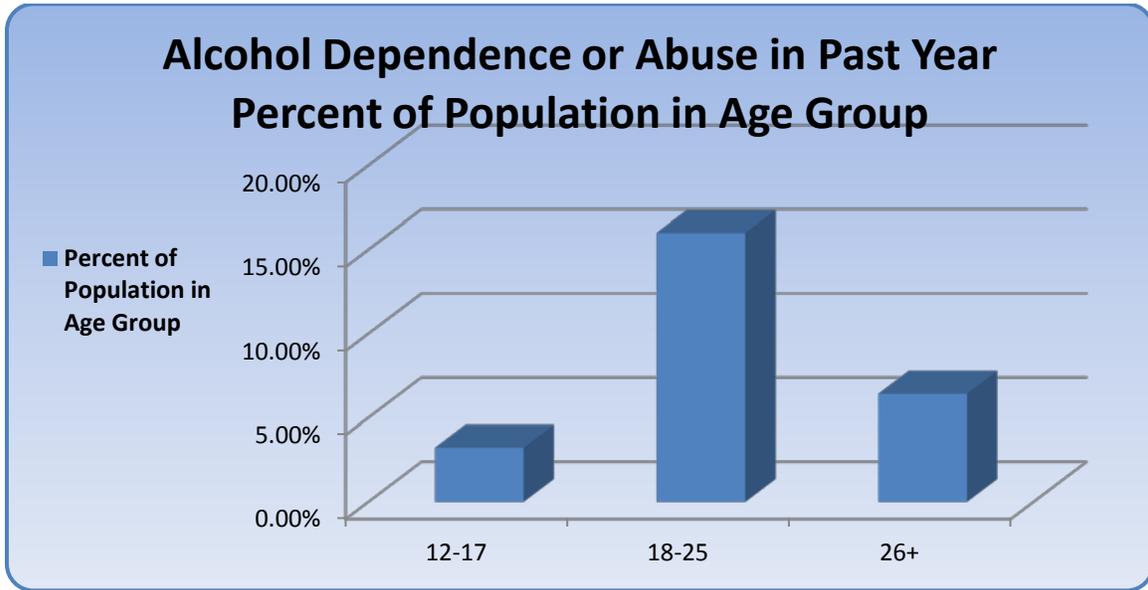


Figure 6



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	6.70%	6.49%	7.49%	6.24%	7.30%	5.19%	6.50%
Population Figure	21,180,632	540,376	116,103	149,652	42,540	68,594	120,891

Figure 7



	12+	12-17	18-25	26+
Percent of Population	7.39%	3.22%	15.99%	6.41%
Population Figure	518,585	20,425	149,252	349,323

Figure 7 above illustrates the degree of alcohol dependence among youth in Virginia. More than three percent of children ages 12-17 suffer from alcohol dependence or abuse, and that number is higher (almost 16 percent) for young adults ages 18-25. Nearly 20 percent of all Virginians ages 12-25 suffer from alcohol dependence.

c. Needing but not receiving treatment for alcohol use - Figures 8-10 illustrate the extent to which individuals in Virginia need but do not receive any treatment for alcohol dependence. The greatest proportion of individuals needing but not receiving treatment are in Regions 1 and 3, but the greatest overall numbers of those individuals are in Regions 1 and 2.

Figure 8

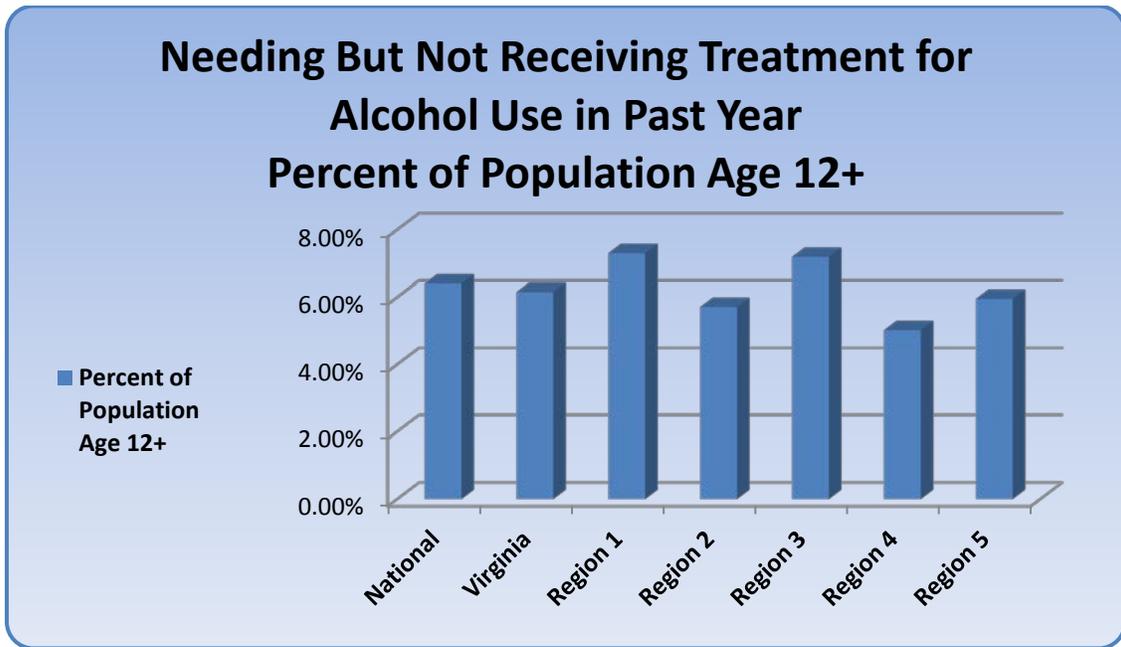
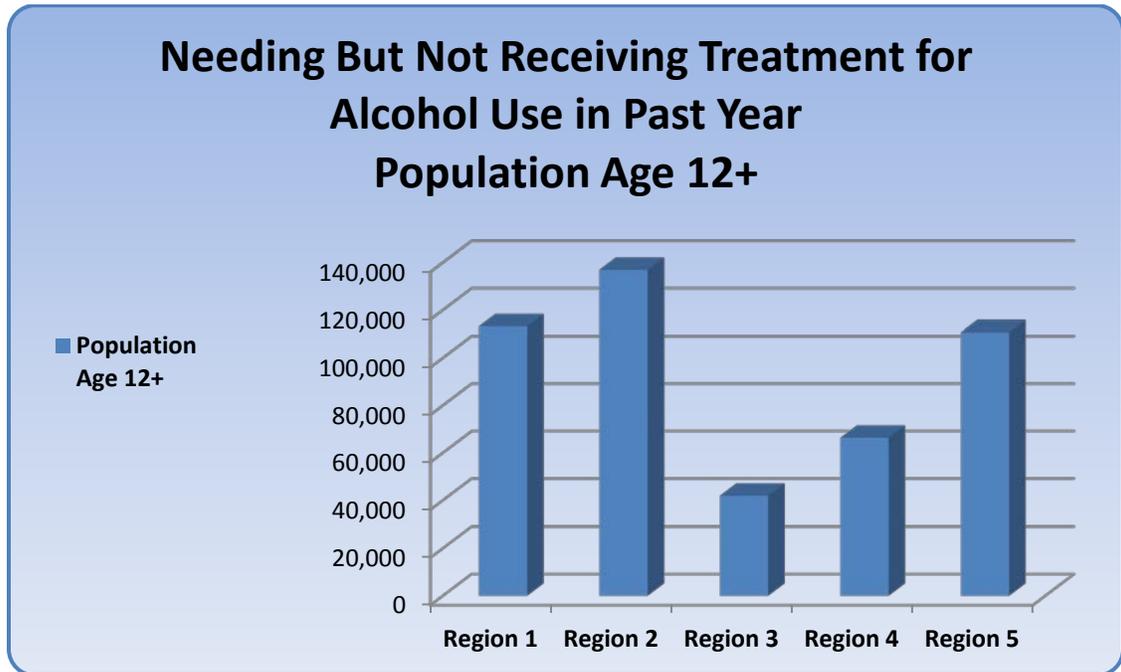


Figure 9

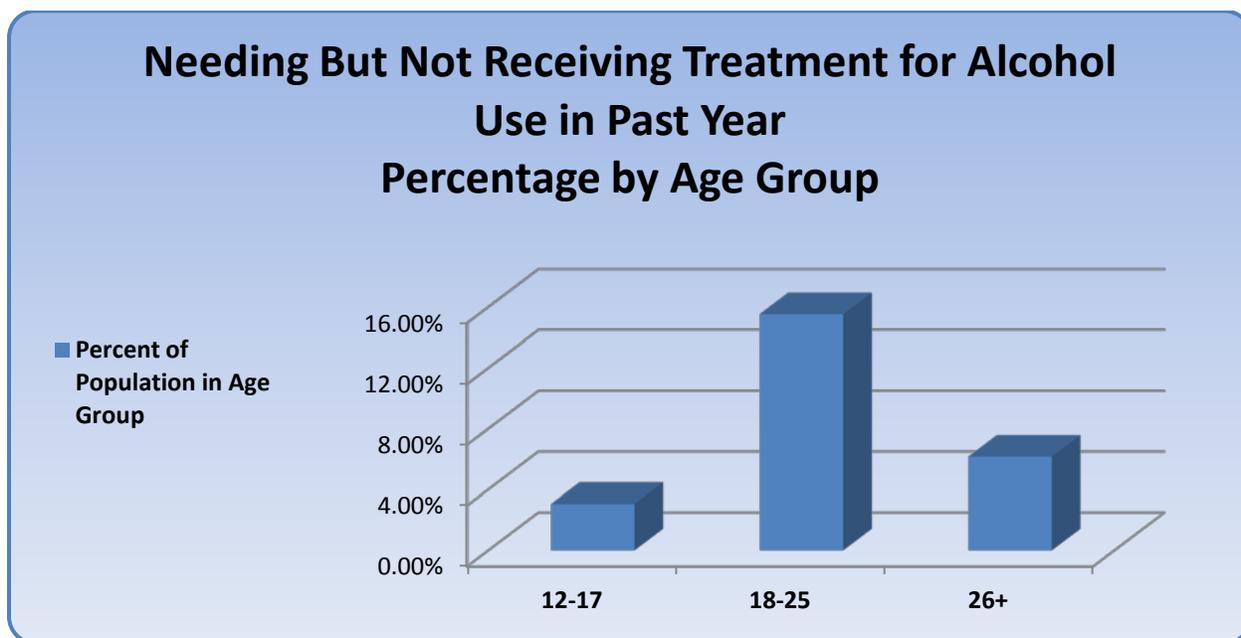


	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	6.40%	6.15%	7.30%	5.71%	7.19%	5.02%	5.95%

Population Figure	20,232,246	512,067	113,158	136,941	41,899	66,347	110,662
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As illustrated earlier, adolescents and young adults in Virginia exhibit higher rates of alcohol dependence than in the general population. Those same age groups also have higher rates of needing but not receiving treatment, as the Figure 10 below indicates.

**Figure 10**



	12+	12-17	18-25	26+
Percent of Population	7.10%	3.04%	15.51%	6.14%
Population Figure	498,234	19,283	144,772	334,608

**Illicit drugs** include both illegal and legal drugs that are used illicitly. Illicit drug use is on the rise in the United States. In 2012, an estimated 9.27 percent of Americans aged 12 or older were current (in the last 30 days) illicit drug users. This is an upward trend from 8.0 percent in 2008 and 7.9 percent in 2004. Marijuana, psychotherapeutics, and prescription medications lead the list of the most abused illicit drugs. In Virginia, the incidence of illicit drug use is highest in Region 5 and lowest in Region 2, as shown in Figure 11. In actual numbers, Figure 12, Region 5 has the highest actual number of people using illegal drugs, with Regions 1 and 2 at nearly the same level. Region 3 has the fewest overall number of individuals identified as current illicit drug users.

