I: State Information

State Information

Plan Year

Start Year:
2012

End Year:
2013

State SAPT DUNS Number

Number
627383102

Expiration Date

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

Agency Name
Virginia Department of Behavioral Health and Developmental Services

Organizational Unit
Office of Behavioral Health Services

Mailing Address
P. O. Box 1797

City
Richmond

Zip Code
23219-1797

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

First Name
James

Last Name
Stewart

Agency Name
Virginia Department of Behavioral Health and Developmental Services

Mailing Address
P. O. Box 1797

City
Richmond

Zip Code
23219-1797

Telephone
804-786-3921

Fax
804-371-6638

Email Address
jim.stewart@dbhds.virginia.gov

State CMHS DUNS Number

Number
627383102

Expiration Date

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

Agency Name

Virginia Department of Behavioral Health and Developmental Services

Organizational Unit

Office of Behavioral Health Services

Mailing Address

P. O. Box 1797

City

Richmond

Zip Code

23219-1797

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

First Name

James

Last Name

Stewart

Agency Name

Virginia Department of Behavioral Health and Developmental Services

Mailing Address

P. O. Box 1797

City

Richmond

Zip Code

23219-1797

Telephone

804-786-3921

Fax

804-371-6638

Email Address

jim.stewart@dbhds.virginia.gov

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

From

7/1/2009

To

6/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

4/17/2012 10:25:03 PM

V. Contact Person Responsible for Application Submission

First Name

Jason

Last Name

Lowe

Telephone

804-786-0464

Fax

804-786-9248

Email Address

jason.lowe@dbhds.virginia.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	William A. Hazel, Jr., M.D.
Title	Secretary
Organization	Virginia Department of Health and Human Resources

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Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

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

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	William A. Hazel, Jr., M.D.
Title	Secretary
Organization	Virginia Department of Health and Human Resources

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Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

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

Name	William A. Hazel, Jr., M.D.
Title	Secretary
Organization	Virginia Department of Health and Human Resources

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Virginia agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	William A. Hazel, Jr., M.D.
Title	Secretary
Organization	Virginia Department of Health and Human Resources

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

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

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

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

Page 22 of the Application Guidance

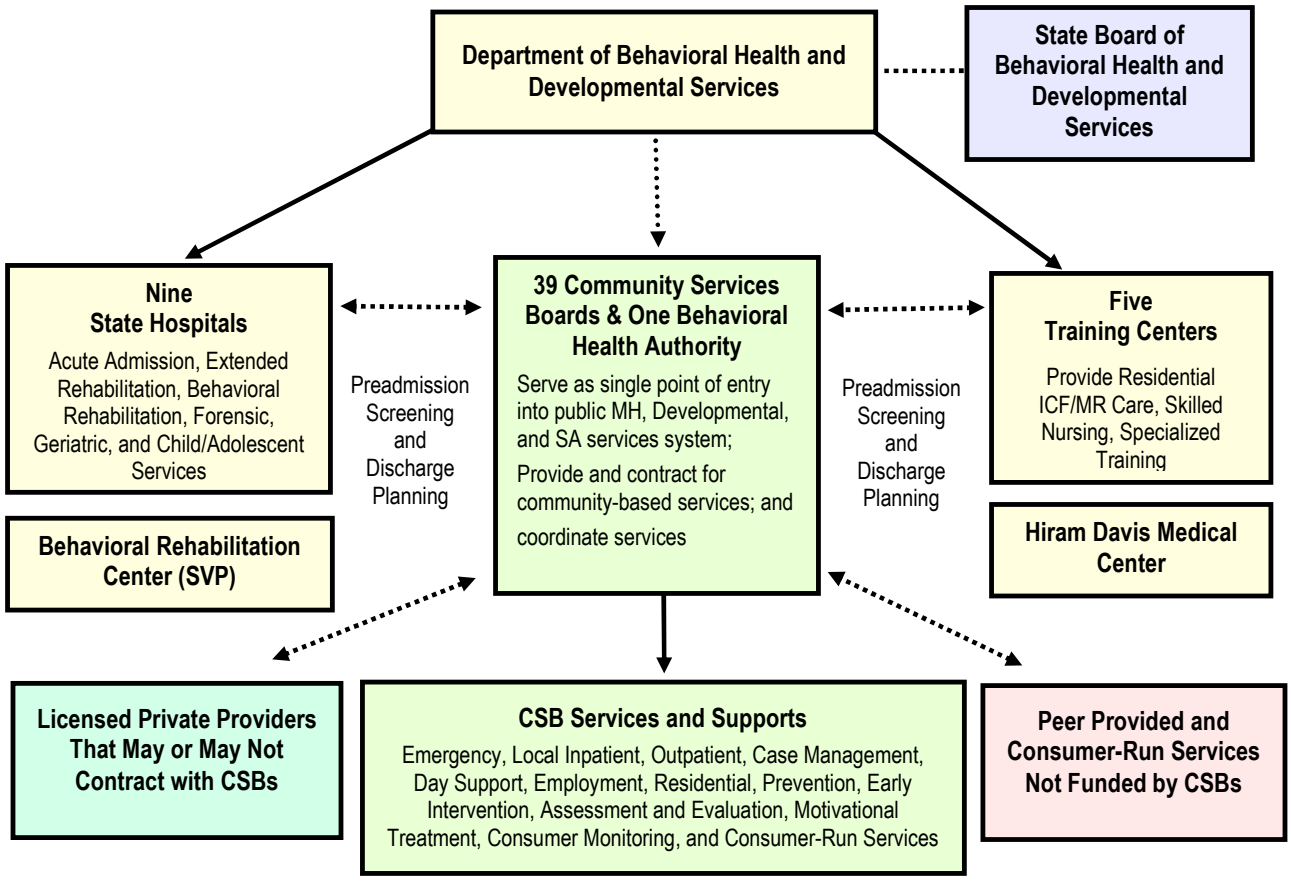
Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

The public behavioral health (mental health and substance abuse) and developmental services system in Virginia includes the Department of Behavioral Health and Developmental Services (DBHDS), which serves as the Single State Alcohol and Drug Agency (SSA) and State Mental Health Authority (SMHA); a state policy board appointed by the Governor; eight state hospitals, five training centers, a medical center, and a behavioral rehabilitation center for sexually violent predators (SVP) operated by the Department; and 39 community services boards and one behavioral health authority (referred to as CSBs) that provide services directly or through contracts with private providers. Maps of CSB service areas and the locations of state facilities are included in this section of the application.

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



Section 37.2 of the *Code of Virginia* establishes the Department as the state authority for the Commonwealth's publicly-funded behavioral health and developmental services system. By statute, the State Board offers policy direction for Virginia's services system.

The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment and prevention services and supports for individuals and families whose lives are affected by mental health or substance use disorders or intellectual disability. The central office seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

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

The Community Services Board System

CSBs are established by the 134 local governments in Virginia pursuant to Chapters 5 or 6 of Title 37.2 of the *Code of Virginia* and may serve single or multiple jurisdictions. CSBs provide services directly and through contracts with private providers, which are vital partners in delivering behavioral health and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. CSBs advocate for individuals who are receiving services or who are in need of services, act as community educators, organizers, and planners, and advise their local governments about behavioral health and developmental services and needs.

While not part of the Department, CSBs are the primary operational partners with the Department and its state facilities in Virginia's public behavioral health and developmental services system. The Department's relationships with all CSBs are based on the community services performance contract, provisions of Title 37.2 of the *Code of Virginia*, State Board policies and regulations, and other applicable state or federal statutes or regulations. The Department contracts with, provides consultation to, funds, monitors, licenses, and regulates CSBs.

<u>CSB Mental Health Services</u>

CSBs provide a wide array of mental health services to children, youth and adults. These include crisis intervention and crisis stabilization, outpatient services (including psychiatric consultation and medication management), case management, day treatment, assertive community treatment, employment support, residential and in-home services. Mental health

services to children are provided in a Systems of Care framework. In State Fiscal Year (SFY) 2010, an unduplicated 108,158 individuals received CSB mental health services. A significant number of these individuals have severe disabilities; of the individuals receiving mental health services in SFY 2010, 44,540 adults (41 percent) had a serious mental illness and 21,929 youth (20 percent) had or were at risk of having a serious emotional disturbance. (This does not include 5,188 adults with serious mental illness and 1,149 youth with or at risk of serious emotional disturbance who received only emergency services.) Between FY 2008 and FY 2010, the number of individuals receiving CSB mental health services increased from 101,796 to 108,158 (6 percent).

CSB Substance Abuse Services

In FY 2010, an unduplicated 38,661 individuals received substance abuse services from CSBs. About 10 percent were under the age of 18. Services include outpatient services, case management, residential detoxification, day treatment, jail services, medication assisted treatment, residential treatment, and supportive housing. About half of the 40 CSBs provide medication assisted treatment (methadone or buprenorphine). All CSBs provide some specialized services to pregnant women and women with dependent children and there are also three regional programs that provide residential services to pregnant and postpartum women and women with dependent children. There are eight programs that provide intensive wrap-around case management services to pregnant and post-partum women in close collaboration with local social services and health departments.

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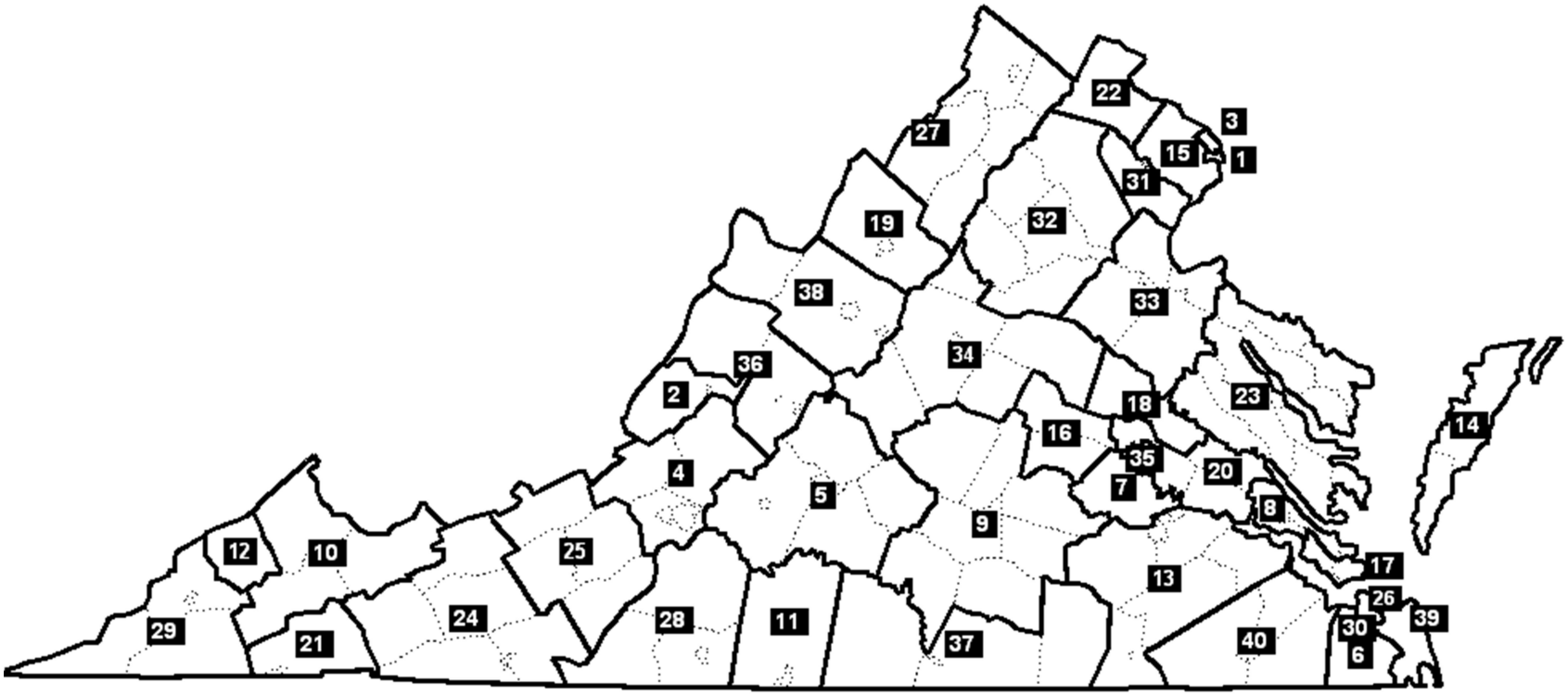
CSB Prevention Services

DBHDS defines prevention as activities that involve people, families, communities and systems working together to promote their strengths and potentials. Prevention goals and activities are primarily focused on substantially reducing the incidence of mental illness, developmental disabilities, and alcohol and other drug dependency and abuse. The emphasis is on the enhancement of protective factors and the reduction of risk factors. Through the performance contract, CSBs are required to develop and execute prevention plans for the communities they serve, and they are required to engage community partners in developing necessary coalitions in the development and execution of these plans. In FY 2010, a total of 569,922 individuals were served in the Universal Direct category of Prevention Services. Selective and Indicated programs were provided to 60,846 individuals and 730,775 individuals were involved in Universal Indirect programs.

Virginia Community Services Boards



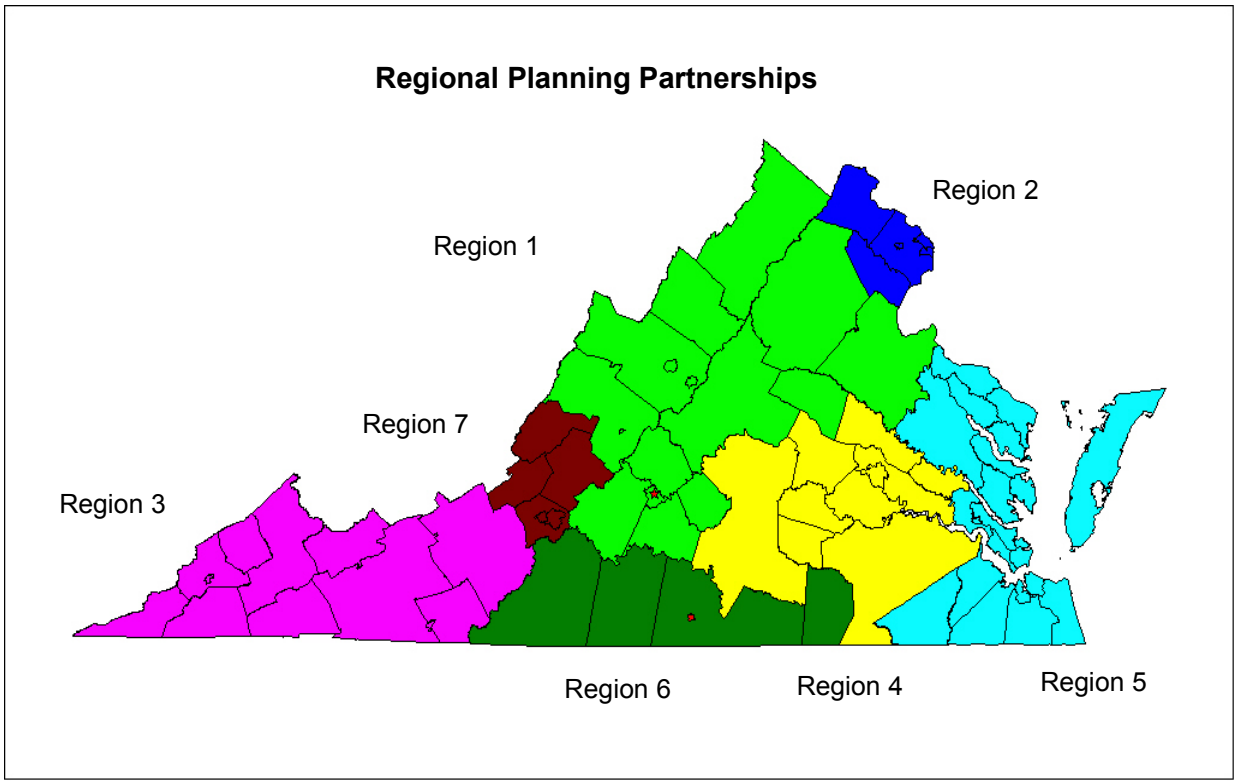
1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

State Hospital System

The Department operates eight state hospitals for adults across Virginia: Catawba Hospital (CAT) in Salem, Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Piedmont Geriatric Hospital (PGH) in Burkeville, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton. The Commonwealth Center for Children and Adolescents (CCCA) in Staunton is the only state hospital for children with serious emotional disturbance.

Regional Planning Partnerships

Seven regional partnerships have been established to promote regional service delivery and promote regional utilization management. Partnership participants include CSBs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family members, advocates, and other stakeholders. Each regional partnership has established a regional utilization review team or committee to manage the region's use of inpatient beds and certain residential crisis stabilization and substance abuse treatment resources. The following map depicts the seven regional partnership areas.



Relationships with Private Providers

In FY 2010, the Department licensed 705 providers of behavioral health (mental health and substance abuse), developmental, developmental disability waiver, and residential brain injury services. This includes CSBs as well as private providers. This included 140 licenses issued to new providers. Licensed providers must meet regulatory standards of health, safety, service provision, and individual rights.

In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example, through various Medicaid-funded services such as inpatient psychiatric treatment. Private providers are an especially important source of treatment for children and adolescents, as well as substance abuse treatment for persons with opiate addiction, as many consumers receiving CSB treatment for opiate addiction, including injection drug users (IDUs), are referred to private providers for methadone or Medication Assisted Treatment.

Peer/Recovery Support Services

The Department utilizes Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds to support the delivery of peer and recovery support services to Virginians with behavioral health disorders. Peer services are provided by independent consumer-run programs and CSBs, and through collaboration between CSBs and consumer-run programs. Services include outreach, individual and group peer support, education on recovery and wellness, assistance with meeting basic needs, job skill development, employment readiness activities, and social and recreational opportunities. In addition, MHBG and SAPTBG funds are used to support the work of statewide consumer and family organizations, such as the Virginia Chapter of the National Alliance on Mental Illness (NAMI Virginia), the Virginia Organization of Consumers Asserting Leadership (VOCAL), Mental Health America of Virginia, and the Substance Abuse and Addiction Recovery Alliance (SAARA). These organizations offer a variety of information, referral and support services across the state, and also advocate for the needs of individuals with behavioral health disorders and their families.

Services for Populations of Interest

<u>Military Personnel and Their Families</u>

Virginia has one of the largest active-duty and retired military populations in the nation. In 2008, the Virginia General Assembly established the Virginia Wounded Warrior Program (VWWP) within the Department of Veterans Services (DVS). The WWWP is operated by DVS in cooperation with the Department of Behavioral Health and Developmental Services, CSBs, and the Department of Rehabilitative Services. The program serves veterans of any era who are Virginia residents, members of the Virginia National Guard and Armed Forces Reserves not in active federal service, and family members of these veterans and service members. Services provided include identification and treatment of Post-Traumatic Stress Disorder; identification and referral for traumatic brain injury services; peer support groups; marriage counseling; family and child counseling; substance abuse treatment; case management services, and

referral to other needed services. In addition to services provided by clinicians, WWWP employs Peer Support Specialists who are veterans that facilitate peer support groups and provide outreach to other veterans and their families.

Homeless Individuals

The Department allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) Program to provide outreach, engagement and case management services to homeless persons with SMI/SUD in the 15 areas of the state with the highest prevalence rates of homelessness. Virginia's PATH programs assist consumers to access housing, mental health and substance abuse treatment services, entitlement benefits and other needed services to assist them in the process of recovery. Of the estimated 2,209 individuals to be served by Virginia PATH during SFY 2012, approximately 80% are estimated to be literally homeless. These individuals are the priority of the PATH programs. The majority of Virginia's PATH programs are in urban areas and are focused on conducting street and shelter outreach to identify individuals with SMI who meet the PATH definition of homeless with the goal of assisting the individual to obtain housing, engage in behavioral health services, and access disability and other benefits. The SSI/SSDI Outreach, Access and Recovery (SOAR) model of engagement is an additional service provided to PATH-enrolled consumers by six of Virginia's PATH programs.

In addition, Governor Robert McDonnell has established a Housing Initiative for all Virginians with a special focus on reducing homelessness, in which DBHDS is a primary partner.

Individuals with Criminal Justice Involvement

State and national surveys show that 16 percent of all jail inmates have some form of mental illness and approximately 75 percent have a substance use disorder. Nearly 42 percent of referrals to CSBs for substance abuse treatment come from the criminal justice system. These individuals are likely to be arrested due to behaviors related to their symptoms. Many jail inmates are not able to access treatment services while incarcerated or when they return to the community. This lack of treatment access can lead to continuing acute illness or relapse, as well as engagement in criminal activity, including violent acts.

On January 28, 2008, then-Governor Timothy Kaine issued Executive Order 62 which established the Commonwealth Consortium for Mental Health/Criminal Justice Transformation. With ongoing support from current Governor Robert McDonnell, the Consortium is working to develop a comprehensive approach to address the challenging needs of individuals with mental illness in the Commonwealth's criminal justice system. Under the leadership of the Secretaries of Health and Human Resources and Public Safety, the Consortium was developed to provide representation from the three branches of government, dozens of state agencies and statewide organizations, serving as partners, members and advisors to the Consortium. The Consortium has hosted statewide meetings and seen the development of multiple programs and processes for creating positive systems change.

On May 11, 2010, Governor McDonnell established the Virginia Prisoner and Juvenile Offender Re-Entry Council (Executive Order 11), to support offenders in achieving a successful transition into their communities. As behavioral health issues are a major component of offender re-entry, DBHDS has played a significant role as a participant in the Council's activities and has also facilitated the inclusion of appropriate advocacy organizations for input.

Rural Populations

The Commonwealth of Virginia covers a wide and diverse geographic area. Depending on its location, one CSB might serve a combined population of urban, suburban and ex-urban or rural areas. Twenty-four of the 40 CSBs are located in primarily rural areas; during SFY 2010, these CSBs served 53% of all mental health consumers and 40% of those receiving substance abuse treatment.

Individuals in need of behavioral health services in rural areas face special challenges. CSBs vary according to budget size and population density, and many in rural areas do not have the infrastructure to support the services that are needed in the community. Access to transportation, especially for persons not eligible for Medicaid, is often an issue. CSBs use different approaches, such as sharing services regionally with other CSBs and collaborating with local and regional contract agencies to meet the service needs of their consumers. Telepsychiatry and telecommunication, for example, are in use in some rural areas to facilitate specialty psychiatric services for adult consumers, children and their families, and veterans.

Cultural, Racial and Ethnic Minorities

Consumers in Virginia's public behavioral health system are highly diverse. According to the 2010 U.S. Census, 68 percent of Virginia's general population is white, but nearly 40 percent of individuals receiving CSB mental health and substance use services are of some other race, including those who self-identify as biracial or multi-racial. In addition, more than 5% of MH/SA consumers self-identify as Hispanic/Latino, which is one of the largest and fastest-growing ethnic groups in the state.

The Department recognizes the disparities in mental health, intellectual disability and substance abuse services and supports for cultural, racial and ethnic minorities, both in our state and nationwide. The *U.S. Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity* (2001) found that behavioral health disparities are inextricably linked to race, culture, and ethnicity where people of color, as well as members of other underserved cultural groups, have less access to, and availability of, behavioral health care services. Even when services are available, members of these groups tend to receive a poorer quality of care that does not meet their unique needs.

In order to address these disparities in Virginia's behavioral health system, in 2008 the Department established the Office of Cultural and Linguistic Competence (OCLC). OCLC is leading efforts to provide improved services to multicultural consumers and is working toward eliminating the disparities within our system. OCLC is focusing on expanding the number of culturally and linguistically competent service providers, stakeholders, and staff within the

public and private sector. The Department defines culture in the broad sense, as there are other aspects of an individual in addition to race, language, and ethnicity that contribute to his or her sense of self. These may include specific attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, or homelessness). Multiple memberships in subgroups contribute to an individual's personal identity and sense of "culture". Understanding how these factors affect a person is important to providing culturally competent care.

Through the OCLC, in 2009 the Department developed and released its *Position Statement on Culturally and Linguistically Appropriate Services*, which established ten principles as the foundation for providing effective multicultural behavioral and developmental services. The position statement supports recommendations regarding multicultural diversity published in the *Mental Health: A Report of the Surgeon General* (1999) and *Mental Health: Culture, Race, Ethnicity: Supplement to Mental Health: Report of the Surgeon General* (2001), and led to the development of the Department's first *Plan for Cultural and Linguistic Competency in Behavioral Health and Developmental Services*, also released in 2009. The Plan was updated in late 2010 and includes the following four major goals for 2011-2012:

Goal 1: Complete a system-wide organizational assessment of culturally and linguistically appropriate services.
Goal 2: Increase the number of resources for training and workforce development.
Goal 3: increase the number of organizations with written plans for cultural and linguistic competency.
Goal 4: Increase the number of organizations with written plans for cultural and linguistic competency.

The OCLC, along with the Department's multi-agency, multi-disciplinary Cultural and Linguistic Competency Steering Committee, is responsible for implementing the action steps necessary to achieve these goals.

II. Planning Steps

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

Revision requested:
Can the state please provide in narrative if the goals outlined in the Department's Plan for Cultural and Linguistic Competency are being initiated currently and if so is there a person that is coordinating this initiative and is he\she within DBHDS?

Response:
These goals are currently being initiated by Cecily Rodriguez, Director of Cultural and Linguistic Competency, DBHDS.

II. Planning Steps

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These goals are currently being initiated by Cecily Rodriguez, Director of Cultural and Linguistic Competency, DBHDS.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Data to support Virginia's behavioral health needs assessment and planning processes are available from several sources on a routine and ad hoc basis. These sources encompass the full spectrum of available data sources on mental health and substance use disorders, from wide-scope sources such as the National Survey on Drug Use and Health and the Treatment Episode Data Set, to the Community Consumer Submission, Virginia's unique data system, to individual surveys conducted of various stakeholders throughout the Commonwealth. DBHDS utilizes these data to assist in the identification of needs and gaps in the Commonwealth's behavioral health service continuum. These data sources are described below in more detail.

Core DBHDS Databases:

Community Consumer Submission 3 (CCS3) – CCS is Virginia's unique, client-level data collection system that is used in partnership with CSBs and BHAs statewide. CCS is a compilation of demographic, clinical, and service utilization data for all individuals served by CSBs, the public community behavioral health service providers serving those in the Commonwealth with behavioral health disorders.

AVATAR – This is the client-level DBHDS inpatient facility database, including demographic, clinical and service information about inpatients of DBHDS hospitals.

CARS – This is the financial reporting system for CSBs, showing expenditures by service category.

Databases External to DBHDS

Virginia Health Information (VHI) – DBHDS obtains quarterly demographic, clinical and service utilization data from VHI about users of community psychiatric hospitals.

Medicaid – DBHDS obtains regular reports from the Department of Medical Assistance Services about utilization of BH services reimbursed through Medicaid.

Office of Comprehensive Services – DBHDS uses OCS data about service recipients and services provided to children with behavioral health disorders under the Comprehensive Services Act.

Other Global Data Sources

Treatment Episode Data Set (TEDS) – TEDS is part of SAMHSA's Drug and Alcohol Services Information System (DASIS). TEDS is a compilation of data on the demographic and substance abuse characteristics of admissions to (and more recently, on discharges from) substance abuse treatment. TEDS involved data on almost two million admissions reported by over 10,000 facilities to the 50 States, District of Columbia, and Puerto Rico over the 12 month period of a calendar year.

National Outcome Measures (NOMs) – NOMs were developed jointly by SAMHSA, the states, and the District of Columbia to track and measures real-life outcomes for people in recovery from mental health and substance abuse disorders. The identifiers selected as NOMs, including metrics such as housing, employment, retention, and social connectedness embody meaningful outcomes for people who are striving to attain and sustain recover, build resilience, and work, learn, live and participate in their communities.

National Survey on Drug Use and Health (NSDUH) – The NSDUH provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. Virginia uses Nationwide as well as state-level

estimate from the NSDUH to inform other state agency partners as well as the General Assembly on substance use and mental health disorders in Virginia. NSDUH data also aids needs assessment processes throughout the Commonwealth and state-level estimate data is used in future program planning processes.

Ad Hoc Data Sources

Joint Commission of Health Care (JCHC) – The JCHS is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of health care areas, including behavioral health.

Commission on Youth – The Commission on Youth is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of topics relevant to supporting Virginia's youth, including youth with behavioral health disorders.

Crime Commission – The Crime Commission is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of topics relevant to criminal justice, including persons with behavioral health disorders involved in the criminal justice system.

Office of the Chief Medical Examiner (OCME) – Part of the Virginia Department of Health, the OCME provides surveillance data on violent death including suicide, drug-related deaths, etc.

Office of the Inspector General (OIG) for Behavioral Health and Developmental Services – The OIG regularly conducts ad hoc studies of specific behavioral health issues, services and operations to identify needs and solutions for the behavioral health service system.

Joint Legislative Audit and Review Commission (JLARC) – The General Assembly's "watchdog" entity, JLARC conducts policy studies for the Legislature, including those involving behavioral health.

Commission on Mental Health Law Reform – The Commission on Mental Health Law Reform is a four-year Supreme Court study panel that completed research and policy studies in areas related to mental health law reform, including access to behavioral health services.

DBHDS *Comprehensive State Plan*

DBHDS also completes a biennial ***Comprehensive State Plan***, which is a comprehensive environmental scan and needs assessment related to issues of strategic importance to the public behavioral health care system (e.g., the impact of aging, services and supports to veterans and military families, etc.). The ***Comprehensive State Plan*** covers the six year period including the current biennium and the two biennia going forward, and is updated every two years.

DBHDS *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*

The ***Creating Opportunities*** strategic planning process was initiated in 2010 in order to complete a more focused needs assessment and planning process. The plan identifies priority behavioral health services strategic initiatives and major DBHDS activities to be addressed over the next two years. These initiatives and activities are intended to:

- Continue progress in advancing the DBHDS vision of a system of behavioral health services and supports that promotes self-determination, empowerment, recovery,

resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life;
- Support the Governor's expressed intentions to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services; and
- Assure that the services system is efficient and well-managed and that its core functions are performed in a manner that is effective and responsive to the needs of individuals receiving services and their families.

The ***Creating Opportunities*** plan is the basis for Virginia's FY 2012-13 Block Grant Application Plan. The ***Creating Opportunities*** plan built on previous planning efforts, enabling DBHDS to structure an accelerated and condensed planning process that will allow implementation of the following initiatives to begin quickly. For each strategic initiative, an implementation action team was established to develop detailed implementation plans that will include specific action steps, outcomes, and timelines. These teams utilized a variety of data sources, which are described below based on the priority area indicated in Table 2.

- **2011 CSB Emergency Response Service Survey (Priority #1)** – This survey documented the current availability and access to the full range of emergency response and crisis intervention services, as well as two key elements of the involuntary commitment process - pre-hearing assessment and commitment hearing attendance.
- **2011 Virginia Hospital and Healthcare Association Survey (Priority #1)** – This survey was performed at community inpatient psychiatric units and emergency departments throughout the Commonwealth in March 2011. The survey asked about interactions between CSBs and emergency departments/psychiatric units to determine how effectively and efficiently the CSBs' emergency services units were functioning in the various hospitals' catchment areas.
- **Peer Services and Supports Survey (Priority #2)** – This survey was performed at all CSBs/BHAs and state facilities, gathering information about which ones provide peer-based recovery support services, at what level and how those positions are funded, whether those services are strictly for MH or SA consumers. This survey also gathered information from other states concerning how they license and/or certify peer services and supports in their states.
- **Substance Abuse Services Directors Survey (Priority #3)** – Performed in March 2011, key informants interviews were conducted with the Substance Abuse Services Directors at all CSBs. Content areas addressed in the structured interview were admissions policies, assessment and clinical dispositions, outpatient and intensive outpatient services, case management, residential services, supportive living arrangements, medication assisted treatment, access to psychiatric services, services for specific populations, peer-based services, recovery support services, critical unmet need, community substance abuse issues, and Medicaid reimbursement for substance use disorders services.
- **Comprehensive Survey of Children's Services (Priority #4)** – Conducted from November 2010 to January 2011, this survey was performed in partnership with the Virginia

Association of Community Service Boards. Performed at all CSBs, this survey was designed to determine the extent to which CSBs provide the full comprehensive service array that is needed to support a child-centered, family-focused system of care for the Commonwealth's children and adolescents with behavioral health disorders.

- **2010 Recovery Oriented System Indicator (Priority Areas #5 and #6)** - The ROSI surveyed more than 3,500 adult recipients of behavioral health services from CSBs in the Commonwealth in calendar year 2010. The ROSI measures the attitudes of service recipients in eight domains – meaningful activities, basic material resources, peer support, choice, social relationships, formal services, formal services staff, and self/holism.
- **Office of the Inspector General Review of CSB Mental Health Case Management Services for Adults (Priority Area #7)** – Prepared in March 2006, the Inspector General sought input from a wide range of stakeholders including individuals receiving services, advocacy groups, community and facility providers and DBHDS. Reviews were performed at all CSBs and focused on consumer-centered services, coordination of services, services guided by the recovery model, the connection between individuals receiving services and case managements, case management activity and outreach, and case management preparation and support.
- **Prevention Data Sources (Priorities #8 and #9)** – The Strategic Prevention Framework State Incentive Grant (SPF-SIG) epidemiologist has developed a Needs Assessment Workbook that will be used by Virginia and other SPF-SIG grantees to assess needs. Virginia does not currently have a comprehensive state-wide youth survey that provides jurisdiction-specific information on youth behavior and needs. However, the Department of Health is also planning to conduct a survey in fall 2011 that will provide supplemental data to help guide future prevention prioritization efforts.

Other state agencies that DBHDS have or are working to have data sharing efforts in place with include the Department of Education, Department of Criminal Justice Services, Department of Motor Vehicles, Department of Alcoholic Beverage Control, Department of Health (including the Office of the Chief Medical Examiner), Department of Social Services, and the Virginia Employment Commission.

Data to support Virginia's behavioral health needs assessment and planning processes are available from several sources on a routine and ad hoc basis. These sources encompass the full spectrum of available data sources on mental health and substance use disorders, from wide-scope sources such as the National Survey on Drug Use and Health and the Treatment Episode Data Set, to the Community Consumer Submission, Virginia's unique data system, to individual surveys conducted of various stakeholders throughout the Commonwealth. DBHDS utilizes these data to assist in the identification of needs and gaps in the Commonwealth's behavioral health service continuum. These data sources are described below in more detail.

Core DBHDS Databases:

Community Consumer Submission 3 (CCS3) – CCS is Virginia's unique, client-level data collection system that is used in partnership with CSBs and BHAs statewide. CCS is a compilation of demographic, clinical, and service utilization data for all individuals served by CSBs, the public community behavioral health service providers serving those in the Commonwealth with behavioral health disorders.

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Ad Hoc Data Sources

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Crime Commission – The Crime Commission is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of topics relevant to criminal justice, including persons with behavioral health disorders involved in the criminal justice system.

Office of the Chief Medical Examiner (OCME) – Part of the Virginia Department of Health, the OCME provides surveillance data on violent death including suicide, drug-related deaths, etc.

Office of the Inspector General (OIG) for Behavioral Health and Developmental Services – The OIG regularly conducts ad hoc studies of specific behavioral health issues, services and operations to identify needs and solutions for the behavioral health service system.

Joint Legislative Audit and Review Commission (JLARC) – The General Assembly's "watchdog" entity, JLARC conducts policy studies for the Legislature, including those involving behavioral health.

Commission on Mental Health Law Reform – The Commission on Mental Health Law Reform is a four-year Supreme Court study panel that completed research and policy studies in areas related to mental health law reform, including access to behavioral health services.

DBHDS *Comprehensive State Plan*

DBHDS also completes a biennial ***Comprehensive State Plan***, which is a comprehensive environmental scan and needs assessment related to issues of strategic importance to the public behavioral health care system (e.g., the impact of aging, services and supports to veterans and military families, etc.). The ***Comprehensive State Plan*** covers the six year period including the current biennium and the two biennia going forward, and is updated every two years.

DBHDS *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*

The ***Creating Opportunities*** strategic planning process was initiated in 2010 in order to complete a more focused needs assessment and planning process. The plan identifies priority behavioral health services strategic initiatives and major DBHDS activities to be addressed over the next two years. These initiatives and activities are intended to:

- Continue progress in advancing the DBHDS vision of a system of behavioral health services and supports that promotes self-determination, empowerment, recovery,

resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life;
- Support the Governor's expressed intentions to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services; and
- Assure that the services system is efficient and well-managed and that its core functions are performed in a manner that is effective and responsive to the needs of individuals receiving services and their families.

The ***Creating Opportunities*** plan is the basis for Virginia's FY 2012-13 Block Grant Application Plan. The ***Creating Opportunities*** plan built on previous planning efforts, enabling DBHDS to structure an accelerated and condensed planning process that will allow implementation of the following initiatives to begin quickly. For each strategic initiative, an implementation action team was established to develop detailed implementation plans that will include specific action steps, outcomes, and timelines. These teams utilized a variety of data sources, which are described below based on the priority area indicated in Table 2.

- **2011 CSB Emergency Response Service Survey (Priority #1)** – This survey documented the current availability and access to the full range of emergency response and crisis intervention services, as well as two key elements of the involuntary commitment process - pre-hearing assessment and commitment hearing attendance.
- **2011 Virginia Hospital and Healthcare Association Survey (Priority #1)** – This survey was performed at community inpatient psychiatric units and emergency departments throughout the Commonwealth in March 2011. The survey asked about interactions between CSBs and emergency departments/psychiatric units to determine how effectively and efficiently the CSBs' emergency services units were functioning in the various hospitals' catchment areas.
- **Peer Services and Supports Survey (Priority #2)** – This survey was performed at all CSBs/BHAs and state facilities, gathering information about which ones provide peer-based recovery support services, at what level and how those positions are funded, whether those services are strictly for MH or SA consumers. This survey also gathered information from other states concerning how they license and/or certify peer services and supports in their states.
- **Substance Abuse Services Directors Survey (Priority #3)** – Performed in March 2011, key informants interviews were conducted with the Substance Abuse Services Directors at all CSBs. Content areas addressed in the structured interview were admissions policies, assessment and clinical dispositions, outpatient and intensive outpatient services, case management, residential services, supportive living arrangements, medication assisted treatment, access to psychiatric services, services for specific populations, peer-based services, recovery support services, critical unmet need, community substance abuse issues, and Medicaid reimbursement for substance use disorders services.
- **Comprehensive Survey of Children's Services (Priority #4)** – Conducted from November 2010 to January 2011, this survey was performed in partnership with the Virginia

Association of Community Service Boards. Performed at all CSBs, this survey was designed to determine the extent to which CSBs provide the full comprehensive service array that is needed to support a child-centered, family-focused system of care for the Commonwealth's children and adolescents with behavioral health disorders.

