Virginia Substance Abuse Prevention Block Grant Annual Report

2020-21

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Submitted to:

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Introduction

The Substance Abuse Block Grant (SABG) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Virginia's Department of Behavioral Health and Developmental Services (DBHDS) Office of Behavioral Health Wellness (OBHW) distributes grant funds to 40 Community Services Boards (CSBs) across the commonwealth to plan, implement and evaluate prevention activities aimed at preventing and/or decreasing substance use.

This report, prepared by OMNI Institute (OMNI), provides an overview of block grant prevention activities during the 2020-21 fiscal year (July 2020 through June 2021). OBHW has contracted with OMNI since 2014 to evaluate Virginia's block grant activities and provide training and technical assistance (TA) to build evaluation capacity among Virginia's prevention workforce. OMNI is a nonprofit, social science consultancy that provides integrated research and evaluation, capacity building, and data utilization to accelerate positive social change.

Strategic Planning Process

Since 2014, OMNI and OBHW have partnered to implement the Strategic Prevention Framework[1] within block grant activities to provide program structure, build capacity for data-driven prevention and promote sustainability. In 2017 and 2018, OMNI conducted a statewide needs assessment[2] to identify prevention needs and determine program direction. The assessment synthesized a broad array of national, state, and local secondary data sources to better understand the status and needs related to behavioral health in Virginia. The assessment also utilized primary data collection through facilitated discussions with the Statewide Epidemiological Outcomes Workgroup and OBHW staff. In addition, a SWOT (strengths, weaknesses, opportunities, and threats) analysis with local prevention staff to gather information and understand prevention priorities. From this effort, the following priority areas were identified:

Block Grant Prevention Priority Areas[3]

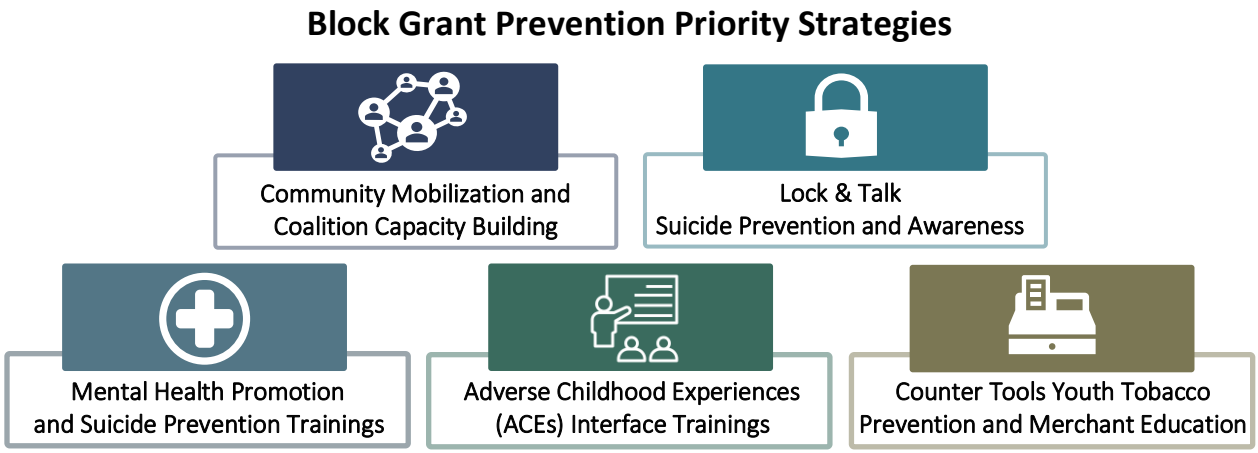
Alcohol	Alcohol is the most used substance in Virginia with 25% of high school youth and 55% of adults consuming alcohol in the past 30 days.
Tobacco and Nicotine	23% of high school youth used tobacco or electronic vapor products in the past 30 days. 23% of adults used tobacco products in the past 30 days.
Mental Health and Suicide	1,139 suicides were recorded in Virginia in 2019, a rate of 13 per 100,000 persons. 16% of Virginia high school youth have considered suicide.

[1] Substance Abuse and Mental Health Services Administration (2019). A Guide to SAMHSA's Strategic Prevention Framework. Rockville, MD: Center for Substance Use Prevention. https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

[2] OMNI Institute (2018). Virginia Statewide Substance Use and Behavioral Health Needs Assessment. https://vasisdashboard.omni.org/ExportFiles/VA%20Needs%20Assessment%20Report_August%202018_Final.pdf

[3] Data on high school youth from the 2019 Virginia Youth Survey. Data on adult substance use from the 2018-2019 National Survey on Drug Use and Health. Data on suicide rates from the Center for Disease Control.