Figure 11

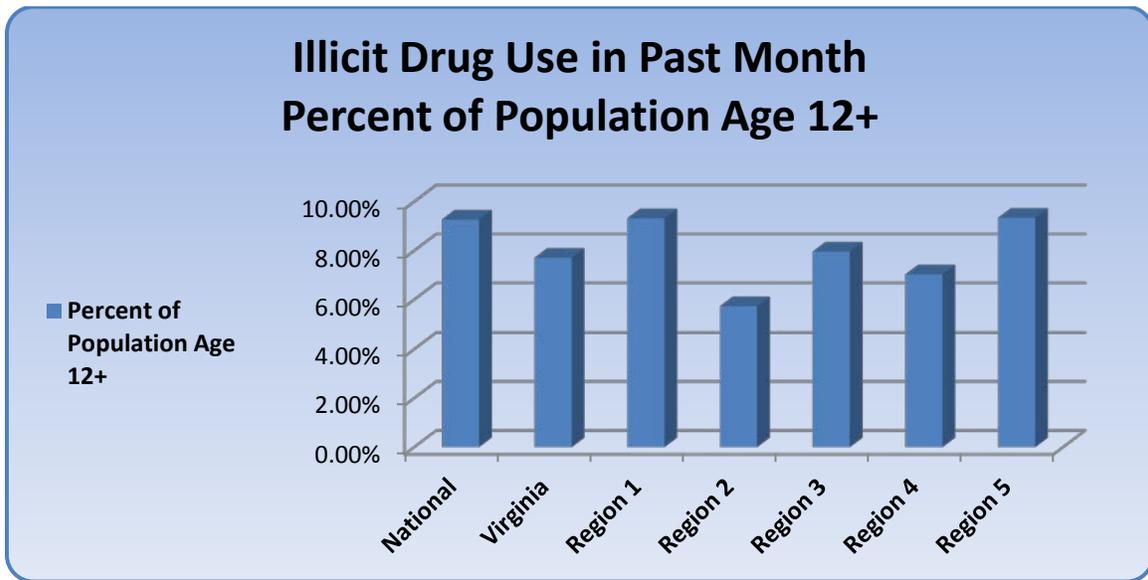
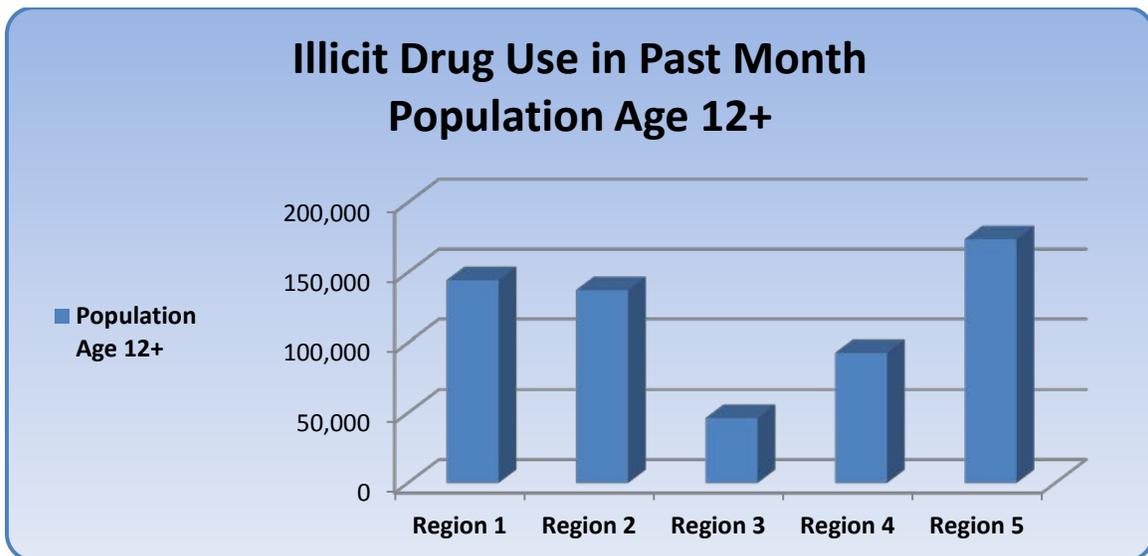


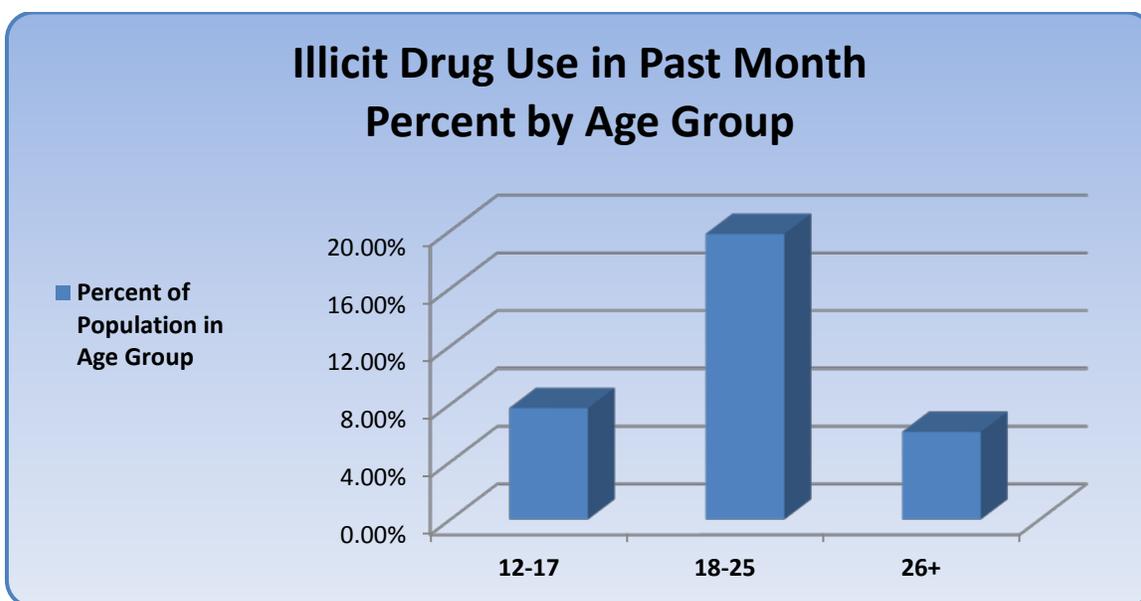
Figure 12



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	9.27%	7.71%	9.32%	5.73%	7.96%	7.03%	9.34%
Population Figure	29,305,143	641,957	144,470	137,421	46,386	92,912	173,711

When viewed by age group, the incidence of current illicit drug use is significantly higher than that of alcohol dependence in Virginia. Whereas around 20 percent of Virginians ages 12-25 are currently abusing or dependent on alcohol, almost 30 percent are illicit drug users. Figure 13 shows the percentage of illicit drug use in the past month by age group. The majority of that higher incidence is due to the 18-25 age group (15.99 percent for alcohol use, 19.78 percent for illicit drug use).

Figure 13



	12+	12-17	18-25	26+
Percent of Population	8.04%	7.73%	19.78%	6.08%
Population Figure	564,198	49,033	184,628	331,339

a. Marijuana use of individuals age 12 and older in Virginia is not as high as the national average in most of regions; with the exception of regions 1 and 5. Figure 14 shows Region 1 has the highest proportion of use (Region 5 is second) while Figure 15 shows Region 5 has the highest number of actual persons using marijuana in the last year (Region 1 ranks second in total number of users).

Figure 14

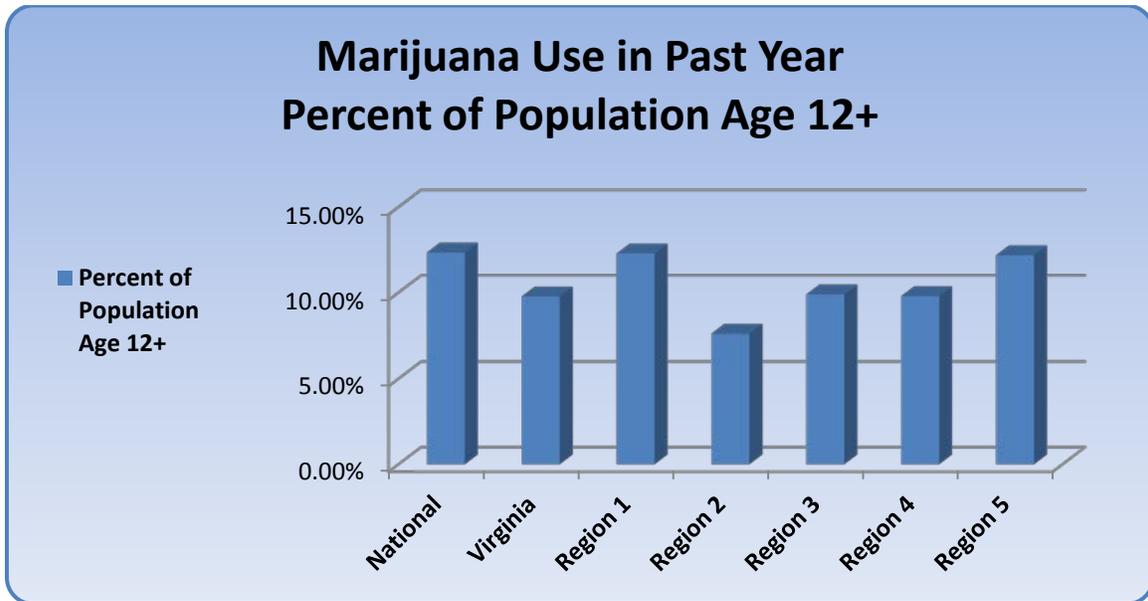
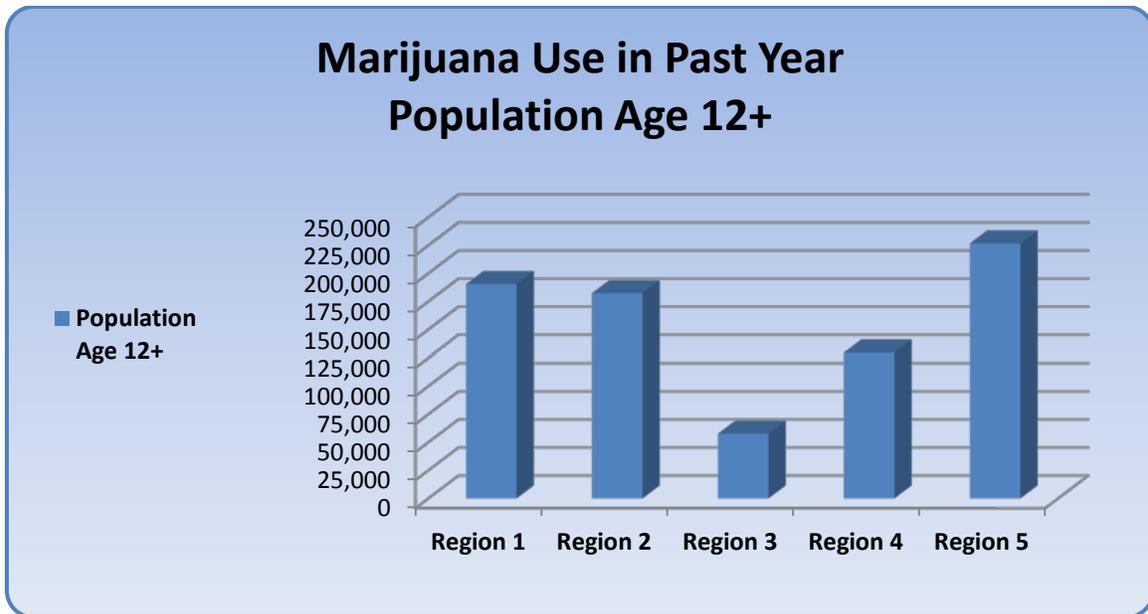