- **2010 Recovery Oriented System Indicator (Priority Areas #5 and #6)** - The ROSI surveyed more than 3,500 adult recipients of behavioral health services from CSBs in the Commonwealth in calendar year 2010. The ROSI measures the attitudes of service recipients in eight domains – meaningful activities, basic material resources, peer support, choice, social relationships, formal services, formal services staff, and self/holism.
- **Office of the Inspector General Review of CSB Mental Health Case Management Services for Adults (Priority Area #7)** – Prepared in March 2006, the Inspector General sought input from a wide range of stakeholders including individuals receiving services, advocacy groups, community and facility providers and DBHDS. Reviews were performed at all CSBs and focused on consumer-centered services, coordination of services, services guided by the recovery model, the connection between individuals receiving services and case managements, case management activity and outreach, and case management preparation and support.
- **Prevention Data Sources (Priorities #8 and #9)** – The Strategic Prevention Framework State Incentive Grant (SPF-SIG) epidemiologist has developed a Needs Assessment Workbook that will be used by Virginia and other SPF-SIG grantees to assess needs. Virginia does not currently have a comprehensive state-wide youth survey that provides jurisdiction-specific information on youth behavior and needs. However, the Department of Health is also planning to conduct a survey in fall 2011 that will provide supplemental data to help guide future prevention prioritization efforts.

Other state agencies that DBHDS have or are working to have data sharing efforts in place with include the Department of Education, Department of Criminal Justice Services, Department of Motor Vehicles, Department of Alcoholic Beverage Control, Department of Health (including the Office of the Chief Medical Examiner), Department of Social Services, and the Virginia Employment Commission.

Commonwealth of Virginia Combined Application

Amended on March 26, 2012

Step 2: Identify the unmet service needs and critical gaps within the current system

Virginia Department of Behavioral Health and Developmental Services is currently engaged in an intensive strategic planning and implementation process, Creating Opportunities, which has identified substance abuse treatment services identified as a crucial area of need. In the spring of 2011, DBHDS interviewed all 40 community services boards (CSBs) to get detailed information about critical services gaps. VaDBHDS staff also reviewed significant studies conducted by legislative bodies and the Office of the Inspector General. In addition, staff conducted a series of meetings with stakeholders representing providers and other state agencies to assure that their perspectives were represented. A report of the resulting strategic plan, ***Creating Opportunities for People in Need of Substance Abuse Services***, has been presented to the Governor and published to the agency's website (http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf). The following information summarizes the findings of this plan.

Within Virginia's current system, unmet service needs and critical gaps include: 1) a lack of timely access to treatment services; 2) gaps in capacity in needed services that provide more intensive treatment; and 3) lack of services that have been proven by research to be effective. In Virginia, people with substance use disorders wait an average of nearly 19 days for services; individuals don't always receive services that are intensive enough or that are proven to be effective; and many do not receive the services they need because those services do not exist at all.

To identify unmet service needs and critical gaps within the current system, VaDBHDS surveyed the community services boards (CSBs) to obtain a detailed picture of the CSB substance abuse treatment services system. A consistent theme emerged: people who need substance abuse

treatment through the publicly-funded system lack access to adequate capacity of the array of services necessary to support recovery. People must be able to get to the service; the service must have capacity to serve them; and the service must provide the intensity and duration needed for recovery. Typically, a person in need of substance abuse treatment will need access to an array of services to match the stage of treatment, medical, psychological or psychiatric, or practical needs they are experiencing. Individuals will begin treatment with different services, depending on their specific clinical and practical needs. One person might begin treatment for alcoholism in a detoxification setting to get the body physically clear of alcohol, then begin psychological aspects of treatment in a day treatment program that provides intensive services, such as group, individual and family therapy services multiple hours per day, multiple hours per week, assuming he or she has a safe living environment to go home to at night and on the weekend. Another person, addicted to a narcotic, might receive medication assisted treatment on a daily basis and participate in group and family counseling on a weekly basis, along with case management.

Services need to be matched in duration and intensity to the person's needs, based on the extent of abuse or dependence, the type of drugs (including alcohol) used, and the level of support available to the person from family and friends. In addition, within the array, the actual services should be based on evidence (research) that they work, and this requires training and ongoing supervision for the counselor.

Quality is another essential component of treatment. Evidence-based practices (EBPs) are tailored to meet the needs of the individual served. Some EBPs are effective for almost every population in every setting and some are designed to meet the clinical needs of a particular population (e.g., criminal justice system, adolescents, women with histories of trauma) or specific clinical issues (e.g., co-occurring mental illness) or diagnosis (e.g., narcotic dependence). Clinicians must be trained not only to know how and when to use an EBP; they also must be coached and supervised appropriately if they are to maintain their effectiveness. Furthermore, if people seeking treatment services in the community have had exposure to an EBP in another setting (such as Corrections), it is important to maintain the continuity of this approach to support the person's progress toward recovery.

The following are examples of unmet service needs and critical gaps that have been identified in Virginia's current system:

- According to the 2006 Office of the Inspector General report (*Review of Community Services Board Substance Abuse Outpatient Services for Adults,* Report #129-06, p. 17), two-thirds of CSBs report inadequate case management services, and utilization data from CSBs indicate that only one-quarter of persons receiving substance abuse treatment services receive any case management services at all.

- Data from the NSDUH indicate that nearly one in five Virginia adolescents regularly engage in binge drinking. CSB utilization data indicate that fewer than 10% of those receiving substance abuse treatment services are adolescents. The FY 2009 Comprehensive Services Gap Analysis (Office of Comprehensive Services. FY09 CSA Critical Service Gaps. January 29, 2010) reported that among all the services gaps in the state for children and adolescents, intensive substance abuse services ranked second, topped only by the need for crisis intervention and stabilization.

- Information gathered in 2008 by the Office of the Inspector General (*Review of Community Services Board Child and Adolescent Services,* Report #149-08, p.19) indicates that children/adolescents seeking services wait an average of 26 days to access any services. The same source reports that CSBs have inadequate capacity to serve children, rarely perform comprehensive assessments on which to base treatment plans, don't integrate findings about the child's substance use into the treatment plan, and have difficulty retaining staff that are knowledgeable about providing services to children and adolescents.

- Information from a specialized SAMHSA grant-funded project that focused on the needs of adolescents indicated that CSB staff lack the specialized knowledge and skills to provide services to youth with substance use or co-occurring mental health disorders.

- Although Virginia's Project Link sites have been highly successful in helping substance-addicted mothers deliver healthy babies, treat their addiction, improve their understanding of effective parenting, and provide "wrap-around" services to address the health and social needs of the family, VaDBHDS currently funds only eight Project Link sites, and these sites have not had an increase in funding since inception.

- Although peer-run support services can often provide effective and low-cost supplemental supports to treatment, and can tide people over until treatment is available, the VaDBHDS Creating Opportunities survey indicated that only half of the CSBs are using these types of services.

- Effective treatment begins with a thorough assessment of the issues and problems of the person seeking services. Although three out of four CSBs use a standard instrument to assess the clinical needs of people seeking services, the instruments are not scientifically validated, and fewer than that are using industry standard criteria for deciding what clinical services are needed to address the clinical substance use disorder problems that are identified in the assessment. Thus, decisions about what services are to be provided are often subjective. Mental health needs of adults seeking services for substance use disorders from CSBs are under-assessed and undertreated. The lack of thorough assessment and diagnosis severely hampers the effectiveness of treatment. Few community services boards use scientifically valid instruments to assess the clinical needs of people seeking treatment for either mental illness or substance use disorders. Many community services boards have developed idiosyncratic approaches to clinical assessment. The lack of a uniform scientific approach to an assessment undermines the treatment planning process so that it is difficult to determine if consumers are receiving the appropriate intensity or duration of treatment that will be effective in addressing their addiction. A substantial number of people who seek services for either mental illness or substance use disorder in fact have both disorders, yet these individuals are rarely appropriately assessed, so treatment only addresses one type of problem. This limits the effectiveness of either type of treatment.

- The Joint Legislative Audit and Review Commission (JLARC) study (Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) *Mitigating the Cost of Substance Abuse in Virginia,* House Document No. 19, p. v.) noted that the demand for services consistently exceeds the supply that can be provided with existing resources, and more intensive forms of treatment are often not available at all. The same study found that CSBs tend to offer more lower-intensity services and refer people needing more intense services to private providers, which is often too expensive.

- The 2006 Office of the Inspector General study (*Review of Community Services Board Substance Abuse Outpatient Services for Adults,* Report #129-06, p. 17) of outpatient substance abuse treatment for adults in CSBs found that the range, variety and capacity of substance abuse services are not adequate to meet the needs of consumers in the majority of Virginia communities. Less than 50% of CSBs have access to any residential treatment, only a quarter of CSBs have long-term residential treatment, and almost all have inadequate capacity to meet needs. This shortage in capacity becomes even more critical when addressing the needs of special populations, such as women who are pregnant or who have dependent children, adolescents, and those with severe physical dependence on alcohol or certain sedatives.

- The lack of access to an array of services results in people not receiving the appropriate intensity or duration of treatment they need to successfully attain recovery. While nearly all CSBs offer outpatient services, the intensity of this service—meeting with a counselor once a week—is not enough to have impact on the person's behavior, thinking, or other aspects of the person's substance use disorder.

- The 2006 Office of the Inspector General report (*Review of Community Services Board Substance Abuse Outpatient Services for Adults,* Report #129-06, p. 40) acknowledges that state Probation and Parole offices across the state report long wait times for services from CSBs and that the array of services needed by these individuals was often not available.

- Only about one-third of CSBs report that they have the capacity to provide group counseling at least three times per week and individual counseling, if needed, which is the minimal level needed to help individuals change their behavior and thinking that continue their substance use disorder.

- Currently CSBs do not have the capacity (work force) to provide Intensive Outpatient services. Only about one-third of CSBs report that they provide services at the level of intensity offered by IOP services. Services provided by the remaining CSBs are at a frequency of once per week or less, which does not provide the intensity required to support or sustain recovery.

- Currently, half the CSBs lack local social detoxification services, and a quarter lack local medical detoxification services. There are only about 100 beds for this purpose in the state.

- VaDBHDS Creating Opportunities survey of CSBs indicated that CSBs ranked the need for additional detoxification capacity as the second highest needed service in the next five years.

- The 2006 Office of the Inspector General report (*Review of Community Services Board Substance Abuse Outpatient Services for Adults,* Report #129-06, p. 17) indicates that half of CSBs lack any access to opiate maintenance treatment, yet opiates are frequently seen in 65 % of communities and they lead the list of all drugs considered by CSB staff to be increasing in use. The 2011 survey conducted for this report indicated no significant change in this capacity.

- Although methadone treatment is very effective in terms of preventing people from relapsing to illegal drug use and helping them to stabilize, engage in employment, and become productive citizens, currently there are only 19 methadone clinic sites in Virginia, and many people in need of services are more than one hour away from the closest site.

- Although over 400 people per year die due to abuse of prescription medication, usually narcotic pain medication, and this problem appears to be growing, over half the CSBs lack access to medication assisted treatment, the evidence-based treatment for narcotic addiction.

- Currently there are only three publicly-funded residential treatment programs designed to meet the needs of women with dependent children in Virginia.

- Funds for transitional therapeutic communities (TTCs) were eliminated during 2008, although outcome data indicated significantly improved outcomes among TTC participants.

- In the VaDBHDS Creating Opportunities survey, CSBs indicated that the lack of safe, sober housing is a significant barrier to recovery, but one-third indicate that they have no access to this type of resource.

- The Joint Legislative Audit and Review Commission (JLARC) noted in its 2008 report (Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) *Mitigating the Cost of Substance Abuse in Virginia,* House Document No. 19, pp. 81-85) that although three-quarters of the CSBs had incorporated some evidence-based practices (EBPs) in their array of services, their inclusion needed to be more widespread. In addition, fewer than half of CSBs have the appropriate supervisory framework to assure that they are properly implemented, which can undermine effectiveness.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:
2012

End Year:
2013

Number	State Priority Title	State Priority Detailed Description
1	Strengthen the responsiveness of behavioral health emergency response services and maximize the consistency, availability, and accessibility of services for individuals in crisis.	Many Virginians do not have access to a basic array of emergency and crisis response services. As a result, high numbers of individuals with behavioral health disorders continue to be involuntarily hospitalized and incarcerated, the most restrictive and costly options available. This could be reduced by increasing access to emergency and crisis response and diversion services, implementing recovery-oriented crisis response practices, and managing intensive services more consistently.
2	Increase peer services and supports by expanding peer support specialists in direct service roles and recovery support services.	Peer support and recovery support are enormously helpful for many individuals with mental health, substance use, or co-occurring disorders. However, DBHDS does not have an office, section, or division for “consumer affairs” that can provide leadership for peer and recovery services as is available in many other states.
3	Increase the statewide availability of substance abuse treatment services.	Untreated substance-use disorders cost the Commonwealth millions of dollars in cost-shifting to the criminal justice system, the health care system, and lost productivity, not to mention the human suffering and effects on family and friends. Meanwhile, the publicly-funded treatment system lacks timely access to critical evidence-based treatment and support services, with an average wait-time of 19 days from first contact to receipt of actual services. Additional capacity for key services would improve access and produce long-term savings.
	Develop a child and	

4	adolescent mental health services plan to enhance access to the full comprehensive array of child and adolescent behavioral health services as the goal and standard in every community.	Virginia's behavioral health services for children faces multiple challenges including an incomplete, inconsistent array of services, inadequate early intervention services, a need for workforce development and inadequate oversight and quality assurance. As a first step, the General Assembly directed DBHDS to develop and submit a plan to "identify concrete steps to provide children's mental health services, both inpatient and community-based, as close to children's homes as possible" for consideration during its 2012 session.
5	Address the housing needs for individuals with mental health and substance use disorders.	Safe, decent, and affordable housing is essential to recovery, and housing stability is correlated to lower rates of incarceration and costly hospital utilization. Generally, individuals should not spend more than 30% of their income on housing. Monthly Supplemental Security Income (SSI) payments are $674 in Virginia while the average fair market rent for a one-bedroom unit is $887. Auxiliary grants subsidize housing for individuals receiving SSI, but are limited to assisted living facilities and adult foster care homes and cannot be used for other housing arrangements. Medicaid does not pay for housing, only services.
6	Create employment opportunities for individuals with mental health and substance use disorders.	People who are employed contribute to the economy and improve their sense of self worth. Certain interventions are proven to help adults with serious mental illness (SMI) transition from income subsidies to successful competitive employment. Today, CSBs report full or part-time employment rates for service recipients of only 14% among adults with SMI and 32% among adults with substance use disorders.
7	Strengthen the capability of the case management system to support individuals receiving behavioral health services.	Case management (service coordination and intensive case management) aids with the navigation and best usage of the publicly-funded system of services by helping individuals connect with appropriate services and receive day-to-day support to ensure stable community living. In Virginia, there is no standard training and no system for assuring that case managers have the knowledge and skills needed to be effective. As a result, the level and quality of such services varies widely from community to community.
8	Ensure that each CSB/BHA convene or join prevention planning coalitions.	It is important to ensure that prevention personnel at each CSB/BHA convene or join prevention planning coalitions covering each jurisdiction in the catchment area to assess needs and service gaps, develop plans, and implement and evaluate evidence-based programs and practices to prevent substance abuse and emotional and behavioral disorders in children and adolescents.
9	Update the Statewide Suicide Prevention plan by June 30, 2013.	DBHDS is the lead agency for suicide prevention across the lifespan in Virginia. However, Virginia's latest statewide plan was developed in 2004 and needs to be updated.

Footnotes:

As indicated elsewhere in the Block Grant application, Virginia drew these priorities from the Creating Opportunities Plan that has been developed by DBHDS. This plan is built on previous planning efforts, enabling DBHDS to structure an accelerated and condensed planning process that will allow implementation of these initiatives to begin quickly. It is important to note that the Creating Opportunities plan is

primarily focused on internal infrastructure development, and therefore includes some priorities that do not lend themselves to easily quantifiable or measureable performance indicators. Where possible, these performance indicators (and relevant baseline measurements) have been provided (please see Table 3, Step 4). As the Creating Opportunities plan continues to be implemented, this will allow Virginia to move towards more quantifiable priorities in subsequent plans.

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:
2012

End Year:
2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		1. Expand statewide capacity and fill identified gaps in emergency and crisis response services and expand services that prevent or reduce the need for crisis response services. Based on a statewide assessment, additional resources are needed to expand Crisis Intervention Teams (CIT) and PACT programs, establish police reception and drop off centers and emergency critical time intervention services, and increase purchase of local inpatient		

Strengthen the responsiveness of behavioral health emergency response services and maximize the consistency, availability, and accessibility of services for individuals in crisis.	Strengthen the responsiveness of behavioral health emergency response services. (Criterion 1: Comprehensive Community-based MH Delivery System)	psychiatric services. [This strategy is contingent on additional state funding] 2. Train services providers on recovery-based emergency and crisis response best practices and increase peer support workers employed in emergency response services and use of psychiatric advance directives and wellness recovery plans. 3. Expand the Cross-System Mapping process to more communities to enable community behavioral health and public safety systems to better understand the consumer's experience, identify service gaps, explore opportunities for diversion or system improvement, and develop local action plans. 4. Participate as an active partner in Virginia interagency suicide prevention initiatives. 5. Participate in a Joint NAMI-Virginia	Increase number of individuals who receive behavioral health emergency services during the previous 12 months who received follow-up substance abuse or mental health services.	Data will be collected via CCS. This measure reports the percent of all individuals who receive behavioral health emergency response services during the previous 12 months who receive at least one substance abuse or mental health service of any type in the month following admission and who also receive at least one mental health or substance abuse service of any type every month for at least the following five months (with a particular focus on the priority populations of pregnant women, women with dependent children, and IVDUs, with a goal of improving from 25% to 27% in 2013). Baseline, FFY 2012: 25% FFY 2013: 27%

		CIT Coalition conference to be held in September 2011.		
Increase peer services and supports by expanding peer support specialists in direct service roles and recovery support services.	Increase peer services and supports. (Criterion 1: Comprehensive Community-based MH Delivery System)	1. Establish a DBHDS Office of Peer Services and Recovery to promote collaboration and information exchange with the peer community, CSBs, and state facilities and support peer services and recovery supports development across Virginia. [This strategy is contingent on state funding] 2. Work with DMAS to expand peer support services by changing the state Medicaid plan to add peer support as a distinct service, and implement a state certification program for peer support specialists. [This strategy is contingent on state funding]	Progress toward the establishment of a DBHDS Office of Peer Services and Recovery.	Data will be maintained by DBHDS. Baseline, FFY 2012: Plan developed and budget request made to establish Office of Peer Services and Recovery. FFY2013: Establishment of DBHDS Office of Peer Services and Recovery.
		1. Expand statewide capacity and fill identified gaps in the substance abuse services. Based on a statewide		

Increase the statewide availability of substance abuse treatment services.	Increase the statewide availability of substance abuse treatment services. (Criterion 1: Comprehensive Community-based MH Delivery System)	assessment, additional investment of resources is needed in the following services: substance abuse case management; capacity to serve adolescents using evidence-based practices; intensive coordinated care for pregnant and post-partum women who are using drugs; peer-run support services; enhanced uniform screening and assessment for substance use disorders and co-occurring mental illness; community diversion services for young non-violent offenders; intensive outpatient services detoxification; medication assisted treatment; detoxification services; residential services for pregnant women and women with children in Southwest Virginia; SA-specific vocational counselors; and supportive living capability. [This strategy is	Decrease statewide average number of days waiting from first contact to first clinical appointment at CSBs.	Data to be collected via CCS, with CSB survey to be used as needed. This measure reports the average number of calendar days from the date of the first contact or request for service until the first scheduled appointment in a substance abuse service accepted by an individual for all individuals admitted to the substance abuse services program area in the previous 12 months (with a particular focus on insuring that statutory requirements for the priority populations of pregnant women, women with dependent children, and IVDUs are met) with a goal of decreasing the statewide average number of days waiting from 19 days (current) to 18 days in 2013. Baseline, FFY2012: 19 days FFY2013: 18 days

	contingent on state funding] These strategies, such as medication assisted treatment and expanded detoxification, include services to people who inject drugs (IVDU), as well as ongoing screening for TB and referral to local health departments and other local resources for treatment when necessary. 2. Implement a substance abuse services workforce development initiative. [This strategy is contingent on state funding]		
	1. Establish a Comprehensive Service Array as a guide for children's behavioral health service development. 2. Expand child and adolescent behavioral health services statewide to fill identified gaps in base services. Based on a statewide assessment, these services include regional crisis stabilization units		

Develop a child and adolescent mental health services plan to enhance access to the full comprehensive array of child and adolescent behavioral health services as the goal and standard in every community.	Develop plan to enhance access to the full comprehensive array of child and adolescent behavioral health services. (Criterion 3: Children's Services)	for children and mobile child crisis response units, psychiatric services and case management. [This strategy is contingent on state funding] 3. Continue the current role of the Commonwealth Center for Children and Adolescents for the foreseeable future. 4. Implement a children's behavioral health workforce initiative. Additional resources are needed for this initiative. [This strategy is contingent on state funding] 5. Improve DBHDS quality management and quality assurance and oversight capacity for child and adolescent behavioral health services. Additional resources are needed for this initiative. [This strategy is contingent on state funding]	Increase the percentage of children admitted to the mental health services program who received follow up outpatient services within 30 days of admission.	Data to be collected via survey to CSBs and other data sources. This measure reports the percent of children admitted to the mental health services program area during the previous 12 months who receive one hour of outpatient services within 30 days of admission and who also receive at least two additional hours of outpatient services within 30 days of admission.
		1. Continue to participate in cross-secretarial and interagency		

Address the housing needs for individuals with mental health and substance use disorders.	Address the housing needs for individuals with mental health and substance use disorders. (Criterion 4: Targeted Services to Rural and Homeless Populations and Older Adults)	activities to leverage housing resources and create affordable housing options for individuals receiving behavioral health services, including: a) Governor's Housing Initiative recommendations to create a range of housing opportunities. b) Governor's Homeless Outcomes Workgroup activities to increase access to substance abuse and mental health treatment, peer recovery programs, and Housing First Projects. 2. Provide training and consultation to services providers to increase affordable housing and appropriate supports by leveraging housing resources and implementing supportive housing models. 3. Work with DMAS to assess the potential benefits of expanding Virginia's CMS Money Follows the	Increase number of CSBs receiving training and consultation addressing consumer housing challenges.	Data will be collected via DBHDS consultation notes, participant attendance rolls, and other sources. Baseline, FFY 2012: 0 CSBs FFY 2013: 40 CSBs

	Person (MFP) program to individuals transitioning from state hospitals. 4. Include housing stability of individuals receiving CSB behavioral health services as a Performance Contract goal and responsibility and track outcomes on a regular basis.		
	1. Work with public and private services providers and employers to implement an “Employment First” policy that emphasizes integrated and supported employment. Implementation will include an “Employment First” leadership summit, a statewide awareness and education campaign, and regional trainings. 2. Provide training and consultation to services providers on implementing innovative supportive employment models and establishing		Data will be collected via CCS. This measure

Create employment opportunities for individuals with mental health and substance use disorders.	Create employment opportunities for individuals with mental health and substance use disorders. (Criterion 1: Comprehensive Community-based MH Delivery System)	integrated supported employment teams that include CSBs, DRS, and ESOs. 3. Expand access to specialized vocational counseling and employment support for people receiving treatment for substance use disorders. [This strategy is contingent on state funding] 4. Work with DMAS to incorporate supported employment evidence-based practice models in Medicaid Day Support, Mental Health Support Services and Psychosocial Rehabilitation regulations. 5. Include employment of individuals receiving CSB behavioral health services as a performance contract goal and responsibility and track employment status on a regular basis.	Increase percentage of adults admitted to mental health services with serious mental illness who receive case management services and who were employed full- or part-time during past 12 months.	reports the percent of adults admitted to the mental health services program area with serious mental illness who receive at least one mental health case management service of any duration and were employed full- or part-time or receive individual or group supported employment services at any point in the previous 12 months (with a particular focus on persons with co-occurring disorders who are members of the priority populations of pregnant women, women with dependent children, and IVDUs), with a goal of increasing from 15% to 16% in 2013. Baseline, FFY 2012: 15% FFY 2013: 16%
		1. Adopt basic and disability-specific case management		

Strengthen the capability of the case management system to support individuals receiving behavioral health services.	Create employment opportunities for individuals with mental health and substance use disorders. (Criterion 1: Comprehensive Community-based MH Delivery System)	curricula based on case management core competencies and develop new case management training modules. 2. Establish a state certification program for case managers to demonstrate that they meet competency and training requirements. [This strategy is contingent on state funding]	Increase percentage of adults admitted to mental health services with serious mental illness who received follow-up case management services.	Data will be collected via CCS. The measure reports the percent of adults admitted to mental health services during the previous 12 months with serious mental illness who receive one hour of case management services within 30 days of admission and who also receive at least five additional hours of case management services within 90 days of admission (with a particular focus on persons with co-occurring disorders who are members of the priority populations of pregnant women, women with dependent children, and IVDUs) with a goal of increasing from 50% to 51% in 2013. Baseline, FFY 2012: 50% FFY 2013: 51%
Ensure that each CSB/BHA convene or join prevention planning coalitions.	To increase the number of jurisdiction-based prevention planning coalitions that CSB/BHA prevention staff lead, or participate in.	Utilize the DBHDS-CSB Performance Contract to support CSB/BHA leadership of, or participation in, jurisdiction-based prevention coalitions to develop prevention service plans with goals and objectives, provide evidence-based services, evaluate 20% of program participants and submit web-based reports on coalitions annually in the fall.	Increase number of jurisdiction-based prevention planning coalitions that are led by CSBs or in which CSBs participate.	Data will be reported by CSBs/BHAs to DBHDS through KIT Solutions, LLC, database. Baseline, FFY 2012: 68 Prevention Coalitions FFY 2013: 88 Prevention Coalitions
	Update the	Analyze and evaluate needs assessment and		

Update the Statewide Suicide Prevention plan by June 30, 2013.	Statewide Suicide Prevention plan by June 30, 2013. (Criterion 1; Comprehensive Community-based MH Delivery System)	planning data from 2011 regional summits, and use this data and Suicide Prevention Workgroup to update Virginia's suicide prevention plan.	Progress toward the development of a statewide plan to reduce the number of suicides across the lifespan.	Data will be collected and maintained by DBHDS. Baseline, FFY 2012: Committee established and preliminary discussions of updating state suicide prevention plan. FFY 2013: Updated plan published and disseminated.

Footnotes:

As indicated elsewhere in the Block Grant application, Virginia drew these goals, priorities, and performance indicators from the Creating Opportunities Plan that has been developed by DBHDS. This plan is built on previous planning efforts, enabling DBHDS to structure an accelerated and condensed planning process that will allow implementation of these initiatives to begin quickly. It is important to note that the Creating Opportunities plan is primarily focused on internal infrastructure development, and therefore includes some goal areas and objectives that do not lend themselves to easily quantifiable or measureable performance indicators. Where possible, these performance indicators (and relevant baseline measurements) have been provided. As the Creating Opportunities plan continues to be implemented, this will allow Virginia to move towards more quantifiable goals, priorities, and performance indicators in subsequent plans.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 CMHS - Services Purchased Using Reimbursement Strategy

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Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy	Other
No Data Available		

Footnotes:

Form 4 for CMHS BG 2012 & 2013 are included as attachments.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy

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Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy	Other
Grant/contract reimbursement	Community-based substance abuse treatment, prevention and peer-run services	

Footnotes:

This information is for SAPT 2012. Form 4 for SAPT 2013 and CMHS BG 2012 & 2013 are included as attachments.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2012

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	10-25% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	10-25% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		<10% 6
Other		N/A 6

Footnotes:

Mental Health - FY 2012

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2012

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	10-25% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	10-25% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		<10% 6
Other		N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

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Start Year: 2012

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

No data entered because no CMHS funds are expended for Prevention in Virginia and this table is not a required element of the application.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SA - Primary Prevention Planned Expenditures Checklist

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Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$358,295	$	$	$	$
Information Dissemination	Selective	$18,500	$	$	$	$
Information Dissemination	Indicated	$2,883	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$379,678	$	$	$	$
Education	Universal	$4,575,765	$	$	$	$
Education	Selective	$692,087	$	$	$	$
Education	Indicated	$54,206	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$5,322,058	$	$	$	$
Alternatives	Universal	$279,751	$	$	$	$
Alternatives	Selective	$720,179	$	$	$	$
Alternatives	Indicated	$2,424	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$1,002,354	$	$	$	$
Problem Identification and Referral	Universal	$248,376	$	$	$	$
Problem Identification and Referral	Selective	$33,881	$	$	$	$
Problem Identification and Referral	Indicated	$73,860	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$356,117	$	$	$	$
Community-Based Process	Universal	$622,182	$3,203,586	$	$	$

Community-Based Process	Selective	$94,408	$	$	$	$
Community-Based Process	Indicated	$4,543	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$721,133	$3,203,586	$	$	$
Environmental	Universal	$313,539	$	$	$	$
Environmental	Selective	$9,862	$	$	$	$
Environmental	Indicated	$282	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$323,683	$	$	$	$
Section 1926 Tobacco	Universal	$140,000	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$140,000	$	$	$	$
Other	Universal	$307,373	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$307,373	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report

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Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$
11. Total	$	$	$	$	$	$

Footnotes:

This form is not a required element of this application for CMHS funds.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SA - Projected State Agency Expenditure Report

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Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$32,071,485	$	$111,704	$95,258,260	$	$
2. Primary Prevention	$8,552,396	$	$3,203,586	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital	$	$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$2,138,099	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$42,761,980	$	$3,315,290	$95,258,260	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$2,138,099	$	$	$	$	$
11. Total	$42,761,980	$	$3,315,290	$95,258,260	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year: 2012

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$	$ 132,688	$	$ 230,293		$362,981
2. Quality Assurance	$	$	$	$ 165,581		$165,581
3. Training (Post-Employment)	$	$ 35,238	$	$ 48,535		$83,773
4. Education (Pre-Employment)	$	$	$	$	$	$
5. Program Development	$	$ 86,083	$	$ 158,219		$244,302
6. Research and Evaluation	$	$ 38,384	$	$ 184,072		$222,456
7. Information Systems	$	$ 27,997	$	$ 72,622		$100,619
8. Total	$	$320,390	$	$859,322	$	$1,179,712

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

Virginia does not currently have a service delivery system of consumer direction or self-direction as defined in this Application, i.e. "a delivery mode through which a range of services and supports are planned, budgeted, and directly controlled by an individual…" Virginia does not offer a voucher or equivalent system that allows the individual with mental health or substance use disorders to directly control the funds for purchasing the services they feel best serve their plan. However, there are policies, requirements, and initiatives in place that promote or require participation by the individual receiving services (or their representative) and family members in treatment planning and decisions regarding services and supports.

1) Policies

Virginia's Vision is "...a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships." The public system of care is expected to incorporate the principals of this Vision in its planning, operations and services.

In 2009, the reaffirmed priorities for the public behavioral health system which included:

- Full implementation of self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policies and practices that reflect the unique circumstances of individuals.
- Incorporating principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expanding services and supports to support individual and family choice, community integration, and independent living.
- Providing sufficient capacity to meet individuals' needs wherever they live in Virginia, specifically:
    - The levels of services and supports they need,
    - When and where they need them,
    - In appropriate amounts, and
    - For appropriate durations.

State Board Policy 1007 addresses services for children and adolescents and their families, and says that children and their families in need of services shall have access to an integrated system of child-centered and family-focused behavioral health and developmental prevention, early intervention, treatment, and habilitation services. Programs for children and their families should be specialized and flexible and be delivered by specially trained staff so to meet the individual needs of the child and family in community settings. Community settings are construed broadly in this policy to include public or private inpatient or residential treatment facilities, which are part of the overall continuum of care. The policy includes, but is not limited to, the following principles:

- Children and their families are able to access individualized services that are tailored to build on their unique strengths and to meet their changing needs.

- Services are sensitive and responsive to the cultural and linguistic diversity and special requirements of children and their families.
- Families and surrogate families are consistently and integrally involved as partners in all aspects of planning, delivering, and evaluating services for their children.
- All participants in the services system are responsive and accountable to each other.

2) Licensing Regulations

Additionally, DBHDS is responsible for licensing public and private providers who serve persons with mental health or substance use, developmental or intellectual disorders. In order to obtain and maintain a license, the program must demonstrate that an Individualized Service Plan (ISP) that addresses the individual's needs and preferences has been developed in accordance with the state human rights regulations which apply to all licensed public and private providers (12VAC35-105-660). The human rights regulations requires providers to only deliver service that is in a treatment plan tailored specifically to the individual's (or their representative or guardian) expressed needs and preferences (12VAC35-115-60).

3) Advance Directives

In 2009, the Virginia General Assembly enacted major revisions of the Commonwealth's Health Care Decisions Act (HCDA) based on recommendations of the Supreme Court's Commission on Mental Health Law Reform. The HCDA now provides a legal mechanism for persons with chronic health conditions, including serious mental illness, to document their treatment instructions and preferences, and to authorize a healthcare agent to make treatment decisions for them during periods of incapacity. These advance directives (ADs) may also contain individualized, patient-centered plans to prevent crises, as well as to manage and recover from them.

Beginning in January, 2010, key behavioral health stakeholders have initiated a multi-pronged strategy to promote use of advance directives by mental health consumers and to assist them in completing and executing these legal instruments. This effort is coordinated by the stakeholders under the Coordinating Committee for Promoting Use of Advance Directives by People with Mental Illness. This effort includes the following activities:

- Four CSB pilot sites are incorporating AD facilitation into routine practice and compiling "lessons learned" for further dissemination.
- State organizations including NAMI, VOCAL, the MHA, and VOPA, are training and supporting stakeholders to use of advance directives.
- Standardized advance directive forms have been developed.
- Health law experts are clarifying the legal aspects of executing and enforcing advance directives to eliminate barriers to use.
- Training activities has been provided to AD facilitators, and to wider audiences of advocates, providers, and service recipients.
- New elements are being added to EHRs to document facilitation and execution of ADs.
- A web site has been established to access AD resources.

4) Children and Families

Ensuring that families of children with mental health and co-occurring disorders are empowered to make informed decisions, supported to have self-determination and responsibility, and participate in the behavioral health system is of the utmost importance. Families must be an active and equal partner in the development of their child's treatment and Plan of Care within the behavioral health system.

DBHDS has worked steadily to support and empower a statewide organization of parents with children with mental health and related disorders. To that end, DBHDS has collaborated with the National Alliance on Mental Illness of Virginia to enhance the prominence of family support, to increase DBHDS responsiveness to caregiver needs, and to distribute family resource materials and information as needed. This collaboration will:

- Assist families in navigating the system and access services in a timely manner.
- Assist families with community networking, resource mapping, organizing and utilizing information that connects them to community resources, both public and private.
- Work with families to identify natural and informal supports (friends, family members, clergy, teachers, etc.) that would assist them with identifying mental health treatment and/or provide additional support to the family.
- Assist families in developing working partnerships with service providers.
- Provide training to family members in leadership skills to increase family involvement on a statewide basis at the policy, management, and service level.
- Developing a family support program evaluation process.

5) Data

DBHDS does not currently have data indicating percentages of SMHA or SSA funded individuals who are self directing their care through a complete process of planning, budgeting and purchasing services.

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

In administering Virginia's publically-funded, community-based behavioral health services system, DBHDS works with the state's network of 40 community services boards (CSBs). DBHDS also operates nine inpatient psychiatric facilities.

Data on CSB static service capacity (FTEs and bed days) and expenditures for each core service are collected in the Community Automated Reporting System (CARS). DBHDS also maintains a data system through its Licensing Office that contains information on provider characteristics of CSBs.

Client-level data from CSBs are collected using the Community Consumer Submission, Version 3 (CCS3). CCS3 is an agency-developed application designed to be consistent with TEDS and NOMs data definitions. CCS3 collects data on the numbers and characteristics of individuals receiving direct and contracted services from CSBs, as well as data on admissions, discharges and types and amounts of services received. Service data in CCS3 is collected for each service as defined in the Department's Core Services Taxonomy v7.2, which crosswalks onto services as defined in previous years' SAPT Block Grant applications. Data on CPT codes are not collected at the state level. The information requested in Table 5 can be provided only for the services that map onto that previous taxonomy. No data on prescribed medications is collect at the state level for individuals receiving community-based services.

Each CSB is responsible for developing an extract program to prepare data for submission that meets DBHDS IT specifications. Extracts of required data are submitted monthly. CSBs have utilities to detect data errors before submitting the data to DBHDS. When DBHDS receives data, the data are subjected to an extensive series of data edits.

A majority of CSBs have obtained platforms capable of supporting an electronic health record (HER) and a number of them have begun implementing EHR functionalities. Eight different vendor systems are currently in use. Several CSBs are in the process of acquiring new commercial information systems, and are aware of the significance of selecting software that has been certified by the Certification Commission for Health Information Technology (CCHIT).

Recently the Data Management Committee of the Virginia Association of Community Services Boards began work with DBHDS on a process to review the current data structure across systems and recommend improvements. This group prefaced an outline of its four-phase plan by observing, "A significant restraint in CSBs migrating to a cleaner data sharing model is the wide disparity of CSB MIS systems. The team did not envision unpacking the current system. It believes the best way forward is to leverage Federal meaningful use mandates around EHR functionality to ultimately get all CSBs at the same baseline for EHR data collection and sharing." The group estimates that, given the current status of EHR implementation in Virginia, full implementation to the point of being able to report a full year of the data requested in Table 5 may take 4-5 years.