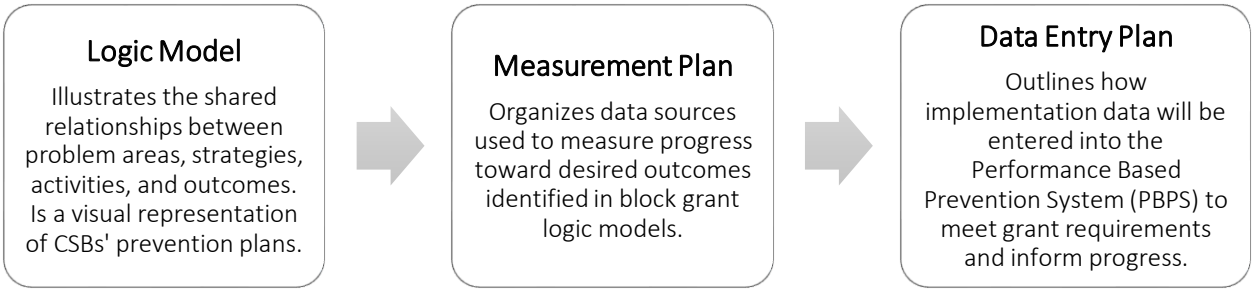
To impact Virginia's three prevention priority areas and reach desired outcomes, the OBHW team explored data from the needs assessment and selected key risk and protective factors underlying the priority areas that could be targeted through new or existing prevention strategies. Based on these discussions, the OBHW team selected five priority prevention strategies to target alcohol use, tobacco use, and mental health and suicide prevention across the commonwealth. For more detailed information on the strategic planning process, please see the 2019 Strategic Planning Report produced by OMNI.[4]



As a result of strategic planning, OMNI developed a statewide logic model for the 2020-2025 Block Grant funding period that details the shared relationships between the three priority areas, the risk and protective factors underlying these areas, the priority strategies selected to target those factors, and the desired short-term and long-term impacts of these strategies (See Appendix A). For the first time, in fiscal year 2020-21, CSBs were required to implement all five priority prevention strategies, while also reserving some prevention funds to implement strategies focused on local priorities. The next section of this report describes the evaluation planning process CSBs used to identify those local priorities.

Evaluation Roadmap Process

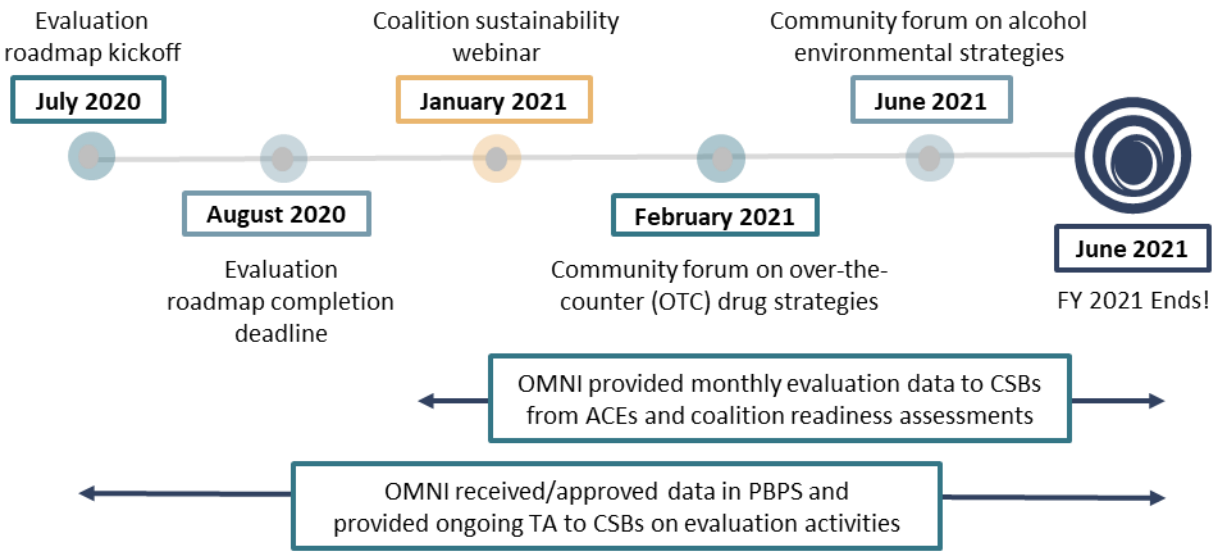
Building on the success of the strategic planning process, OMNI developed a comprehensive process to support CSBs in creating individual prevention evaluation plans to monitor progress towards local and state outcomes. This process, known to CSBs as the "evaluation roadmap" integrates each community's logic model, measurement plan, and data entry plan into one document for ease of use in data entry and reporting. Each component of the roadmap is linked to the others and allows CSBs to organize their data to illustrate the prevalence of each priority area, demonstrate progress towards outcomes, and track implementation data. Each component of the roadmap is described in more detail below.