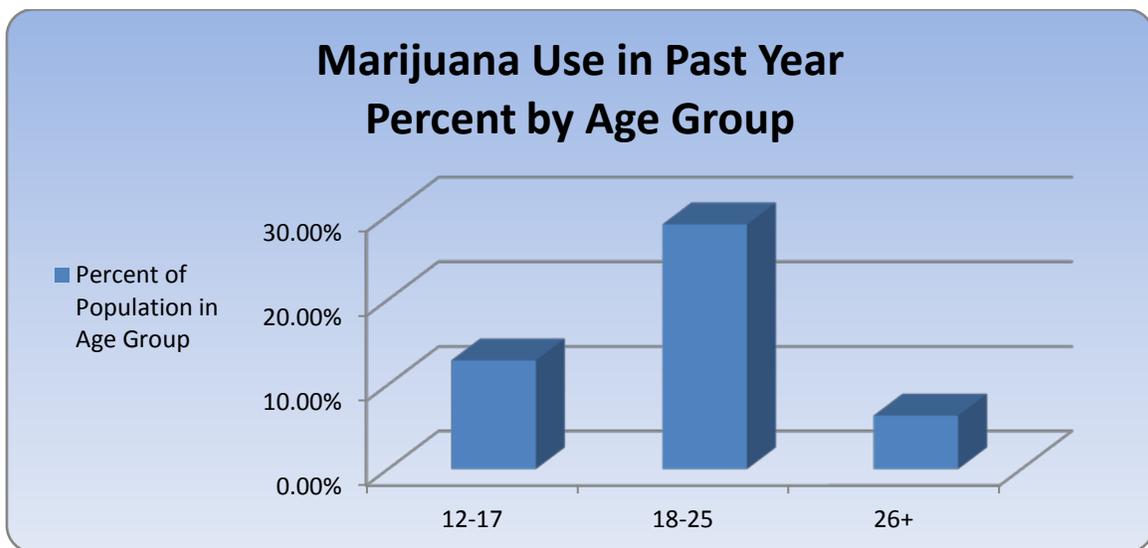
Figure 15



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	12.34%	9.77%	12.28%	7.60%	9.89%	9.79%	12.18%
Population Figure	39,010,299	813,478	190,353	182,268	57,633	129,390	226,531

Figure 16 shows more than 12 percent of those between the ages of 12-17 and more than 30 percent of those between the ages of 18-25 currently use marijuana in Virginia, proportions higher than illicit drugs as a whole. These numbers dwarf the proportion of adults age 26 and older who currently use marijuana, and provide a startling picture of the prevalence of marijuana use by Virginia’s adolescents and young adults.

**Figure 16**



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

b. Cocaine use is not tracked for this report due to the low level of use in Virginia (1.36 percent), which is lower than the national average (1.69 percent).

c. Nonmedical use of pain relievers (commonly referred to as prescription drug abuse) continues to be an area of primary concern for Virginia. In the past, the southwest region of the state had been disproportionately affected by this phenomenon, as Region 3 had the highest proportion of nonmedical use of pain relievers. However, the most recent data indicate that this problem has spread throughout the state. As shown in Figure 17, Region 4 now leads the state in the highest proportion of individuals using pain relievers for nonmedical purposes, with the rate for Region 1 being nearly as high. Unfortunately, a problem that was initially isolated to one part of the state has now spread statewide, and without specific attention and strategies to address the trend, this problem will continue to ravage lives and communities across the Commonwealth.

Region 2 has the highest overall number of individuals using pain relievers for nonmedical use as shown in Figure 18. The abuse of these drugs by young people presents a critical concern, as rates of abuse are nearly three times as high for adolescents between the ages of 18-25 as it is for adults, as shown in Figure 19. Additionally, the continued efforts at the national, state, and local level to address the diversion of prescription pain relievers has reduced their supply for illicit use, leading individuals who have become addicted or dependent to opioids to turn to heroin because it is inexpensive and easier to obtain than prescription pain medication.

Figure 17

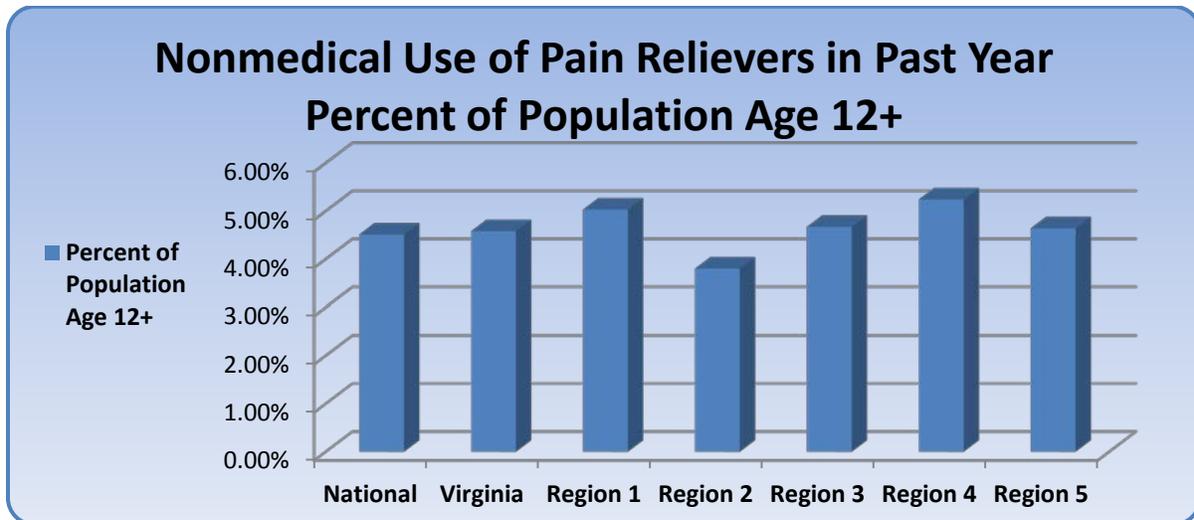
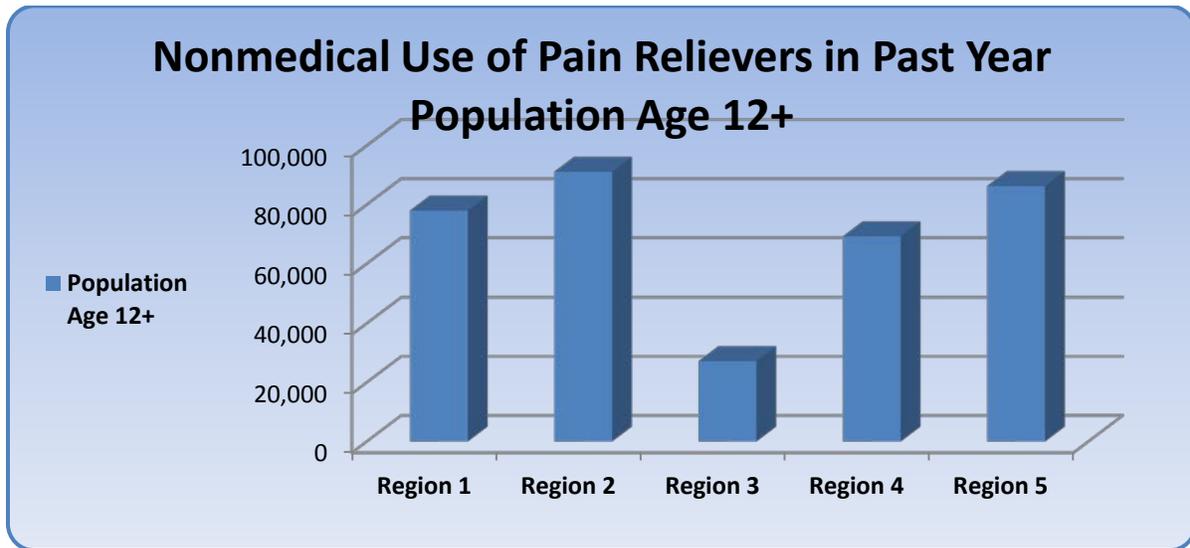
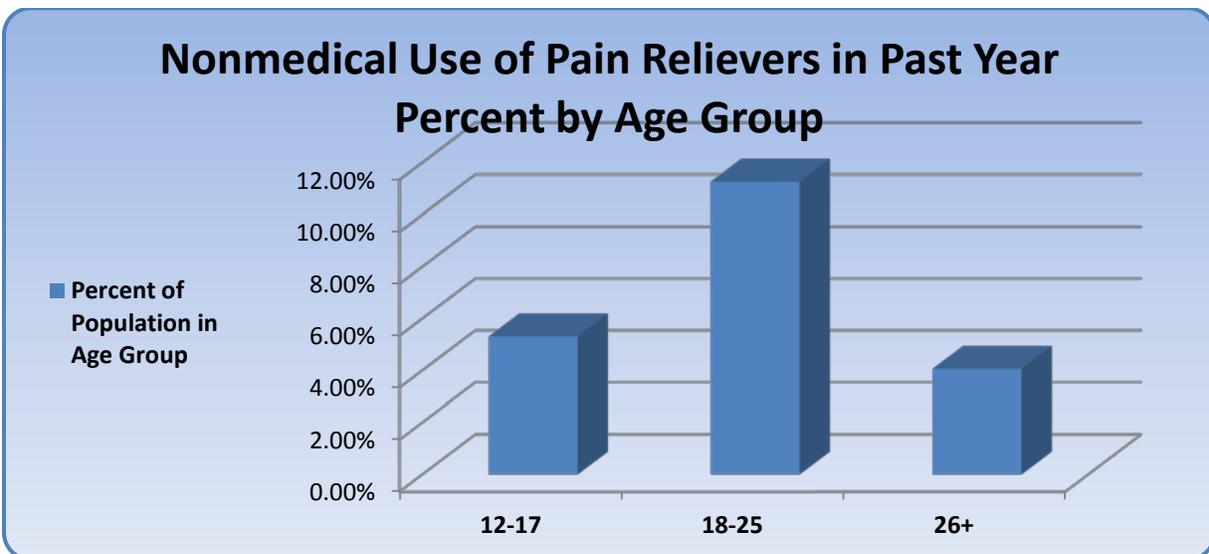


Figure 18



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	4.51%	4.58%	5.03%	3.80%	4.67%	5.24%	4.64%
Population Figure	14,257,411	381,344	77,970	91,134	27,214	69,254	86,298

Figure 19



	12-17	18-25	26+
Percent of Population	5.31%	11.26%	4.06%
Population Figure	33,683	105,102	221,256

d. Needing but not receiving treatment for illicit drug use is more prevalent in Region 5 than in any other region, followed by Region 3 in Figure 20. While prevalence rates are low in Region 2, it ranks second (behind Region 5) in Virginia in the number of individuals needing but not receiving treatment for illicit drug use, Figure 21. As shown in Figure 22, in spite of the high prevalence rates for illicit drug use for the 12-17 and 18-25 age groups in Virginia, the percentages of individuals needing but not receiving treatment are low: 3.28 percent for ages 12-17 and 7.2 percent for ages 18-25 (both figures are decreases from 2012). However, in actual numbers, approximately 20,800 youth between the ages of 12-17 who need treatment are not receiving it, while approximately 67,000 young adults between the ages of 18-25 who need treatment are not receiving the help they need.