DBHDS has a contract with KIT Solutions to develop and maintain a data base to monitor sub-recipient primary prevention programs. This data base allows for the input of staff members'

program-provided hours, goals and objectives, programs descriptions, and participant numbers and demographics.

Data from DBHDS inpatient services is collected in the AVATAR data system. AVATAR is a third-party vendor application that supports the agency billing functions for services delivered in these facilities. Automated billing is done for Medicaid, Medicare, commercial insurance, patient income and private payers. Basic client-level demographic and diagnostic data are maintained in AVATAR which are used to meet state, federal and agency reporting requirements. Data on prescribed medications in facilities is maintained in a separate pharmacy data base.

Specific Block Grant Application Questions:

- *For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?*
  Each community service board has its own national provider (I-SATS) identifier. In CCS3, each CSB has its own unique identifier. DBHDS is able to crosswalk this CSB ID with the appropriate I-SATS number.

- *Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?*
  The licensing data base mentioned above assigns a unique identifier to each provider. Licensed programs are considered "state approved" for listing in I-SATS.

- *Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?*
  Currently, DBHDS has a unique client identifier generated by applying the MD-5 hashing algorithm to the client's Social Security Number (SSN) or, in the absence of an SSN, to a concatenation of the CSB provider ID and the CSB Client ID. There is a current initiative to develop unique identifiers state-wide through the Department of Motor Vehicles (DMV).

- *Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?*
  Client-level service data is reported in CCS3. Some data on services is aggregated over the one-month reporting period.

- *Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?*
  CCS3 currently collects DSM-4 diagnostic codes, supplemented by some 5-digit ICD-9 diagnostic codes, as needed. Service data in CCS is collected for each service as defined in the Core Services Taxonomy v7.2, which crosswalks onto services as defined in previous years' block grant applications. CSBs systems collect CPT codes for billable

services, but many do not collect codes for non-billable services. Data on CPT codes are not collected at the state level.

- *Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?*
  Data on client Medicaid numbers are collect in CCS3 for individuals receiving services from a community services boards. Medicaid provider number can be cross-walked to the ID number for each CSB. Combining data from the CARS system and Medicaid payment reports would allow aggregation of payment data for individuals receiving services through community services boards.

- *Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?*
  Reports on community-based behavioral health services funded through Medicaid are produced on an ad-hoc basis.

- *Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system OMB No. 0930-0168 40 interoperability, electronic health records, Federal IT requirements or similar issues?*
  The Secretary of Health and Human Resources holds monthly meetings with the CIOs of the departments in his secretariat (which includes the Department of Medical Assistance Services (DMAS), the state Medicaid agency, to address IT issues, requirements and needs.

- *Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?*
  In 2009, The Governor's Health Information Technology Advisory Commission (HITAC) was created by Executive Order 95. The Secretary of Health and Human Resources chairs the Commission. The Commission enlists input from a broad range of stakeholders including physicians, HIE and privacy experts, hospital and insurance executives and community services board staff.

  On June 15, 2011, the Virginia Department of Health (VDH), Office of Information Management and Health Information Technology issued RFP (VDH-2011-00520) for "Project Management Services" for the "Statewide HIE". The Governor's HIT Advisory Commission created the strategic and operational plans for the HIE were approved by the Office of the National Coordinator. The Commonwealth of Virginia received $11.6 million for the project.

  VDH intends to contract with a private, not-for-profit organizations to create and manage the HIE's operations on an ongoing basis. This means that the awardee of the contract will need to establish the governance body, the management structure,

business operations, and technology infrastructure for the HIE. VDH also expects that the not-for-profit HIE contractor will also subcontract with a private sector firm or firms to operate the technology infrastructure for the HIE.

- *Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?*
  As an HHR agency, DBHDS staff participate in HHR stakeholder groups with the HHR Secretary. In addition, Virginia Medicaid completed a Behavioral Health MITA (BH-MITA) state self- assessment in 2010/2011 that served to align efforts with state and federal direction/vision.

Additional Information

- *Provide information regarding your State's current efforts to assist providers with developing and using Electronic Health Records;*
  Virginia Health Quality Center, the Quality Improvement Organizations (QIO) contractor to CMS, is also contracted to serve as Virginia's Regional Extension Center for Health Information Technology. The mission of the Regional Extension Center is to provide comprehensive, low-cost technical assistance to make it easier for the Commonwealth's priority primary care providers (PPCPs) to adopt electronic health records (EHRs), integrate them into the patient care process, and attain meaningful use in two areas: EHR implementations with the goal of meaningful use; and to assist existing EHR implementations to attain meaningful use. This initial focus on primary health care is being expanded to include behavioral health care.

  DBHDS has formed a project team to develop the requirements document for EHRs in state inpatient facilities in order to integrate patient information with CSB data systems. Subcommittees have been formed to develop the requirements for their specific area. .

- *Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment;*
  The *Code of Virginia* requires that funding for community-based behavioral health services be distributed through the CSBs. Historically, this has been accomplished through annual grants of state and federal funds. Switching this to an encounter/claims based approach would require working with the legislature on changes to the *Code* and Appropriations Act and would be disruptive. In addition, the available infrastructure at DBHDS to manage such a transition is severely limited from severe staff reductions taken in recent years. As mentioned above, the EHR infrastructure necessary to facilitate this change is at least 4-5 years from full implementation.

- *Identify the specific technical assistance needs your State may have regarding data and information technology specifically in Section IV.K.*
  - Guidelines on further integration of MH and SA services

- Implementation of business intelligence tools
- Technical support for system sizing
- Telecommunication and interface requirements to Federal HIS areas.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

The Department's Division of Quality Management and Development has been working with CSBs to develop the infrastructure to support a continuous quality improvement program. During 2011, consensus was reached on a number of possible indicators related to mental health recovery, substance abuse services and children's mental health services. Reports on these indicators will be made available on the Department's website quarterly, giving the current quarter's metrics along with those of the previous three quarters to track improvement. A process will be developed to discuss the results with various stakeholder groups, including consumers and their families. Procedures already in place in the Offices of Licensing and Human Rights address critical incidents, grievances and complaints and will be evaluated and modified, as necessary. Measures are planned for Mental Health, Substance Abuse and Children's Services.

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IV. F. Quality Improvement Reporting

Revision requested:
** Please provide a date when the measures will be on Department's website.

Response:
The measures will be posted on the DBHDS no later than June 30, 2013.

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Amended on March 28, 2012

IV. F. Quality Improvement Reporting

Revision requested:
** Please provide a date when the measures will be on Department's website.

Response:
The measures will be posted on the DBHDS no later than June 30, 2013.

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

The Commonwealth of Virginia currently has no federally recognized tribes, so this section does not apply to our state.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

As described earlier, Virginia's public behavioral health system is composed of 40 CSBs that manage and provide the full continuum of mental health and substance abuse services, either directly or through contracts with non-CSB providers, throughout the state. The primary funding for CSB behavioral health services comes from several sources including (1) State General Funds (SGF) provided through DBHDS to CSBs in the form of annual allocations, (2) CMHS and SAPT Block Grant funds, which are allocated to CSBs as part of their annual award from DBHDS, (3) Local funds allocated directly to CSBs by the localities they serve, and (4) Medicaid funds, which are paid to CSBs on a fee-for-service basis by DMAS, the state Medicaid authority. CSBs also receive fee-for-service funding for services provided to children and adolescents referred under the locally controlled Comprehensive Services Act (CSA). In addition, DBHDS uses CMHS funds to contract directly with a small number of non-profit peer-run service and support organizations.

Medicaid-funded CSB services are subject to continuing utilization review by DMAS and its utilization review contractors and focuses on appropriateness of admission, clinical necessity of the service, provider qualifications, appropriateness of service authorization, reconciliation of services with claims, etc. CSA providers are also subject to utilization review, including a newly implemented state requirement to complete an independent CSB clinical assessment for all admissions. It should be noted that individual CSBs and regions have implemented many local and regional utilization management strategies to minimize the use of inpatient care, but beyond the requirements described above, state-level utilization management requirements and strategies are not now in place for SGF and Block Grant funds allocated to CSBs.
Federal Health Reform will have a significant impact on Virginia and on the state's service management approach. Through the Secretary of Health and Human Resources *Virginia Health Reform Initiative*, the Commonwealth is examining care coordination and care management models that can be used in the delivery of health care in Virginia, including behavioral health care.

In addition, language was added to the FY 2012 State Budget requiring DMAS and DBHDS, with stakeholders, to *"…develop a blueprint for…..implementation of a [Medicaid] care coordination model for individuals in need of [Medicaid] behavioral health services not currently provided through a managed care organization. The overall goal … is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations."*

Among many other requirements, the above Medicaid "blueprint" will improve value and access, engage consumers fully, utilize best practices, improve outcomes and efficiency, and employ standardized methods of tracking consumer satisfaction, consumer outcomes, service utilization and costs in a manner that provides "actionable data" to providers and administrators.

The *Virginia Health Reform Initiative* and refinements in Virginia's Medicaid program, as described above, will shape behavioral health service management strategies into the future.

However, the specific processes, strategies, resource needs, and timeframes for these results are not known at this time.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2012

Priority	Performance Indicator	Selected
Strengthen the responsiveness of behavioral health emergency response services and maximize the consistency, availability, and accessibility of services for individuals in crisis.	Increase number of individuals who receive behavioral health emergency services during the previous 12 months who received follow-up substance abuse or mental health services.	þ
Increase peer services and supports by expanding peer support specialists in direct service roles and recovery support services.	Progress toward the establishment of a DBHDS Office of Peer Services and Recovery.	þ
Increase the statewide availability of substance abuse treatment services.	Decrease statewide average number of days waiting from first contact to first clinical appointment at CSBs.	þ
Develop a child and adolescent mental health services plan to enhance access to the full comprehensive array of child and adolescent behavioral health services as the goal and standard in every community.	Increase the percentage of children admitted to the mental health services program who received follow up outpatient services within 30 days of admission.	þ
Address the housing needs for individuals with mental health and substance use disorders.	Increase number of CSBs receiving training and consultation addressing consumer housing challenges.	þ
Create employment opportunities for individuals with mental health and substance use disorders.	Increase percentage of adults admitted to mental health services with serious mental illness who receive case management services and who were employed full- or part-time during past 12 months.	þ
Strengthen the capability of the case management system to support individuals receiving behavioral health services.	Increase percentage of adults admitted to mental health services with serious mental illness who received follow-up case management services.	þ
Ensure that each CSB/BHA convene or join prevention planning coalitions.	Increase number of jurisdiction-based prevention planning coalitions that are led by CSBs or in which CSBs participate.	þ
Update the Statewide Suicide Prevention plan by June 30, 2013.	Progress toward the development of a statewide plan to reduce the number of suicides across the lifespan.	þ

Footnotes:

DBHDS has several initiatives underway that will position it to begin implementation of a data dashboard. The Department is working with the Virginia Information Technology Agency (VITA, the commonwealth's information technology authority) on developing enhancements to system architecture and installation of SQL 2008. A plan is in place to access development resources to make use of the embedded SQL Server Reporting Services and SQL Server Analysis Services modules to develop standardized reports and a data warehouse/data mart.

DBHDS is also working with CSBs to develop a CQI process to identify and track critical quality improvement measures using individual data from the Community Consumer Submission (CCS) system. A primary focus will be the provision of actionable data in a timely manner that will enable CSBs to use the data to improve the quality and outcomes of services for individuals.

While improvements are being made to existing data systems, DBHDS recognizes that implementation of fully functional electronic health records will have a profound effect on improving its ability to collect and report individual-level data from CSBs. Recent discussions with CSB IT staff indicate that full EHR implementation will take between four and five years.

CQI reporting is tentatively scheduled to begin by January 2012 and system architecture enhancements by the following spring. These activities will provide the basis for reporting outcome and performance measures using individual-level data in a dashboard format. Federal reporting requirements prior to these enhancements or that require full EHR functionality will be addressed with data collected by surveying the community services boards.

Because all of the efforts described above are developmental and incomplete at this point, the performance indicators provided below (and in Table 3) are subject to change as the above coordinated processes continue to move forward. Together these efforts will assist DBHDS in identifying the most universal, accurate, valid, and reliable metrics possible that will be incorporated into a data dashboard and assist development of an array of program effectiveness and quality improvement measurement activities.

Table 10 Plan Year **2012-2013**

Priority Area	Performance Indicator
Strengthen the responsiveness of behavioral health emergency response services and maximize the consistency, availability, and accessibility of services for individuals in crisis.	Conduct and complete ten additional Cross-System Mapping workshops in Virginia localities.
Increase peer services and supports by expanding peer support specialists in direct service roles and recovery support services.	Progress toward the establishment of a DBHDS Office of Peer Services and Recovery.
Increase the statewide availability of substance abuse treatment services.	Decreased statewide average number of days waiting from first contact to first clinical appointment at CSBs.
Develop a child and adolescent mental health services plan to enhance access to the full comprehensive array of child and adolescent behavioral health services as the goal and standard in every community.	Increased number of CSBs providing the base level of children services (crisis response, case management, psychiatric, and intensive in-home).
Address the housing needs for individuals with mental health and substance use disorders.	Increased number of CSBs receiving training and consultation addressing consumer housing challenges.
Create employment opportunities for individuals with mental health and substance use disorders.	Progress toward the establishment of an "Employment First" policy.
Strengthen the capability of the case management system to support individuals receiving behavioral health services.	Progress toward the establishment of a basic and disability-specific case management curriculum.
Ensure that each CSB/BHA convene or join prevention planning coalitions.	Increased number of jurisdiction-based prevention planning coalitions that are led by CSBs or in which CSBs participate.
Update the Statewide Suicide Prevention plan by June 30, 2013	Progress toward the development of a statewide plan to reduce the number of suicides across the lifespan.

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IV. I. State Dashboards

Revision requested:
Please review Performance Indicators and insure that they are measurable, i.e,

Example 1: Decreased statewide average number of days waiting from first contact to first clinical appointment at CSBs from 18 days (current) to 15 days in 2013.

Example 2: Increase number of CSBs receiving training and consultation addressing consumer housing challenges from 20 currently to 40 in 2013.

Response:
Performance indicators remain under development as DBHDS works in partnership with the provider community. DBHDS has also established a leadership position to assist in this development.

IV. I. State Dashboards

Revision requested:
Please review Performance Indicators and insure that they are measurable, i.e,

Example 1: Decreased statewide average number of days waiting from first contact to first clinical appointment at CSBs from 18 days (current) to 15 days in 2013.

Example 2: Increase number of CSBs receiving training and consultation addressing consumer housing challenges from 20 currently to 40 in 2013.

Response:
Performance indicators remain under development as DBHDS works in partnership with the provider community. DBHDS has also established a leadership position to assist in this development.

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Virginia has a strong suicide prevention partnership in place. Following publication of the *National Strategy for Suicide Prevention* in 2001, the Virginia Commission on Youth (a joint commission of the Virginia General Assembly) published the *Youth Suicide Prevention Plan*, and amended the *Code of Virginia* to designate VDH as the lead agency for youth suicide prevention in the Commonwealth.

In 2003, the Joint Commission on Health Care (another General Assembly body) directed Virginia's Secretary of Health and Human Resources to lead a cross-government effort to formulate a comprehensive plan for suicide prevention across the life span. This effort produced the *Suicide Prevention Across the Life Span Plan for the Commonwealth* (Senate Document 17, 2004) which is attached. The plan recommended a series of important actions to be taken in leadership and infrastructure development, surveillance, public awareness, and intervention.

Following publication of the 2004 plan, DBHDS was designated in the *Code of Virginia* as the lead agency for suicide prevention across the lifespan in Virginia, but the primary state agency partners (including VDH and the Department for the Aging) were unsuccessful in obtaining new appropriations to support the comprehensive expansion of suicide prevention activities contemplated in the 2004 plan. In the meantime, VDH successfully obtained CDC and SAMHSA grant support for youth suicide prevention activities, and the Office of the Chief Medical Examiner (OCME) joined the National Violent Death Reporting System which enabled more in-depth data collection and surveillance capability for suicide deaths in Virginia. At the same time, the Virginia Department of Veterans Services (DVS) established the Virginia Wounded Warriors Program to integrate behavioral health, health, education and other supports for military veterans and families.

In 2009, DBHDS reconvened a state level suicide prevention stakeholder workgroup to establish a new collaborative structure to address suicide in Virginia. This group currently includes DBHDS, VDH (including the OCME), DVS, the Virginia Department for the Aging, the Virginia Association of Community Services Boards (local BH providers), NAMI of Virginia, VOCAL (the state peer organization), and other suicide prevention survivor and support representatives. The purpose of the group is to plan and implement Virginia suicide prevention activity in a collaborative and efficient manner.

In addition to coordination of interagency activities, to date the Suicide Prevention Workgroup has completed a statewide assessment of local suicide prevention partnerships and activity, and hosted seven regional summits in May and June 2011. These one-day summits brought community stakeholders together to learn about how suicide is affecting their communities, and what suicide prevention resources and services are available to them; to identify their communities' needs in regard to suicide; and to initiate planning to address those needs. A brief needs assessment was completed along with future planning steps for each region during each summit. Currently, this information is being collated and a report will be developed to identify the next steps in the process.

Virginia's most recent suicide prevention plan (SD 17, 2004) is attached. Virginia DBHDS will use the existing Suicide Prevention Workgroup and related resources to update the plan by June 30, 2013.

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

DBHDS has identified the following primary data and technical assistance needs during the process of developing this plan that may assist in implementation of the proposed plan:

- Development of a Behavioral Health Advisory Council as described in Section IV.O. of this application, and
- Development of an Office of Peer and Recovery Supports in the Department's central office.

In addition, the Department may need technical assistance in these data and information technology areas:

- Integration of MH and SA client, service and funding data for reporting and quality improvement;
- Implementation of business intelligence tools;
- Technical support for system sizing, and
- Telecommunication and interface requirements to Federal HIS areas.

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IV.
K. Technical Assistance Needs

Revision requested:
Please indicate what efforts have been, or are being, undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Response:
Regarding the establishment of a Behavioral Health Council, DBHDS is taking steps to evolve the Mental Health Planning Council into the Behavioral Health Planning Council. Virginia has a Substance Abuse Services Council as a statutory body with some members appointed by the Governor. The purpose of the Substance Abuse Services Council is to advise the governor and the legislature and to produce an interagency plan. Both bodies have discussed this change and are planning a joint meeting in May. Technical assistance regarding process would have been very helpful.

Regarding the establishment of an Office of Peer and Recovery Supports, DBHDS did not receive the additional funding from the General Assembly necessary to establish a position to provide leadership to that office. However, staff have been working with on ongoing group of peers (both SA and MH) to address issues of peer training and program standards. In addition, DBHDS was selected to participate in the BRSS-TACS policy conference taking place in late April 2012, and we expect that experience will be useful in our efforts to engage peers in the delivery of support services.

DBHDS continues to work with its provider partners to integrate service and funding data for reporting and quality improvement by developing and implementing effective performance indicators. These indicators should be available on the DBHDS website by June 30, 2013. DBHDS has hired a new Chief Information Officer to assist in all aspects of these technical assistance needs. Funds have been identified to hire a number of new Information Technology staff to provide further assistance.

DBHDS is in the process of upgrading its server environment with SQL 2008 and training IT staff to make use of its business intelligence capability. The Department is working closely with the public sector providers to monitor the status of their upgrades to electronic health records and the implications of that process for data reporting.

IV.
K. Technical Assistance Needs

Revision requested:
Please indicate what efforts have been, or are being, undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Response:
Regarding the establishment of a Behavioral Health Council, DBHDS is taking steps to evolve the Mental Health Planning Council into the Behavioral Health Planning Council. Virginia has a Substance Abuse Services Council as a statutory body with some members appointed by the Governor. The purpose of the Substance Abuse Services Council is to advise the governor and the legislature and to produce an interagency plan. Both bodies have discussed this change and are planning a joint meeting in May. Technical assistance regarding process would have been very helpful.

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DBHDS continues to work with its provider partners to integrate service and funding data for reporting and quality improvement by developing and implementing effective performance indicators. These indicators should be available on the DBHDS website by June 30, 2013. DBHDS has hired a new Chief Information Officer to assist in all aspects of these technical assistance needs. Funds have been identified to hire a number of new Information Technology staff to provide further assistance.

DBHDS is in the process of upgrading its server environment with SQL 2008 and training IT staff to make use of its business intelligence capability. The Department is working closely with the public sector providers to monitor the status of their upgrades to electronic health records and the implications of that process for data reporting.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Virginia's behavioral health system provides many opportunities to engage service recipients, persons in recovery and families members in various planning, service development and oversight activities. Some examples include the following:

State Board of Behavioral Health and Developmental Services

The State Board of BHDS is a policy making body with statutory authority to establish policy for DBHDS Central Office, DBHDS facilities and CSBs. Among other requirements, Section 37.2-200 of the *Code of Virginia* requires that "*The nine members shall consist of one consumer or former consumer, one family member of a consumer or former consumer, one consumer or former consumer or family member of a consumer or former consumer, one elected local government official, one psychiatrist licensed to practice in Virginia, and four citizens of the Commonwealth at large*."

Agency Vision

The Vision of the State Board and Department, which guides policy development and operations, describes the service system as *"… a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership."*

Policy 1040 on Consumer and Family Member Involvement

In 2006, the State Board adopted Policy 1040 (SYS) 06-3 *Consumer and Family Member Involvement and Participation* which articulates the importance of consumer and family member involvement and participation. The policy identifies ways in which the Department, state facilities, and CSBs can support the involvement and participation of consumers and family members as partners in the design, operation, and evaluation of the public services system, and calls upon the Department, state facilities, and CSBs to support individual and family involvement and participation on committees, work groups, task forces, and other planning or deliberative bodies. It encourages CSBs to work closely with the boards of supervisors or city councils and county administrators or city managers of their local governments to help them appoint individuals who are receiving or have received services and family members who are knowledgeable about the services system to CSBs.

State Human Rights Committee

The State Board and DBHDS administer the statewide human rights program for persons receiving services in programs licensed or operated by DBHDS. The *Code of Virginia* [Sec.37.2-204] regulating membership of the SHRC requires: "*One-third of the appointments made to the state or local human rights committees shall be current or former consumers or family members of current or former consumers, with at least two consumers who are receiving or who have received within five years of their initial appointment public or private mental health, mental retardation, or substance abuse treatment or habilitation services on each committee….*"

Creating Opportunities Strategic Planning Process

In spring of 2010, DBHDS formed planning teams which included consumers and family members to identify areas of focus for a strategic planning initiative called *Creating Opportunities* which is the basis for this Plan. One major recommendation from this process, and a strategy outlined in this Plan, is for DBHDS to establish an office of peer services and recovery supports to strengthen and expand Virginia's use of peer-provided services and supports.

Training and Support for Consumers and Families

DBHDS supports several peer and family organizations to provide training, education, support and technical assistance to communities, providers, individuals in recovery and families. These include:

- VOCAL (Virginia Organization of Consumers Asserting Leadership) – VOCAL is a statewide MH peer organization that promotes mental health recovery, self-determination and peer leadership through a variety of peer-run services. These include technical assistance to peer-run programs (the VOCAL CO-OP); WRAP training across the state (Project REACH); information, outreach and connection through the Web; training opportunities, meetings and conferences; book publishing; and art projects (the VOCAL Network and *Firewalkers*). Vocal is also involved in Virginia's effort to expand use of psychiatric advance directives (PADs).
- SAARA (Substance Abuse Addiction and Recovery Alliance) – SAARA is a statewide grassroots organization with 15 local affiliates who provide advocacy and educational opportunities for individuals, families and professional partners (e.g., Recovery Coach Training), and technical assistance to develop and support local affiliate chapters across Virginia.
- NAMI-Virginia (National Alliance on Mental Illness of Virginia) – NAMI-VA provides education and support to families and peers through several programs (In Our Own Voice, Peer-To-Peer, Basics, etc). NAMI-VA is also partner in expanding use of PADs.
- SAARA, VOCAL and NAMI VA have begun partnering on projects with peer and recovery services as they have many similar goals and to better serve consumers and families with co-occurring challenges.
- MHAV (Mental Health America of Virginia) – MHAV provides self-advocacy and leadership training to persons in recovery through programs such as CELT (Consumer Empowerment Leadership Training). MHAV provides administrative and fiscal support to the MH Planning Council and is also partner in expanding use of PADs and supports Virginia's Advance Directives website.
- Oxford House, Inc. – DBHDS provides resources for 4 staff who assist in the establishment of recovery houses, provide technical assistance to and monitors existing houses and supports a revolving loan program,
- DBHDS funds 13 additional peer-run direct service programs for people with mental illness, substance use disorders, and co-occurring disorders.

MH Planning Council and Substance Abuse Services Council

The Virginia Mental Health Planning Council and the Substance Abuse Services Council meet regularly and provide advisory assistance to DBHDS and to the service system. Consumers and family members are well represented on these Councils.

Virginia Summer Institute for Addiction Studies

For several years, DBHDS has collaborated with provider and consumer organizations to provide a multi-day training event, the Virginia Summer Institute for Addiction Studies, to improve knowledge and skills of providers working with persons with substance abuse disorders. Consumer organizations participate in the planning of this event and offer workshops of benefit to consumers, peer specialists and family members.

Annual Peer Support Conference

For the 3rd year, DBHDS will help sponsor a statewide conference focused on MH and SA peer and recovery services. These conferences have brought consumers and family members from both the MH and SA communities together with professional staff from CSBs and state facilities to learn more about peer services and recovery oriented systems of care.

Specific Child and Family Initiatives

Ensuring that families of children with mental health and co-occurring disorders are empowered to make informed decisions, supported to have self-determination and responsibility, and are involved and participate in the behavioral health system is of the utmost importance at both the state and local levels. DBHDS has worked to support and empower a statewide organization of parents with children with mental health and related disorders. To that end, DBHDS has collaborated with the National Alliance on Mental Illness-Virginia to enhance family support visibility, DBHDS's responsiveness to caregiver needs, and distribute family resource materials and information as needed. This collaboration will result in:

- Assisting families in navigating the service system including accessing needed services in a timely manner.
- Assisting families with community networking, resource mapping, organizing and utilizing information that connects them to community resources from both the public and private sectors.
- Working with families to identify natural and informal supports (friends, family members, clergy, teachers, etc.) that would assist them with identifying mental health treatment and/or provide additional support to the family.
- Assisting families in developing working partnerships with service providers.
- Providing training to identified family members in the development of leadership skills to increase family involvement on a statewide basis at the policy, management, and service level.
- Developing a family support program evaluation process.

L. Involvement of Individuals and Families

Revision request: Can the state please address how individuals and family members are presented with opportunities to proactively engage and participate in treatment planning, shared decision making and the behavioral health service delivery system.

Response:
DBHDS has a substantial history of involving individuals directly in the planning and delivery of their own care, as well as engaging families and other significant supports. Licensing regulations recently promulgated for adult services (12VAC35-105-10 *et seq*) require the involvement of the individual and "authorized representative" in the development of the individualized services plan (ISP), and require that the ISP be person-centered and engage the individual and others in the development of the plan for services, transitions among services, and discharge planning. In addition to licensing, DBHDS has promulgated human rights regulations (12VAC35-115 *et seq*) which require that every provider be a member of a local human rights council, and DBHDS employs behavioral health professionals to provide advocacy for individuals and family members who believe that their rights have been violated. These regulations also require that providers engage individuals in making decisions about services, including meaningful participation in the development of service and discharge plans, and provider must document these interactions in the individual's service record.

Since 2010, DBHDS has been working closely with researchers at the University of Virginia, CSBs and advocacy organizations to develop a State-wide infrastructure in which advance healthcare planning is a standard part of mental health service provision. The primary piece of advance healthcare planning in Virginia is the Advance Directive. Advance Directives, which were expanded with the Health Care Decisions Act of 2009 to include mental health, have been shown to empower individuals in their recovery and reduce involuntary commitment. In order to maximize the benefits of Advance Directives to individuals and their families, DBHDS is working to create a curriculum for Advance Directive facilitators—individuals who are trained to assist individuals in the completion of their Advance Directive. Offering individuals facilitation can significantly increase the likelihood of completing an Advance Directive, as well as increasing satisfaction with and confidence in their future care.

DBHDS is in the midst of implementing a strategic plan that fully embraces self-determination, empowerment and recovery for individuals receiving services through its system of state facilities and the 40 CSBs. The strategic foci of the plan include an extensive emphasis on the involvement of individuals and their families in planning, developing and implementing services, and peers have been involved in every aspect of the development and implementation process of this strategic planning activity. Initiatives include increased attention to housing and employment options that make it possible for individuals in recovery from behavioral illnesses to live successfully and independently in the community, and DBHDS has recently hired coordinators for both housing and employment services.

Individuals with the lived experience of behavioral illness and their families are represented on local community services boards, comprising nearly 45% of total board members statewide (10.8% individuals; 34% family members) and are also represented on the State Board of DBHDS.

Locally, the emphasis on engaging individuals and their families is manifested in activities such as family groups that provide support as well as information about the illness of their loved one, and training for individuals in developing Wellness Recovery Action Plans (WRAP). DBHDS contracts with NAMI-Virginia to provide statewide outreach, education and support to families of adults, children and adolescents with mental illness.

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IV: Narrative Plan

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

Strategies to Implement ICTs in DBHDS Activities

1) Use of Facebook group page

In 2011, DBHDS developed a Facebook group page to increase its presence in the online community. Still in the early stages of implementation, this Facebook group will provide individuals with increased access to DBHDS, whether they are seeking assistance themselves or on behalf of someone else. The Facebook group also affords DBHDS additional networking opportunities by linking DBHDS with providers throughout the Commonwealth and with other state-level behavioral health organizations, federal partners, and a vast array of information, support, advocacy, and research organizations and groups.

2) Smartphone App workshop at VSIAS

The 2011 Virginia Summer Institute for Addiction Studies (VSIAS), sponsored in part by DBHDS, included a workshop about using smartphone applications such as the Addition CHESS project (A-CHESS, a project of NIATx) to support individuals in recovery. A-CHESS is a smartphone application that gives individuals another tool for their recovery portfolio. A-CHESS includes a panic button that individuals can use when they feel triggered towards relapse. Pressing the panic button automatically calls or sends a text message to individuals pre-identified by the user. The application also provides access to message boards and other online communities where individuals can share their recovery stories and gain support from other individuals.

3) Telepsychiatry

Dickenson County is a small, rural county located in the mountains of far southwest Virginia. Its rural geography is an obstacle to accessing effective treatment. Dickenson County Behavioral Health Services (DCBHS) has overcome this challenge by providing telepsychiatry services in their catchment area. For several years the agency has utilized telepsychiatry to supplement medication management services provided by a part-time, on-site general practice physician. Telepsychiatry services are provided by a board-certified psychiatrist located in Arizona with whom appointments are scheduled on regular days via a Polycom connection. Service recipients with the most challenging needs are treated by the psychiatrist, while the part-time general practitioner provides medication management services for others with less complex medication needs. Service recipients indicate that the telepsychiatry is just as valuable as in-person contact and feel as if their psychiatrist is in the room with them. Similar programs are active at the Danville-Pittsylvania, Southside, Cumberland Mountain, Planning District One and Mount Rogers Community Services Boards. These are all rural CSBs where telemedicine and telepsychiatry help CSBs overcome transportation and access barriers in their catchment areas.

Similar telepsychiatry and telemedicine programs exist in other areas of the state. A program similar to Dickenson County's exists at Harrisonburg-Rockingham CSB, which is working with the University of Virginia School of Medicine 60 miles away in Charlottesville.

4) Teleconferencing

DBHDS made funds available for the purchase of teleconferencing equipment and infrastructure at all CSBs/BHAs and state hospitals. This made meetings, conferences, and other collaborative activities were easier to plan, coordinate, and attend by staff, service recipients, and other interested parties. Training events are also provided through teleconference and web-based portals as well.

5) Wellness Wired

Among the social networking options available to Virginia's consumers is access to an innovative interactive Website called Wellness Wired (WW). WW is an Internet, videoconferencing and Information Technology platform designed to provide mental health consumers and advocates with the latest tools and technology resources. WW is operated by Mental Health America of Virginia (MHAV) through a contract with DBHDS that is funded with Mental Health Block Grant dollars. WW offers Webinar, Webmeeting and videoconferencing capabilities, online forums and chats, unique online Wellness Recovery Action Plan (WRAP) and Psychiatric Advance Directive tutorials, and other social networking services. In addition to these services, through this contract MHAV also provides video editing and DVD production, IT consultation and technical assistance, basic Web design and hosting, and online streaming video services at no charge to organizations or individuals involved with mental health advocacy. MHAV developed and is hosting the websites of several of Virginia's small consumer-run organizations through WW.

DBHDS' Use of ICTs in the Future

DBHDS recognizes that the use of ICTs is an increasingly important element in the behavioral health services continuum of care. These emerging technologies can have strong positive effects on individuals' ability to follow treatment regimens and can assist in the maintaining wellness and recovery. DBHDS is not currently promoting any applications of ICTs except those mentioned above. There are no current plans to incentivize the use of ICTs in the next two years. However, such activities may be considered in the future pending the availability of staff and resources promote and support these uses. Additionally, DBHDS is currently hiring a new Chief Information Officer, who will help guide the Department in promoting and supporting the use of ICTs.

M. Use of technology

Revision request: If possible – Can the state please provide brief responses to e. thru h.

e. Are their barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

Response: There are several significant barriers to implementing ICTs to address the needs with behavioral health issues. First is the cost associated with developing any independent applications for ICTs. The second is barrier is creating an understanding of how these applications would be implemented and then orienting and training providers about how to help individuals receiving services utilize the applications effectively. DBHDS would need extensive technical assistance, not to mention financial resources, to actively promote the use of wide-scale ICTs in the imminent future.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

Response: Although 14 CSBs are currently working closely with FQHCs to implement clinical services, there are no plans at this time to utilize ICTs in these activities. DBHDS is not aware of how FQHCs are planning to implement ICTs. The Virginia Community Healthcare Association reports a membership of 29 FQHCs. As DBHDS provides community behavioral health services through CSBs, the CSBs would need to develop application content that is local and the coordinate with the local FQHC. The situation is the same for local general and specialty hospitals.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

Response: DBHDS does not have imminent plans to implement ICTs other than those described in 1-5 of the original submission. There are no plans to evaluate these applications at this time.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs.

Response: Please see response to item g.

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Response: Please see response to item g.

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

DBHDS has in place a number of strategic partnerships with other governmental entities that will assist Virginia in successfully implementing both treatment and prevention initiatives detailed in its Behavioral Health Assessment Plan.

Treatment Partnerships

Service Delivery Partners

DBHDS maintains partnerships with several state agencies for the delivery of services, such as:

- **Department of Medical Assistance Services (DMAS)** – DBHDS collaborates with DMAS (the state Medicaid agency) on Medicaid service development initiatives.
- **Department of Rehabilitative Services (DRS)** – DBHDS has a contract with DRS for delivery of vocational services to local CSB service recipients. DBHDS also works with DRS on brain injury service issues.
- **Department of Health (VDH)** – DBHDS collaborates with VDH in suicide prevention, surveillance of drug-related death, and suicide.
- **Department of Health Professions (DHP)** – DBHDS is represented on the Advisory Council of the Prescription Monitoring Council and collaborates with the Board of Pharmacy and the Board of Counseling.
- **Department for the Aging (DOA)** – DBHDS collaborates with this agency on behavioral health policy and services for older adults.
- **Department of Veterans Services (DVS)** – DBHDS is a partner with DVS on delivering services and supports to military veterans and families, and on suicide prevention.

Planning Partners

Virginia is well-positioned with partnerships in place to address the goal areas described in this Block Grant Plan. Key agency partners have participated in developing Plan goals in critical areas, including:

- **Child and Adolescent Services** – Agency stakeholders such as the Department of Medical Assistance Services, the Office of Comprehensive Services, the Department of Juvenile Justice, and the Inspector General for Behavioral Health and Developmental Services provided stakeholder input into the priorities for system development.
- **Substance Abuse Treatment Services** – The Departments of Corrections, Juvenile Justice, Criminal Justice Services, Health, Health Professions, Social Services, Medical Assistance Services, and Rehabilitative Services have been involved in developing Plan goals for this area.
- **Housing** – DBHDS participated in the Governor's Housing Initiative, and Homeless Outcomes Workgroup, with other housing and support agencies such as the Departments of Housing and Community Development, Social Services, Corrections, Criminal Justice Services, and others.
- **Employment** – The Departments of Medical Assistance Services and Rehabilitative Services have been involved in developing Plan goals for this area.

Health Reform Partners (the Virginia Health Reform Initiative)

DBHDS participates in the Virginia Health Reform Initiative, led by the Secretary of Health and Human Resources, which is an interagency effort to prepare the Commonwealth to deliver and manage health and behavioral health services under the federal Affordable Care Act. This effort includes the following state agency partners:

- George Mason University Center for Health Policy Research and Ethics
- Department of Health
- Department of Health Professions
- Department of Medical Assistance Services
- Department of Behavioral Health and Developmental Services
- Department of Rehabilitative Services
- Department of Human Resources Management
- State Corporation Commission Bureau of Insurance

Existing Cross-Agency Partnerships

Virginia has in place several structures external to DBHDS that foster cross-agency collaboration, policy-making, management and service delivery. Examples include:

- **The State Executive Council (SEC)** – This is the policy-making authority for services to children and youth provided under the Comprehensive Services Act. The SEC includes members from the Departments of Education, Social Services, Behavioral Health and Developmental Services, Health, Juvenile Justice, the Supreme Court of Virginia, the Governor's Office, and the General Assembly.
- **The Criminal Justice/Mental Health Transformation Initiative** – This is a multi-stakeholder effort authorized under Executive Order of the Governor to support collaboration and program development between law enforcement, jails and prisons, the judiciary, and the behavioral health system to reduce criminal justice involvement of persons with behavioral health disorders, and to improve treatment and supports for these persons in the criminal justice system.
- **Governor's Housing Policy Advisory Committee** – This is a cross-agency gubernatorial effort to expand affordable and accessible housing for all Virginians, including persons with disabilities (see above). The Transformation effort is led by the DBHDS CJ/MH Transformation Director.
- **Virginia Prisoner and Juvenile Offender Re-Entry Council** – This is a cross-agency gubernatorial initiative to improve services, supports and outcomes for people returning to Virginia communities from prisons and jails. DBHDS is a partner in this effort.