[4] OMNI Institute (2019). Virginia Substance Abuse Prevention Block Grant Strategic Planning Report. https://vasisdashboard.omni.org/ExportFiles/VA%20strategic%20plan%20report_FINAL.pdf

Timeline of Evaluation Activities

During the 2020-21 fiscal year, OMNI worked with CSBs to support implementation of prevention strategies, provide TA around data entry and reporting requirements, and host events to provide ongoing discussions around new opportunities to address emerging behavioral health concerns. The timeline below provides an overview of key activities that occurred in the 2020-21 fiscal year.



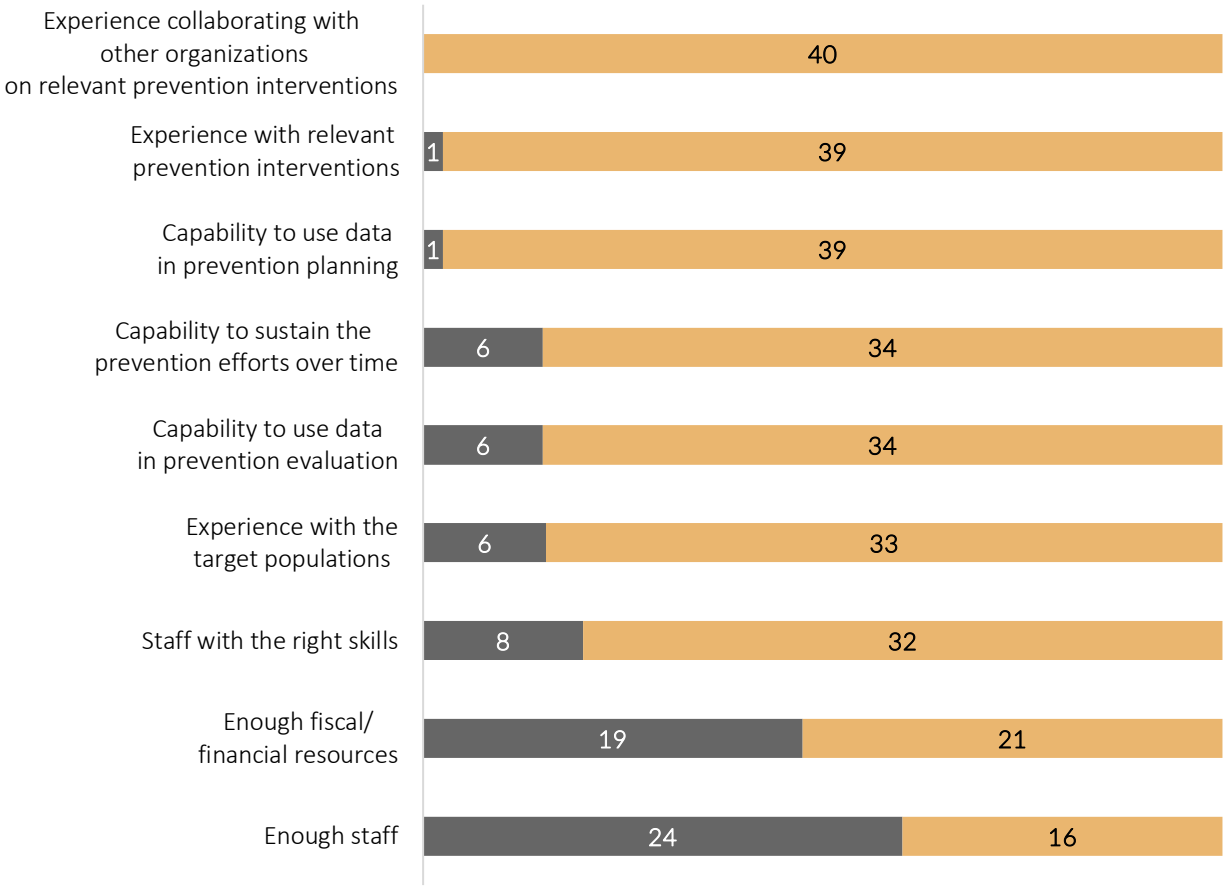
Prevention Capacity

In addition to providing support around assessment, planning, implementation, and evaluation of prevention efforts, OMNI provides capacity building services to Virginia CSBs. These efforts are focused on promoting data literacy, bolstering data infrastructure, and supporting the prevention workforce in building the skills and relationships necessary to effectively carry out their prevention efforts. To assess the capacity of the prevention workforce across these areas, OMNI developed an end-of-year survey of CSB staff with some questions adapted from the Community Level Instrument[5]. Selected data from this survey are shared in this section to demonstrate the current capacity of the BG prevention workforce.

CSBs largely agreed that they have ample capacity to implement their block grant prevention interventions. CSBs were asked how much they agreed or disagreed that their organizations have enough capacity in nine key areas to effectively implement their interventions. All 40 CSBs agreed that they have experience collaborating with other organizations on relevant prevention interventions. Nearly all (39) agreed they have capability to use data in prevention planning and experience with relevant prevention interventions. However, over half of all CSBs (24) disagreed or strongly disagreed that they have enough staff with just less than half (19) saying they have enough fiscal/financial resources.

[5] Program Evaluation for Prevention Contract (PEP-C). (2014) Community-Level Instrument-Revised (CLI-R). https://www.samhsa.gov/sites/default/files/pfs-com-lev-inst.pdf

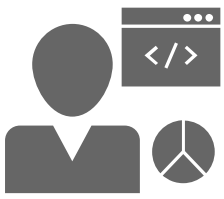
CSBs **Agree/Strongly Agree** or **Disagree/Strongly Disagree** they have enough capacity in each area



"The lack of staff has severely impacted our ability to fully partner within community initiatives with the school systems and the police department." **– Harrisonburg-Rockingham CSB**

"We have been diligent in maintaining relationships with community partners and even though we have lost some, we have also gained many." **– Blue Ridge Behavioral Healthcare**