Figure 20

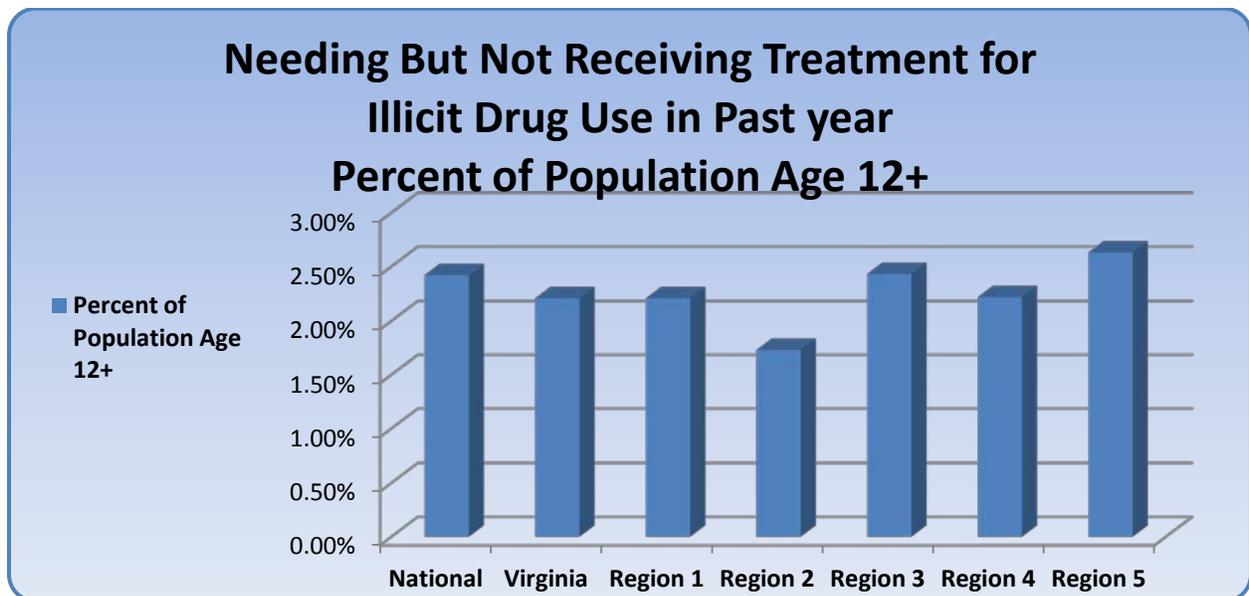
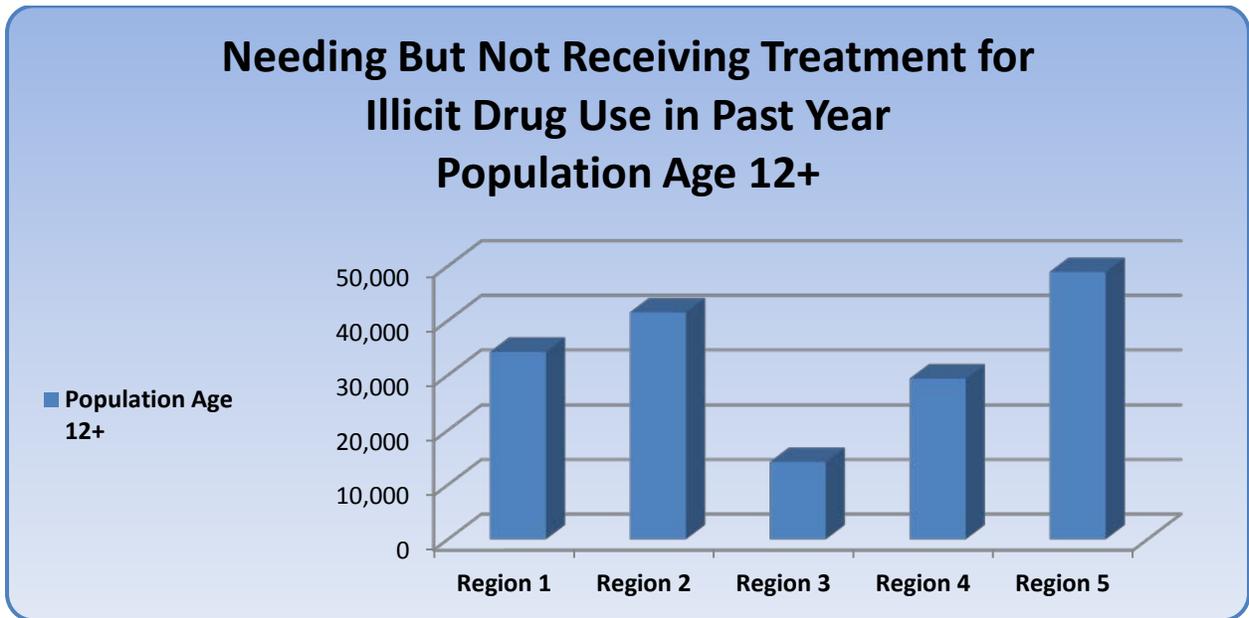
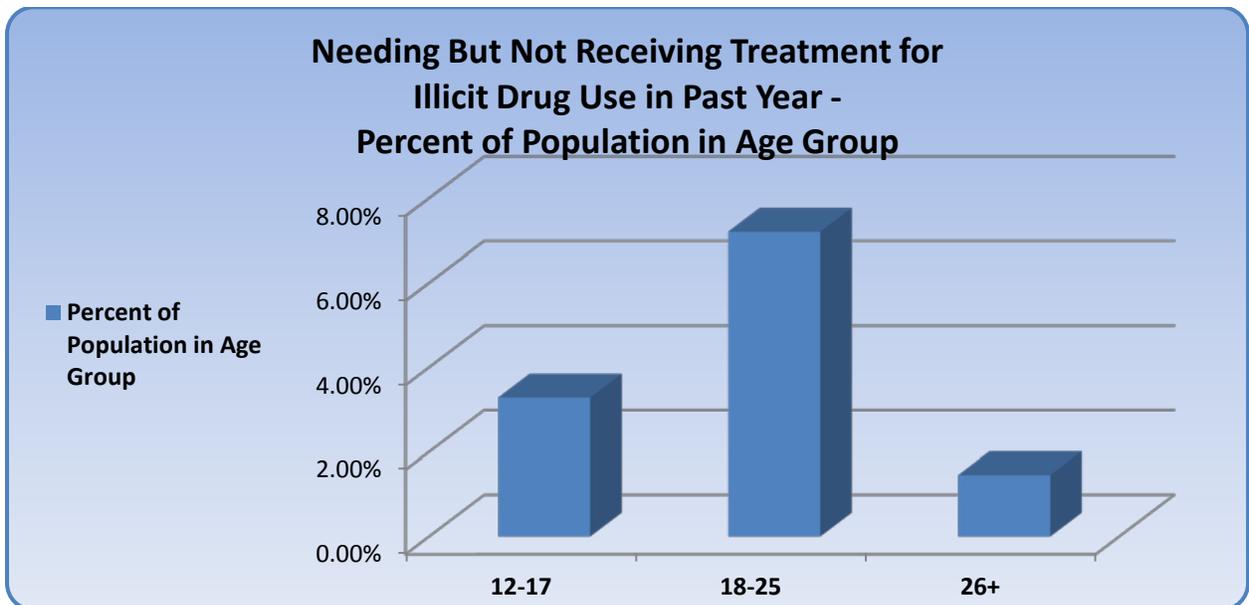


Figure 21



	National	Virginia	Region 1	Region 2	Region 3	Region 4	Region 5
Percent of Population	2.42%	2.21%	2.21%	1.73%	2.43%	2.22%	2.63%
Population Figure	7,650,318	184,011	34,257	41,490	14,160	29,341	48,914

Figure 22

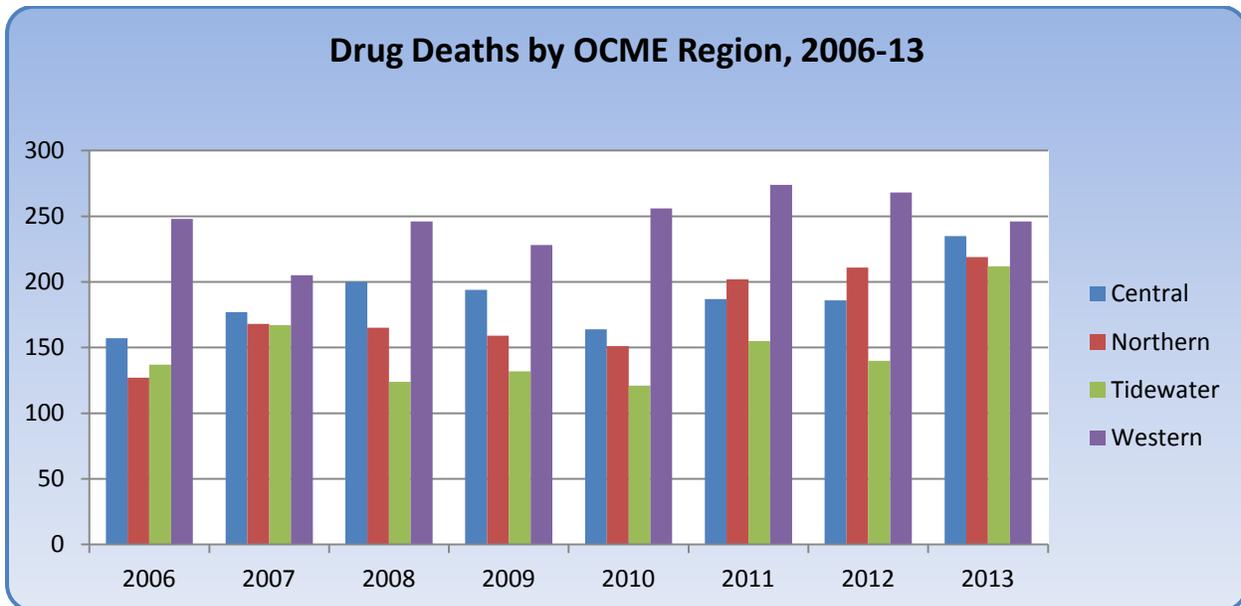


	<b>12-17</b>	<b>18-25</b>	<b>26+</b>
Percent of Population	3.28%	7.20%	1.45%
Population Figure	20,806	67,206	79,020

**Office of the Chief Medical Examiner**

The Office of the Chief Medical Examiner (OCME) produces an annual report on causes of death in the state. Alarming, the most recent report available, *The Office of the Chief Medical Examiner 2013 Annual Report*, indicates that the number of drug caused deaths since 2010 has increased 31.8 percent. In 2013, 912 individuals died from drug related causes, with 51 percent of these deaths due to prescription drugs and 26.75 percent due to illicit drugs. The statewide death rate from drug caused deaths in 2011 was 11 per 100,000, higher than the rate of deaths by motor vehicle crashes in Virginia. Although this problem started in the far southwestern region of the state due to abuse of prescription pain medication, it has spread eastward as illustrated by Figure 23. For the first time, the incidences of drug-caused deaths were almost evenly distributed across all four of the OCME regions. Appendix D displays a list of localities by OCME region.