Prevention Partnerships

DBHDS provides leadership and guidance for the prevention of substance abuse, behavioral and emotional disorders, and suicide and manages state-level prevention planning, collaboration with other state systems and groups, and the SAPT prevention set-aside funds which support universal selected and indicated prevention services provided through the 40 CSBs. Local prevention services target children, youth, parents, young adults to age 25, and community

change. The underage drinking initiative, supported by the Commonwealth's Strategic Prevention Framework State Incentive Grant (SPF-SIG), is a partnership of the Governor's Office on Substance Abuse Prevention (GOSAP) and DBHDS Prevention Services.

Virginia collaborates with other state systems and numerous professional organizations to ensure prevention services address issues related to education, health, child development, law enforcement, juvenile justice, substance abuse including alcohol, tobacco and other drugs, veterans, fire safety, and others. These collaborative relationships are coordinated by:

- Governor's Office for Substance Abuse Prevention (GOSAP)
- The SPF-SIG Advisory Council
- The SPF-SIG Epidemiology Workgroup
- The SPG-SIG Evidence-Based Practice (EBP) Workgroup
- The Prevention and Promotion Advisory Council to the State Board
- The Suicide Prevention Advisory Council
- The newly formed advisory council for DBHS-Prevention Services substance abuse, emotional, and behavioral disorders
- Child Abuse Prevention, Virginia Department of Social Services

The resulting prevention activities include joint planning efforts, shared funding through joint requests for applications for local programs or for cooperative state programs, and combined community services and training opportunities that are open to service providers in other systems. GOSAP, the SPF-SIG Advisory Council and Epidemiology Workgroup, and the Prevention and Promotion Advisory Council to the State Board of the Department participated in the development of the new Prevention Services Plan.

Letters of Support and MOUs

Virginia will develop letters of support, memoranda of understanding, or other documents from current and future governmental treatment and prevention partners indicating agreement with descriptions of their roles and collaboration, as needed.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

At the time of this writing, Virginia does not have a State Behavioral Health Advisory Council as described in the Combined Block Grant application. However, Virginia currently has several planning and information-sharing bodies that include a range of stakeholders, including consumers, family members, service providers, elected officials and other concerned citizens. These groups serve to advise the Governor and DBHDS leadership on policy, budget, operations and services for individuals with mental health and substance use disorders and their families. Among the existing entities are the following statutorily required groups:

- **State Board of Behavioral Health and Developmental Services -** The State Board, established in the *Code of Virginia*, Sec. 37.2-200, is a policy-making body comprised of nine citizens from across the Commonwealth. At least one-third of the members must be consumers or family members of consumers, with at least one being a direct consumer of services. The Board has the statutory authority for the establishment of policy for the Department, state facilities and CSBs. Members are appointed by the Governor and confirmed by the General Assembly. The Board meets a minimum of four times annually.

- **Mental Health Planning Council (MHPC) -** As required by the Block Grant statute, the MHPC serves as an on-going forum for consumers, families and other advocates, state agencies, and mental health providers and planners around the Commonwealth. The MHPC reviews the annual Mental Health Block Grant plan, and provides advice on the allocation and use of Block Grant funds. The MHPC also addresses a wide variety of prevailing issues related to the public behavioral health system. The Council meets six times annually.

- **Substance Abuse Services Council (SASC) -** The SASC is authorized in the *Code of Virginia*, Sec. 2.2-2696, with the purpose of advising the State Board, the Governor and the General Assembly on policies and goals related to the state's substance abuse treatment and prevention efforts, and on coordination of public and private efforts to control substance abuse in Virginia. The SASC's 30 members include State agency representatives, professional and advocacy organizations, service providers, and members from the law enforcement and criminal justice sectors.

To create an effective State Behavioral Health Advisory Council as envisioned by SAMHSA and described in the Block Grant application guidance, DBHDS will need to structure such a Council in the context of the existing bodies described above. Over the next year, the Department will be working to develop a State Behavioral Health Advisory Council. DBHDS will request technical assistance from SAMHSA in this area.

IV: Narrative Plan

Table 11 List of Advisory Council Members

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Start Year: 2012

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Mary Ann Beall	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		2809 Rosemary Lane Falls Church, VA 22042 PH: 703-533-2144	
Anne Burhans	Others (Not State employees or providers)	Civil Rights for The Elderly	6061 Captains Walk Broad Run, VA 20137 PH: 540-349-2733	
Anne Cutshall	Others (Not State employees or providers)	Virginia Association for the Deaf-Blind		Ann_adventures@verizon.net
Betty Etzler	Others (Not State employees or providers)	Family Preservation Services, Inc.	PH: 540-381-7500	betzler@provcorp.com
Catherine Hancock	State Employees	Virginia Department of Medical Assistance Services		catherine.hancock@dmas.virginia.gov
Donna Sue Harmon	Individuals in Recovery (from Mental Illness and Addictions)	Center for Recovery and Wellness, Inc.		donnasue.harmon@yahoo.com
			9612 Running Creed Rd	

James A. Johnson	Individuals in Recovery (from Mental Illness and Addictions)		Glen Allen, VA 23060 PH: 804-553-4102	
Jim Martinez	State Employees	Dept of Behavioral Health and Developmental Services	PH: 804-371-0757	jim.martinez@dbhds.virginia.gov
Patricia Meyer	Providers	Norfolk Community Services Board	PH: 757-823-1623	patricia.meyer@norfolk.gov
Lisa Moore	Providers	Mount Rogers CSB	PH: 276-223-3200	Lisa.Moore@mrcsb.state.va.us
Bonnie Neighbour	Individuals in Recovery (from Mental Illness and Addictions)	VOCAL	PH: 804-343-1777	bonnie@vocalvirginia.org
Steven Peed	State Employees	Virginia Department of Juvenile Justice		Steven.Peed@djj.virginia.gov
Michael Pendrak	Individuals in Recovery (from Mental Illness and Addictions)		8616 Woodbine Ln Annandale, VA 22203 PH: 703-208-9720	
Paula Price	Others (Not State employees or providers)	Mental Health America of Virginia		paulakprice@gmail.com
Mira Signer	Others (Not State employees or providers)	NAMI Virginia	PH: 804-285-8264	msigner@namivirginia.org
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Melissa Harless	Individuals in Recovery (from Mental Illness and Addictions)	Mount Rogers CSB		melissa.harless@mrcsb.state.va.us
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Robert Friedline	Family Members of Individuals in Recovery (from Mental Illness and Addictions)			

Footnotes:

Revision request: The state had mentioned that a Behavioral Health Advisory Council would be developed as envisioned by SAMHSA in Section O. Please state which Advisory Council the state is providing information on in footnotes.

Response: This list refers to the Mental Health Planning Council.

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year: 2012

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	40	
Individuals in Recovery (from Mental Illness and Addictions)	8	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	3	
Vacancies (Individuals and Family Members)	11	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	27	67.5%
State Employees	6	
Providers	2	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	5	
Total State Employees & Providers	13	32.5%

Footnotes:

Revision request: The state had mentioned that a Behavioral Health Advisory Council would be developed as envisioned by SAMHSA in Section O. Please state which Advisory Council the state is providing information on in footnotes.

Response: This list refers to the Mental Health Planning Council.

IV: Narrative Plan

P. Comment On The State Plan

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Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

For the FFY2012 Combined Mental Health and Substance Abuse Block Grant Application, notice of a public hearing was posted on Virginia's electronic Town Hall and published in the Commonwealth's major newspapers on August 21, 2011. Copies of the public notices are on file. Notice was sent to all forty of the community services boards and to other interested stakeholders. The notice included the date of a public hearing, as well as the fact that a draft of the application was available for review online at the Department's website. Notice was sent to members of the Mental Health Planning Council in advance of its meeting on August 17th. The MHPC reviewed the draft and discussed its content during the meeting.

The public hearing was conducted on August 25, 2011, at 10:00 a.m. in Richmond, Virginia, at the offices of the Department of Behavioral Health and Developmental Services. One member of the public, representing the Virginia Organization of Consumers Asserting Leadership (VOCAL), attended the public hearing. She stated that "VOCAL would like to see an increase in the percentage of Block Grant funds allocated to peer-run programs and a decrease in the percentage allocated to CSBs. Also, we would like a larger percentage of the Block Grant funds allocated to CSBs to be used to partner with peer-run programs." No other comments were made during the Public Hearing.

Table 5 Projected Expenditures for Treatment and Recovery Supports*

*** Projected Expenditures for Treatment and Recovery Supports for Mental Health – FY 2012, has been entered directly into Table 5**

Projected Expenditures for Treatment and Recovery Supports for Mental Health – FY 2013						
Category	**Services**	**< 10%**	**10-25%**	**26-50%**	**51-75%**	**> 75%**
Healthcare Home/Physical Health	NA					
Engagement Services	Motivational Treatment, Consumer Monitoring, Assessment and Evaluation, and Early Intervention Services	X				
Outpatient Services	Outpatient Services, Medication Assisted Treatment		X			
Medication Services	NA					
Community Support (Rehabilitative)	Rehabilitation Services	X				
Recovery Supports	Case Management Services, Supported Employment, Sheltered Employment, Consumer-Run Services		X			
Other Supports (Habilitative)	Supportive Residential Services	X				
Intensive Support Services	Partial Hospitalization, Ambulatory Crisis Stabilization, Assertive Community Treatment		X			
Out-of-Home Residential Services	Highly Intensive, Residential Crisis Stabilization, Intensive, and Supervised Residential Services		X			
Acute Intensive Services	Emergency Services, Acute Inpatient Services, Inpatient Medical Detox Services		X			
Prevention (Including Promotion)	Prevention Services	X				
System improvement activities		X				
Other	NA					

Table 5 Projected Expenditures for Treatment and Recovery Supports

Projected Expenditures for Treatment and Recovery Supports for Substance Abuse - FY 2012						
Category	**Services**	**< 10%**	**10-25%**	**26-50%**	**51-75%**	**> 75%**
Healthcare Home/Physical Health	NA					
Engagement Services	Motivational Treatment, Consumer Monitoring, Assessment and Evaluation, and Early Intervention Services	X				
Outpatient Services	Outpatient Services, Medication Assisted Treatment			X		
Medication Services	Medication assisted treatment	X				
Community Support (Rehabilitative)	NA					
Recovery Supports	Case Management Services, Consumer-Run Services		X			
Other Supports (Habilitative)	Supportive Residential Services	X				
Intensive Support Services	Partial Hospitalization, Ambulatory Crisis Stabilization, Assertive Community Treatment	X				
Out-of-Home Residential Services	Highly Intensive, Residential Crisis Stabilization, Intensive, and Supervised Residential Services		X			
Acute Intensive Services	Emergency Services, Acute Inpatient Services, Inpatient Medical Detox Services	X				
Prevention (Including Promotion)	Prevention Services		X			
System Improvement activites		X				
Other	NA					

Projected Expenditures for Treatment and Recovery Supports for Substance Abuse - FY 2013						
Category	**Services**	**< 10%**	**10-25%**	**26-50%**	**51-75%**	**> 75%**
Healthcare Home/Physical Health	NA					
Engagement Services	Motivational Treatment, Consumer Monitoring, Assessment and Evaluation, and Early Intervention Services	X				
Outpatient Services	Outpatient Services, Medication Assisted Treatment			X		
Medication Services	Medication assisted treatment	X				
Community Support (Rehabilitative)	NA					
Recovery Supports	Case Management Services, Consumer-Run Services		X			
Other Supports (Habilitative)	Supportive Residential Services	X				
Intensive Support Services	Partial Hospitalization, Ambulatory Crisis Stabilization, Assertive Community Treatment	X				
Out-of-Home Residential Services	Highly Intensive, Residential Crisis Stabilization, Intensive, and Supervised Residential Services		X			
Acute Intensive Services	Emergency Services, Acute Inpatient Services, Inpatient Medical Detox Services	X				
Prevention (Including Promotion)	Prevention Services		X			
System Improvement activites		X				
Other	NA					

Table 4 Plan Year **2012**

Services Purchased Using Reimbursement Strategy - CMHS

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	
Grant/contract reimbursement	Community based mental health promotion, treatment and peer-run support services
Risk based reimbursement	
Innovative Financing Strategy	
Other reimbursement strategy	

Table 4 Plan Year **2013**

Services Purchased Using Reimbursement Strategy - CMHS

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	
Grant/contract reimbursement	Community based mental health promotion, treatment and peer-run support services
Risk based reimbursement	
Innovative Financing Strategy	
Other reimbursement strategy	

Table 4 Plan Year 2013

Services Purchased Using Reimbursement Strategy - SAPT

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	
Grant/contract reimbursement	Community based substance abuse prevention, treatment and peer-run support services
Risk based reimbursement	
Innovative Financing Strategy	
Other reimbursement strategy	

REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES

Suicide Prevention Across The Life Span Plan for the Commonwealth of Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

COMMONWEALTH of VIRGINIA

Office of the Governor

Jane H. Woods
Secretary of Health and Human Resources

(804) 786-7765
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MEMORANDUM

TO: The Honorable Mark R. Warner, Governor
The General Assembly of Virginia

FROM: Jane H. Woods
Secretary of Health and Human Resources

DATE: October 26, 2004

RE: Senate Joint Resolution 312 (2003)
Suicide Prevention Across the Life Span for the Commonwealth

The 2003 General Assembly, through Senate Joint Resolution 312, requested that the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, formulate a comprehensive Suicide Prevention Across the Life Span for the Commonwealth.

Enclosed for your review and consideration is the report prepared in response to this request. All affected stakeholders listed in the legislation were involved in the development of this plan.

Preface

Authority
Senate Joint Resolution 312 (2003) requests the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention across the Life Span Plan for the Commonwealth.

Study Group Membership

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Table of Contents

Executive Summary

Introduction

In 2003, the General Assembly agreed to Senate Joint Resolution 312 requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention across the Life Span Plan for the Commonwealth. The General Assembly directed the Department of Health (VDH) and the Department for the Aging (VDA) to develop the plan, with participation from the Departments of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; and any other state agency with an interest, responsibility, or role in suicide prevention.

The Suicide Prevention across the Lifespan Plan was developed with the input of stakeholders from around the Commonwealth, through research into national and state resources, and with guidance and review by an Interagency Committee. The goals from the National Strategy for Suicide Prevention (National Strategy), developed by the United States Department of Health and Human Services in 2001, were adapted to Virginia and form the basis for the Virginia goals. One of the National Strategy's objectives is to "increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector; and c) support plan development, implementation , and evaluation in its communities." This plan, with emphasis on the entire lifespan, responds to this objective.

Epidemiology of Suicidal Behaviors

In 2002, there were 792 suicides in the Commonwealth, or about two suicides per day, for an age-adjusted rate of 10.8 suicides per 100,000 people.[i] It was the eleventh leading cause of death among all Virginians and the third leading cause of death for youth. Twice as many people died from suicide in Virginia as compared to homicides. Suicides occur in all areas of Virginia. The highest rates are in rural areas, primarily in the Southwest and West Piedmont areas. Firearms are the major means chosen by those who die by suicide; suffocation (mostly by hanging) is the second most common method, followed by drugs and gases.[a] For every suicide, there are about 25 suicide attempts; suicide attempts are three times more common in women than in men.[b] In the U.S., about 90 percent of people who completed suicide had a mental illness, including alcohol and/or substance use disorders and some had multiple diagnoses.[c] Therefore, in this country, the problem of suicide is inextricably linked to the issue of mental health and substance abuse.

[i] Age-adjusted rates are standardized to a common population age distribution, in this document, the Year 2000 U.S. population. This allows for comparison among populations in spite of differing age distributions.

The Institute of Medicine, in its landmark report, Reducing Suicide: A National Imperative, summarizes risk factors for suicide succinctly:

> Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness and loss of economic security, and other cultural and societal influences. Resiliency and coping skills, on the other hand, can reduce the risk of suicide. Social support, including close relationships, is a protective factor.[d]

and

> Converging evidence across disciplines indicates that suicide is related to stress: developmental and adult trauma; cumulative stressors, including multiple morbidities; acute and chronic social and cultural stressors; and capacity to cope with stress. Suicide can be considered an expected outcome of a significant subgroup of mentally ill patients who experience accumulative life stresses, just as cardiac infarction is an expected outcome of untreated high blood cholesterol.[e]

Effective Strategies

In the field of suicide prevention, a widely used model for grouping strategies is the Universal, Selective, and Indicated prevention model. ***Universal*** strategies are designed to reach all the members of a community or population. ***Selective*** strategies are targeted for the population groups at higher risk for becoming suicidal, for example, those with undiagnosed and untreated mental health conditions and aim at preventing the onset of suicidal behaviors. ***Indicated*** strategies are intended to prevent suicide among those most at risk for suicide and showing early signs of suicide potential, such as people who have attempted suicide.

Integrated programs combine universal, selective and indicated strategies. Program evaluations have indicated the effectiveness of this approach; there is also compelling logic to this strategy. Why increase public awareness without having adequate services and community support to help those most in need? Strengthening mental health services is valuable when coupled with actions that reduce barriers toward utilization of services.

Summary of Plan

Leadership Development and Infrastructure

Goal 1: Develop broad-based support for suicide prevention.
Objectives:

- Establish state-level oversight and leadership by assigning the Department of Mental Health, Mental Retardation and Substance Abuse Services as the lead agency.
- Identify and support strong regional and/or local coalitions.
- Identify sustainable and reliable funding for basic suicide prevention functions.
- Increase awareness of and support by state and local leaders.

Goal 2: Improve and expand surveillance systems.
Objectives:

- Systematically collect, analyze and disseminate data measures and reports to constitute the Virginia Suicide Prevention Surveillance System.
- Increase the number of localities regularly conducting suicide follow-back studies.
- Promote and support national efforts to standardize data collection methods.

Goal 3: Promote and support research, including evaluation, on suicide and suicide prevention.
Objective:

- Increase applied research in Virginia on suicide prevention.

Awareness

Goal 4: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
Objective:

- Increase the percentage of the population who recognize the importance of disclosing mental health symptoms to family, friends, or health care professionals and obtaining care for these problems.

Goal 5: Promote Awareness that Suicide is a Public Health Problem that is Preventable.
Objective:

- Conduct a public information campaign on the problem of suicide.

Intervention

Goal 6: Develop and implement community-based suicide prevention programs.
Objectives:

- Reduce the suicide rate in those planning districts with high male suicide rates.
- Establish effective programs aimed at population groups at high-risk for suicide.
- Integrate suicide prevention components in more community programs.

Goal 7: Promote efforts to reduce access to lethal means and methods of self-harm.

Objective:

- Reduce the rate of self-inflicted suicide firearm deaths.

Goal 8: Implement training for recognition of at-risk behavior and delivery of effective treatment.
Objectives:

- Increase the number of trained gatekeepers.
- Increase the number of education programs for family members and others in close relationships with those at risk for suicide.

Goal 9: Develop and promote effective clinical and professional practices.
Objectives:

- Increase the proportion of primary care practices with systems to assure accurate diagnosis, effective treatment, and follow-up for suicidal behaviors, depression, substance misuse, and other mental health conditions.
- Increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.
- Increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
- Increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.
- Increase the proportion of institutional settings that apply guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior.

Goal 10: Increase access to and community linkages with mental health and substance abuse services.
Objectives:

- Increase the proportion of the population with insurance coverage for mental health and substance abuse services.
- Expand local mental health services, especially in areas with high suicide rates.
- Improve integration and coordination among organizations/agencies including health, mental health, and spiritual.

Goal 11: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.
Objective:

- Identify and inform the media of inappropriate portrayal of or reporting on suicides, suicidal attempts, and mental illness.

Financial and Staffing Resources Envisioned for Plan Implementation

In an attempt to quantify the additional resources that would be necessary for implementation of the Suicide Prevention across the Life Span Plan for the Commonwealth, input was solicited from the members of the Interagency Committee. Committee members were asked to review the plan and estimate the amount of resources their agency would need to address the objectives that were relative to their agencies' work. Responses were received from Virginia Department of Health's Center for Injury and Violence Prevention and Office of the Chief Medical Examiner, Virginia Department for the Aging and Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. In total, the preliminary estimate of the additional resources needed to implement the objectives listed in the Suicide Prevention across the Life Span Plan for the Commonwealth is $307,470 in fiscal year 2006 and $4,814,633 in fiscal year 2007.

Introduction

In 2003, the General Assembly agreed to Senate Joint Resolution 312 requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth (Appendix A). The General Assembly directed the Department of Health (VDH) and the Department for the Aging (VDA) to develop the plan, with participation from the Departments of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; and any other state agency with an interest, responsibility, or role in suicide prevention. The General Assembly expected the plan to:

- Address suicide prevention across the life span.
- Place special emphasis on effective strategies to prevent suicide among adolescent and elderly Virginians and other high-risk populations.
- Integrate applicable goals, objectives and strategies from the National Strategy for Suicide Prevention as well as previous planning efforts in Virginia and other states.
- Establish the Commonwealth's public policy regarding the prevention of suicide.
- Identify the lead agency responsible for carrying out that policy.
- Propose the creation of a permanent oversight body to monitor the implementation of the plan.
- Propose initiatives and interventions to effectively implement that policy.
- Identify the sources and amounts of resources to implement those initiatives and interventions.

The Suicide Prevention Plan was developed with the input of stakeholders from around the Commonwealth, through research into national and state resources, and with guidance and review by an Interagency Committee.

Input was first obtained through the **Third Annual Virginia Suicide Prevention, Intervention and Healing Conference**, held in May 2002. At that conference, approximately 125 individuals from around the Commonwealth participated in regional planning sessions (Appendix C). Participants, who were divided into five groups by Health Planning Region, were asked to identify priorities for each region, using the National Suicide Prevention Strategy and Virginia Youth Suicide Prevention Plan as a basis.

In the fall of 2003, the Virginia Department of Health contracted with Virginia Commonwealth University to hold focus groups to obtain input on critical issues in suicide prevention and recommendations for action (Appendix C). Participants in the focus groups included representatives from law enforcement agencies, public school systems, mental health agencies, community services boards, health departments, hospitals, nonprofit organizations, a variety of community services agencies, and the Interagency Suicide Prevention Coordinating Committee. In addition, two sessions were

held with college and university staff and a faith-based group to gain information on specific training needs.

The goals from the National Strategy for Suicide Prevention, developed by the United States Department of Health and Human Services in 2001, were adapted to Virginia and form the basis for the Virginia goals. The plan also addresses outcome objectives from the national objectives, the Healthy People 2010 Objectives, and the corresponding Virginia Healthy People 2010 Objectives (Appendix H). Healthy People 2010 is the prevention agenda for the nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

One particularly valuable resource was the Institute of Medicine's landmark review, Reducing Suicide: A National Imperative, published in 2002.[g] This comprehensive review of the literature and knowledge-base on suicide prevention relied on the analysis of many national experts in the field, both in the medical and social sciences. Additionally, Virginia suicide prevention plans, studies, grant applications, legislation, data, and published literature were resources used for the development of the plan.

History of Statewide Suicide Prevention Efforts in Virginia

In 1987, in response to the growing problem of suicide among youth, the General Assembly established a Joint Subcommittee to study the causes of suicide among children and youth and to develop strategies to implement effective youth suicide prevention programs. A report was completed in 1988 and was followed in 1989 by a similar report, this time focusing on suicide among the elderly. In 1990, the Department for the Aging presented a Suicide and Substance Abuse Prevention Plan for the Elderly. It was not until 2001 that a Youth Suicide Prevention Plan was prepared by the Virginia Commission on Youth. A key recommendation of this plan was the designation of the Virginia Department of Health as the lead agency for youth suicide prevention. The *Code of Virginia* was modified that same year to reflect the recommendation and the new biennium budget included an appropriation, for each year, of $150,000, to the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services. Staff was hired at each agency to initiate youth suicide prevention activities: statewide training, development and distribution of materials, and organization of statewide conferences. Major funding, in the form of a grant from the Centers for Disease Control and Prevention, was secured by VDH.

Also in 2001, the National Strategy for Suicide Prevention: Goals and Objectives for Action was released which examined the problems and provided national goals and objectives to prevent suicide across the lifespan. One of its objectives is to "increase the proportion of States with comprehensive suicide prevention plans that a) coordinate across government agencies, b) involve the private sector; and c) support plan development, implementation , and evaluation in its communities." This plan, with emphasis on the entire lifespan, responds to the national objective.

Major Suicide Prevention Accomplishments since 1988 in Virginia and Significant National Events

1988

- Report by the Joint Committee Studying Youth Suicide Prevention in response to the growing problem of youth suicide.

1989

- Report by the Virginia Department for the Aging (VDA) on suicide and substance abuse among the elderly.

1990

- Statewide Suicide and Substance Abuse Prevention Plan for the Elderly by the Department for the Aging.

1994

- Local child death review teams established in the Piedmont Region, Fairfax County, and Hampton Roads.

1995

- Virginia State Child Fatality Review Team was established by the General Assembly. The multidisciplinary review team systematically analyzes, among other fatalities, child suicides to determine if the deaths could be prevented and to make recommendations for education, training, and prevention.

1999

- Surgeon General's Call to Action to Prevent Suicide.
- Virginia legislation passed directing the Board of Education, in cooperation with the DMHMRSAS and the VDH, to develop guidelines for licensed school personnel to use in contacting parents or, if conditions warrant, the local or state services agency when they believe a student to be at imminent risk for attempting suicide.
- Suicide Prevention Guidelines written and disseminated to school personnel by the DOE.

2000

- Appropriation of $75,000 each to VDH and DMHMRSAS for each year of the 2000-2002 Biennium for activities to be conducted in response to the Youth Suicide Prevention Plan.
- A Study of Suicide in the Commonwealth by the Virginia Department of Health.
- Report on *Suicide Fatalities among Children and Adolescents in Virginia 1994-95*, by the State Child Fatality Team.
- Healthy People 2010, national goals and objectives, by the U.S. Department of Health and Human Services.

2001

- National Strategy for Suicide Prevention: Goals and Objectives for Action.
- Youth Suicide Prevention Plan by the Virginia Commission on Youth, with the assistance of the VDH; DMHMRSAS and the Department of Education. The plan recommends, among other items, amending the *Code of Virginia* to designate the Virginia Department of Health as lead agency for youth suicide prevention and increasing funding for both VDH and DMHMRSAS for youth suicide prevention activities.
- Report by the Virginia State Crime Commission on personalized handguns.
- VDH is designated as lead agency for youth suicide prevention in the Commonwealth, by amendment to the *Code of Virginia* (§32.1-73.7). VDH is mandated to report annually to the Governor and the General Assembly on its youth suicide prevention activities.
- DMHMRSAS initiated the proclamation of Childhood Depression Awareness Day, declared by the Governor on May 8, 2001.
- Interagency Youth Suicide Prevention Coordinating Committee formed by VDH with representation from DMHMRSAS, DOE, community services boards, and local health departments.
- Virginia Youth Suicide Prevention Advisory Committee established to advise DMHMRSAS on mental health recommendations from the Youth Suicide Prevention Plan.

- The Virginia Suicide Prevention Council is established as a public private partnership.
- Position of Youth Violence Prevention Consultant filled by the Center for Injury and Violence Prevention at VDH.
- Applied Suicide Intervention Skills Training (ASIST) and Question, Persuade, Refer (QPR) training initiated by VDH and DMHMRSAS.

2002

- Suicide prevention award of $966,992 over three years to VDH by the Centers of Disease Control and Prevention. VDH's efforts focus on training and distribution of materials to promote early recognition of the warning signs of depression and suicide in order to provide active intervention and referral of those who may have a tendency toward suicide.
- Third Annual Virginia Suicide Prevention, Intervention and Healing Conference held, sponsored by DMHMRSAS, Virginia Suicide Prevention Council, and VDH.
- Senate Joint Resolution No. 108 directs the Joint Commission on Behavioral Health Care, in cooperation with DMHMRSAS and VDH, to develop a plan and strategy for suicide prevention in the Commonwealth.
- Funding received to implement the National Violent Death Reporting System in Virginia, which will link information on violent deaths from sources such as forensic pathology, law enforcement, forensic science and vital records.
- DMHMRSAS initiated the proclamation of Childhood Depression Awareness Day declared by the Governor on May 7, 2002.
- Website on suicide prevention created by VDH (www.preventsuicideva.org).
- Report on *Suicide Associated Deaths and Hospitalizations, Virginia 2000,* by the Center for Injury and Violence Prevention, VDH.
- Report on *Child Death in Virginia: 2001*, by the Virginia State Child Fatality Review Team.

2003

- Developing a Plan and Strategy for Suicide Prevention in the Commonwealth by the Joint Commission on Behavioral Health Care. Main recommendation is to charge the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to lead an interagency and cross-secretarial effort to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth.
- Senate Joint Resolution 312 was passed by the General Assembly. It requests the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth.
- Suicide Prevention Guidelines revised to include criteria for following up with parents of students expressing suicidal intentions after initial contact has occurred.
- Interagency Youth Suicide Prevention Coordinating Committee's name is changed to Interagency Suicide Prevention Coordinating Committee and is expanded to cover the lifespan and representation broadened to include the Virginia Department for the Aging, the Virginia Commission on Youth, and the Department of Corrections.
- Regional Planning Sessions for Suicide Prevention held in Abingdon, Lynchburg, Arlington, Prince William County, and Norfolk and with representatives of faith-based organizations, higher education institutions, and with the Interagency Suicide Prevention Coordinating Committee.

Epidemiology of Suicidal Behaviors in Virginia

In 2002, the latest year for which data are available, there were 792 suicides in the Commonwealth, or about two suicides per day, for an age-adjusted rate of 10.8 suicides per 100,000 persons.[i] It was the eleventh leading cause of death among all Virginians and the third leading cause of death for youth. Twice as many died from suicide in Virginia as compared to homicides.[h] In 2001, Virginia's suicide rate ranked 31st highest in the nation.[i] The national target is 5.0 suicides per 100,000 by the year 2010.[j]

For every suicide, there are about 25 suicide attempts; thus there were about 19,800 suicide attempts in 2002 in Virginia. Suicide attempts are three times more common in women than in men. Also, each suicide intimately affects at least 6 other people.[k]

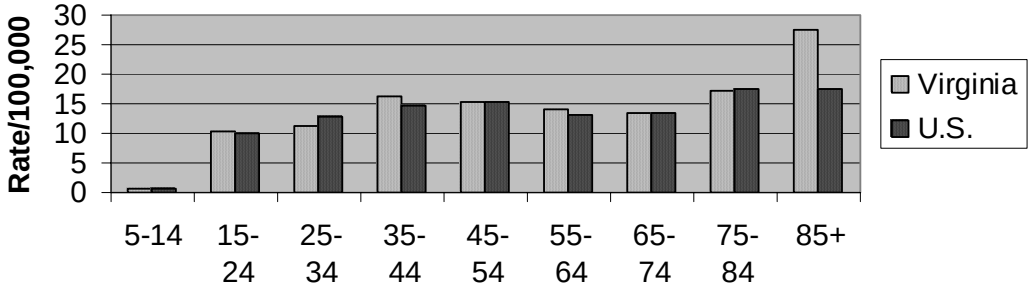
In 2002, the 792 suicides can be broken down as follows:

- 617 (78%) were suicides by males
- 535 (68%) of the suicides were by 25 - 64 year olds
  - 341 (64%) of these suicides were by white males
- 490 (62%) were deaths by firearms
  - 422 (86%) of the suicides by firearms were by males

Comparisons with National Rates

Suicide rates for Virginia in 2001 were very similar to those for the U.S., with the exception of the elderly aged 85 and over (Figure 1). The 2000-2002 average for this age group in Virginia was 37% higher than the national rate for 2001.

Figure 1: Age-Specific Suicide Rates, Virginia and U.S., 2001



Source: Virginia Center for Health Statistics

[i] Age-adjusted rates are standardized to a common population age distribution, in this document, the Year 2000 U.S. population. This allows for comparison among populations in spite of differing age distributions.

Trends

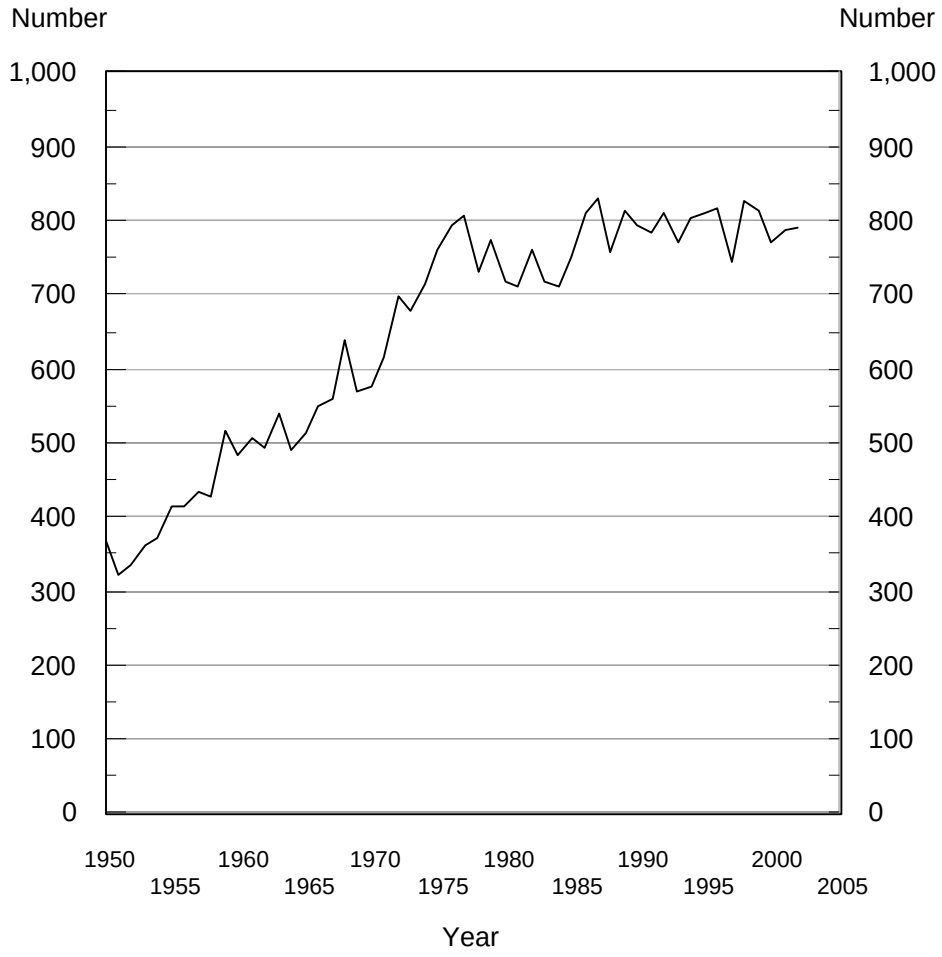
While the number of suicides in Virginia has risen by a third since 1970, it has stabilized since 1990 (Figure 2). Suicide death rates rose rapidly between 1950 and the mid-70s but have since declined by about 30% such that in 2002, the rate was similar to that of the mid-1950s (Figure 3). The suicide rate to 45-64 year olds has declined dramatically: since 1975, the rate has halved. Suicide rates for 20-44 year olds and 65-74 year olds have each declined since 1975 by 31%. The suicide rates of 15-19 year olds has remained relatively stable, however the rate for 2002 (5.8/100,000) is the lowest since 1975 – this rate will have to be monitored to see whether it indicates the beginning of a downward trend. The rate for the elderly ages 75 and over fluctuates greatly but both the rates for 75-84 year olds and for those 85 and over do not appear to have changed much during the past 28 years (Charts 1 to 10 in Appendix E)[i]. Rates for white males and females have declined since 1975 but for non-white males and females show little change (Figure 4).

Geographic Distribution

Suicides occur in all areas of Virginia. The highest rates are in rural areas, primarily in the Southwest and West Piedmont areas. For the most recent four-year period (1999-2002), Appendix F shows the cities/counties and planning districts with at least 20 suicides over a four-year period and rates at least as high as the Virginia rate. In descending order, the counties of Buchanan, Scott, Russell, Wise, Lee, Dinwiddie, Pulaski, and Tazewell had suicide rates at least 1.75 times the state rate and accounted for 232 suicides (7% of total) over a 4-year period. Lenowisco (Planning District 1) and Cumberland Plateau (Planning District 2) had rates at least twice as high as the state rate and the rate of West Piedmont (Planning District 12) was at least 1.5 times the state rate. Mount Rogers (Planning District 3) and the Roanoke Area (Planning District 5) had rates that were 1.25 times higher. Outside of these Planning Districts, Dinwiddie, Louisa, Culpeper, Isle of Wight, Shenandoah and Warren counties had similarly high rates. Together, the suicides in these areas accounted for 25% (786 suicides) of the total during those four years. Fairfax County had the highest number of suicides, at 274 over a 4-year period, but with a rate well below the state rate (7.0/100,000).