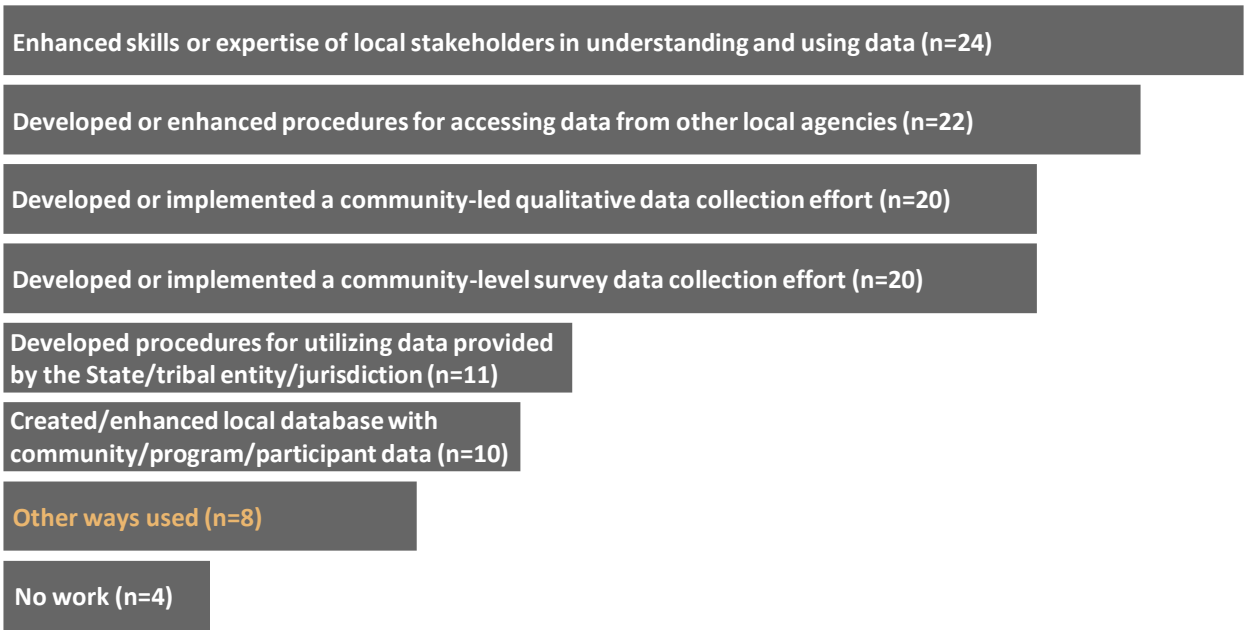
Data Infrastructure



In addition to reporting on their capacity, CSB staff answered questions about the data infrastructure of their organization. CSBs weighed in on measures they took to develop or enhance data infrastructure needed for data-driven needs assessment, planning, and evaluation during the block grant funding period. At least half or more of all CSBs (a) Enhanced skills or expertise of local stakeholders in understanding and using data, (b) Developed or enhanced procedures for accessing data from other local agencies, (c) Developed or implemented a community-led qualitative data collection effort, and (d) Developed or implemented a community-level survey data collection effort. Roughly a quarter of all CSBs reported involvement with other systems or

methods, with only four reporting they had not done work to develop their data infrastructure. *(Note: This question will be asked of CSBs again at the end of the funding period to determine how this may have changed over time.)*

Most CSBs developed or enhanced their data infrastructure in multiple ways, with only four CSBs reporting they hadn't done any data infrastructure development.



CSBs also reported eight other unique ways they bolstered data infrastructure:

- Developed or implemented a youth community-level data collection effort
- Developed quantitative and qualitative evaluation measurements and data collection for direct service initiatives
- Developed a Data Action Resource Team "DART" to collect data closer to real time
- Enhanced skills of staff in understanding and using data
- Created outcome measure for virtual events
- Participated in a community needs assessment done by local non-profit hospital
- Reached out to FAACT organization to use their platform for data

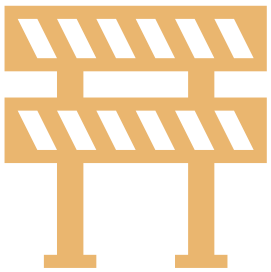
All 40 CSBs reported stressful events such as COVID-19 acted as barriers to their prevention activities. CSBs were asked to indicate which of 19 demographic, environmental, or cultural factors introduced barriers to their Block Grant prevention activities. They also shared the level of impact (low, medium, high) that each factor had in the past fiscal year. The average number of barriers reported across all CSBs was 13.