**Figure 23**

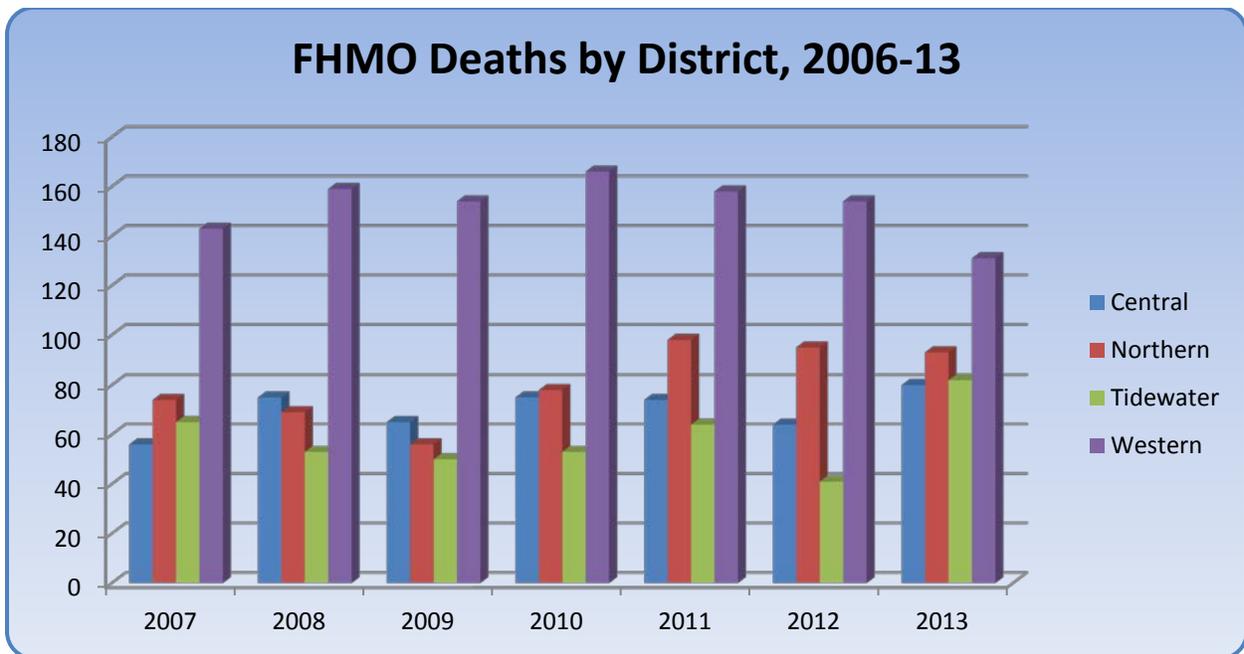


	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>Central</b>	157	177	200	194	164	187	186	235
<b>Northern</b>	127	168	165	159	151	202	211	219

<b>Tidewater</b>	137	167	124	132	121	155	140	212
<b>Western</b>	248	205	246	228	256	274	268	246
<b>Total</b>	669	717	735	713	692	818	805	912

As described above, the abuse of prescription drugs continues to be an area of concern in Virginia. In 2007, the OCME began tracking deaths specifically attributed to fentanyl, hydrocodone, methadone, and oxycodone (FHMO). While the trend in deaths related specifically to these substances has decreased statewide, it has increased in two regions of the state (Central and Tidewater), as illustrated by Figure 24.

**Figure 24**

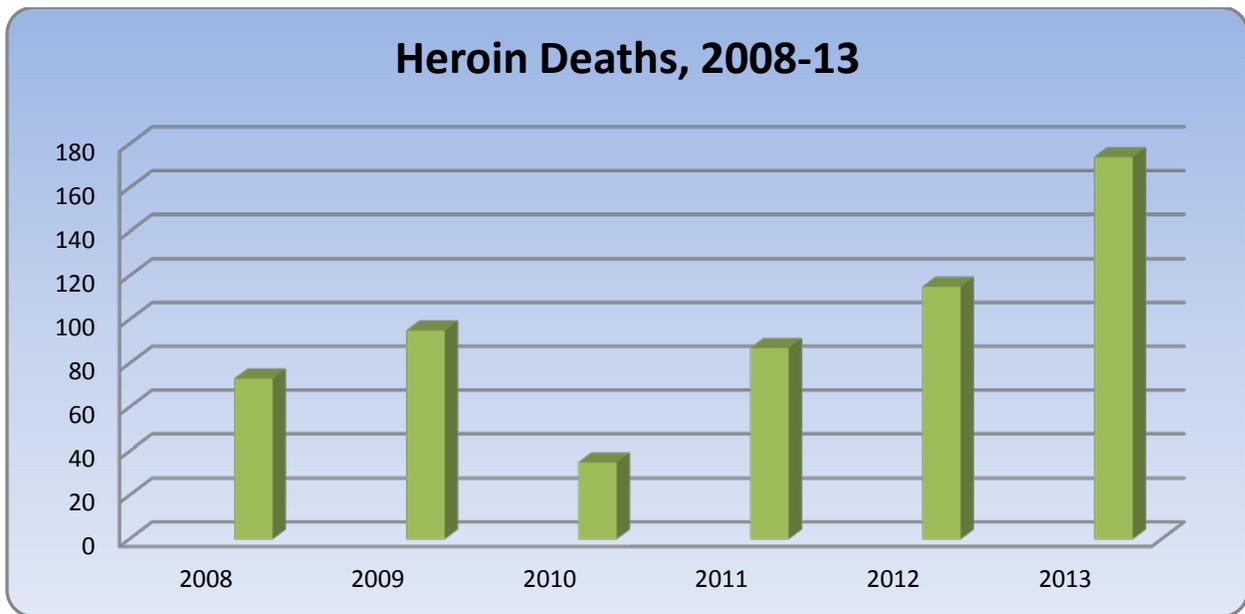


	2007	2008	2009	2010	2011	2012	2013
<b>Central</b>	56	75	65	75	74	64	80
<b>Northern</b>	74	69	56	78	98	95	93
<b>Tidewater</b>	65	53	50	53	64	41	82
<b>Western</b>	143	159	154	166	158	154	131

Virginia continues to be successful in addressing the issue of diversion of prescription pain relievers for illicit use. Through effort and persistence, the Prescription Monitoring Program at

the Virginia Department of Health Professions (DHP), federal and state law enforcement, and other entities have helped to increase the rate of diversion, and thus the rate of deaths, caused by prescription pain relievers, which are opioid-based. An unintended consequence has been that many of those who have become addicted to or dependent on those prescription pain relievers have begun to use heroin, another opioid, because it is inexpensive and, relative to prescription pain medication, often easier to obtain. The number of heroin deaths spiked in Virginia in 2013 as shown in Figure 25, and it is believed that the relative scarcity of opioid-based prescription pain relievers available for illicit use is part of the reason. Heroin deaths doubled from 2011 (87) to 2013 (174).

**Figure 25**



	2008	2009	2010	2011	2012	2013
<b>HEROIN</b>	73	95	35	87	115	174

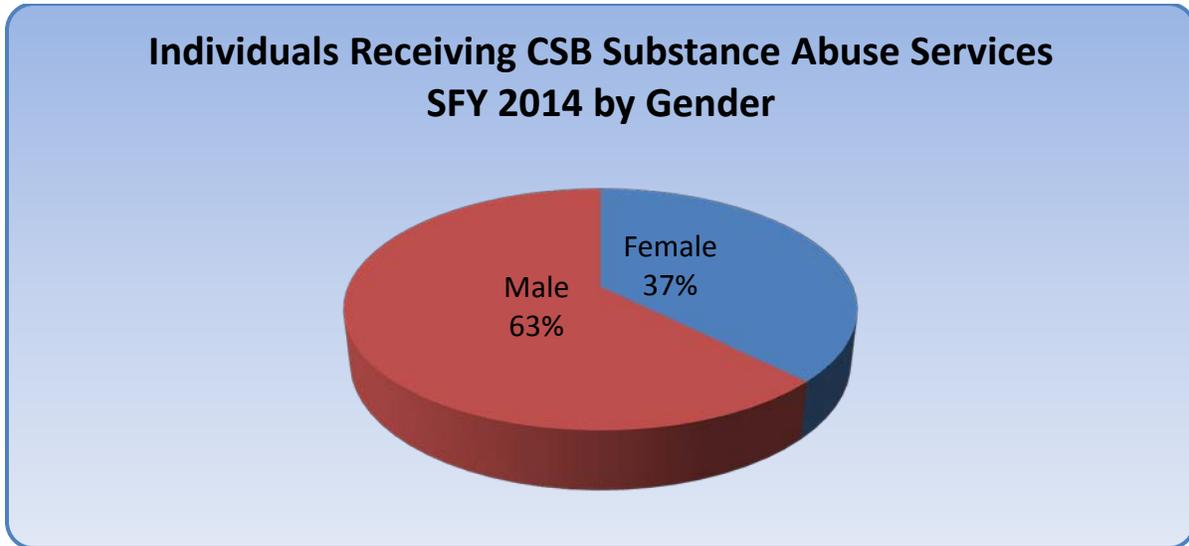
### **PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES**

The table below displays the amount of revenue for substance abuse services by source for FY 2014.

<b>Source of Funding</b>	<b>Amount</b>
Federal Funds	\$41,514,129
State Funds	\$47,271,548
Local Funds	\$35,545,196
Fees	\$13,963,682
Other Funds	\$5,312,221
<b>Total</b>	<b>\$143,606,776</b>

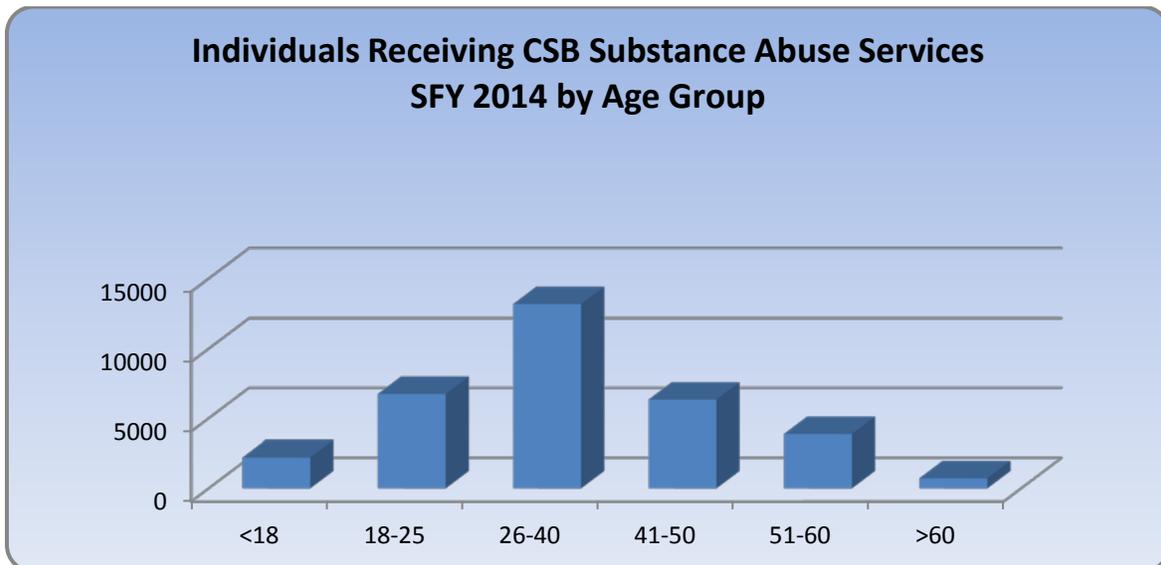
Figures 26-28 below present data on the gender, age and race of the individuals served in FY 2014.