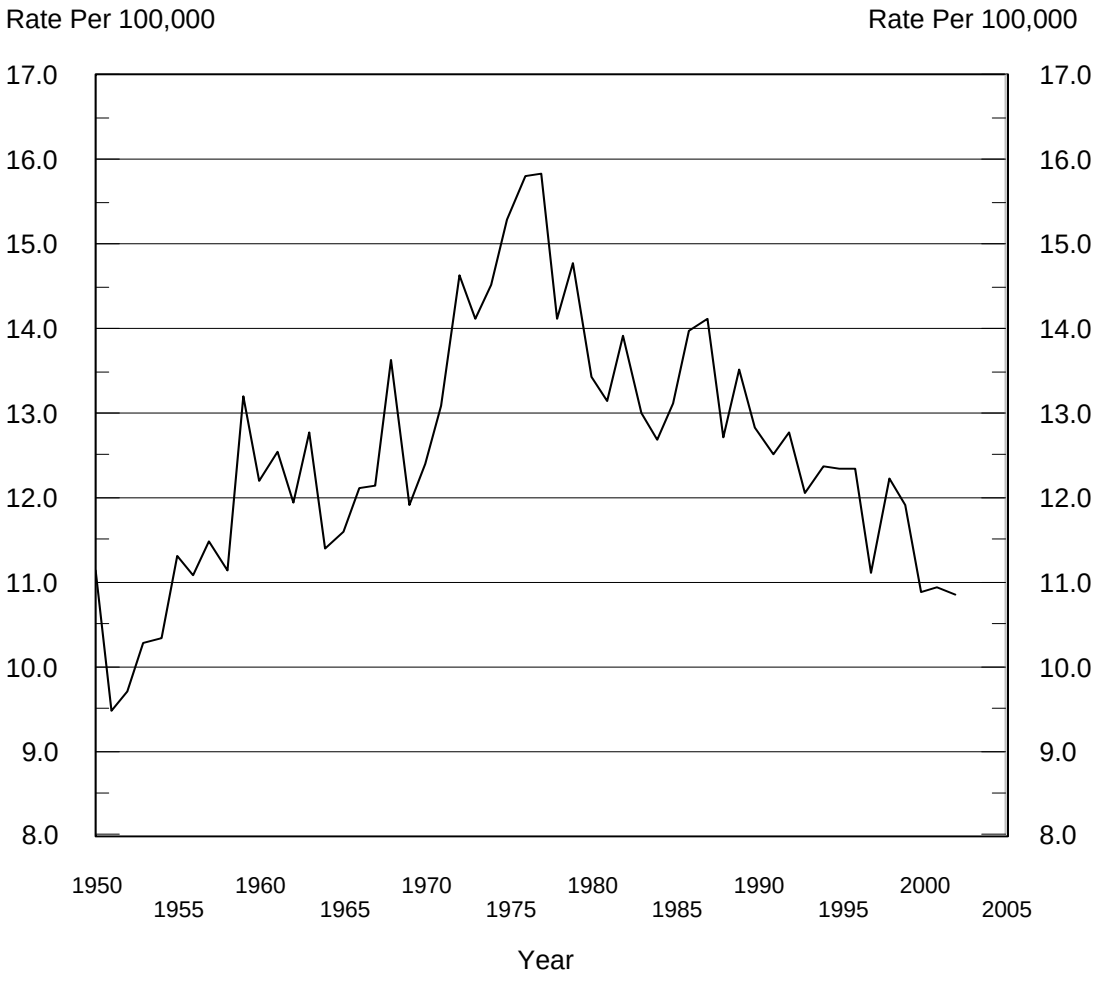
[i] Rates for ages 85 and over, 1975 – 2002: The straight-line descriptor of the rates has a slight positive slope: it rises from 18.9/100,000 in 1975 to 22.9/100,000 in 2002. However, it fails conventional probability tests as a descriptor, indicating no increase during those years.

Figure 2
Total Resident Deaths From Suicide
Virginia, 1950-2002



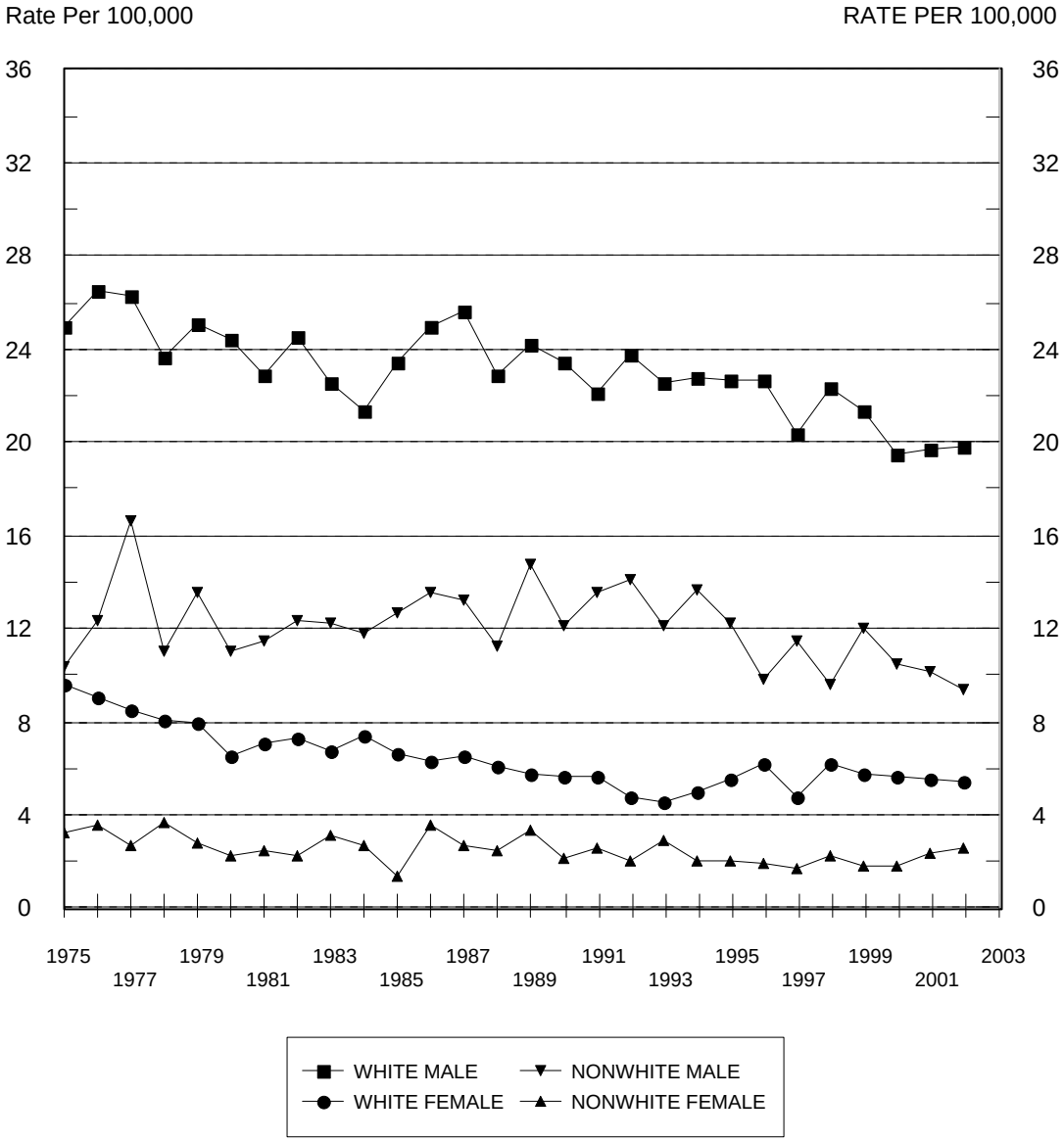
SOURCE: Virginia Center For Health Statistics

Figure 3
Total Resident Death Rates From Suicide
Virginia, 1950-2002



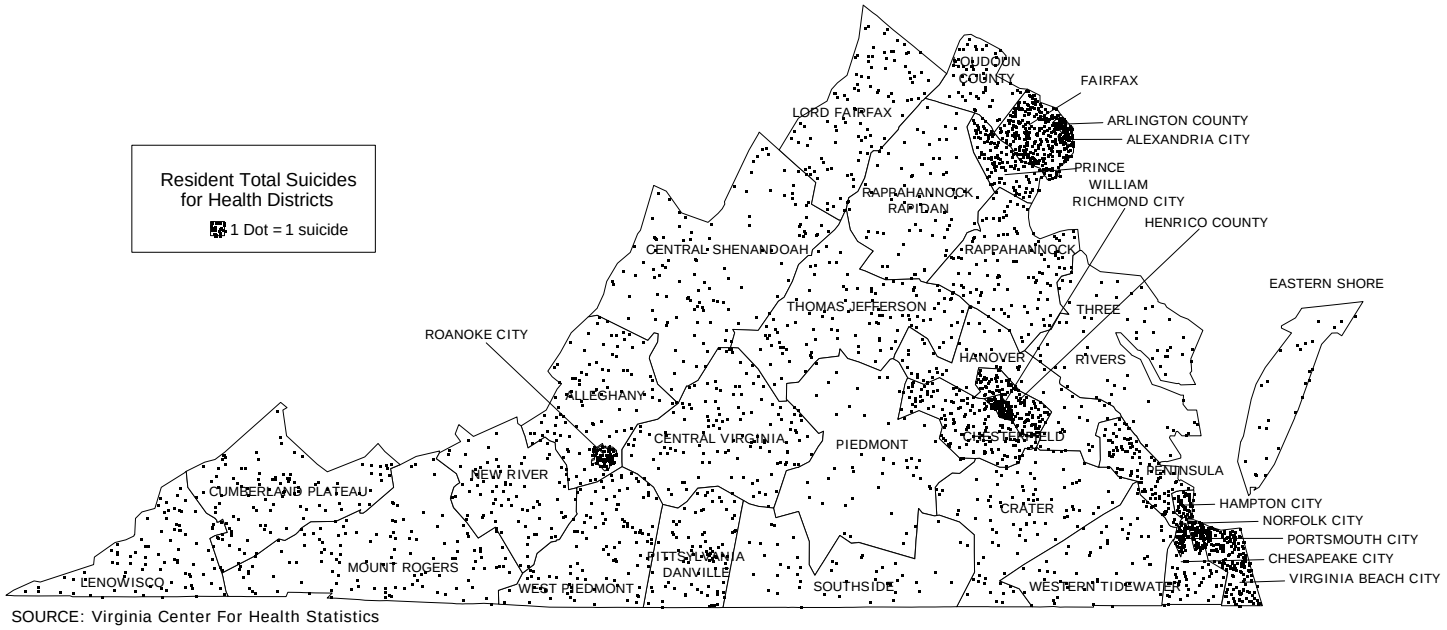
The Rates Are Per 100,000 Population of the U.S. Census and the VA State Data Center
SOURCE: Virginia Center For Health Statistics

Figure 4
Resident Suicide Death Rates By Race And Sex
Virginia, 1975-2002



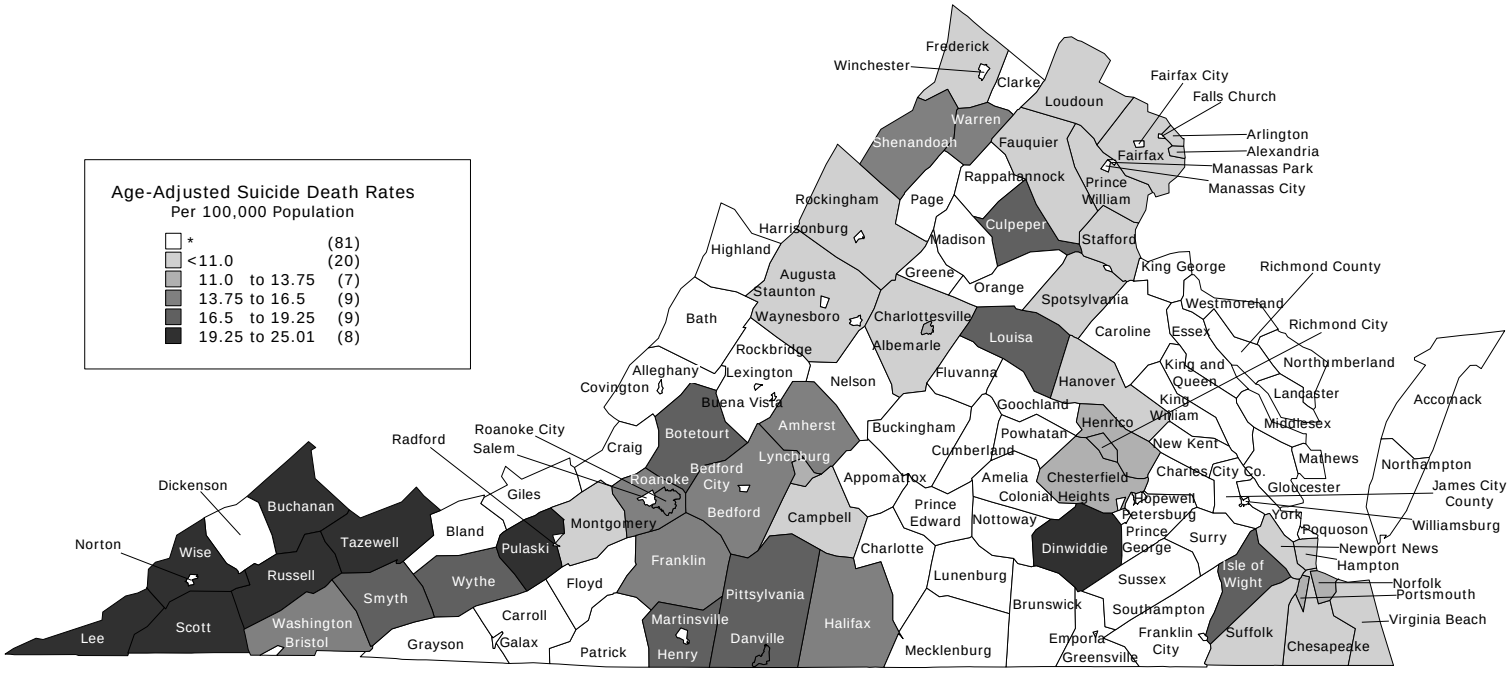
SOURCE: Virginia Center For Health Statistics

Figure 5: Resident Total Suicides for Health Districts in Virginia, 1999-2002



SOURCE: Virginia Center For Health Statistics

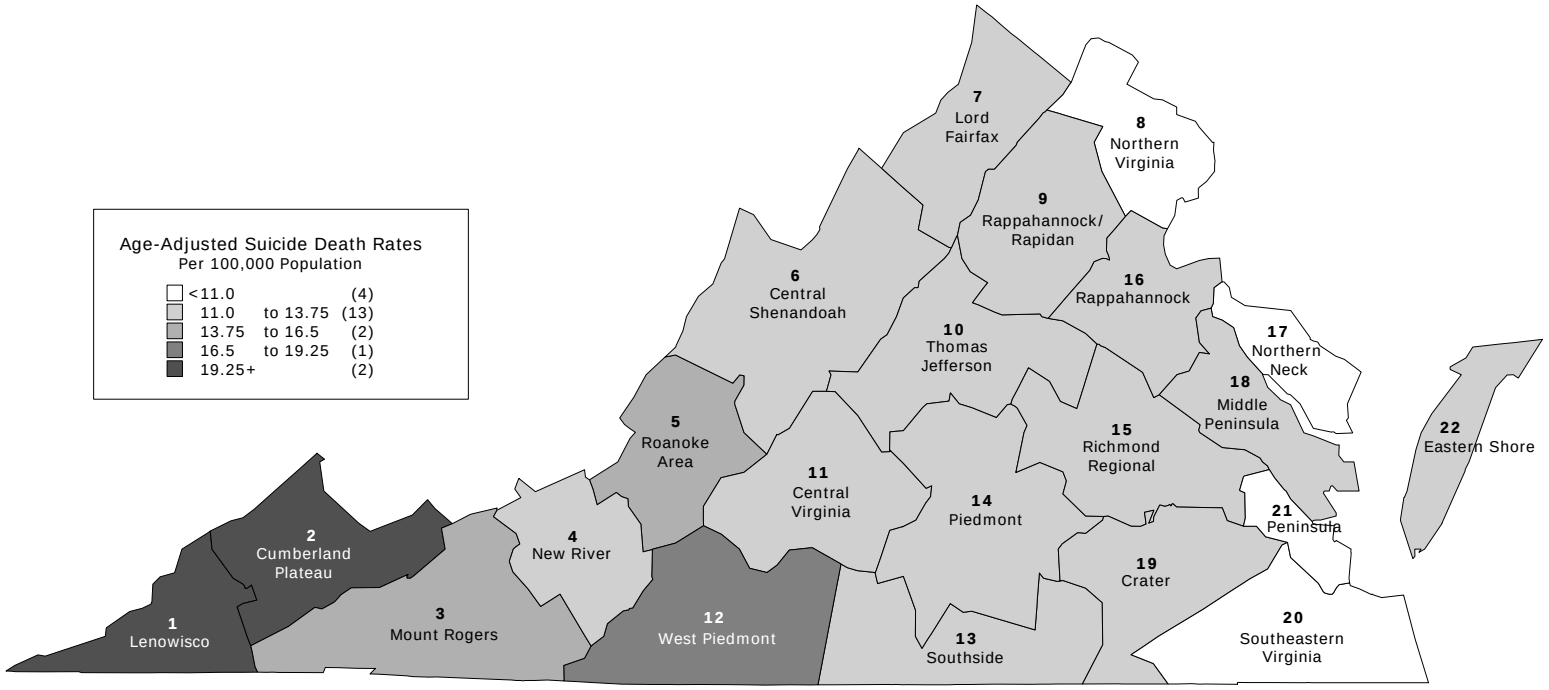
Figure 6: Resident Age-Adjusted Suicide Death Rates Per 100,000 Population By City and County Virginia, 1999-2002



Source: Virginia Center for Health Statistics

* Number of cases too small (<20) to calculate reliable rate
Note: 11.0/100,000 is the age-adjusted rate for Virginia

Figure 7: Resident Age-Adjusted Suicide Death Rates Per 100,000 Population By Planning District Virginia, 1999-2002

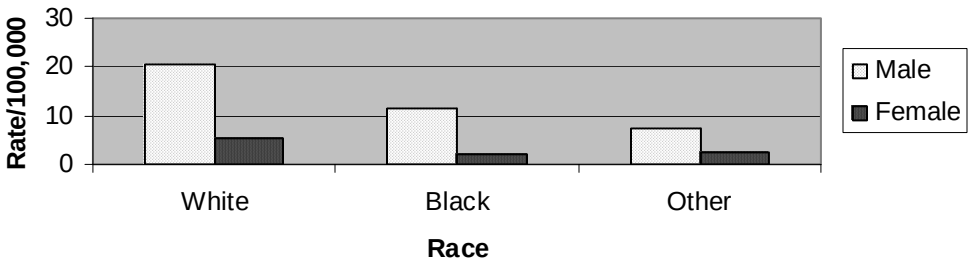


Source: Virginia Center for Health Statistics
Note: 11.0/100,000 is the age-adjusted rate for Virginia

Gender and Race

In 1999-2002, males in Virginia had age-adjusted suicide rates that were four times higher than those of females (18.6 and 4.6 respectively). The rate for white males was highest, 20.7 as opposed to 11.4 for black males. Black females had the lowest rates, at 2.1 and the rate for white females was 5.4 (Figure 8).

Figure 8: Age-Adjusted Suicide Rates by Gender and Race, Virginia, 1999-2002



Source: Virginia Center for Health Statistics

The pattern of suicide over the lifespan is strikingly different among the four major race/gender categories[i]. Among white males, the suicide rates rise steadily through age fifty-four; thereafter they rise dramatically and peak for those ages 85 and over. By contrast, the suicide rate peaks twice for black males: between 20 and 34 years and then again among those ages 85 and over. Between the ages of 5 and 34, the rates for both white and black males are similar. The rates for females are relatively low throughout the lifespan but reach the highest point between the ages of 35 - 44 for white females and 35 - 54 for black females. The rates for black females are very low: the highest rate for any age group is 4.1/100,000 (Figure 9).

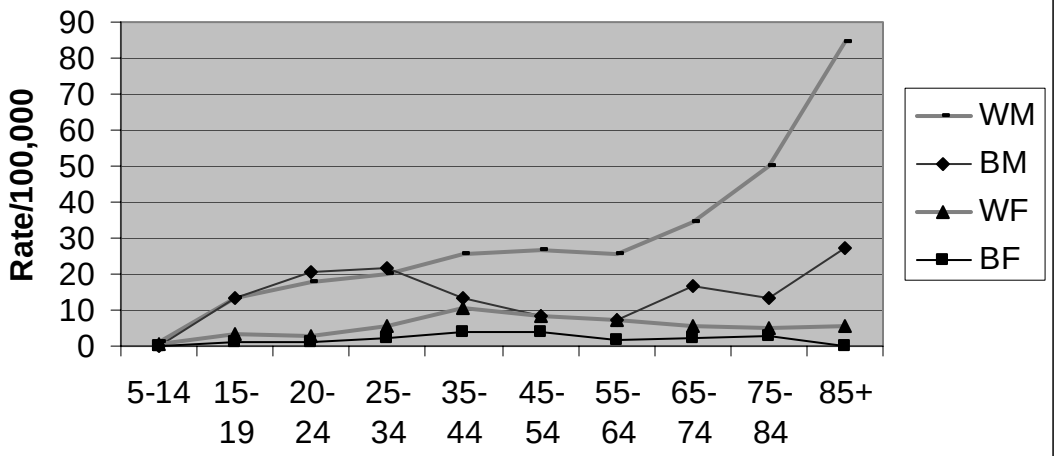
Mechanism of Suicide

In all age groups, firearms are the major means chosen by those completing suicide. Most recently, suffocation (mostly hanging) has become a more common means among 10-14 year olds nationally.[1] In Virginia, suffocation (mostly by hanging) is the second most common method, followed by drugs and gases (Figure 10).

[i] Rates for other race categories are available, but the numbers are so small that they are not deemed reliable.

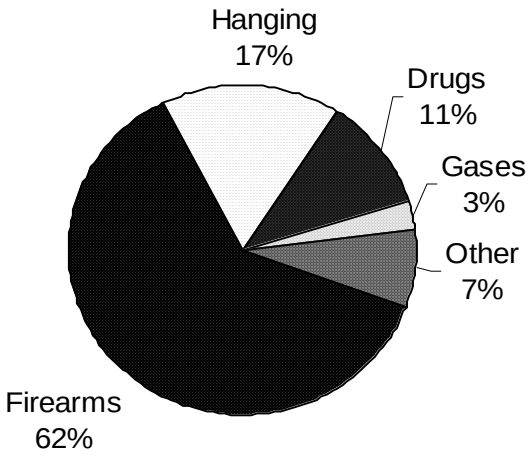
Since 1988, the suicide rate by firearms and gases has declined by 23% and 64% percent, respectively. The rate of suicide by suffocation, though, has risen during this same period. Suicide by drugs has fluctuated (Figure 11).

Figure 9: Age-Specific Suicide Rates by Race and Gender, Virginia, 1999 - 2002



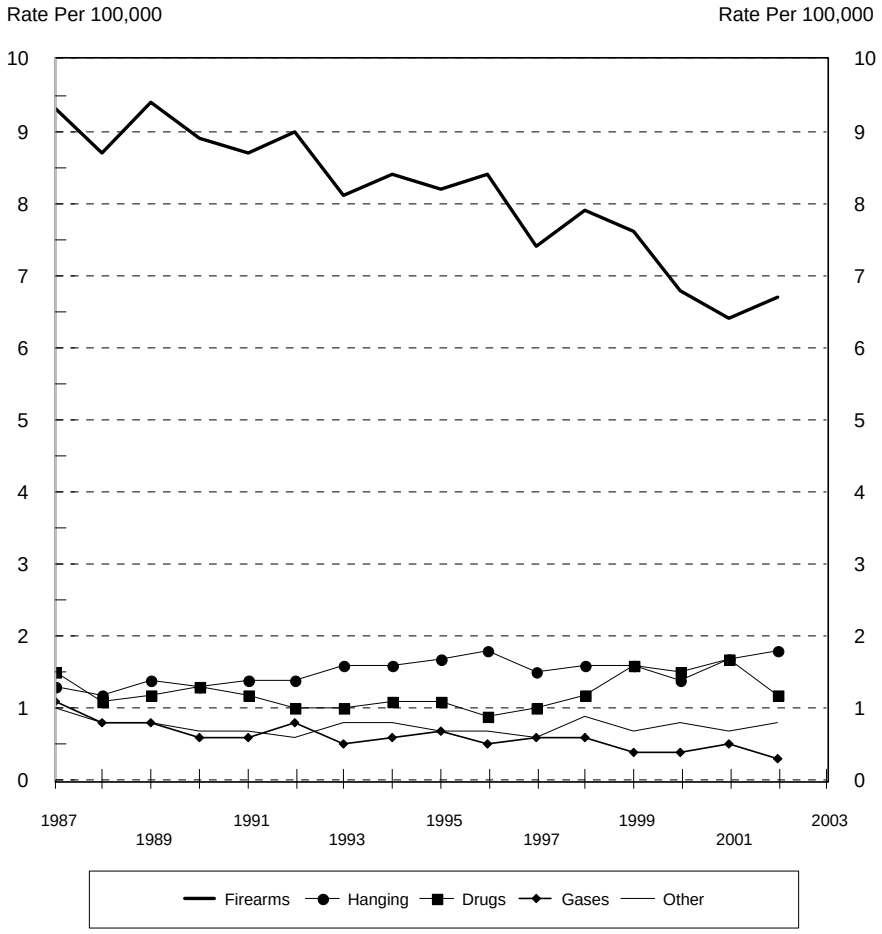
Source: Virginia Center for Health Statistics

Figure 10: Mechanism of Suicide, Virginia, 2002



Source: Virginia Department of Health

Figure 11
Resident Suicide Death Rates By Method
Virginia, 1987-2002



SOURCE: Virginia Center For Health Statistics

Suicidal Behaviors

For the first time in 2003, the Virginia Department of Health, in collaboration with the Centers for Disease Control and Prevention, included questions on suicidal behavior in the annual Behavioral Risk Factor Surveillance System, a random telephone survey of adults ages 18 and older. Table 1 shows the percentage of respondents reporting various suicidal behaviors and the estimated number of adults in Virginia who would expect to exhibit these behaviors based on the reported percentages.

Table 1: Estimated Prevalence of Self-Reported Suicidal Behaviors, Among Adults Ages 18 and Over in Virginia, 2003

Suicidal Behavior	Frequency (%)	Estimated No. of Adults in Virginia with Behavior, 2003
Seriously considered attempting suicide	**3.0**	**166,802**
Serious plan to attempt suicide	**1.4**	**77,841**
Attempted suicide	**0.5**	**27,800**
Suicide attempt that required medical attention	**0.2**	**11,120**

Source: Behavioral Risk Factor Surveillance System, Virginia Department of Health, 2004

In addition, nearly 2% of the surveyed adults reported suffering from depression, anxiety, or an emotional problem that limited their activities. Of those women who had a baby in the past year, 12.7 percent said they had felt sad or blue before pregnancy, 30.4% reported this feeling during pregnancy, and 38% after pregnancy.[m]

The Centers for Disease Control and Prevention conducts a national survey of youth in grades nine through twelve in public and private schools. This survey includes questions to determine risk behaviors, including questions about sadness, hopelessness, and suicidal thoughts and behaviors. Data specific to Virginia is unavailable from this study. Results from most questions are available since 1991 and indicate[n]:

- Nearly 30% of youth have felt sad and hopeless for two weeks or more during the past year, such that they have stopped some usual activities. This feeling is higher among females (33%) than males (20%). Among Hispanic females, this percentage is particularly high – 45% in 2003.
- Overall, 17% of youth seriously considered attempting suicide in 2003, with a higher percentage among females (21%) than males (13%), although the rate for black females is lower (15%).
- Fewer youth seriously considered suicide in 2003 (17%) as compared to 1993 (24%). This finding is consistent among all females and white males. Among minority males there appears to be a decline, but it may not be significant.
- Close to 9% of youth attempted suicide during the past year. The percentage was over twice as high among females (11.5%) than males (5%) and was lowest among white male youth (4%) and highest among Hispanic females (15%).
- Three percent of youth reported attempting suicide in the past twelve months and required medical attention as a result. These attempts appear to be somewhat higher among minority youth.
- Although data for youth of other (neither white, black nor Hispanic) are available, the rates are based on small numbers and are generally not reliable.

Data on suicidal behaviors is also available from Virginia Poison Centers and from hospital discharge reports. In 2003, 5,705 (called suicidal poison exposures) were reported to Virginia Poison Centers, for an average of 16 calls per day. Two-thirds of the callers were female and one-fourth were children and youth under the age of twenty. Ninety-three percent of callers were exposed in their own residences. Among 6-19 year olds, the most common types of exposures among callers were to analgesics (37%), antidepressants (15%), sedatives/antipsychotics/hypnotics (10%), cough and cold preparations (6%), and antihistamines (5%). Among adults 20 years or older, the most common exposures were to sedatives/antipsychotics/hypnotics (22%), analgesics (22%), antidepressants (16%), alcohols (9%), and antihistamines (4%)[o].

Self-inflicted injuries resulted in 4,210 hospitalizations in Virginia in 2002 and accounted for 11.4% of all injury-related hospitalizations. Self-inflicted injuries accounted for 13.6% of the injury hospitalizations for females and 9% of the injury hospitalizations for males. When considering age, certain patterns of hospitalization occur. The 15-34 year age group experienced the highest percentage of all injury hospitalizations attributable to self-inflicted injuries (Appendix G). For example, 12.7% of all those hospitalized for injury in Virginia were 15-19 year olds who were hospitalized for self-inflicted injuries, while only 3.3% of all those hospitalized for injury were those 65 years of age and older who were hospitalized for self-inflicted injuries. Similar conclusions can be drawn when analyzing the proportion of injury hospitalizations within a particular age group that were attributable to injury. About a quarter of all injury hospitalizations experienced by those 15-44 were due to self-inflicted injury (Appendix G) in comparison to the elderly for whom self-inflicted injuries are an insignificant percentage (1%) of injury hospitalizations.

Risk and Protective Factors[i]

In the U.S., about 90 percent of people who completed suicide had a mental illness, including alcohol and/or substance use disorders and some had multiple diagnoses. About 50% of those who completed suicide were not in treatment. Those who were in treatment often were not adequately medicated, sufficiently followed after acute treatment, and/or did not adhere to treatment. However, over 95% of those with mental disorders never attempt or complete suicide. Among those who attempt suicide, 30-90% have a depressive disorder and up to two-thirds are intoxicated with alcohol. Therefore, in this country, the problem of suicide is inextricably linked to the issue of mental health and substance abuse.

About 28-30% of the US population has a mental or addictive disorder, but only about a third of those with mental illness receive treatment. In 1997, a national survey found that in children and adolescents ages 6 to 17 years with mental health problems severe enough to indicate a clinical need for mental health evaluation, 79% did not receive a mental health evaluation or treatment in the past year.[p] Barriers to receiving treatment include

[i] Unless otherwise noted, the source of information for this section from Institute of Medicine. 2002. *Reducing Suicide: A National Imperative.* Washington, D.C.: National Academy Press.

stigma, limited insurance coverage, fragmentation of services, and low availability of services, especially in rural areas and communities with large minority populations.

Care to people with mental health problems is provided by mental health providers but also primary care practitioners and the clergy. Older adults, African Americans, and Hispanic Americans more often seek help for mental health issues, including suicide, from clergy rather than from mental health professionals. About half of people with depression and other mental disorders obtain mental health treatment in primary care settings. Nearly 75% of persons dying by suicide see a medical professional within their last year of life. About 40% of these people had contact with a primary care provider within a month of their death; 20% within a week before suicide. Among older people, 70% saw a health professional within a month of the suicide.

Researchers have identified patterns of high risk for suicide during certain periods of treatment, such as immediately after discharge from a hospital and early in treatment, before consistent drug and therapy treatments have been established.

Specific diagnoses associated with suicide attempts include:

- 30-90% with depressive disorder. As compared with the population as a whole, those with major depressive disorder have a 40 times higher risk of suicide.
- 30% with a personality disorder, in particular borderline personality (BPD) and antisocial personality disorders. Although BPD affects 2% of adults; 40-90% of people with BPD have attempted suicide.
- 25% with an alcohol abuse disorder. As compared to a psychiatrically healthy population, those with this disorder have 115 times greater risk of suicide.
- 20% with anxiety disorders, including post-traumatic stress disorder
- 5% with schizophrenia; they have 40 times greater risk of suicide than the population as a whole.
- 5% with bipolar disorder. This condition affects about 1.2% of the population but 25-50% of those with this disorder will attempt suicide at least once.
- Mood disordered individuals with impulsive aggression are at much greater risk for suicidal behavior than are those without this characteristic.

However, not all suicides or persons who attempt suicide have a mental health condition. A recent study found a significantly higher likelihood of suicide attempts, independent of effects of mental disorders, among people suffering from lung disease, ulcer, and AIDS with the number of physical illnesses related to an increased odds of suicide attempt.[q]

Specific protective and risk factors associated with suicide are presented in the charts below. Of particular note is the relationship between childhood trauma and suicidal behaviors. In a review of multiple studies, it was found that adults with a history of childhood physical and sexual abuse were 1.3 to 25 times more likely than adults without a past history to attempt suicide. Conversely, from 20-49 percent of child sexual abuse victims do not exhibit noticeable symptoms. The most common outcomes of sexual or physical abuse are depression and post-traumatic stress disorder but also include impaired social attachments, low self-esteem, substance abuse, and delinquent behavior. In

particular, childhood sexual abuse is a risk factor in about 9-20 percent of suicide attempts. This abuse is more likely when parents are depressed or substance abusers.

New biological research is showing a link between chronic stress, impulsivity, genetic inheritance and suicidal behaviors. Eventually, this research could help practitioners identify and follow patients who may be at most risk for suicidal behaviors. For example, irregularities of the hypothalamic-pituitary-adrenal axis, one of the body's primary stress response systems that becomes dysfunctional after trauma, such as abuse or chronic stress, are associated with suicide, independent of psychiatric diagnosis. Low levels of the neurotransmitter serotonin, associated with increased impulsive aggression, have been found in the brains and cerebrospinal fluid of serious suicide attempters and suicide victims.

Risk factors vary across the lifespan. For example, youth are more likely to exhibit irritability, acting out behaviors, and anger rather than exhibiting sad and depressed affect. Suicide victims under 30 are more likely to have problems with substance abuse, impulsive aggressive personality disorders, and precipitants such as interpersonal and legal problems than those over 30. Among the elderly, widowhood, serious medical illness, and social isolation are risk factors. In the U.S., the highest suicide rate is among bereaved elderly white men.

The Institute of Medicine, in its landmark report, Reducing Suicide: A National Imperative, summarizes risk factors for suicide succinctly:

> Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness and loss of economic security, and other cultural and societal influences. Resiliency and coping skills, on the other hand, can reduce the risk of suicide. Social support, including close relationships, is a protective factor.[r]

and

> Converging evidence across disciplines indicates that suicide is related to stress: developmental and adult trauma; cumulative stressors, including multiple morbidities; acute and chronic social and cultural stressors; and capacity to cope with stress. Suicide can be considered an expected outcome of a significant subgroup of mentally ill patients who experience accumulative life stresses, just as cardiac infarction is an expected outcome of untreated high blood cholesterol.[s]

Protective Factors

- Effective clinical care for mental, physical and substance use disorders.
- Easy access to a variety of clinical interventions and support for help-seeking.
- Restricted access to highly lethal means of suicide.
- Strong connections to family and community support.
- Support through ongoing medical and mental health care relationships.
- Skills in problem solving, conflict resolution and nonviolent handling of disputes.
- Cultural and religious beliefs, including those that discourage suicide and support self preservation.

Adapted from Risk and Protective Factors for Suicide, Suicide Prevention Resource Center, www.sprc.org

Risk Factors for Suicide

Biopsychosocial Risk Factors:

- Mental disorders, particularly mood disorders, especially depression, and schizophrenia, anxiety disorders and certain personality disorders.
- Alcohol and other substance use disorders.
- Hopelessness.
- Impulsive and/or aggressive tendencies.
- History of trauma or abuse, in particular sexual abuse.
- Some major physical illnesses.
- Previous suicide attempt.
- Family history of suicide.

Environmental Risk Factors:

- Job or financial loss; low socio-economic status.
- Relational or social loss, such as divorce or death.
- Easy access to lethal means.
- Local clusters of suicide that have a contagious influence.

Sociocultural Risk Factors:

- Lack of social support and sense of isolation.
- Stigma associated with help-seeking behavior.
- Barriers to accessing health care, especially mental health and substance abuse treatment.
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma).
- Exposure to, including through the media, and influence of others who have died by suicide.

Adapted from USDHHS National Strategy for Suicide Prevention: Goals and Objectives for Action, 2001. Public Health Service, Rockville, MD.

High Risk Populations

High-risk populations are those that are known to have a higher than average suicide rate or rate of suicidal behaviors and risk factors. Based on the research, high-risk populations include:

For suicide

- Men
- Elderly men, in particular widowers
- Rural residents
- Unemployed youth who have dropped out of school
- Incarcerated populations – most often young white males arrested for non-violent offenses and intoxicated upon arrest, frequently within 24 hours of incarceration.
- Dentists, physicians, and nurses
- Mathematicians and scientists, artists and social workers
- Homosexual/bisexual males

Note: Although police have been cited as having higher risk for suicide, studies have shown inconsistent results.

Suicidal thoughts or attempts

- Women
- Youth, in particular females, especially Hispanic females

Effective Strategies[i]

In the field of suicide prevention, a widely used model for grouping strategies is the Universal, Selective, and Indicated prevention model. ***Universal*** strategies are designed to reach all the members of a community or population and include public education campaigns, changes in laws or policies to improve access to care or reduce access to means, strategies aimed at improving the reporting of suicides, and initiatives to improve student wellness, such as sports programs. ***Selective*** strategies are targeted for the population groups at higher risk for becoming suicidal, for example, those with undiagnosed and untreated mental health conditions, the elderly, victims of abuse, unemployed persons, and depressed youth. These initiatives aim at preventing the onset of suicidal behaviors. Examples include the training of those persons in positions of responsibility who are most likely to come into contact with the higher risk population (also referred to as "gatekeeper" training), screening and treatment for depression or substance abuse, and developing supportive networks for elderly widowers. ***Indicated*** strategies are intended to prevent suicide among those most at risk for suicide and showing early signs of suicide potential, such as people who have expressed an intent or attempted suicide. Effective treatment, follow-up and support are considered "indicated" strategies.

The Institute of Medicine report, Reducing Suicide: A National Imperative recognizes that, while the indicative strategies target the groups at highest risk for suicide, these initiatives are limited in their impact on reducing the incidence of suicide because of the low prevalence of many of the high-risk conditions, such as unipolar depression. In comparison, universal and selective strategies have the potential for influencing a larger percentage of the population, including those at high risk, and therefore have a higher chance of reducing suicides.