**Figure 26**



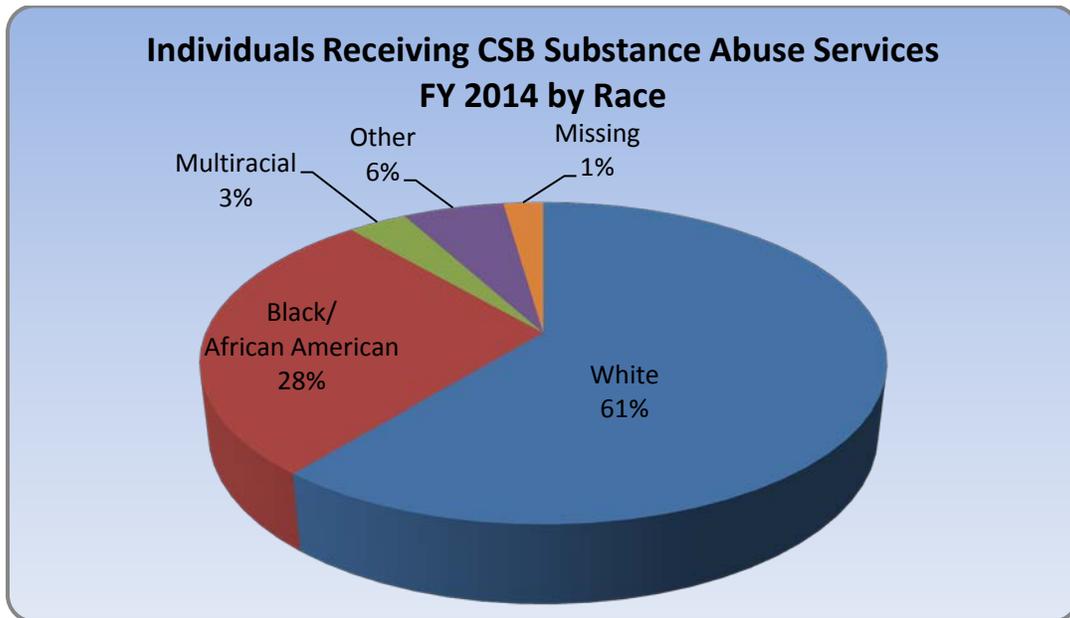
Individuals served were predominately male (20,658 or 63 percent) with 12,371 females (37 percent) receiving services.

**Figure 27**



The average age for service recipients was 34 years of age. Forty percent of these individuals (13,163) were in the 26 to 40 age range.

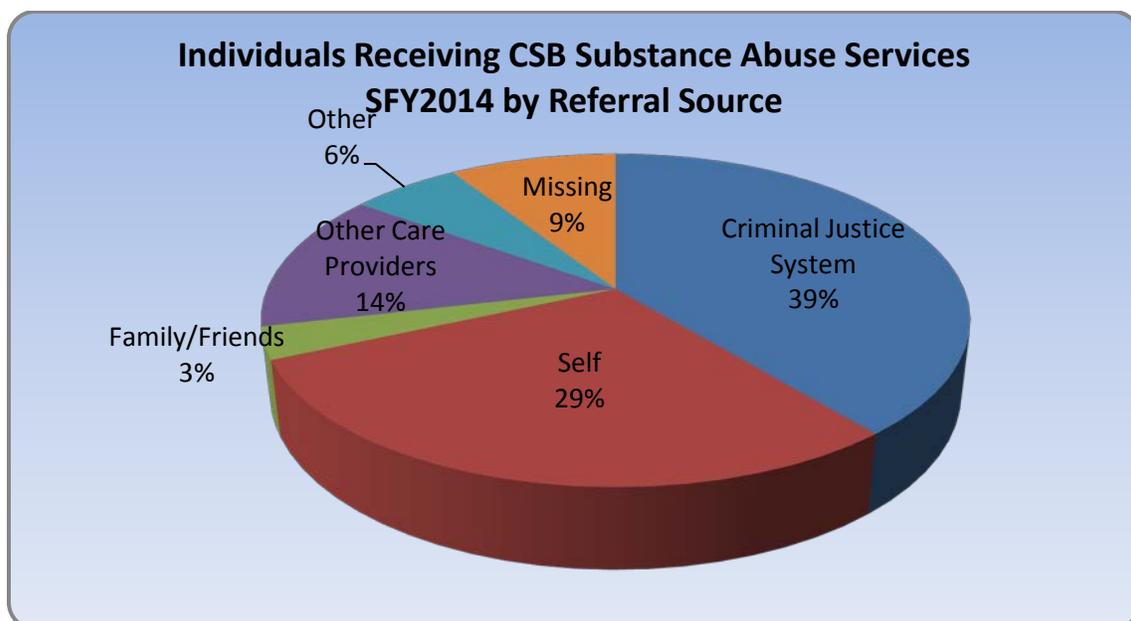
Figure 28



Most individuals served reported their race as White (20,126 or 61 percent) with 9,183 individuals (or 28 percent) reporting their race as Black/African American. Six percent (1,884) reported their race in other categories (Asian, Native American, Pacific Islander) while three percent (1,099) identified themselves as being Multi-Racial.

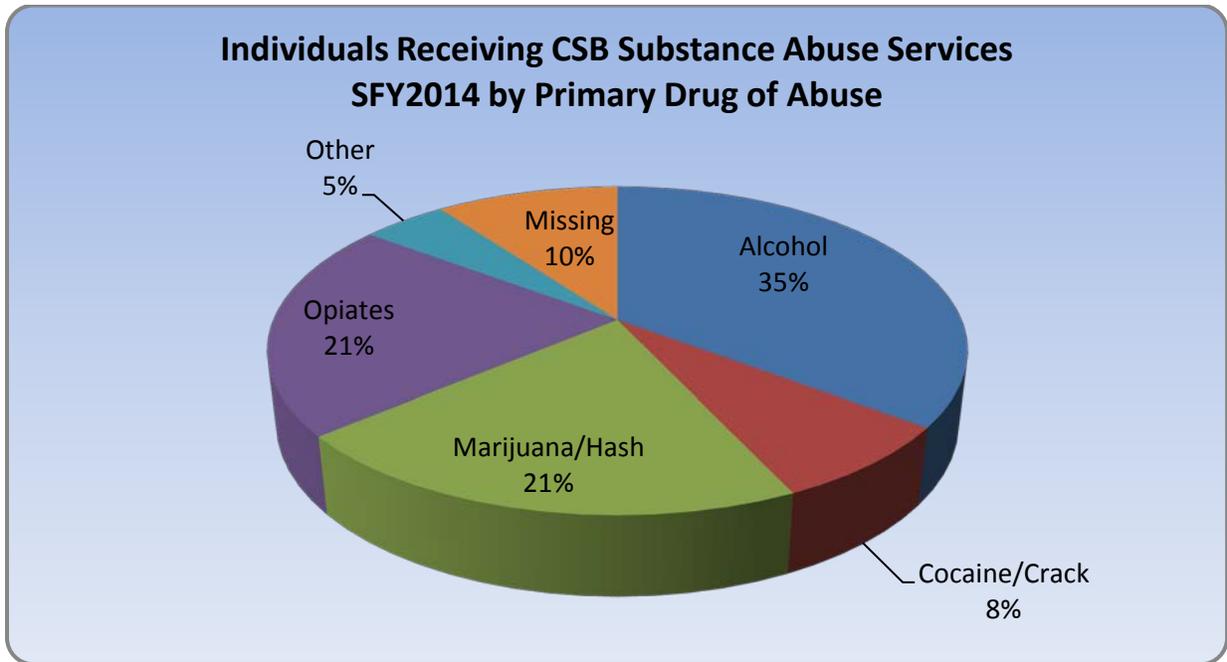
Figures 29-30 display data on sources of referral and primary drugs of abuse for service recipients.

Figure 29



The most common sources of referral were from components of the criminal justice system (12,874 or 39 percent), which along with self-referrals (9,687 or 29 percent), accounted for over half of the individuals served.

Figure 30



Almost 12,000 service recipients (35 percent) reported alcohol as their primary drug of abuse. Marijuana/Hashish (6,863 or 21 percent) and Heroin/Methadone/Other Opiates (7,071 or 21 percent) were the second and third most commonly reported drugs.

## MAJOR ACTIVITIES RELATED TO SUBSTANCE ABUSE SERVICES

### Treatment Services

**Project REVIVE!: Opioid Overdose Reversal.** The 2013 Session of the General Assembly enacted HB 1672 which required DBHDS to develop a pilot program to make naloxone, a medication that reverses opioid overdose, available to friends and family members of individuals at risk of overdose. Working with the VDH, DHP, and community leaders in pilot regions (metropolitan Richmond area and the far southwestern part of the state), DBHDS developed REVIVE!. The legislation also allowed prescribers to prescribe naloxone to a person for use on an individual who may be unknown to the prescriber (“non-patient specific” prescribing) and provided civil immunity to individuals who participate in the pilot. The legislation directed DBHDS to be the lead agency for conducting pilot programs on the administration of naloxone to counteract the effects of opioid overdose emergencies. The General Assembly appropriated \$10,000 to execute the pilot, which began operating in June 2014.

***Synar: Tobacco Law Compliance.*** The Synar Amendment is part of the legislation that authorizes Congress to appropriate funds for the SAPT Block Grant which provides about 40 percent of the funds that DBHDS allocates to the CSBs to support community based substance abuse treatment. The Synar Amendment requires states to: (1) enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18; (2) conduct random, unannounced inspections of tobacco outlets; and (3) report findings to the U.S. Secretary of Health and Human Services annually. States must employ scientifically valid sampling standards to select the retail outlets that are inspected to ensure that the results are representative of retailer noncompliance statewide and must achieve a compliance rate of at least 20 percent. Failure to comply can result in a loss of up to 40 percent of the state's SAPT block grant award, which would be \$16 million in Virginia. Authority for enforcement of the required state code lies with the Department of Alcoholic Beverage Control (ABC), and DBHDS contracts with ABC to conduct annual inspections of about 1,000 retail outlets. As required by the Synar Amendment, ABC recruits young people aged 15 to 17 and trains them to assist in the inspections, accompanied by two adult ABC special agents. Since reporting an initial retailer violation rate of 45 percent in 1996, Virginia's rate improved steadily and has remained below the 20 percent target since 2001. During 2013 and 2014, Virginia reported rates of 9.7 percent and 9.0 percent, respectively.

***Reviews of Community Services Boards.*** DBHDS conducts reviews of five CSBs each year. These CSBs are selected based on financial risk as determined by its internal auditor. In addition, follow-up reviews are conducted on CSBs with outstanding findings. This process is led by the DBHDS Internal Audit Office who are accompanied by program staff from the Office of Substance Abuse Services (OSAS), who make recommendations for changes in policies and procedures, improvements in practices, changes in use of funds, and in use of technical assistance.

***Bringing Recovery Supports to Scale-Technical Assistance Center Strategy (BRSS-TACS).*** In 2012, Virginia was competitively selected by SAMHSA to participate in a policy academy that focused on assisting state behavioral health systems with developing a recovery oriented system of care in their treatment systems for people with substance use disorders or mental illness. The Bringing Recovery Supports to Scale-Technical Assistance Center Strategy (BRSS-TACS) Policy Academy, evolved into a significant strategic activity for DBHDS, resulting in the development of seven regional teams that include individuals in recovery, representatives from state mental health hospitals and CSBs, and the Department of Medical Assistance Services (DMAS) to design, implement and support this effort. OSAS staff served as the project coordinator from submission of the application in 2012 throughout implementation during this period. This initiative sponsored two statewide conferences (June 2013 and May 2014), each of which was attended by approximately 130-140 individuals. The conferences were supported by \$50,000 that Virginia received from SAMHSA, and were led by national leaders in the recovery movement.

***Certification of Peer Recovery Support Specialists in Virginia.*** During the last biennial period covered in this report, DBHDS began work on developing a credentialing process for peer specialists in Virginia that will certify both substance abuse and mental health peer providers with a single credential. Before the creation of the new DBHDS Office of Recovery Services, OSAS staff led this effort, working with community peer leaders throughout 2014 to create a

code of ethics, an implementation plan, consensus on the process and infrastructure for credentialing, and identification of sources of funds to administer and maintain a certification process.

***Peer Support Services in CSBs.*** OSAS continues to provide financial support to seven CSBs that provide substance abuse peer support services by hiring of individuals in recovery or through contract with community based peer led organizations.

***Medication Assisted Treatment.*** Virginia is experiencing significant growth in opioid treatment programs that utilize methadone to treat individuals who are addicted to opioids. DBHDS licenses these programs and provides significant technical assistance to address federal regulations. During the reporting period, OSAS staff provided ongoing technical assistance to 11 potential providers in the following unserved or underserved areas of the state: Chesapeake, Newport News, Fredericksburg, Pulaski, Williamsburg, Danville, and Virginia Beach. By June 30, 2014, eight of these programs had been licensed and three had licensure pending.

***Screening Women for Substance Use and Mental Health Disorders.*** As family care takers, women are often responsible for the physical and emotional well-being of their children. If they are impaired by substance abuse or addiction, the whole family is at-risk. If the woman is pregnant, the health of her baby is at-risk. To help health professionals address this, DBHDS developed information on its website regarding screening and brief intervention services for pregnant women and women of childbearing age. DBHDS partnered with DMAS and VDH to develop the Behavioral Health Risks Screening Tool for Women of Child Bearing Age, a screening tool for pregnant women and women of childbearing age that screens for substance use, mental health, and intimate partner violence. VDH introduced use of the tool in its maternal health program and has translated it into three languages. DBHDS and VDH provided a webinar in July 2012 to train VDH staff on use of the tool.

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

***Virginia Association of Medication Assisted Recovery Programs (VAMARP).*** This conference, held annually in Richmond, provides current, knowledge-based training to professionals and other persons who work with individuals who are dependent on opiates. Attendees include staff providing direct clinical care, community corrections staff, and local and state health department staff. DBHDS contributes staff support and funding from the federal SAPT block grant. The 2012 VAMARP Conference, held October 10-11, focused on: improving the clinical knowledge of counselors and nurses in opiate treatment programs serving individuals with both mental illness and substance use disorders; enhancing knowledge about the connection between hepatitis and injection drug use; reducing stigma; and providing person-centered treatment that focuses on recovery. Using SAPT block grant funds, DBHDS sponsored David Mee-Lee, M.D., who delivered the key-note speech on *Understanding and Using ASAM Criteria and Opiate Treatment Programs*. In 2012, more than 208 attendees participated in the conference. The 2013 VAMARP conference, held October 15-16, focused on: identifying and

addressing specific issues that influence treatment of opioid addiction; medical and clinical issues for counselors, nurses, pharmacists and physicians; and strategies to assist individuals with recovery support and in dealing with stigma. More than 242 attendees participated in the 2013 conference.

Virginia Summer Institute for Addiction Studies (VSIAS). DBHDS provided staff assistance and financial support using SAPT block grant funds for the annual institute held in Williamsburg on July 16-18, 2012, and on July 15-17, 2013. VSIAS connects participants with contemporary experts in the addiction treatment field through workshop sessions, featured forums, and hands-on workshops. Sessions include training in core competencies, specific counseling skills, prevention, recovery, and cultural competency. The learning objectives are to provide knowledge improvement and skill development opportunities to treatment providers, prevention staff, probation and corrections staff, school personnel, social services staff and others who work with adults and youth with substance use disorders. The theme of the 2012 VSIAS was *Professional Treatment – Saving Lives, Saving Dollars*. Topics included evidence-based practices, ethics, and stigma reduction. A total of 366 persons from across the state participated. The theme of the 2013 VSIAS was *Concepts of Addiction Treatment – Untangling the Knot*. Topics included trauma and addiction, clinical supervision, and Recovery Oriented Systems of Care (ROSC). A total of 318 persons from across the state participated.

Adolescent Substance Abuse: When Is It A Problem? Using SAPT block grant funds, OSAS worked with the DBHDS Office of Child and Family Services (OCFS) to sponsor a presentation on May 23, 2013 by Barbara Burke, LCSW, for families who are concerned that their child may have a substance abuse disorder and have questions regarding treatment, recovery, and how to maintain the family system. The three-hour session focused on the signs and symptoms of substance abuse and dependence, the culture of drugs and alcohol, drug use trends, how and when the parent or guardian should intervene, and how to stabilize the family. Fifteen family members attended the session.

Trauma Informed Care and Substance Abuse. Research indicates that many individuals struggling with substance abuse, addiction and mental health issues have experienced severe trauma in their lives that must be addressed as a part of successful treatment. Using SAPT block grant funds, OSAS worked with the OCFS to sponsor a presentation by Patricia Mullen from the Chesterfield Community Services Board and Dr. Allison Jackson. Held on April 22, 2014, the training, designed for direct care professionals, focused on key elements of trauma informed care for substance using adolescents. Participants received an overview of assessment and treatment strategies as well as a review of appropriate assessment tools. The presentation was attended by 127 participants including staff from the Department of Juvenile Justice (DJJ), the Department of Social Services, CSBs, and private providers.

ACCESS Training. Even if they are not currently experiencing a crisis, individuals seeking behavioral health care need to receive treatment in a timely manner. A lack of access to the appropriate clinical services may result in decreased engagement in services and less effective treatment. Unfortunately, a number of individuals may wait weeks to access the appropriate level of care, particularly outpatient and some residential services.

To help CSBs address this problem, the OSAS, along with the Virginia Association of Community Services Boards (VACSB), co-sponsored and financially supported training to help CSB leadership improve timely access to treatment by utilizing different staffing and documentation practices. Scott Lloyd, President of MTM Services, provided training on *Same Day/Open Access to Treatment, Collaborative Documentation, No-Show Management, and Determining Your Costs/Process Measurement*. The training was held in Richmond on August 7-8, 2012 and was attended by over 140 individuals representing CSB leadership, direct service, and data/fiscal management staff, as well as DBHDS staff.

*HPR III Training Institute*. Using SAPT block grant funds, OSAS sponsored national speakers for this annual regional event in September 2012. Michael Nerney trained on *Drugs of Abuse across the Lifespan*; Ken Winters trained on *This is Your Brain on Adolescence*; and Gabriella Grant trained on *Seeking Safety: A Model for Trauma and/or Substance Abuse*. These workshops were attended by 207 persons.

*Clinical Supervision*. Using SAPT block grant funds, DBHDS supported skill and knowledge training in clinical supervision to assure best practices and fidelity to evidence-based treatment models. Approximately 113 new and experienced clinical supervisors from CSBs, state facilities, and the DJJ attended four cycles of a five-day training and skill development program, *Clinical Supervision Workshop and Clinic*, from June through September of 2012 and from March through June of 2014. This training met the requirements of the DHP Board of Counseling and Board of Social Work for supervisors of candidates for either the professional counselor license (LPC) or clinical social worker license (LCSW).

*Psychiatrists and Other Medical Staff*. In collaboration with the University of Virginia and the VACSB, OSAS sponsored and funded with SAPT block grant funds a training workshop in Richmond on August 24, 2012. Approximately 120 psychiatrists, doctors, osteopaths, nurses and other clinical staff from CSBs and state facilities attended. DBHDS also collaborated with the Virginia Health Practitioners Monitoring Program (within the DHP) to provide training about pain management for people who are recovering from addiction.

*Cultural Elements in Treating Hispanic and Latino Populations*. The DBHDS Director of Cultural and Linguistic Competency attended a training of trainers sponsored by the federal training addiction network on a new curriculum to teach substance abuse counselors to work with Hispanic and Latino populations. Following the program, the director and OSAS staff members provided this training to CSB staff on October 16-17, 2013 and on March 4-5, 2014. Approximately 75 persons completed this training.

## **Interagency Relationships**

***Substance Abuse Services Council***. The Substance Abuse Services Council is established in the *Code of Virginia* (§2.2-2696) to advise the Governor, the General Assembly and the State Board of Behavioral Health and Developmental Services on matters pertaining to substance abuse in the State. Its membership consists of 29 members who are representatives of state agencies, advocacy and provider organizations, as well as gubernatorial appointees, delegates and senators. The council, which is staffed by the OSAS, meets four times a year and considers

issues that may have bearing on state policy. For more information about the work of the Council, please see: <http://www.dbhds.virginia.gov/about-dbhds/boards-and-councils/substance-abuse-services-council>.

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

***Supreme Court of Virginia - Drug Treatment Courts Advisory Committee.*** The State Drug Treatment Court Advisory Committee (SDTCAC) was established to: (1) evaluate and recommend standards for the planning and implementation of drug treatment courts; (2) assist in the evaluation of their effectiveness and efficiency; and (3) encourage and enhance cooperation among agencies that participate in their planning and implementation. The Chief Justice of the Supreme Court of Virginia is the SDTCAC Chair. DBHDS is one of 26 members represented on the SDTCAC. The Advisory Committee has three standing committees: the operations committee; the planning and development committee; and the evaluations committee. The DBHDS representative actively participates in the work of the operations committee and the evaluation committee. The operations committee is responsible for the review and initial approval of drug treatment court applications.

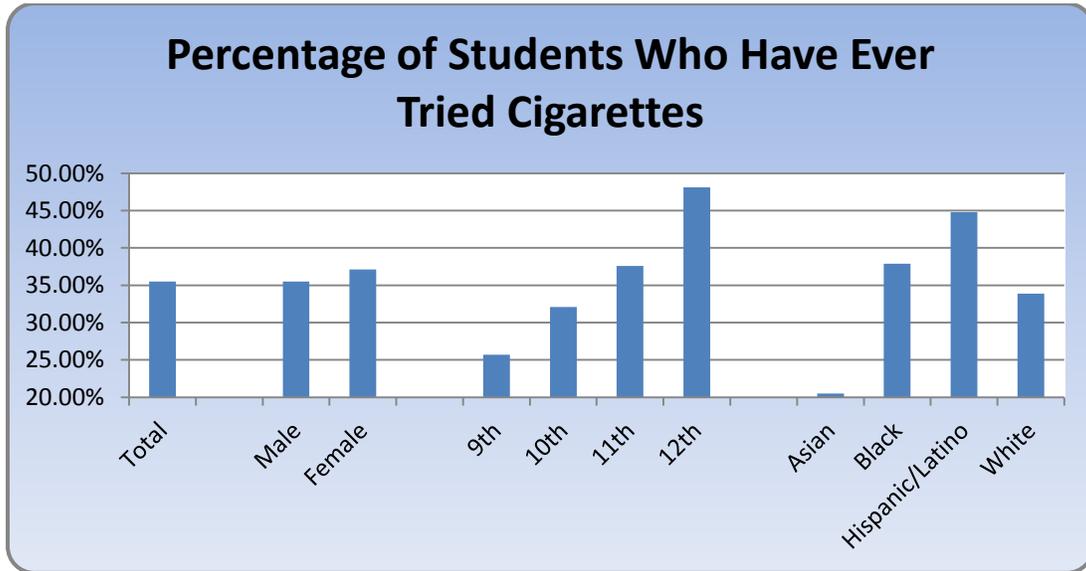
***Virginia Department of Health.*** Due to the strong relationship between substance abuse and health, DBHDS staff routinely participate in a variety of committees and councils sponsored by VDH. These include the Child Fatality Review Team, the Maternal Mortality Review Team, the Home Visiting Consortium and the Community HIV Planning Group.