Demonstrating the effectiveness of suicide prevention initiatives is difficult. Suicides are rare events, so establishing program effectiveness demands very large numbers of participants or very long-term studies and similarly high funding levels. Suicide ideation can be used as an alternate measure, but it is unclear whether suicide ideation is a strong predictor of suicide. Definitional problems plague this area too as researchers use different definitions and tools to identify suicidal intent. Researchers also have shied

[i] Unless otherwise noted, the source of information for this section from Institute of Medicine. 2002. *Reducing Suicide: A National Imperative.* Washington, D.C.: National Academy Press.

away from conducting studies with individuals at risk for suicide because of liability concerns.

Selecting a particular strategy involves evaluating its appropriateness for the intended audience as well as the effectiveness as demonstrated by a rigorous evaluation. Negative effects can occur if adapting the intervention to a population other than the one for which it was designed. Moreover, when evaluating or designing a strategy for a particular group, the cultural norms, beliefs and behaviors or the group must be taken into account.

This section summarizes effective strategies in preventing suicide, suicidal behavior or risk factors that may be targeted to the population as a whole or to specific groups. It does not include a summary of effective medications or therapies that may be prescribed to individuals by clinicians, such as anti-depressants, lithium, or psychotherapy. This is not to minimize the effect of such methods; rather, summarizing such methods is beyond the scope of this document.

Integrated Programs

Integrated programs combine universal, selective and indicated strategies. While examples cited below demonstrate that such approaches can be effective, there is also compelling logic to the integrated approach. Why increase public awareness without having adequate services and community support to help those most in need? Strengthening mental health services is valuable when coupled with actions to reduce barriers toward utilization of those services. Common elements of effective integrated programs are an assessment of the problem that identified the particular risk factors of the community, an integrated program specifically designed to address that problem, and a high level of involvement by leadership.

United States Air Force Program After first conducting a comprehensive assessment of the suicide problem in the United States Air Force, a program was developed with the help of the Centers for Disease Control and Prevention. The program consisted of:

- Involving the Air Force leadership in raising the awareness of mental health and removing the stigma of seeking help for a mental health or psychosocial problem.
- Training personnel at all levels on skills and knowledge of basic suicide and violence risk factors intervention skills, and referral procedures and resources.
- Changing policies to promote help-seeking behaviors.
- Establishing a seamless system of human services and strengthening preventive mental health services.
- Establishing multidisciplinary teams to improve response to traumatic events.

The program evaluation was a quasi-experimental design comparing suicide rates before and after intervention, and controlling for changes in demographic variables. The researchers found a 33% decline in suicide rates and an 18-54% reduction in rates of moderate and severe family violence after program implementation. The authors cite the

possible application of this program to other controlled environments such as workplace settings, larger corporations, and schools and universities.[t]

Integrated Programs on U.S. American Indian Reservations Several integrated interventions to reduce high suicide rates have been used effectively in U.S. American Indian reservations. In one, after an assessment to identify the most predominant risk factors, a program was initiated involving the active and enthusiastic participation of the local tribal members, social and economic improvements, traditional Indian cultural enhancement programs, and increasing mental health services. The suicide rate fell from 173/100,000 in 1972-76 to 45/100,000 in 1981-84. In another community, the suicide rate fell from 267/100,000 to 26.7/100,000 after a program was put into place consisting of suicide awareness, prevention strategies, and a counseling program.

In summary, the Institute of Medicine report states:

> Programs that integrate prevention at multiple levels are likely to be the most effective. Comprehensive, integrated state and national prevention strategies that target suicide risk and barriers to treatment across levels and domains appear to reduce suicide.[v]

Reducing Access to Means

Universal strategies such as technological and legislative measures to reduce access to the means of suicide are considered to have the greatest potential impact because they do not rely on human compliance for their success. For example, introducing blister packs for storing acetaminophen was associated with a 21 percent decrease in overdoses and a 64 percent decline in severe overdoses, whereas overdoses due to benzodiazepines, which were not similarly packaged, remained stable.[w]

In three case-control studies, firearms were found to be between 31.1 and 107.9 times more likely to be used for the suicide if a gun was already in the home than if they were not in the home.[xy] It would seem logical to promote measures to restrict access to lethal means, or at least promote the safe storage of such means in the home, particularly in those where residents have severe mental health conditions.

Quasi-experimental studies have shown a relationship between enactment of gun control legislation and the suicide rate. Counseling by physicians on the removal of guns in the home has limited effectiveness. In one study, only 27% of parents who reported having guns in the home had removed the guns by a follow-up visit after counseling by a physician.[z]

Identifying those At Risk for Suicidal Behavior

Several instruments have been developed and evaluated to assess risk for suicidal behavior. In one, the most widely used Scale for Suicide Ideation (SSI), patients with a score above a 3 were about 6.5 more likely to complete suicide than those whose score

was below this level. Some scales work with some populations better than others so care must be made to select an instrument that is appropriate for the intended purpose and the particular cultural background, age, and gender of the patients.

Follow-up Care

The time immediately after a suicidal patient is discharged from a hospital is one of high risk for suicidal behavior. This may be due to poor adherence to medication but other factors include isolation, access to means, or loss of contact with a health professional. Some institutions have initiated and evaluated follow-up care by a health care provider. Several of these initiatives show promise, with demonstrated reductions in suicidal behavior as compared to a control group.

Programs Aimed at Preventing Youth Suicide

This section summarizes a number of programs or initiatives aiming to prevent youth suicide that have shown some effectiveness in changing knowledge, attitudes or behavior. Several other programs, for example, comprehensive school programs to address youth violence, are being evaluated but final results are not available.

Universal Strategies

Programs and policies that appear effective include:

- Increase in the legal drinking age. Between 1970 and 1990, in states with a minimum legal drinking age of 18 years, the suicide rate among 18-20 year olds was 8 percent higher than states where the minimum legal drinking age was 21.[aa]
- Broad school-based programs promoting mental health and resiliency that target multiple risk and protective factors and which include skills training in an environment with trained, supportive adults.
- Longer-term programs for youth that raise awareness of suicide prevention, develop skills to act on new attitudes and intentions, and include access to services.

Worth noting here is a conclusion reached in the Institute of Medicine report on universal strategies for youth:

> Given that many schools in the United States employ short-term, school-based suicide awareness interventions that may be ineffective and even potentially harmful, evaluation of various models and dissemination of those found safe and effective emerges as a priority. The most effective United States and international programs integrate suicide prevention into a competence-promotion and stress-protection framework, suggesting closer examination of health promotion as a prevention strategy. The evidence reviewed here supports carefully designed, science-based programs, particularly longer-term approaches couched in a broader context of teaching skills and establishing appropriate follow-through and services, as part of an effective armamentarium against

suicide. Brief, didactic suicide prevention programs with no connection to services should be avoided.[cc]

Selective Strategies

Effective strategies include:

- Skill-based, action-oriented training of motivated, responsible adults who come into regular contact with youth (gatekeeper training) can be effective in demonstrating appropriate helping competencies in simulations with youth at risk for suicide. Whether or not more suicidal youth are receiving treatment as a result of gatekeeper training has not been systematically evaluated.
- Youth at risk for suicide who were given personal competency training experienced a reduction in suicide-risk behaviors. For example, one program, Reconnecting Youth, trained youth at risk for school failure and found declines in depression, hopelessness, anger, and stress and significant gains in self-esteem and personal control.
- Early treatment for child abuse victims and early family-based interventions to reduce child abuse can be expected to reduce suicide since childhood sexual abuse is a risk factor in 9 – 20 percent of suicide attempts. Nurse home visitation programs to high risk mothers during pregnancy and infancy have been found to be effective in reducing childhood abuse and neglect when contrasted with a comparison group.
- Treatment for suicide risk factors such as depression and substance use, however it is not known if they specifically reduce suicide.

The American Academy of Pediatrics recommends that pediatricians screen adolescents for a history of sexual assault and potential sequelae[ee]. If effective, screening and treatment could potentially prevent incidents of suicide attempts and other negative consequences.

Indicated Strategies

Strategies falling under this grouping include family support training; case management and skill-building for high-risk individuals; and referrals resources for crisis intervention and treatment. Among high-risk youth, individualized assessment and counseling as well as small-group skills training were successful in reducing depression, hopelessness, and suicidal behaviors compared to a control group.

Programs Aimed at the Elderly

Primary care clinicians can play a key role in preventing suicide among the elderly, particularly as a high percentage of elderly suicide victims see their primary care physicians in the month prior to death. Major depression is the most common psychiatric disorder among elderly who have completed suicide. It follows that interventions promoting the screening and treatment of depression in the elderly by primary care clinicians should be evaluated. Results from one such indicated program, called

PROSPECT, tested the use of Health Specialists working with physicians as care managers to help them recognize depression, recommend treatment, and encourage adherence to treatment. Outcomes of two groups of elderly depressed patients were compared. The intervention was found to be effective, as compared to a control group, in reducing suicidal ideation and depression.[ff]

Programs Aimed at Detainees

A number of initiatives have been implemented in jails and prisons including staff education and skills training, changes in housing practices, changes in supervision, improved follow-up and reporting. However, these initiatives have not been evaluated.

Programs Aimed at Clinicians

Clinicians have an elevated risk for suicide. Since some of these clinicians would be expected to identify and treat or refer those with severe mental health conditions, it follows that reducing help-seeking barriers by clinicians is essential. A consensus statement recently published in the *Journal of the American Medical Association* recommends "transforming professional attitudes and changing institutional policies to encourage physicians to seek help."[gg]

The Suicide Prevention Plan for Virginia

The aims of the plan are to:

1. Prevent deaths due to suicide across the lifespan.
2. Reduce occurrence of other self-harmful acts.
3. Increase recognition of risk factors and improve access to care.
4. Promote awareness of suicide and reduce stigma of mental health.
5. Promote healthy community development, enhancing interconnectedness, resources, and resilience.

Leadership Development and Infrastructure

Goal 1: Develop Broad-based Support for Suicide Prevention.

Objective 1.1: **By 2006, establish state-level oversight and leadership for suicide prevention planning, implementation, monitoring, and evaluation by assigning the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) as the lead agency.**

Recommended Action

- Amend the *Code of Virginia* to assign leadership for the statewide suicide prevention initiative across the lifespan to the Department of Mental Health, Mental Retardation and Substance Abuse Services.
- Amend the *Code of Virginia* to assign oversight to the Joint Commission on Health Care concerning the *Virginia Suicide Prevention Plan across the Lifespan.*
- The Department of Mental Health, Mental Retardation, and Substance Abuse Services (lead agency) should form a Private/Public Suicide Prevention Steering Committee (hereafter referred to as the Steering Committee) to support the agency in implementing, monitoring, evaluating, and revising the *Plan* by coordinating strategies and promoting collaboration at the state, regional and local levels.
- The Department of Health should continue to provide leadership in implementing the *Youth Suicide Prevention Plan*.

Notes

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall have responsibility for leading the implementation of the Virginia Suicide Prevention across the Lifespan Plan and for continuously monitoring implementation as well as evaluating and revising the plan. DMHMRSAS is recommended as the lead agency for this effort because a majority of the objectives of this plan address the issue of mental health services. While it is recommended that DMHMRSAS take the lead for implementing this plan, the sole responsibility for implementing the objectives of this plan does not fall solely on DMHMRSAS. This responsibility shall be coordinated with public and private agencies and organizations with missions related to the prevention of suicide, to include, at a minimum the Departments of Health, Aging, Education, Social

Services, Juvenile Justice, Criminal Justice Services, State Police, Corrections, Community Services Boards, health professional associations, colleges/universities, faith organizations, the Virginia Suicide Prevention Council, and representatives of local/regional coalitions. The Department of Health (VDH) has had the lead responsibility for youth suicide prevention since 2000. The Center for Injury and Violence Prevention at VDH is recommended to continue its leadership regarding youth suicide prevention due to its documented success in addressing the prevention of suicide among youth through its gatekeeper training and media campaigns. The collaborative relationships in the communities and other agencies that have been built by VDH are strong. By retaining the lead in youth suicide prevention and training, VDH will continue to build on its achievement as an established leader in Virginia for youth suicide prevention. The Joint Commission on Health Care shall annually review a report by the lead agency documenting the progress toward meeting plan goals, objectives, and recommended action; utilization of resources; need for additional resources; and other systems or legislative needs. The Joint Commission on Health Care shall submit an annual report to the Governor and General Assembly.

Objective 1.2: **By 2007, DMHMRSAS will identify and support strong regional and/or local coalitions to prevent suicide across the lifespan, particularly in areas with high rates and numbers of suicides.** Such coalitions will:

- Develop local/regional strategies, develop partnerships, seek funding, promote collaboration, coordinate services, and promote a seamless service delivery system.
- Convene regional and statewide training and networking events or conferences to help build awareness and increase networking opportunities.

Recommended Action

- Based on available data, DMHMRSAS and Steering Committee should identify areas where local coalitions and interventions are most needed.
- Leaders and organization representatives in each specified region/locality should form or identify a coalition to take on the leadership for suicide prevention.

Objective 1.3: **By 2008, the state and local/regional lead agencies will have identified and received sustainable and reliable funding for basic, ongoing suicide prevention functions.**

Recommended Action

- DMHMRSAS should seek designation of state and federal funds for basic staff functions in suicide prevention.
- The state and local/regional lead agencies should seek new and varied sources of funding such as government and foundation grants, and corporate support.

Objective 1.4: **By 2008, state and local leaders will be aware and supportive of suicide prevention efforts.**

Recommended Action

- State and local agencies and their partners should educate state, regional and local leaders on the problem of suicide and its prevention.

Goal 2: Improve and expand surveillance systems.

Objective 2.1: **By 2007, DMHMRSAS, in collaboration with the Steering Committee, will identify and begin systematically collecting, analyzing and disseminating data measures and reports that will constitute the Virginia Suicide Prevention Surveillance System**.

Recommended Action

- DMHMRSAS, in collaboration with the Steering Committee, should develop a surveillance plan for suicide prevention, to include the measures, frequency of collection and analysis, resource needs, and data sources. Such measures and data sources may include:
  - ♦ Time trends and geographical and population-specific patterns of suicides.
  - ♦ Awareness of the problem of suicide, its symptoms, and prevention strategies through population-wide surveys.
  - ♦ Attitudes about mental health and substance abuse conditions and care-seeking.
  - ♦ Suicidal behaviors, ideation and related attitudes, risk and protective factors, knowledge and behaviors through adult and youth risk behavior surveys
  - ♦ Assessment of the service system and usage through surveys of providers, such as hospitals, crisis lines, community service boards, and police.
  - ♦ Cost of suicides and suicide attempts and years of productive life lost.
- DMHMRSAS, in collaboration with Steering Committee member agencies, should regularly disseminate accurate local suicide data that is aggregated geographically or by time period to provide stable rates.
- DMHMRSAS, in collaboration with agencies represented by the Steering Committee, should produce and disseminate a comprehensive report every three years on suicide and suicide attempts, integrating data from multiple data systems.

Objective 2.2: **By 2008, increase the number of localities regularly conducting suicide follow-back studies or death reviews.**

Recommended Action

- DMHMRSAS should identify those localities or population groups that could most benefit from such studies.
- Consider modifying the *Code of Virginia* to establish a mechanism for local/regional suicide review/follow-back study, with appropriate representative membership.
- The Office of the Chief Medical Examiner should provide technical support to localities wishing to conduct suicide follow-up studies.

Notes

Follow-back studies consist of the collection of detailed information about the victim, his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents. They can be used to increase understanding of the causes of suicide and to refine prevention strategies. Virginia currently allows for Family Violence Fatality Review Teams to review deaths that occur as a result of abuse between family members or intimate partners.

Objective 2.3: **By 2007, DMHMRSAS and the Virginia Department of Health will promote and support national efforts to improve and standardize data collection methods.**

Examples of such methods include:

- Increasing the proportion of hospitals using standard external cause of injury coding for suicidal behaviors.
- Using standardized protocols for death scene investigations.

Goal 3: Promote and support research, including evaluation, on suicide and suicide prevention.

Objective 3.1: **By 2008, increase applied research in Virginia that will allow for better targeting of scarce resources.**

Recommended Action

- DMHMRSAS should identify researchers in Virginia universities with an interest in suicidology and promote the conduct of applied research, including evaluation, on initiatives and populations in Virginia.
- Member agencies of local coalitions should conduct comprehensive needs assessments in localities with high suicide rates to identify specific local problems and gaps in services. Needs assessments can include:
  - Comprehensive, confidential case studies of suicides and suicidal attempts in the localities, including assessment of systems barriers.
  - Assessment of local agency policies and procedures; availability of and access to services; and social and economic factors.

Awareness

Goal 4: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.

Objective 4.1: **By 2010, increase the percentage of the population who recognize the importance of disclosing mental health symptoms to family, friends, or health care professionals and obtaining care for these problems.**

Recommended Action

- DMHMRSAS, in collaboration with member organizations of the Steering Committee, should launch a public education campaign to improve awareness of mental health and substance abuse issues and the importance of disclosing symptoms and obtaining care with the aim of reducing stigma, myths, and denial of mental health conditions and substance abuse.

Goal 5: Promote awareness that suicide is a public health problem that is preventable.

Objective 5.1: **By 2010, a greater proportion of the population in Virginia will receive public information on the problem of suicide, i.e., that it is preventable, common signs and symptoms, and what the public can do.**

Recommended Action

- DMHMRSAS should:
  - Create an identifiable symbol for use in all public outreach, education, training, and programs.
  - Launch a public education campaign to educate the public about the problem of suicide, its cost, warning signs, causes, available resources, and what the public can do.
  - Expand, strengthen, and publicize the Virginia Suicide Prevention Website (www.preventsuicideva.org) to cover the lifespan.
  - Improve design and distribution of suicide prevention pamphlets.
  - Local coalitions should hold special outreach and community events, speakers and training to local religious, civic, leaders and organization representatives.

Notes

Specific methods of a public awareness campaign can include identifying a well-known personality to champion the cause of mental health, substance abuse, and suicide prevention; billboards; public service announcements; local television infomercials; and posters. Distribution sites include schools, faith organizations, senior centers, hospital emergency departments and clinics, physicians' offices, civic and community organizations, employers, unemployment agencies; bars; and barbers/hair salons. A community assistance section of the website would include funding information; slideshows and handouts for community events; speakers' bureau, trainers, downloadable brochures and other resources; and local resources, comprehensive referral lists, speakers, statistics, and links.

Intervention

Goal 6: Develop and implement community-based suicide prevention programs.

Objective 6.1: **By 2010, reduce the suicide rate in those planning districts with high male suicide rates.** (*Baseline: 36.8/100,000 (66 male suicides) for Lenowisco (Planning District 1), 38.2/100,000 (88 male suicides) for Cumberland Plateau (Planning District 2), and 33.6 (160 male suicides) for West Piedmont (Planning District 12) in 1999-2002; Target: 17.8/100,000).*

Recommended Action

- DMHMRSAS should provide education for regional/local coalition members and other leaders on the problem of suicide and its prevention.
- DMHMRSAS should, in collaboration with a local university, request technical assistance from the Centers for Disease Control and Prevention to:
  - Assess and define the problem of suicide in these areas.
  - Develop an intensive, comprehensive strategy for these areas with a strong evaluation component that is patterned after effective strategies in other rural areas (e.g. programs for rural American Indian communities that promoted social and economic improvements, leadership involvement, traditional culture enhancement programs, and increasing mental health services).
  - Seek financing for such an intervention from a major funding organization.

Objective 6.2: **By 2010, effective programs that address risks and protective factors of population groups at high-risk for suicide will be established.**
Recommended Action
DMHMRSAS should work with state-level representatives/leaders to design or promote programs with demonstrated effectiveness in reducing suicide, suicidal behaviors or associated risk factors. These programs should have strong evaluation components.
Examples:

- *Childhood Trauma:* Promote effective home-visiting programs to prevent trauma and suicide risk.
- *Employers:* Promote the application of comprehensive suicide prevention programs such as the Air Force Suicide Prevention Program.
- *Youth:* Develop effective programs such as those summarized under Effective Strategies.
- *Elderly*: Program could include strategies, in collaboration with Area Agencies on Aging, to raise awareness of this problem and promote connectedness and reduce isolation, particularly among men after a traumatic loss such as death of a loved one. This could be done in conjunction with a replication of the PROSPECT program, as described under Effective Strategies.
- *Colleges/Universities/Technical Centers:* This is the time of onset of many psychiatric disorders and young people typically have lost parental health insurance coverage so this group would seem to be particularly vulnerable to undiagnosed mental health conditions.
- *Health Professionals:* A suggestion would be to provide burnout prevention services to and encourage help-seeking behavior by dentists, physicians, and other at-risk clinical providers.
- *Detainees*: Develop integrated programs, aimed at detainees, particularly within twenty-four hours of arrest, with a strong evaluation component.

Objective 6.3: **By 2010, increase the proportion of family, youth, elderly, and other community service organizations with integrated suicide prevention components as part of their programs.**
Recommended Action

- DMHMRSAS and Steering Committee members should meet with state representatives/leaders of family, youth, elderly, and other community service organizations to educate them on the problem of suicide, and provide materials for and promote the integration of suicide prevention components into their programs.

Goal 7: Promote efforts to reduce access to lethal means and methods of self-harm.

Objective 7.1: **By 2010, reduce the rate of self-inflicted firearm deaths.** (*Baseline: 6.7/100,000 in 2002; Target: 4.1/100,000).*
Recommended Action
DMHMRSAS and State Police should:

- Identify geographical areas and other population groups with high rates of firearm deaths implicated in suicides and homicides.

- In areas with high firearm death rates, educate the public about local firearm fatality statistics and the safe storage and handling of firearms.
- Train health professionals and other gatekeepers about firearm fatality statistics and the safe storage and handling of firearms.
- Train health professionals and other providers about the importance of discussing the safe storage and handling of firearms and other lethal means with family members or close contacts of individuals who are in crisis or have mental disorders, substance abuse problems, or suicidal thoughts.

Notes

The American Academy of Pediatrics states that "during routine evaluations, pediatricians need to ask whether firearms are kept in the home and discuss with parents the risks of firearms as specifically related to adolescent suicide. Specifically for adolescents at risk of suicide, parents should be advised to remove guns and ammunition from the house.[hh]"

Goal 8: Implement training for recognition of at-risk behavior and delivery of effective treatment.

Objective 8.1: **By 2008, increase the number of trained gatekeepers.**

Recommended Action

- Members of the Steering Committee should meet with leaders of statewide professional organizations,[i] state agency/organization personnel,[ii] and regional organizations[iii] representing gatekeepers for populations at high risk for suicide, to:
    - ♦ Explain the problem of suicide, areas and populations at high risk, risk and protective factors, and what can be done to prevent them.
    - ♦ Promote the availability of suicide prevention training (such as currently offered QPR and ASIST training) or identify other suitable training.
    - ♦ Explore the possibility of obtaining continuing education credits for such training or requiring such training for recertification, and
    - ♦ Explore the possibility of co-sponsorship of and charges for training.
- Meet with regional/local coalition leaders to provide the tools for and request their promotion of suicide prevention training to local leaders, including business, educational, religious, media, human services, foundation, and civic leaders.

Objective 8.2**: By 2010, increase the proportion of counties in which education programs are available to family members and others in close relationships with those at risk for suicide.**

[i] Including professional organizations for physicians, dentists, providers of nursing care, physician assistants, emergency personnel, psychologists, social services personnel, clinical social workers, counselors, clergy, educational faculty and staff, adult and juvenile correctional workers, divorce and family law and criminal defense attorneys, bartenders, hairdressers and barbers.

[ii] Including mental health, Comprehensive Services Act, health department, social services, unemployment services, senior centers, and corrections personnel.

[iii] Including Area Agencies on Aging and Area Health Education Centers.

Recommended Action
The Department of Mental Health, Mental Retardation and Substance Abuse Services should work to:

- Assess the availability of family education programs, in collaboration with the Virginia chapter of the National Alliance for the Mentally Ill and the Community Services Boards.
- Promote establishment and utilization of family education programs through the regional/local coalitions, community service boards, local foundations, civic groups, and major employers.

Goal 9: Develop and promote effective clinical and professional practices.

Objective 9.1: **By 2009, increase the proportion of primary care practices that have systems to assure accurate diagnosis, effective treatment, and follow-up for depression, substance misuse, and other mental health conditions.**
Recommended Action
DMHMRSAS should work with Virginia primary care provider associations (medical, osteopathy, nurse and other allied health professionals) and graduate schools, as appropriate, to:

- Promote the screening or assessment, with effective tools, for depression, substance abuse, and other mental health conditions as recommended by the U.S. Preventive Services Task Force (USPSTF) and the American Academy of Pediatrics (AAP).
- Promote the establishment of linkages and practices to assure proper follow-up of patients following screening for depression and substance abuse.
- Incorporate depression, substance abuse, and other mental health assessment, prevention and referral as part of graduate training**.**

Notes
The National Strategy has several objectives to increase the screening for depression, substance abuse, and suicide risk by primary care providers. However, the USPSTF issued a report (May 2004) that states the evidence is insufficient to recommend screening office patients for risk of committing suicide[ii]. The USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup.[jj] The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. Such screening practices are not recommended for adolescents.[kk] As for drug abuse, the USPSTF takes a neutral stance on routine screening but does state that clinicians should be on the alert for signs and symptoms of drug abuse and ask about their use within the context of a trusting, nonjudgemental and confidential relationship.[ll] The AAP recommends that: 1) Pediatricians screen adolescents for a history of sexual assault and potential sequelae[mm]; 2) Pediatricians ask questions about depression, suicidal thoughts, and other risk factors associated with suicide in routine history-taking thoughout adolescence[nn]; 3) Pediatricians discuss the hazards of alcohol and other drug use with their patients as a routine part of risk behavior assessment[oo].

Objective 9.2: **By 2009, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to effectively assess suicide risk, intervene to reduce suicidal behaviors among their patients, and provide follow-up to prevent further suicidal behaviors.**

Recommended Action

The Licensing Office of the Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Assure that licensing regulations require written policies and procedures to effectively assess suicide risk, intervene to reduce suicidal behaviors among their patients, and provide follow-up to prevent further suicidal behaviors.
- Assess the proportion of such specialty centers that have these policies and procedures.

Objective 9.3: **By 2009, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.**

Recommended Action

The Department of Mental Health, Mental Retardation and Substance Abuse Services should work with local/regional coalitions, especially those in areas with high suicide rates, to:

- Assess the barriers patients and providers face in assuring completion or regular maintenance of treatment.
- Reduce these barriers through increased funding, training, or policy changes.

Objective 9.4: **By 2009, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.**

Recommended Action

The Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Promote the application of effective follow-up policies and practices among hospital emergency departments, particularly in areas with high suicide rates.

Objective 9.5: **By 2009, increase the percentage of institutional settings that apply guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior.**

Recommended Action

The Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Meet with leaders of institutional settings to promote application of guidelines, once national guidelines have been developed.
- Monitor the application of such guidelines.

Goal 10: Increase access to and community linkages with mental health and substance abuse services.

Objective 10.1: **By 2010, increase the proportion of the population with expanded benefits for mental health and substance abuse services.**
Recommended Action
The Department of Mental Health, Mental Retardation and Substance Abuse Services should:

- Work with insurance companies and the legislature to expand benefits for services to improve mental health.
- Work with the Department of Medical Assistance Services to explore the expansion of Medicaid eligibility for mental health services.

Objective 10.2: **By 2010, expand and improve local mental health services, especially in areas with high suicide rates.**
Recommended Action
The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to expand and improve local mental health services, in accordance with the Comprehensive State Plan, 2004 – 2010[pp] and in response to the President's New Freedom Commission on Mental Health[qq], with special emphasis on areas with high suicide rates.

Objective 10.3: **By 2010, improve integration and coordination among organizations/agencies including physical health, mental health, and spiritual health.**
Recommended Action
DMHMRSAS and Steering Committee should:

- Conduct a study to identify policies at the state level that prevent integration and coordination of services at the local level and recommend changes or develop new policies to promote such integration and coordination. Such policy analyses and changes should be promoted by local coalitions as well.
- Promote integration of suicide prevention activities into existing programs targeting populations at high risk for suicide. Examples include:
  - Incorporate mental health and suicide risk assessment and referral into health and/or social services outreach and home-visiting programs for high-risk populations.
  - Incorporate screening for depression into substance abuse prevention and treatment programs.

Local/regional coalitions should:

- Convene community leaders to identify and implement collaborative opportunities for more effective service.

Goal 11: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.

Objective 11.1**: By 2008, identify the extent to which there is inappropriate portrayal of or reporting on suicides, suicidal attempts, and mental illness and inform the media of the problem.**

Recommended Action

DMHMRSAS should:

- Examine the News Clipping Service results for indications of the extent of inappropriate reporting on or portrayal of suicides, suicidal attempts, and mental illness.
- In collaboration with local/regional coalitions, meet with representatives of the radio, TV, news media and journalism schools, in each of the major media markets, to inform them on suicide risk in their geographical area, risk factors, solutions, and discuss the use of the American Foundation for Suicide Prevention's guidelines: Reporting on Suicide: Recommendations for the Media[i].

Notes

While the Reporting on Suicide: Recommendations for the Media focuses on news reporting, there are apparently no similar consensus recommendations formulated for the entertainment media.

[i] Developed in collaboration with the Office of the Surgeon General, the Centers for Disease Control and Prevention, the National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, the World Health Organization, the National Swedish Centre for Suicide Research, and the New Zealand Youth Suicide Prevention Strategy.

Financial and Staffing Resources Envisioned for Plan Implementation

In an attempt to quantify the additional resources that would be necessary for implementation of the Suicide Prevention across the Life Span Plan for the Commonwealth, input was solicited from the members of the Interagency Committee. Committee members were asked to review the plan and estimate the amount of resources their agency would need to address the objectives that were relative to their agencies' work. Below are the responses received from Virginia Department of Health's Center for Injury and Violence Prevention and Office of the Chief Medical Examiner, Virginia Department for the Aging and Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. In total, the preliminary estimate of the additional resources needed to implement the objectives listed in the Suicide Prevention across the Life Span Plan for the Commonwealth is $307,470 in fiscal year 2006 and $4,814,633 in fiscal year 2007.

Department of Mental Health, Mental Retardation and Substance Abuse Services

In a letter from the Commissioner of DMHMRSAS (Appendix I), Dr. Reinhard states:

> the Department of MH, MR and SA Services has no staff or other resources devoted to suicide prevention across the lifespan, and would need significant new funding to implement the *Suicide Prevention Across the Life Span Plan for the Commonwealth*. Funding is needed to support suicide prevention staff, research and data collection infrastructure, direct services by community services boards, public awareness initiatives, training, and support for coalition-building with local and regional entities.

Below are the costs associated with implementation of the plan as estimated by DMHMRSAS. A full cost breakdown through FY2010 is included as Appendix J.

	FY2006		FY2007	
	FTEs		FTEs	
Suicide Prevention Manager (Pay Band 6)	1.0	$94,500	1.0	$97,335
Suicide Prevention Specialist (Pay Band 5)	- -	- -	5.0	$405,000
Research Coordinator (Pay Band 5)	- -	- -	1.0	$81,000
Admin / Office Specialist III (Pay Band 3)	- -	- -	0.5	$54,000
Equipment	- -	$3,000	- -	$21,500
Travel	- -	$2,500	- -	$18,750
Office / Supplies	- -	$1,500	- -	$11,250
Research Infrastructure	- -	- -	- -	$30,000
Contractual Services - Public Awareness	- -	- -	- -	$82,500
Contractual Services - Training	- -	- -	- -	$85,000
Contractual – Community Leadership	- -	$40,000	- -	$80,000
CSB Direct Services - $50,000 per CSB	- -	- -	- -	$2,000,000
Yearly total	**1.0**	**$141,500**	**7.5**	**$2,966,335**

Department of Health Center for Injury and Violence Prevention

The Center for Injury and Violence Prevention currently addresses the issue of youth suicide prevention through statewide coordination of prevention, surveillance, public awareness and training. This work is supported through a $300,000 grant from the Centers for Disease Control and Prevention. The bulk of the funds go towards training gatekeepers in recognizing and responding to people at-risk of suicide. During the first two years of the grant, 450 presentations and 72 two-day skills trainings have been provided to over 24,000 people through a statewide network of trainers. However, the funds will be unavailable after October 2005. Therefore, CIVP would need an additional funds to continue to offer training in accordance with the plan.

	FY2006*	FY2007
1 FTE to coordinate trainings	$50,100	$68,804
Contractual Services	$74,246	$98,995
Supplies and Materials	$38,474	$51,299
Continuous Charges	$3,150	$4,200
Total	**$165,970**	**$223,298**

* FY2006 numbers represent 75% of a fully-funded year.

Department of Health Office of the Chief Medical Examiner

While the OCME conducts suicide surveillance, it lacks personnel with suicide follow-back study expertise and the fiscal resources for this activity. Given the inextricable link between suicide, mental health and substance abuse, the OCME would need additional resources to undertake this challenging task. Below are the costs associated with implementation of the plan as estimated by OCME.

	FY2006	FY2007
3 FTEs to coordinate follow-back studies	--	$275,000
1 FTE to provide technical assistance to localities	--	$100,000
Total	--	**$375,000**

Department for the Aging

In order for each local Area Agency on Aging (AAA) to incorporate suicide prevention activities into current health promotion/disease prevention activities, additional funding is needed as estimated by the Department for the Aging.

	FY2006	FY2007
1 FTE in each of the 25 AAA	--	**$1,250,000**

References

Executive Summary

[a] All Virginia suicide data is from the Virginia Center for Health Statistics, Virginia Department of Health, Richmond, Virginia.

[b] McIntosh, J.L. (2003). *U.S.A. Suicide: 2001 Official Final Data*. Retrieved June 12, 2004, from the American Association of Suicidology web site: http://www.suicidology.org/associations/1045/files/2001datapg.pdf

[c] USPHHS, Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System: Youth Online Comprehensive Results, 1991 – 2003. Retrieved July 29, 2004, from the Centers for Disease Control and Prevention web site: http://apps.nccd.cdc.gov/yrbss/

[e] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press, p. 424.

[f] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press, p. 434.

Suicide Prevention across the Lifespan Plan

[g] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press.

[h] All Virginia suicide data is from the Virginia Center for Health Statistics, Virginia Department of Health, Richmond, Virginia

[i] McIntosh, J.L. (2003). *Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2001*. Retrieved June 12, 2004, from the American Association of Suicidology web site: http://www.suicidology.org/associations/1045/files/2001statepg.pdf

[j] U.S. DHHS, *Healthy People 2010, Volume II (2nd edition).* Retrieved April 20, 2004 from the Healthy People 2010 web site: http://www.healthypeople.gov/document/html/objectives/18-01.htm

[k] McIntosh, J.L. (2003). *U.S.A. Suicide: 2001 Official Final Data*. Retrieved June12, 2004, from the American Association of Suicidology web site: http://www.suicidology.org/associations/1045/files/2001datapg.pdf

[l] Lubell, KM et al. Methods of Suicide Among Persons Aged 10--19 Years --- United States, 1992—2001, MMWR, June 11, 2004 53(22); 471-474.

[m] Behavioral Risk Factor Surveillance System, Virginia Department of Health, 2004

[n] USPHHS, Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System: Youth Online Comprehensive Results, 1991 – 2003. July 29, 2004.

[o] AAPCC Toxic Exposure Surveillance System (TESS), 2003 data.

[p] 1997 National Survey of America's Families

[q] Goodwin, RD et al. 2003. Suicide attempts in the United States: the role of physical illness. *Social Science Medicine* 56(8): 1783 – 1788.

[r] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press, p. 424.

[s] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press, p. 434.

[t] Knox KL, et al. 2003. Risk of suicide and related adverse outcomes after exposure to a suicide prevention program in the US Air Force: cohort study. *British Medical Journal* 327:1376-1380.

[v] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press, p. 436.

[w] Turvill JL, Burroughs AK, Moore KP. 2000. Change in occurrence of paracetamol overdose in UK after introduction of blister packs. *Lancet*, 355(9220): 2048-2049.

[x] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press. p. 282

[y] Loftin et al. 1991. Effects of restrictive licensing of handguns on homicide and suicide in the District of Columbia. *New England Journal of Medicine*, 325(23): 1615-1620.

[z] Brent et al. 2000. Compliance with recommendations to remove firearms in families participating in a clinical trial for adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(10): 1220-1226.
[aa] Birckmayer, J., and Hemenway, D. (1999). Minimum-age drinking laws and youth suicide, 1970-1990. *American Journal of Public Health, 89*, 1365-1368.

[cc] Institute of Medicine. 2002. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press. p. 296-297.

[ee] American Academy of Pediatrics, Committee on Adolescence. 2001. Care of the Adolescent Sexual Assault Victim, *Pediatrics.* 107(6): 1476 – 1479.
[ff] Bruce ML, et al. 2004. Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients: A Randomized Controlled Trial. *JAMA* 291(9): 1081-91.
[gg] Center C., et al. Confronting Depression and Suicide in Physicians: A Consensus Statement. JAMA 2003 289 (23): 3161-6.
[hh] American Academy of Pediatrics, Committee on Adolescence. Suicide and Suicide Attempts in Adolescents. *Pediatrics*, 2000; 105(4): 871 – 874.
[ii] U.S. Preventive Services Task Force. *Screening for Suicide Risk: Recommendation and Rationale*. May 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm
[jj] U.S. Preventive Services Task Force. *Screening for Depression: Recommendations and Rationale*. May 2002. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/3rduspstf/depressrr.htm
[kk] U.S. Preventive Services Task Force. *Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: Recommendation Statement*. April 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/3rduspstf/alcohol/alcomisrs.htm
[ll] U.S. Preventive Services Task Force. 1996. *Guide to Clinical Preventive Services, 2nd edition*. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/cpsix.htm
[mm] American Academy of Pediatrics, Committee on Adolescence. 2001. Care of the Adolescent Sexual Assault Victim, *Pediatrics.* 107(6): 1476 – 1479
[nn] American Academy of Pediatrics, Committee on Adolescence. Suicide and Suicide Attempts in Adolescents. *Pediatrics*, 2000; 105(4): 871 – 874.
[oo] American Academy of Pediatrics, Committee on Substance Abuse. Alcohol Use and Abuse: A Pediatric Concern. *Pediatrics*, 2001; 108(1): 185 - 189.
[pp] Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. 2003. Comprehensive State Plan, 2004 – 2010. Richmond, Virginia.
[qq] New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America*. Retrieved June 18, 2004 from the Mental Health Commission web site: http://www.mentalhealthcommission.gov/reports/Finalreport/FullReport.htm

APPENDICES

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Appendix A

ENROLLED

SENATE JOINT RESOLUTION NO. 312

Requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth. Report.