## **Prevention Services**

***Overview of Substance Abuse Prevention.*** Prevention strategies are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use across the lifespan. Strategies reducing risk factors, increasing protective factors in individuals, families, schools, communities, and the environment, in addition to reducing consumption and related consequences. Prevention services are delivered prior to the onset of a disorder.

Annually, DBHDS receives \$8,098,544 (20 percent) of SAPT block grant to support state and local infrastructure and services through the CSBs. In Figures 31-34, data from the 2013 Virginia Youth Survey indicate early substance use.

Figure 31



Total	Male	Female	9th	10th	11th	12th	Asian	Black	Hisp/Lat	White
35.5%	35.5%	37.1%	25.7%	32.1%	37.6%	48.1%	20.5%	37.9%	44.8%	33.9%

As shown in Figure 31, tobacco smoking and nicotine continue to be a drug of choice for youth with 35.5 percent of those responding to the survey reporting having tried tobacco smoking by taking one or two puffs, and with 48.1 percent of 12<sup>th</sup> graders reporting use. A higher percentage of males than females report use. Use among Hispanics outnumbers use among Asian, Black and White youth, with 44.8 percent of Hispanic youth reporting use.

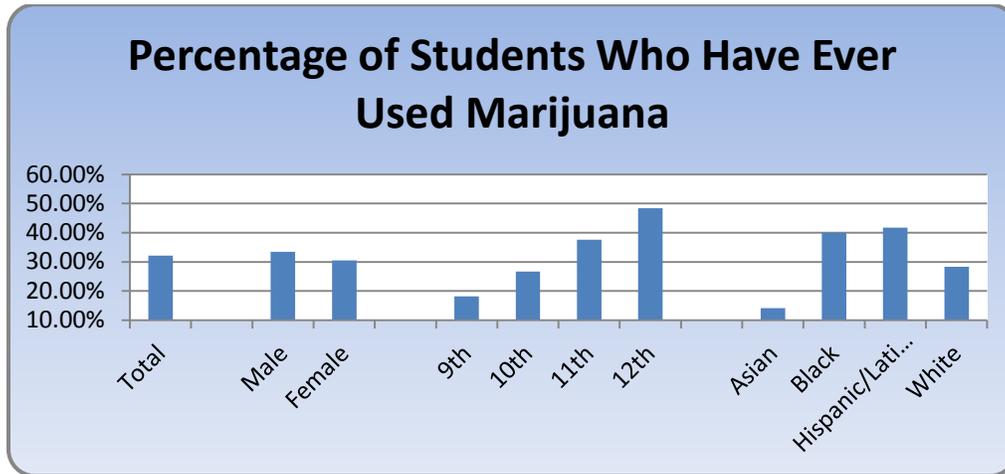
Figure 32



Total	Male	Female	9th	10th	11th	12th	Asian	Black	Hisp/Lat	White
55.3%	54%	56.5%	40.8%	51.1%	62.4%	69.3%	27.2%	52.9%	57.3%	58.4%

Among survey respondents, 55 percent of high school youth report having had at least one drink in their lifetime, Figure 32. The proportion increases to 69.3 percent for 12<sup>th</sup> graders. The proportion for White youth, at 58.4 percent, is greater than that for Asians, Blacks and Hispanics. A greater proportion (56.5 percent) of females drink than males.

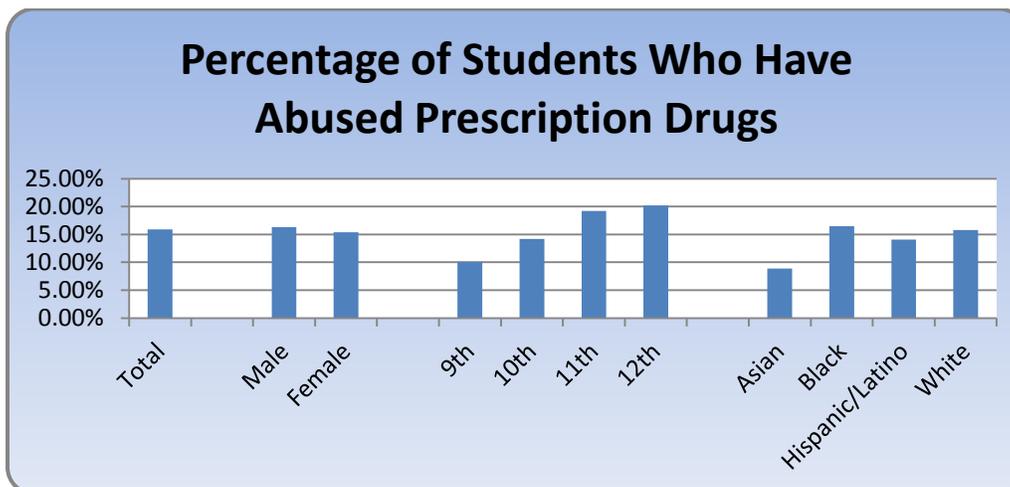
**Figure 33**



Total	Male	Female	9th	10th	11th	12th	Asian	Black	Hisp/Lat	White
32.1%	33.4%	30.5%	18.2%	26.7%	37.6%	48.4%	14.1%	40%	41.8%	28.3%

Figure 33 shows that 32.1 percent of high school youth who participated in the survey have used marijuana at least once. A greater proportion of Hispanic youth use (48.4 percent) and 33.4 percent of high school males report use. Among 9<sup>th</sup> graders, 18.2 percent report having used at least once, increasing to 48.4 percent among seniors.

**Figure 34**



Total	Male	Female	9th	10th	11th	12th	Asian	Black	Hisp/Lat	White
15.0%	15.0%	15.0%	10.0%	14.0%	18.0%	20.0%	8.0%	16.0%	14.0%	15.0%

15.9%	16.3%	15.4%	10.1%	14.2%	19.2%	20.2%	8.9%	16.5%	14.1%	15.8%
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Prescription drug abuse is increasing across all demographic groups, including youth. As shown in Figure 34, almost 16 percent of high school youth report using a prescription drug not prescribed for them, such as opioid-based pain medication, stimulant medication often prescribed for attention deficit disorder, or benzodiazepines prescribed for anxiety. Data indicated that a slightly higher percentage of males and a slightly higher percentage of black youth are abusing prescription drugs in this age group. Among twelfth graders, 20.2 percent report having used a prescription drug without a prescription in their lifetime.

***Strategic Prevention Framework-State Incentive Grant.*** In April 2010, Virginia was awarded a five year grant of \$7,725,446 to implement the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) program, one of SAMHSA’s infrastructure grants to reduce alcohol related motor vehicle crashes by 18-24 year olds. The SPF-SIG was monitored and implemented in partnership with Virginia State University’s Center for School Community Collaboration through 13 community coalitions. The SPF-SIG, ending in May 2015, demonstrated substantial outcomes by reducing alcohol related motor vehicle crashes for 18-24 year olds by 37 percent in the targeted communities.

***Substance Abuse Prevention Paradigm Shifts.*** Over the past several years, the approach to prevention has undergone a significant change in practice, implementation and delivery of services. Historically, prevention focused exclusively on substance abuse. However, recent research has changed policy and practice to support the integration of substance abuse prevention, mental health promotion, and primary care across the lifespan. Focusing on shared risk factors for substance abuse and mental illness improves outcomes for both. By reducing the incidence and severity of substance abuse and mental illness, physical health outcomes improve as well.

From a practice perspective, prevention services have historically occurred through classroom or evidence-based group programs for youth, but current approaches use a public health model, focusing more on population level or environmental change strategies. These strategies are complemented by those that target individuals and families at greatest risk across the lifespan.

***Prevention System Transformation.*** To accommodate these changes, DBHDS’ approach to prevention has expanded to include mental health promotion and suicide prevention in addition to substance abuse prevention. The office name has changed to the Office of Behavioral Health and Wellness to reflect this transformation. The Strategic Prevention Framework (SPF) model used is being infused into all prevention practices. These include:

*Assessment* – Data from social indicators and epidemiological sources will guide the development of priorities to target populations, substances, key issues, and geographic areas, as well as the selection of outcome measures for state and CSB performance and will inform resource allocation decisions.

*Capacity* – Data collected directly from CSBs will inform workforce development and will assist in collaboration with other stakeholders, such as the Virginia Foundation for Healthy Youth, VDH, and other agencies.

*Planning* - A Comprehensive Substance Abuse Prevention Strategic Plan will be developed based on data at the state and CSB levels.

*Implementation* – In the SPF, at least 75 percent of prevention services must be evidence-based. During the reporting period, CSBs implemented 56 evidence-based prevention programs. In FY 2013, 24,724 individuals (unduplicated) received services and, during FY 2014, 32,878 individuals (unduplicated) received services.

The science of prevention has evolved considerably. SAMHSA has compiled discrete evidence based strategies and programs designed to address specific problems and meet the cultural and developmental needs of specific populations. SAMHSA requires that 25 percent of programs funded with SAPT block grant funds must affect the environment (such as reducing access to alcohol by youth by vigilantly enforcing access laws) and be executed in partnership with local community coalitions.

*Evaluation* - DBHDS and the CSBs will develop an evaluation plan to determine outcomes and performance for management and planning.

All elements of SPF are infused with cultural competency and sustainability of successful outcomes. With this new infrastructure, the DBHDS prevention system, in partnership with the CSBs, will have the capacity to positively impact substance abuse in the state.

## **APPENDICES**

*Code of Virginia*

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

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

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

**Virginia Localities Sorted by National Survey of Drug Use and Health (NSDUH) Region****Region 1**

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

**Region 2**

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

**Region 3**

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

**Region 4**

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

**Region 5**

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

## Substance Use Disorders<sup>1</sup>

### Criteria for Substance Dependence

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

- (1) Tolerance, as defined by either of the following:
  - a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect;
  - b. Markedly diminished effect with continued use of the same amount of the substance;
- (2) Withdrawal, as manifested by either of the following:
  - a. The characteristic withdrawal syndrome for the substance (physiological symptoms that are specific to the substance, i.e., alcohol or other drug);
  - b. The same (or a closely related) substance is taken to relive or avoid withdrawal symptoms.
- (3) The substance is often taken in larger amounts or over a longer period than was intended.
- (4) There is a persistent desire of unsuccessful efforts to cut down or control substance use.
- (5) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances to obtain a supply of the substance), use the substance, or recover from its effects.
- (6) Important social, occupational, or recreational activities are given up or reduced because of substance use.
- (7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

### Criteria for Substance Abuse

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
  - (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance –related absences, suspensions or expulsions from school; neglect of children or household);
  - (2) Recurrent substance use in situations in which it is physically hazardous;
  - (3) Recurrent substance-related legal problems;
  - (4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance (e.g., a person may have had symptoms for cocaine abuse but not for alcohol abuse).

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

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

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

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

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

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

## Services Definitions

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

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

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

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

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

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

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

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

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

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

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