Agreed to by the Senate, February 4, 2003
Agreed to by the House of Delegates, February 13, 2003

WHEREAS, suicide is the second leading cause of death for people aged 10-35 in the Commonwealth; and

WHEREAS, over the last 14 years, attention in the Commonwealth has focused on suicide prevention among the elderly and youth; and

WHEREAS, at the national level, the National Strategy for Suicide Prevention, published in 2001, has prompted a number of states to develop plans for suicide prevention across the life span, from youth to old age; and

WHEREAS, to implement more extensive youth suicide prevention activities and begin initiatives across the life span, the Virginia Department of Health applied in 2002 to the Centers for Disease Control and Prevention and was awarded $967,000 over three years to expand the Commonwealth's suicide prevention efforts; and

WHEREAS, while some suicide prevention activities in the Commonwealth are directed primarily at youth and the elderly, there is no overall suicide prevention strategy across the life span and no single agency acts as a clearinghouse or coordinator of activities related to suicide prevention; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, be requested to formulate a comprehensive Suicide Prevention Across the Life Span Plan for the Commonwealth. Agencies that shall participate in this effort include the Departments of Health; Mental Health, Mental Retardation and Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; the Department for the Aging, and any other state agency that has a specific interest, responsibility, or role in the development of the plan. The Department of Health and the Department for the Aging shall be the agencies responsible for actually developing the plan, supporting the Secretary's efforts. All affected stakeholders shall be involved in the development of this plan. The plan shall address suicide prevention across the life span with a special emphasis on effective strategies to prevent suicide among adolescent and elderly Virginians and all other identified high-risk populations. In developing the plan, previous planning efforts in Virginia and in other states, as well as the National Strategy for Suicide Prevention, shall be reviewed and applicable recommendations, goals, objectives, and strategies shall be integrated into this new comprehensive plan. The plan shall establish the Commonwealth's public policy regarding the prevention of suicide, identify the lead agency responsible for carrying out that policy, propose initiatives and interventions to effectively implement that policy, and identify the sources and amounts of resources to implement those initiatives and interventions. Finally, the plan shall propose the creation of a permanent oversight body to monitor the implementation of the plan.

The Secretary of Health and Human Resources shall submit to the Division of Legislative Automated Systems an executive summary and report of its progress in meeting the request of this resolution no later than the first day of the 2005 Regular Session of the General Assembly. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B

ITEM 305.		Item Details($) First Year FY2003	Item Details($) Second Year FY2004	Appropriations($) First Year FY2003	Appropriations($) Second Year FY2004
	Department of Health (601)				
305.	Administrative and Support Services (44900)			~~$13,981,441~~ *$13,288,802*	~~$13,985,163~~ *$10,725,674*
	General Management and Direction (44901)	~~$4,086,689~~ *$3,978,280*	~~$4,090,411~~ *$4,383,936*		
	Computer Services (44902)	~~$5,085,646~~ *$4,810,622*	~~$5,085,646~~ *$1,770,440*		
	Accounting and Budgeting Services (44903)	~~$1,730,868~~ *$1,593,819*	~~$1,730,868~~ *$1,590,119*		
	Personnel Services (44914)	~~$1,763,258~~ *$1,663,169*	~~$1,763,258~~ *$1,713,565*		
	Procurement and Distribution Services (44918)	~~$1,314,980~~ *$1,242,912*	~~$1,314,980~~ *$1,267,614*		
	Fund Sources: General	~~$12,819,526~~ *$12,161,951*	~~$12,823,248~~ *$9,563,759*		
	Special	~~$1,161,915~~ *$1,126,851*	$1,161,915		

Authority: §§ 3.1-530.1 through 3.1-530.9, 3.1-562.1 through 3.1-562.10, 32.1-11.3 through 32.1-11.4, 32.1-16 through 32.1-23, 35.1-1 through 35.1-7, and 35.1-9 through 35.1-28, Code of Virginia.

A. Out of this appropriation, $912,609 from the general fund the second year is provided toward the costs of the required relocation of the agency's central office staff to the James Madison Building. General and special fund appropriations in this item that are unexpended at the end of the first year shall be reappropriated to offset the impact of second year funding reductions in this item.

B. As part of the Department's ongoing suicide prevention efforts, the Department of Health, in cooperation with the Departments of Mental Health, Mental Retardation, and Substance Abuse Services; Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; Aging and other state agencies shall lead an effort to formulate a comprehensive suicide prevention plan. The plan shall address suicide prevention across the life span with an emphasis on adolescents, the elderly, and high-risk populations. The plan shall establish Virginia's public policy regarding the prevention of suicide, identify the lead agency responsible for carrying out that policy, propose initiatives and interventions to effectively operationalize that policy, identify the sources and amounts of resources to implement the initiative, and propose the creation of a permanent oversight body to monitor implementation. The plan should be completed by June 30, 2004, and presented to the Governor and General Assembly for their consideration and possible action during the 2005 legislative session.

List of Attendees at Suicide Prevention Conference and Focus Groups

2002 Suicide Prevention Conference

Keith Acosta
Virginia Beach Police Department

Faye Adams
Dept. of Rights of Virginians with Disabilities

Paige Akin
Richmond Times-Dispatch

Evol Alexander
Central Virginia Community Services Board

Sheree Alston
MPNN-CSB

Donald Anderson
Newport News Public Schools

Suzanne Augustine
Highlands Juvenile Detention Center

Mary Azoy
CrisisLink

Robin Bailey
Roanoke City Dept. Of Social Services.

Willnette Bailey
Va. School. For the Deaf, Blind & Multi-Disabled

Kathryn A. Baker
Valley CSB

Sheilah Benjamin
Middle Peninsula-Northern Neck

April Bennett
Valley CSB

Scott Bishop
Virginia Beach Police Department

Samiya Blakey
Plaza Middle School

Richard Boothe
Central Virginia Community Services Board

Gretchen Bousman
Roanoke City Dept. Of Social Services.

Janet Boyce
Probation & Parole - District #23

Anna L. Briley
Tidewater Child Development Clinic

John Brinkman

Charles S. Broadfield
Broadfield-Janus Assoc., Inc.

Heidi Buckner
Loudoun County Public Schools

Reese Butler
Hopeline

Linda Sierra Carey
The Choice Group

Wendy Carria
Arlington County Public Schools

Joan K. Carter
Community Services Board, District 19

Lenny Carter

Kelley Elaine Caspary
Virginia Beach Psychiatric Center

Sharon Christenenbury
Southside Community Services Board

H. Carlyle Church
Jerusalem Baptist Church

Warren Clark
Catawba Hospital

James Clemons

Jessye Cohen

Veronica Coleman
Pleasant Grove Baptist Church

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Glenda Collins
Lonesome Pine Office on Youth

Maryann L. Contreras
Life Coach Sentara Mental Health

Pamela Fitzgerald Cooper
Va. Dept. of MHMRSAS

Brandi Creasy
Central Virginia Community Services Board

Derek Creekmore
Portsmouth Police Department

Penny Crone
Middle Peninsula-Northern Neck Community Services Board

Margaret Nimmo Crowe
Virginia Alliance for Family and Children

Stephen Louise Cunningham
Virginia Beach Psychiatric Center

Derek Curran
Hampton-Newport News CSB

Neil Curtis
Waynesboro City Schools

Mary Herbert Daly
Children's Hospital of the King's Daughters

Paulette Daniel
Richmond Behavioral Health Authority

Patricia Davenport
Virginia School for the Deaf and Blind

Cecile A. Davis
Crisis Center

Doreen E. Davis
Alleghany Highlands CSB, Mental Health

Rebecca J. Davis
Virginia Rural Health Resource Center

Wanda G. Davis
Halifax County Dept. of Social Services

Sam Desai
Central Health, Rivermont School

Amanda DiGirolamo
Virginia Alliance for Family and Children

Delores Dodson
Eastern Shore Coalition Against Domestic Violence

Melinda Dooley
Central Virginia Community Services Board

Ellen R. Dotas
Valley CSB

Donzaleigh Douglas
Newport News Public Schools

Betsy Draine
DMHMRSAS

Sandy Dunahay
Pidemont Community Services Board

Jerry Earnhardt
Crisis Line of Central Virginia

Debra Echtenkamp
Loudoun County Public Schools

Barbara Eden

Jack Eden

Laurie Edmond
Arlington County Mental Health

Rachel Edmunds
Stafford County Schools

Jill H. Farrell
CSB Colonial Services Board

Jeri Fields
Prince William County Schools

Ann Fierstos
Alexandria Community Services Board

Heather Fisher
Virginia Beach Psychiatric Center

Page Moss Fletcher

Ralfella C. Folston
Emergency Services

Judith Forsythe

Fred Fox
AFSP, AAS, ECF, VaSPC

Gail Fox
James Madison University

Miriam Friedland

J. Kevan Frye
Northwestern Regional Juvenile Detention Center/ City of Winchester

Beth Gibson
Virginia School for the Deaf and Blind

Carolyn E. Glover
Newport News Public Schools

Shelia Gresham
Chesapeake Community Services Board

Jupie Hamilton
U.S. Navy Family Advocacy Program

Agustus Harper
Crossroads Community Services Board

Stacy Harper
Valley CSB

Annette Harris
Emergency Services

Vickie V. Hawkins
First Home Care

Ginger Hendricks

Karen Hicks
Valley CSB

Kim P. Hicks
Culpeper County High School

David Hillis
Norfolk Garden Baptist

Judie Hogendorf

William Hogewood

Peggy Holmes
Lynnhaven Middle School

Shirley Hopkins
Sexual Assault Victims' Advocacy Serv.

Eileen Horan
Suffolk Public Schools

Patti Horgas
Johns Hopkins University

Crystal Horning
Mennonite Mutual Aid

Margie S. Howell

Jim Iman
Va. Beach Police Dept., 1st Prec.

Brenda Jackson
Crossroads Community Services Board

Debra Jefferson
Central Virginia Community Services Board

David A. Jobes

Deborah Johnson
Arlington County Mental Health

Karen Johnson
Blue Ridge Behavioral Healthcare

Natalie Johnson
Middle Peninsula-Northern Neck Community Services Board

Randy Jones
MPNN-CSB

Tisha Jones-Diggs
Arlington County Mental Health

Ronnie Kahn
People Places of Charlottesville

Patricia Marie Kellam
Shore Memorial Hospital

Suzanne K. Keller
Virginia Department of Health

Fred Kelly
Community Services Board, District 19

Kathy Kiser
Prince George Public Schools

Arlene Krohmal
CrisisLink

Mary Douglas Krout
Healing After Suicide - Compassionate Friends

Rose Marie Larsen
Virginia Beach Schools

Jennifer Lasam
Valley CSB

Lori Lattarulo
Va. Dept. of MHMRSAS

David Lawless
Prince William Group Home For Girls

Sarah Lawman
Virginia Beach Schools/Kempsville High

Kjersh Lee
City of Virginia Beach MHMRSA

Frank J. Leonardi
U.S. Navy Family Advocacy Program

Lynda Leslie
Commonwealth Catholic Charities

Christy Letsom
The Planning Council

Patrick Lipsky
The Planning Council

David Litts

Mark Long
Navy Environmental Health Center

Theresa Long
Pleasant Grove Baptist Church

William Longstreet

Keri M. Lubell
CDC

Barbara Lucas
Lynnhaven Middle School

Maria Luna-Wolfe
New Life Metropolitan Community Church

Marty Luna-Wolfe
New Life Metropolitan Community Church

Michelle Lynch
Valley CSB

Nicole Lynch
Virginia Commonwealth University

Karen Marshall
Hopeline

Majoria Martin
Senior Connections Capital Area Agency on Aging

Kathy Maurer
Ocean Lakes High School

Barbara McCall
Dept. of Mental Health

Janet McCoy
Emergency Operation Center

Jamie Fiore McFarland

Staria Mitchell
Lynchburg City Schools

Adriene Montgomery

Susan Moon
Central Virginia Community Services Board

Regina Morales
Arlington County Child and Family Services (Mental Health & SA Services)

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

John Morgan
Chesterfield Community Services Board

Andrea Morris

James Moseley
Pleasant Grove Baptist Church

Van Mullis
Virginia Beach Probation Office

Vance Mullis
Hampton Adult Probation

Mary Murray
Virginia School for the Deaf & Blind

Patricia Neiger
MPNN-CSB

Tom Neiger
MPNN-CSB

Bob Paul Newman
Virginia Beach Psychiatric Center

Sabina O. Newton
Middle Peninsula-Northern Neck Community Services Board

Cathie Niemann
Virginia Beach City Schools

Rebecca K. Odor
Virginia Department of Health

Christine O'Malley
Sexual Assault Victims' Advocacy Serv.

Erin Overby

Cindy Pannullo
St. Nicholas Catholic Church

Kathryn Perrin
Prince William Youth Suicide Prevention Coalition

Desaline Perry
Hamptom Roads Regional Jail

Dorothy Peterson
Carroll County Schools

Marie Pierce
Pleasant Grove Baptist Church

Jody Poggendorf
Richmond Behavioral Health Authority

Kate Stokely Powell
CONTACT Crisis Line of Danville Pittsylvania Co.

Tony Powell
Central Virginia Community Services Board

Anne Priode
UVA Medical Center - Psychiatry

Paul Quinnett
QPR Institute

Shani C. Reams
Va. Aligned Against Sexual Assault VAASA

Jerry Reed

Wava Reigel
The Crisis Line

James S. Reinhard
DMHMRSAS

Blair Rhodes
Central Virginia Community Services Board

Susan Rieves-Austin
Blue Ridge Behavioral Healthcare

Heidi Rist
Valley CSB

Jenny Roberts
Roanoke City Dept. Of Social Servs.

Megan Robinson
Christopher Newport University

Sharon Robinson
Schiffert Health Center Virginia Tech

Calvin Rogers
Pleasant Grove Baptist Church

Mozell Rogers
Pleasant Grove Baptist Church

Appendix C
List of Attendees at Suicide Prevention Conference and Focus Groups

Candace Saban
New River Valley Community Services (NRVCS)

Stephanie Samuels

Rick R. Sanders
Community Corrections Hampton Probation and Parole

Delores Sartor
Eastern Shore Coalition Against Domestic Violence

Agatha Savage
Maryview Behavioral Medicine

Nancy Scagel
Schiffert Health Center Virginia Tech

Christian Schweiger
Concern Hotline

William Darryl Scott, Sr.
Pleasant Grove Baptist Church

Melba Scudder
Virginia Beach City Public Schools

Linda B. Sibley
Middle Peninsula-Northern Neck Community Services Board

Alice Sink
Middle Peninsula-Northern Neck Community Services Board

Robert Sipe
Middle Peninsula-Northern Neck Community Services Board

Rebecca H. Sitnik
Valley CSB

Robert Sizemore
Alexandria Community Services Board

Cecily Slasor
Virginia Department for the Aging

Lois D. Smith
F. W. Cox High School

Sandra Smith
Va. Dept. of Corrections

Sharon Smith
SMHM

Susan D. Smith
Middle Peninsula-Northern Neck Community Services Board

L. L. Spivey

Cathi Stallings
Arlington County Department of Human Services

Karen Stark
Middle Peninsula-Northern Neck Community Services Board

Dona Sterling-Perdue
Hampton-Newport News CSB

Bob Storer

Marie Strang
The Crisis Line

Bill Sullivan
Virginia Chapter of American Academy of Pediatricians

Christine G. Sutherland

Michael Taylor
Rural Virginia United Coalition (MPNNCSB)

Angela L. Tegeler
Planning Council

Beth Tolley
DMHMRSAS

Sara Townsend
RAFT Crisis Hotline

Domenica Vest
Roanoke City Dept. Of Social Services.

Jim Vetter
Virginia Department of Health

Robert Vogl
Messiah Lutheran Church

H. L. Wade
Staunton City Schools

Dennis Waite

Kathleen Wakefield
I Need A Lighthouse, Inc.

Kathleen Walker
Green Run High School

Amanda Ware
Valley CSB

Gloria J. Warren
Community Corrections Hampton Probation and Parole

Tisha Washington
Richmond Behavioral Health Authority

Bob Watson

Wendy Webb
Roanoke City Dept. Of Social Services.

Jonathan M. Wells
Central Virginia Community Services Board

Dan West
Central Virginia Community Services Board

Christine Westendorf

Henry Westray

Elsie Weyrauch
SPAN USA

Jerry Weyrauch
SPAN USA

Jane Wiggins
Rockingham County Public Schools

Gina Wilburn
Blue Ridge Behavioral Healthcare

Denise Willey
The Crisis Line

Brennetta Williams
Pleasant Grove Baptist Church

Lorraine Williams
CSB

Sara Jo Williams
Center For School Community Collaboration

Lisa Carter Williams
U.S. Navy Family Advocacy Program

Linda Williamson
Hampton-Newport News CSB

Joyce Willis
Southside Community Services Board

Carolsue Wyland
Contact Peninsula

Andy Young
Cape Henry Collegiate School

Paula Zo
Beech Acres

2003 Abingdon Focus Group

Patty Arthur
Bristol Police Department

Nadalyn Baker
Bristol Crisis Center

Cari Braddock
Wise County Schools

Lee Brannon
Washington County Schools

Curtis Burkett
Washington County Schools

Tom Casteel
Washington County Department of Social Services

Bob Craig
Bristol Crisis Center

Tammy Francisco
Washington County Department of Social Services

Laurene Hogans
Bristol Crisis Center

Ramonda Jackson
Scott County Sheriff's Office

Melinda Keesy
Bristol Regional Counseling Center

Susan Murray
Bristol Family Resource Center

Brian Mutter
Bristol Police Department

Israel O'Quinn
Attorney General's Office

Jim Quesenberry
Bristol Crisis Center

Karen Riner
Bristol City Schools

Becky Sensky
Bristol Youth Services

Allen Slagle
Bristol Sheriff's Office

Denise Smith
Johnston Memorial Hospital

James Sproles
Bristol Crisis Center

Kim Sturgill
Smyth County Schools

Vicky Welsh
Wise County Schools

2003 Arlington Focus Group

Mary Azoy
CrisisLink

Ellie Barnes
Fairfax County Public Schools

Wendy Carria
Arlington County Public Schools

David Clayton
Child & Family Counseling Group

Teresa Fein
Arlington County Police

Grover Foehlinger
Fairfax County Public Schools

Fran Gatlin
Fairfax County Public Schools

James Gillespie
Fairfax Partnership for Youth

Jane Ashley Heavey
Center for Well Being

Jennifer Heffron
Fairfax Partnership for Youth

Linda Hutchinson
Yorktown High School

Jim Kelly
Fairfax County Emergency Services

Arlene Krohmal
United Way of National Capital Area

Kathy Persson
Northern Virginia Hospice

Karen Scudder
Fairfax/Falls Church Community Services Board

Jan Siegel
Arlington County Public Schools

Christian Storn-VanLeeuwen
City of Alexandria Public Schools

Rachel Thompson
Madison Senior Center

Dan Zeeman
Fairfax/Falls Church Community Services Board

2003 College Focus Group

Michelle Alexander
College of William and Mary

Jim Grigsby
Germanna Community College

Kendrick Kelly
Virginia State University

Marjorie Kinnaman
Northern Virginia Community College

Pat Lient
Northern Virginia Community College

Barbara Wagar
Mary Washington College

Inaa Woodward
College of William and Mary

2003 Lynchburg Focus Group

Van Avery
Pittsylvania Mental Health Association

Darlene Callands-Younger
Pittsylvania County Jail

Larry Dockery
Pittsylvania County Sheriff's Office

Jerry Earnhardt
Crisis Line of Central Virginia

David Edmonston
Child & Family Community Service Board

Carol England
Lynchburg College

Lenore Holbrook
Alliance

Eileen Houston
Danville/Pittsylvania Community Services Board

Sylvia Lantz
Central Health EMH

Vicki Sandifer
MHA of Central Virginia

Kate Stokely Powell
Contact Danville

Ellen Trappey
Crisis Line of Central Virginia

Vic Vann
Council of Community Services

Elizabeth Webb
MHA of Central Virginia

Faye Whaley
Central Health EMH

2003 Norfolk Focus Group

Kim Birdwell
YWCA Response Sexual Assault Support Services

Julie Dixon
The Planning Council

Maravia Ebony
Norfolk Police Chief's Office

Barbara Gockel
Western Tidewater Community Services Board

George Harden
The Planning Council

Christy Letsom
The Planning Council

George McCormic
City of Virginia Beach Police Department

Sabina Neuten
Middle Peninsula Community Services Board

Margo Perry
Norfolk Public Schools

Jaqueline Schaete
Norfolk Community Services Board

Rosemary Thompson
Chesapeake

Kathy Wakefield
I Need a Lighthouse

Linda Williamson
Hampton-Newport News Community Services Board

2003 Prince William Focus Group

Det. Beth Benham
Fairfax County Police

Linda Bergold
Prince William County Schools

Lt. Meg Carroll
Manassas City Police

Evalee Cluca
Survivor Group Facilitator

Phyllis Fullove-Reid
Emergency 911

Vicki Graham
Helpline

Julie Granahan
Domestic Violence Children's Program

Dan Harris
Prince William County Police

Beth Lewis
Domestic Violence Program

Virginia Youth Suicide Prevention Plan Summary of Recommendations

(Report of the Virginia Commission on Youth, House Document No. 29, 2001)

Leadership

1 – VDH Lead Entity for Youth Suicide Prevention in Virginia

Amend the Code of Virginia to designate the Virginia Department of Health (VDH) as the lead entity for youth suicide prevention in Virginia and require reporting to the Governor and the General Assembly on the status of suicide prevention initiatives.

Universal Prevention Strategies

2 – Statewide Public Awareness

Increase funding for VDH and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout the Commonwealth.

3 – Media Education

VDH should train media professionals throughout the Commonwealth to ensure responsible reporting of suicide in order to reduce the risk of subsequent suicides.

4 – School-based Strategies

The Department of Education (DOE) should revise the *Suicide Prevention Guidelines* to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact is made.

Selective Prevention Strategies

5 – Gatekeeper Training

VDH and DMHMRSAS should develop and deliver Gatekeeper Training to designated audiences throughout the Commonwealth.

6 – Licensing/Certification Requirement

The Board of Health Professions and all state agencies responsible for licensing or certification of youth-serving personnel should require suicide prevention education as a requirement for licensure or certification.

7 – Comprehensive Mental Health Services

DMHMRSAS should continue to develop and implement the plan to provide comprehensive mental health services for children, adolescents and their families.

8 – Community-based Crisis Intervention and Support Services

DMHMRSAS and VDH should increase the capacity of local communities to provide community-based crisis intervention and support services for children, adolescents and their families.

Indicated Strategies

9 – Comprehensive Mental Health Services for At-Risk Children and Youth

DMHMRSAS should continue to expand the availability of comprehensive mental health services for children and youth at-risk for suicide, particularly helping localities to offer skill-building and support groups, school-linked mental health services and family support/survivor services.

10 – Education for Clinicians/Other Working with At-Risk Youth and Their Families

DMHMRSAS and VDH, in cooperation with university medical centers, health sciences centers and professional organizations, should develop, implement and evaluate curriculum and training plans to increase the knowledge and skills of clinicians and others who work with youth at-risk for suicide and their families.

Surveillance and Evaluation Strategies

11 – Adolescent Suicide Attempt Data Collection System

VDH should design and implement an adolescent suicide attempt data collection system to determine the magnitude of the problem, as well as the following characteristics of youth who attempt suicide: demographics, service access and behavioral characteristics.

12 – External Cause of Injury Reporting

VDH should improve the system for reporting external cause of injury (e-codes) by providing training to designated reporters and by requiring e-code reporting for emergency room admission in selected sites around the Commonwealth.

13 – Comprehensive Evaluation

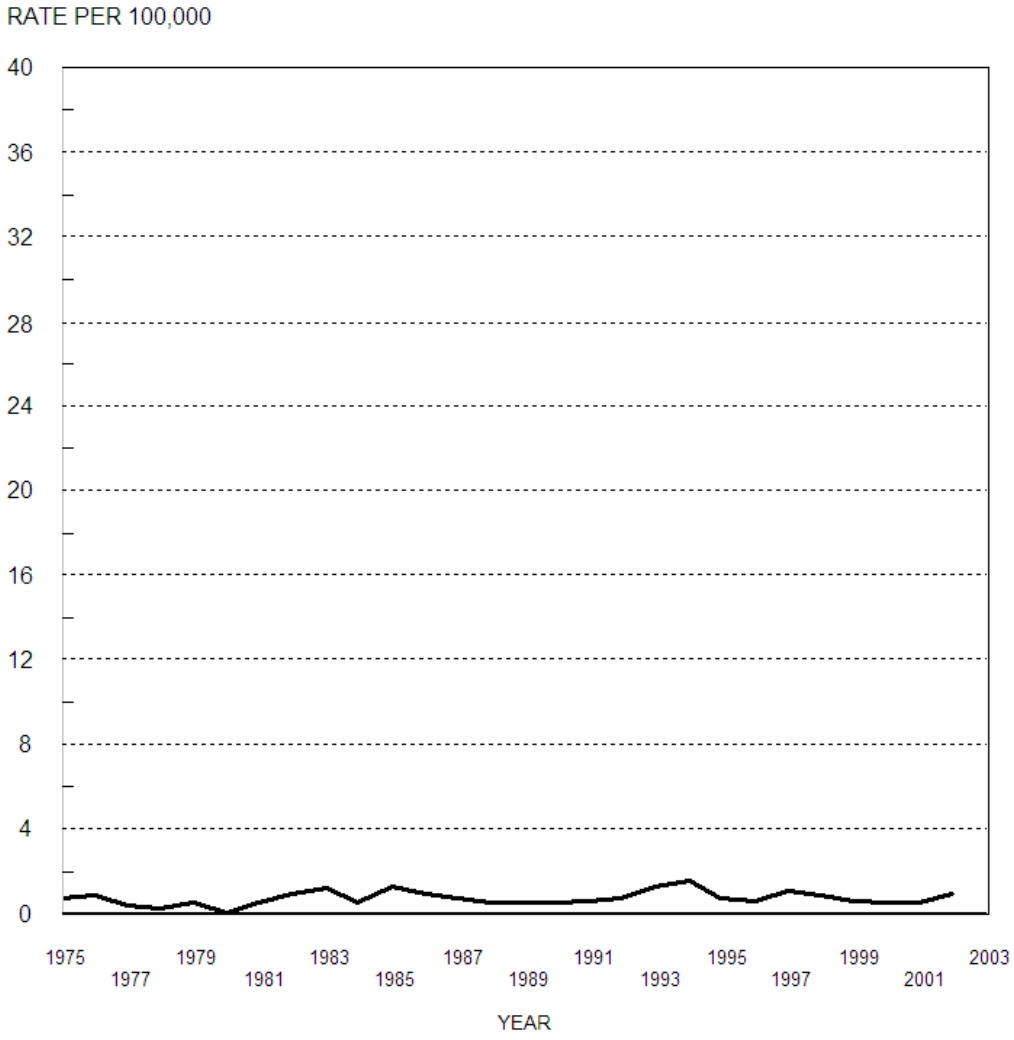
VDH should coordinate comprehensive evaluation of all aspects of suicide prevention program.

Funding

14 – Appropriating Funds

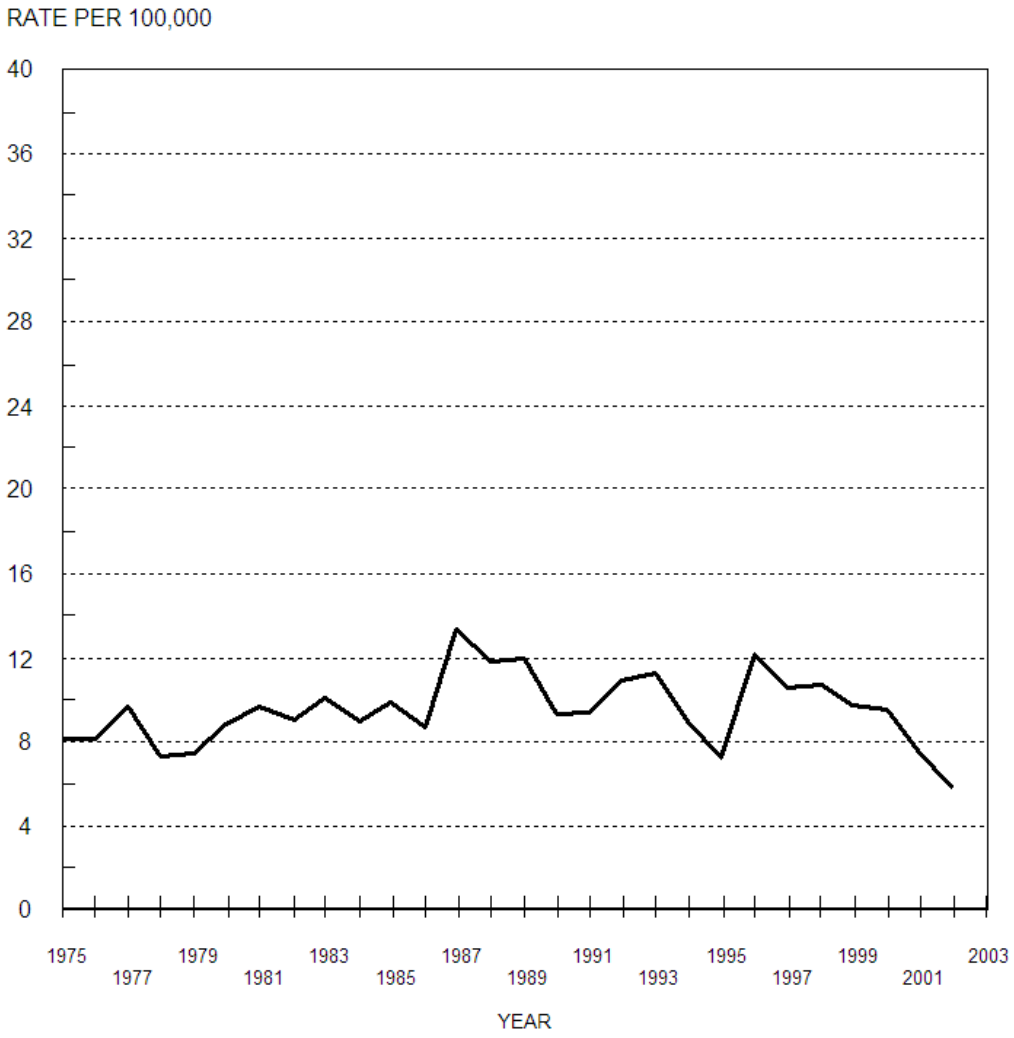
The General Assembly should appropriate funds to the Department of Health, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Education to implement the youth suicide prevention initiatives described in this plan.

CHART 1
RESIDENT SUICIDE RATES, AGES 5-14
VIRGINIA, 1975-2002



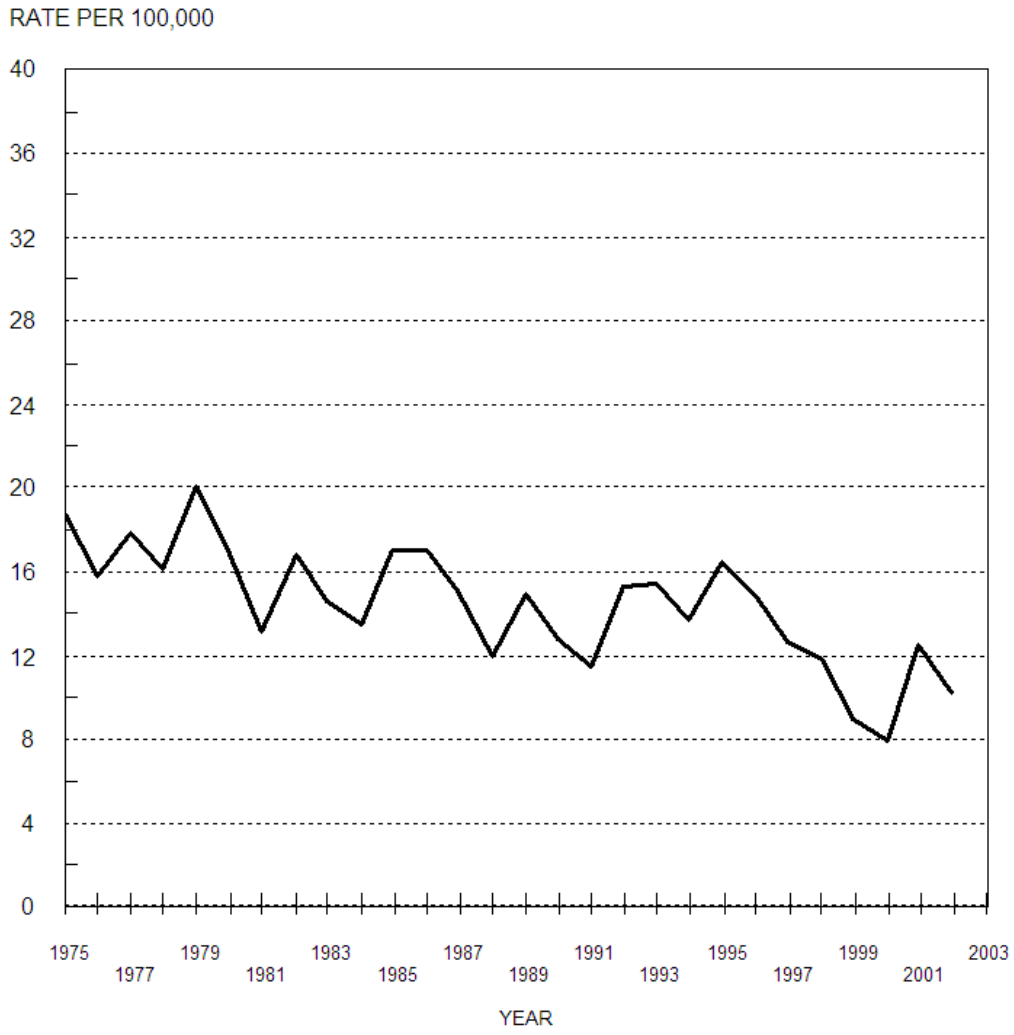
SOURCE: Virginia Center For Health Statistics

CHART 2
RESIDENT SUICIDE RATES, AGES 15-19
VIRGINIA, 1975-2002



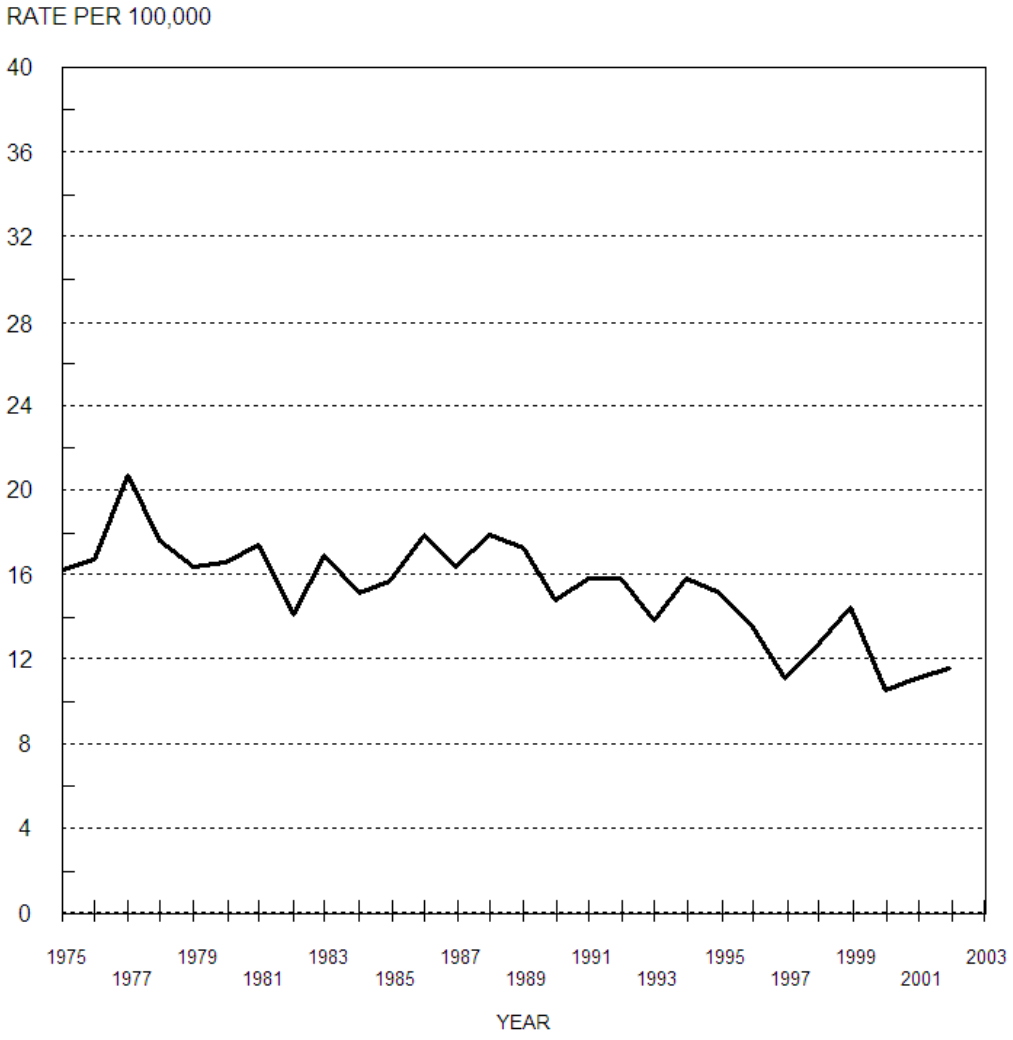
SOURCE: Virginia Center For Health Statistics

CHART 3
RESIDENT SUICIDE RATES, AGES 20-24
VIRGINIA, 1975-2002



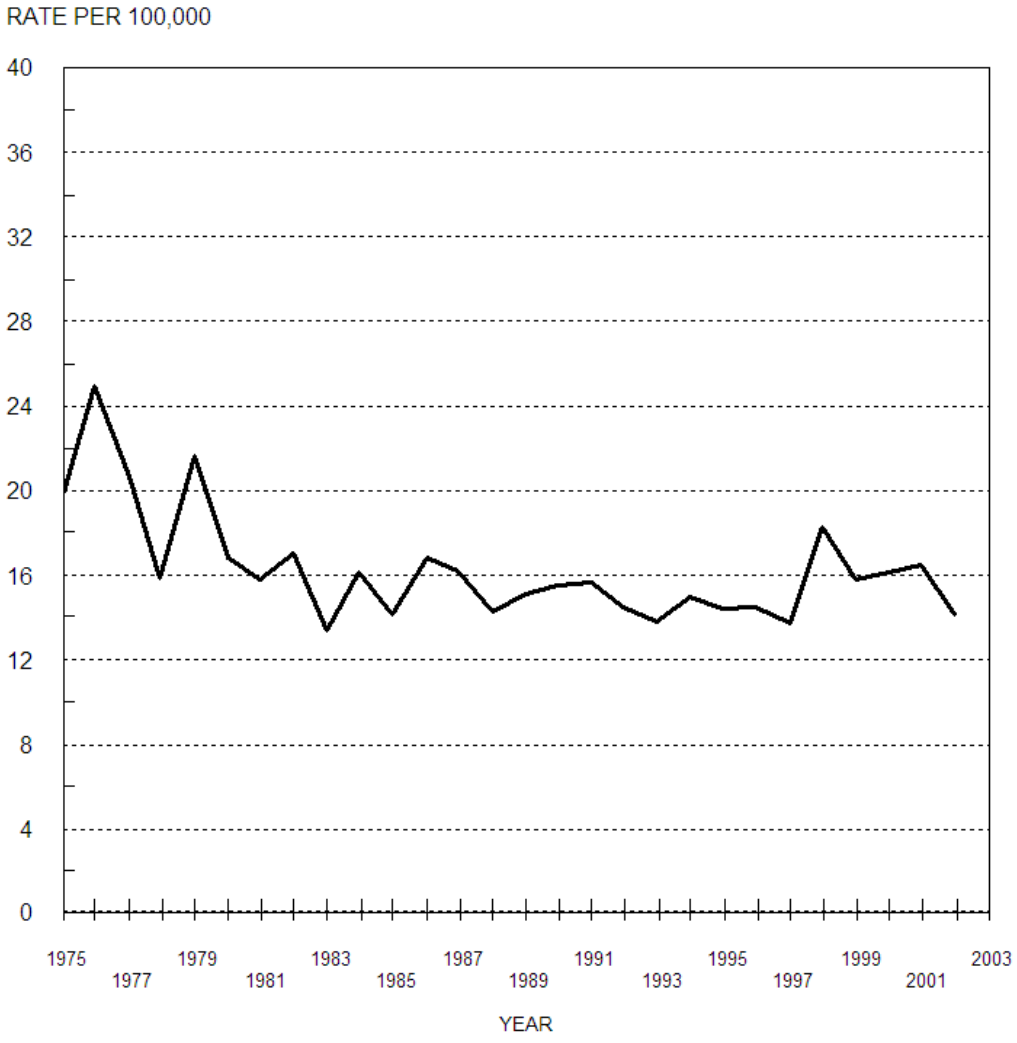
SOURCE: Virginia Center For Health Statistics

CHART 4
RESIDENT SUICIDE RATES, AGES 25-34
VIRGINIA, 1975-2002



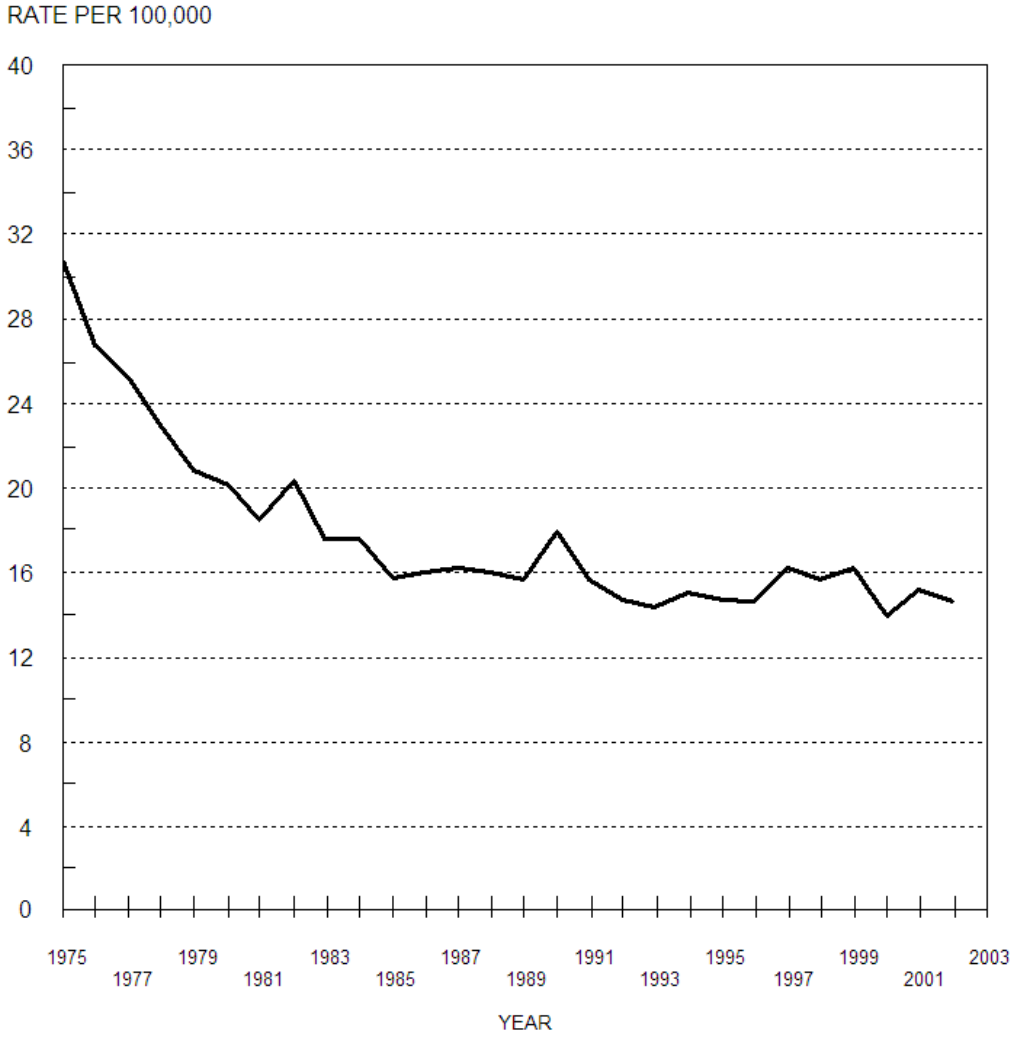
SOURCE: Virginia Center For Health Statistics

CHART 5
RESIDENT SUICIDE RATES, AGES 35-44
VIRGINIA, 1975-2002



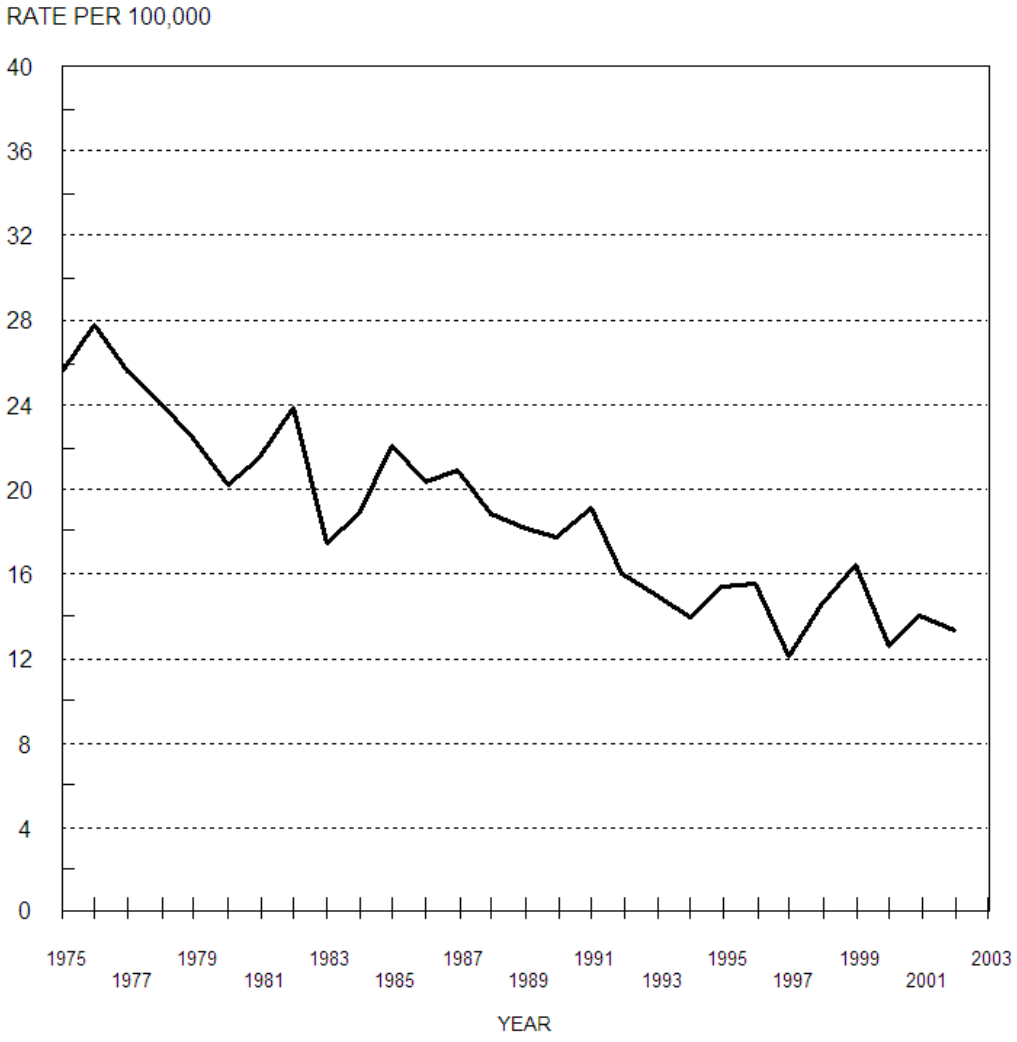
SOURCE: Virginia Center For Health Statistics

CHART 6
RESIDENT SUICIDE RATES, AGES 45-54
VIRGINIA, 1975-2002



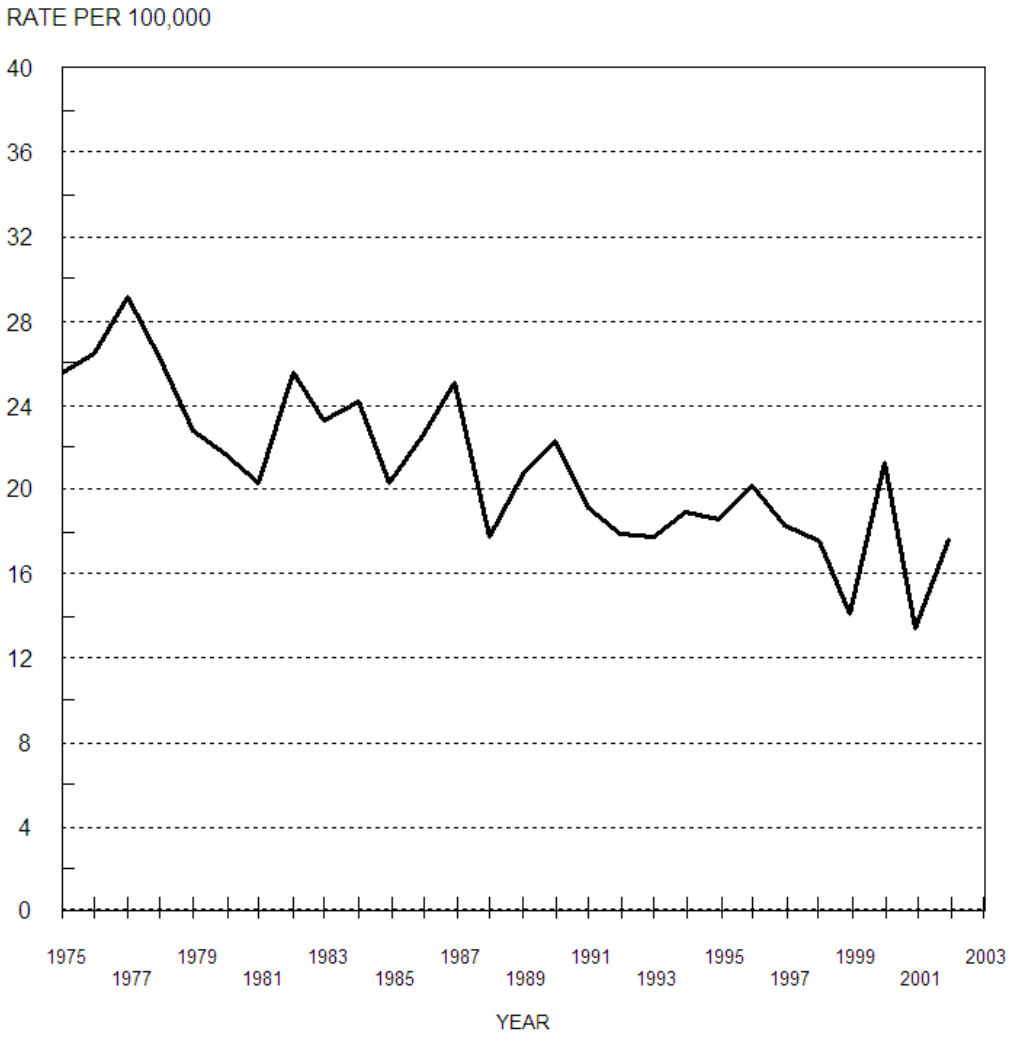
SOURCE: Virginia Center For Health Statistics

CHART 7
RESIDENT SUICIDE RATES, AGES 55-64
VIRGINIA, 1975-2002



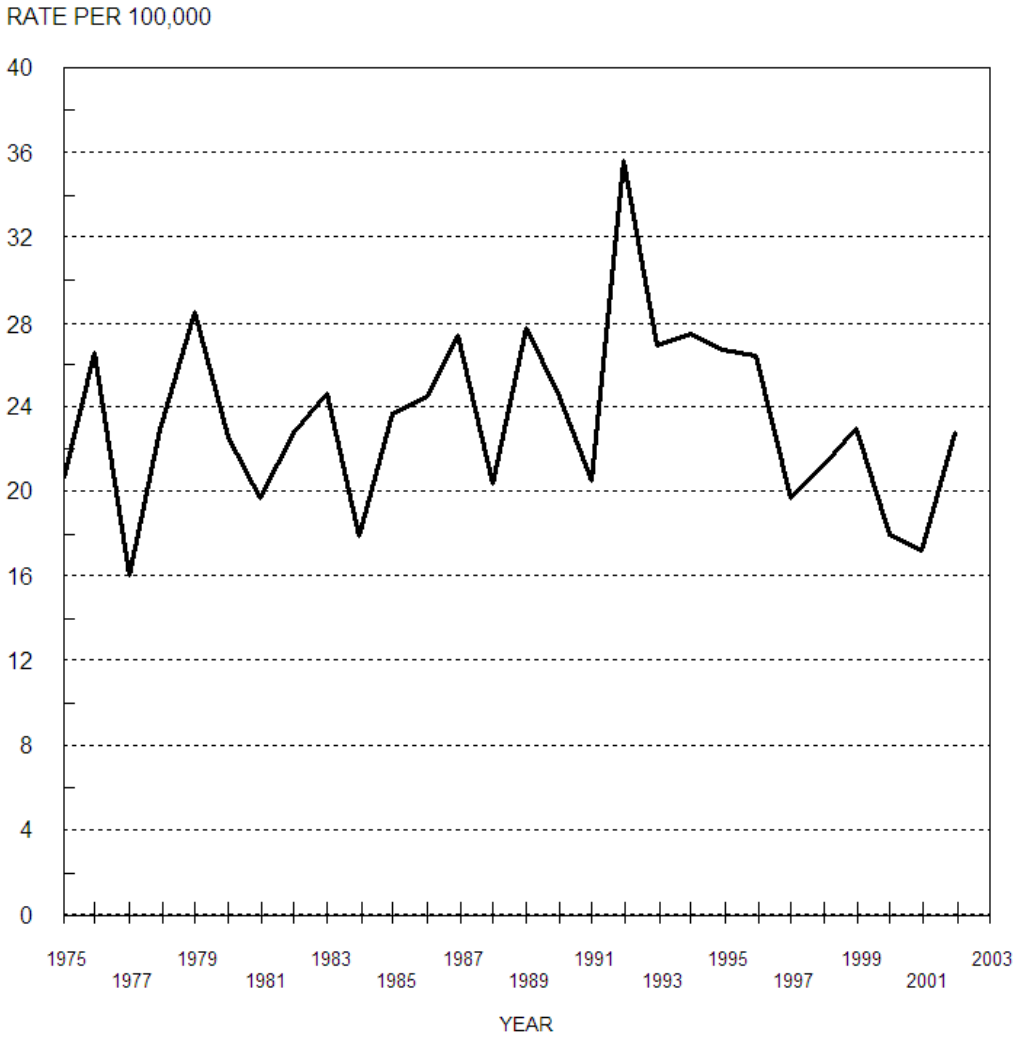
SOURCE: Virginia Center For Health Statistics

CHART 8
RESIDENT SUICIDE RATES, AGES 65-74
VIRGINIA, 1975-2002



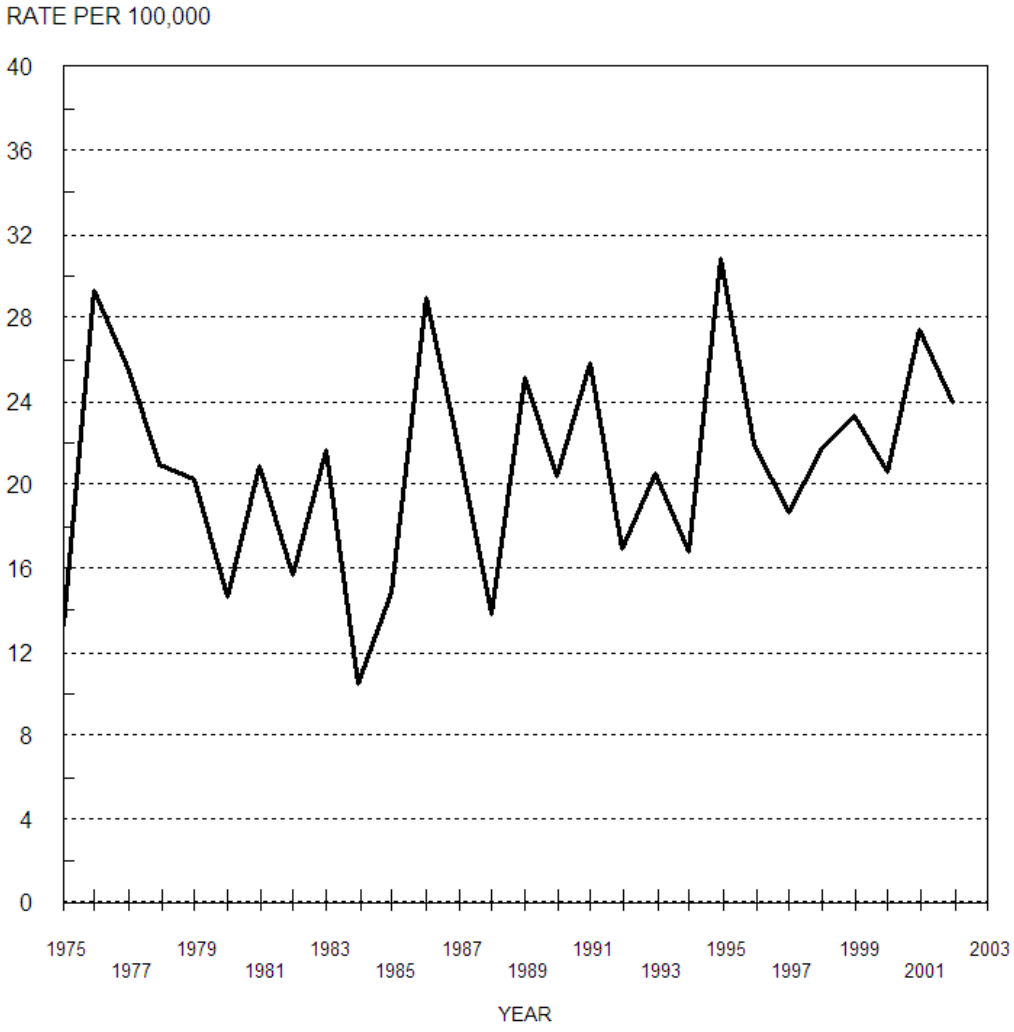
SOURCE: Virginia Center For Health Statistics

CHART 9
RESIDENT SUICIDE RATES, AGES 75-84
VIRGINIA, 1975-2002



SOURCE: Virginia Center For Health Statistics

CHART 10
RESIDENT SUICIDE RATES, AGES 85+
VIRGINIA, 1975-2002



SOURCE: Virginia Center For Health Statistics

Adjusted Suicide Rates by City/County and Planning District, 1999-2002[1]

1. Localities with a rate ≥ 22.0 (2 times state rate)

	No.	Rate
Buchanan	27	25.0
Scott	26	24.9
Russell	30	24.3
Wise	38	22.8
Planning District 1	87	23.2
Planning District 2	110	22.0

2. Localities with a rate ≥ 19.25 (1.75 times state rate)

	No.	Rate
Lee	20	21.9
Dinwiddie	22	21.0
Pulaski	29	20.3
Tazewell	40	20.2

3. Localities with a rate ≥ 16.5 (1.5 times state rate)

	No.	Rate
Danville	36	19.2
Louisa	20	19.1
Pittsylvania	47	18.4
Botetourt	24	18.1
Henry	43	17.1
Wythe	20	16.9
Isle of Wight	20	16.7
Smyth	21	16.6
Planning District 12	184	17.6

[1] This list includes only those localities with at least 20 deaths due to suicides during 1999-2002. Fewer deaths leads may result in unstable rates.

4. Localities with a rate ≥ 13.75 (1.25 times state rate)

	No.	Rate
Culpeper	23	16.8
Amherst	21	16.4
Shenandoah	24	16.0
Warren	20	15.5
Roanoke City	60	15.2
Bedford	37	15.0
Washington	32	14.4
Roanoke County	52	14.2
Henry	28	14.2
Halifax	21	13.9
Planning District 3	116	14.5
Planning District 5	160	14.4

5. Localities with a rate ≥ 11.00 (equal to state rate)

	No.	Rate
Charlottesville	20	13.1
Portsmouth City	49	12.3
Norfolk City	108	12.1
Chesterfield	121	12.0
Richmond City	96	11.9
Lynchburg	29	11.8
Henrico	123	11.6
Planning District 19	92	13.4
Planning District 22	26	12.4
Planning District 13	45	12.2
Planning District 18	42	12.1
Planning District 15	413	11.8
Planning District 14	45	11.3
Planning District 16	108	11.2

Adjusted Male Death Rates Due to Suicides by Planning District, 1999-2002

Planning Districts (P.D.) with Adjusted Rates ≥ 1.25 times the state rate for males.

	No.	Rate
State	**2,476**	**18.6**
P.D. 2(Buchanan, Dickenson, Russell, Tazewell)	**88**	**37.3**
P.D. 1(Lee, Scott, Wise, Norton)	**66**	**36.1**
P.D. 12 (Franklin, Henry, Patrick, Pittsylvania, Danville, Martinsville)	**160**	**32.7**
P.D. 3 (Bland, Carroll, Grayson, Smyth, Washington, Wythe, Bristol, Galax)	**98**	**26.2**
P.D. 5 (Alleghany, Botetourt, Craig, Roanoke City and County, Covington, Salem)	**120**	**23.9**
P.D. 22 (Accomack, Northampton)	**23**	**23.8**
P.D. 7 (Clarke, Frederick, Page, Shenandoah, Warren, Winchester)	**86**	**23.1**
P.D. 11 (Amherst, Appomattox, Bedford County and City, Campbell, Lynchburg)	**99**	**23.0**
P.D. 19 (Dinwiddie, Greensville, Prince George, Surry, Sussex, Colonial Heights, Emporia, Hopewell, Petersburg)	**75**	**22.9**
P.D. 10 (Albemarle, Fluvanna, Greene, Louisa, Nelson, Charlottesville)	**85**	**22.7**

Source: Virginia Center for Health Statistics

Appendix G

Hospitalizations due to Self-Inflicted Injury, Virginia 2002

Age Group	Frequency (Column %)	% of Age Group's Total Injury Hospitalizations
<1 Year	0	
1-4 Years	0	
5-9 Years	3 (.07%)	.5%
10-14 Years	143 (3.4%)	16.5%
15-19 Years	544 (12.7%)	25.9%
20-24 Years	522 (12.4%)	23.5%
25-29 Years	458 (10.9%)	25.8%
30-34 Years	507 (12.0%)	26.6%
35-39 Years	536 (12.7%)	23.6%
40-44 Years	549 (13.0%)	22.7%
45-49 Years	399 (9.5%)	17.3%
50-54 Years	234 (5.5%)	11.7%
55-59 Years	119 (2.8%)	7.0%
60-64 Years	68 (1.6%)	4.6%
65+ Years	139 (3.3%)	1%
Total	**4210 (100%)**	**11.4%**

Source: Virginia Department of Health

Suicide-Related Healthy People 2010 Outcome Objectives

1. By 2010, reduce the suicide rate to **5.0/100,000** (**Healthy People (HP) 18-1).** (*Virginia 2002 Baseline:* **10.8***; U.S. 2010 Target*: **5.0/100,000;** *U.S. Rate in 2001:* **10.7**)

2. By 2010, reduce the rate of suicide attempts by adults**.** (*Virginia 2003 Baseline:* **27,800,** *estimated; Target:* **14,000**)

3. By 2010, reduce the rate of suicide attempts by adolescents (**HP 18-2 and Virginia Healthy People 2010).** (*Virginia 2002 Baseline:* **not available***; U.S. 1999 Baseline:* **2.6% of adolescents in 9th – 12th grades**; *U.S. 2010 Target:* **1%**)

4. By 2010, increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health **(HP 7-2 and Virginia Healthy People 2010).** (*Virginia Baseline:* **not available** *U.S. 1994 Baseline*: **58% of schools** providing education on suicide; *U.S. 2010 Target:* **80%**).

Related Objectives

1. By 2010, reduce the rate of firearm-related deaths **(HP 15-3 and Virginia Healthy People 2010).** (*Virginia 2002 Baseline:* **10.5/100,000 population** *U.S. 1998 Baseline*: **11.3/100,000**; *U.S. 2010 Target*: **4.1/100,000**)

2. By 2010, increase the proportion of children with mental health problems who receive treatment. (**HP 18-7)** (*Virginia baseline:* **not available** *Source of data:* **1997 National Survey of America's Families: 79% of children and adolescents aged 6 to 17 years with mental health problems severe enough to indicate a clinical need for mental health evaluation, did not receive a mental health evaluation or treatment in the past year***; 2010 Target*: **no target established**).

3. By 2010, increase the proportion of adults with mental disorders who receive treatment (**HP 18-9**). (*Virginia Baseline:* **not available**; *U.S. 1997 Baseline:* **23% of adults aged 18 and older with recognized depression**; *U.S. 2010 Target*: **50%**)

Appendix I

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone: (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.state.va.us

October 15, 2004

Robert B. Stroube, M.D., M.P.H., Commissioner
Virginia Department of Health
Post Office Box 2449
Richmond, Virginia 23218-2448

Dear Dr. Stroube:

Thank you again for the opportunity to participate in the development of the *Suicide Prevention Across the Life Span Plan for the Commonwealth*. The *Plan* is comprehensive and well-conceived, and this Department supports the goals and strategies of the *Plan*, as well as our new designation as the lead agency.

Attached please find draft legislation to formalize the designation of DMHMRSAS as the lead agency for suicide prevention, as proposed in Objective 1.1 of the *Plan*. These amendments also preserve the Department of Health's role with respect to youth suicide prevention, as envisioned in the *Plan*.

As you know, the Department of MH, MR and SA Services has no staff or other resources devoted to suicide prevention across the lifespan, and would need significant new funding to implement the *Suicide Prevention Across the Life Span Plan for the Commonwealth*. Funding is needed to support suicide prevention staff, research and data collection infrastructure, direct services by community services boards, public awareness initiatives, training, and support for coalition-building with local and regional entities. I have also attached a summary of these costs.

Again, I appreciate the Department of Health's vision and leadership on this *Plan*, and I look forward to working together to make these activities a reality.

Sincerely,

James S. Reinhard, M.D.

JSR:ibs

Pc: The Honorable Jane H. Woods

Attachment

Department of Mental Health, Mental Retardation and Substance Abuse Services

	FY2006		FY2007		FY2008		FY2009		FY2010	
	FTEs		FTEs		FTEs		FTEs		FTEs	
Suicide Prevention Manager (Pay Band 6)	1.0	$ 94,500	1.0	$ 97,335	1.0	$ 100,255	1.0	$ 103,263	1.0	$ 106,361
Suicide Prevention Specialist (Pay Band 5)	0.0	$ -	5.0	$ 405,000	5.0	$ 417,150	5.0	$ 429,665	5.0	$ 442,554
Research Coordinator (Pay Band 5)	0.0	$ -	1.0	$ 81,000	1.0	$ 83,430	1.0	$ 85,933	1.0	$ 88,511
Admin / Office Specialist III (Pay Band 3)	0.0	$ -	0.5	$ 54,000	0.5	$ 55,620	0.5	$ 57,289	0.5	$ 59,007
Equipment	- -	$ 3,000	- -	$ 21,500	- -	$ 3,750	- -	$ 3,750	- -	$ 3,750
Travel	- -	$ 2,500	- -	$ 18,750	- -	$ 18,750	- -	$ 18,750	- -	$ 18,750
Office / Supplies	- -	$ 1,500	- -	$ 11,250	- -	$ 11,250	- -	$ 11,250	- -	$ 11,250
Research Infrastructure	- -	$ -	- -	$ 30,000	- -	$ 2,000	- -	$ 2,000	- -	$ 2,000
Contractual Services - Public Awareness	- -	$ -	- -	$ 82,500	- -	$ 82,500	- -	$ 82,500	- -	$ 82,500
Contractual Services - Training	- -	$ -	- -	$ 85,000	- -	$ 85,000	- -	$ 85,000	- -	$ 85,000
Contractual Svcs - Community Leadership	- -	$ 40,000	- -	$ 80,000	- -	$ 80,000	- -	$ 80,000	- -	$ 80,000
CSB Direct Services	- -	$ -	- -	$ 2,000,000	- -	$ 2,000,000	- -	$ 2,000,000	- -	$ 2,000,000
Yearly Total	1.0	$ 141,500	7.5	$ 2,966,335	7.5	$ 2,939,705	7.5	$ 2,959,399	7.5	$ 2,979,683

FTE Salary: Starting salary at mid-range plus fringe benefits plus 3.0% yearly cost of living adjustment

Equipment: $3,000 initial per FTE; $500 each subsequent year per FTE

Travel: $2,000 per FTE

Office/ Supplies: $1,500 per FTE

Department of Health Center for Injury and Violence Prevention

	FY2006	FY2007	FY2008	FY2009	FY2010
Suicide Prevention Coordinator	1.0	$50,100	1.0	$68,804	1.0	$70,868	1.0	$72,994	1.0	$75,184
Contractual Services	- -	$74,246	- -	$98,995	- -	$98,995	- -	$98,995	- -	$98,995
Supplies and Materials	- -	$38,474	- -	$51,299	- -	$51,299	- -	$51,299	- -	$51,299
Continuous Charges	- -	$3,150	- -	$4,200	- -	$4,200	- -	$4,200	- -	$4,200
Yearly Total	1.0	$165,970	1.0	$223,298	1.0	$225,362	1.0	$227,488	1.0	$229,678

State funds are not requested for FY 2005 since the federal grant funding is available. One quarter grant funding will be available for FY 2006 therefore the request represents three quarters of funding only. Salary and fringe for coordinator: $50,100 in the initial year represents three quarters funding. Annual cost is $66,800 with a 3% annual salary increase thereafter.

Contractual Services: 50 ASIST Trainings @ $600/training ($30,000); 300 QPR trainings @ $50/training ($15,000), Annual trainer training ($27,000), Annual Radio Campaign ($18,000); Trainers' travel reimbursement @ 24,500 miles x .32/mile($7,963); Coordinator travel @3,225 miles x .32/mile ($1,032)

Supplies/ Materials: ASIST participant materials @$36/ participant x 1,200 participants ($43,200); 30,000 QPR cards ($5,699); general office supplies @$200/month ($2,400)

Continuous Charges: Phone ($1,200); Rent ($3,000)

Proposed Legislation: DMHMRSAS to be lead agency for suicide prevention

§ 32.1-73.7. Department to be lead agency for youth suicide prevention.

With such funds as may be appropriated for this purpose, the Department, in consultation with the Department of Education, the Department of Mental Health, Mental Retardation and Substance Abuse Services, community services boards, and local departments of health, shall have the lead responsibility for the youth suicide prevention program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining to youth suicide prevention in order to develop and carry out ~~a~~ comprehensive youth suicide prevention ~~plan~~ strategies addressing the promotion of health development, early identification, crisis intervention, and support to survivors. The ~~plan~~ strategies shall be targeted to the specific needs of children and adolescents. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested individuals in order to prevent youth suicide within the Commonwealth. The Department shall submit a status report ~~annually by December 1 of each year to the Governor and the General Assembly~~ on its youth suicide prevention activities to the Department of Mental Health, Mental Retardation and Substance Abuse Services annually for inclusion in the report on suicide prevention activities to the Governor and General Assembly pursuant to § 37.1-48.3.

§37.1-48.3 Department to be lead agency for suicide prevention across the lifespan.

With such funds as may be appropriated for this purpose, the Department, in consultation with the community services boards, the Department of Health and local departments of health, and the Department for the Aging shall have the lead responsibility for the suicide prevention across the lifespan program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining to suicide prevention in order to develop and carry out a comprehensive suicide prevention plan addressing public awareness, the promotion of health development, early identification, intervention and treatment, support to survivors and surveillance. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested individuals in order to prevent suicide within the Commonwealth. The Department shall report annually by December 1 of each year to the Governor and the General Assembly on its suicide prevention activities.

The provisions of this section shall not limit the powers and duties of other state agencies. The Department of Health shall continue to be responsible for youth suicide prevention strategies as provided in § 32.1-73.7 of the Code of Virginia.

10/14/04

Attachment: DBHDS Quality Improvement Plan

Virginia's current quality improvement plan for behavioral health is summarized in the language below taken from Exhibit B of the FY 2012 Community Services Performance Contract**.**

Introduction: The Department shall continue to work with Boards to achieve a welcoming, recovery-oriented, integrated services system, a transformed system for individuals receiving services and their families in which Boards, state facilities, programs, and services staff, in collaboration with individuals and their families, are becoming more welcoming, recovery-oriented, and co-occurring disorder capable. The process for achieving this goal within limited resources is to build a system wide continuous quality improvement process, in a partnership among Boards, the Department, and other stakeholders, in which there is a consistent shared vision combined with a measurable and achievable implementation process for each Board to make progress toward this vision. This contract provides further clarification for those implementation activities, so that each Board can be successful in designing a performance improvement process at the local level.

Meaningful performance expectations are part of a continuous quality improvement (CQI) process being developed and supported by the Department and the Board that will monitor the Board's progress in achieving those expectations to improve the quality, accessibility, integration and welcoming, person-centeredness, and responsiveness of services locally and to provide a platform for system wide improvement efforts. Generally, performance expectations reflect established requirements based in statute, regulation, or policy. Performance goals are developmental; once baseline measures are established and implemented, they will become expectations. The initial performance expectations and goals focus on the areas of the public mental health, developmental, and substance abuse services system that have the primary interactions with individuals who are at risk of involvement in the civil admissions process established in Chapter 8 of Title 37.2 of the Code of Virginia, are directly involved in that process, are receiving case management services from the Board, or require service linkages between state facility or local inpatient services and other community services. This emphasis is consistent with the Department's and the Board's interest in assuring that individuals receive the services and supports necessary to link them with the most appropriate resources needed to support their recovery, empowerment, and self-determination. It also is consistent with the recognition that many of these individuals will have co-occurring mental health and substance use disorders or intellectual disability and will need services that are designed to welcome and engage them in co-occurring capable services. The capacity to measure progress in achieving performance expectations and goals, provide feedback, and plan and implement CQI strategies shall exist at local, regional, and state levels.

Implementing the CQI process will be a multi-year, iterative, and collaborative effort to assess and enhance Board and system wide performance over time through a partnership among Boards and the Department in which they are working to achieve a shared vision of a transformed services system. In this process, Boards and the Department engage with stakeholders to perform meaningful self-assessments of current operations, determine relevant CQI performance expectations and goals, and establish benchmarks for goals, determined by baseline performance, to convert those goals to expectations. Then, each Board assesses and reports to the Department

on its progress toward achieving these expectations and goals and develops and implements a CQI plan to meet them. As benchmarks are attained and expectations and goals are achieved, Boards and the Department review and revise the performance expectations, goals, and benchmarks or establish new ones. Because this CQI process focuses on improving services and to strengthen the engagement of Boards in this process and preserve essential services for individuals, funding will not be based on or associated with Board performance in achieving these expectations and goals. The Department and the Board may negotiate Board performance measures in Exhibit D reflecting actions or requirements to meet expectations and goals in the Board's CQI plan. As this joint CQI process evolves and expands, the Department and the VACSB will utilize data and reports submitted by Boards to conduct a broader scale evaluation of service system performance and to identify opportunities for CQI activities across all program areas.