Twenty-six or more CSBs identified that every factor listed had at least some level of impact, whether low, medium, or high. The highest-impact barrier identified (stressful events) included COVID-19 and social/political unrest, which all 40 CSBs indicated was a factor, 38 of which said it had a high or medium

impact. The response option for "other factors" outside of the list garnered additional challenges. Other listed barriers most frequently noted as having an impact were:

Number of CSBs Reporting Medium or High Impact for Most Common Barriers
• Stressful events affecting large portions of the target population, e.g., fires, hurricanes, COVID-19, or social/political unrest (38 CSBs) • Cultural norms, attitudes, or practices favoring substance use (35) • Easy access to alcohol for underage youth (34) • Lack of community awareness of the extent or consequences of substance use/misuse (33)

Several CSBs reported other barriers having at least high or moderate impact on their prevention work:



- Public school closures due to COVID-19 with loss of access to youth
- On-going training pertaining to prevention
- Locality saturated with wineries, breweries, and distilleries having significant impact on the cultural norms around alcohol use
- Not having staff to meet needs of the community; community partners/ organizations pulled to respond to the pandemic in demanding ways.
- Limited in-person service hours
- New carry-out regulations for alcohol
- Marijuana decriminalization
- Rapid expansion of local vape and nicotine retailers

Despite challenges over the year, CSBs were again resilient in the face of COVID-19-related stressors and barriers.

"COVID was a key barrier for our services because we do so many in-person interactions and strategies in our communities. But we were able to work with our schools, our communities and within our agency to provide many of our services on virtual formats. We all worked together to make things work -- that's the beauty of partnerships and teamwork."
– Planning District 1 Behavioral Health Services

Prevention Priorities

The following sections of the report describe the implementation and impact of the five priority strategies across the commonwealth during this fiscal year. Implementation data in these sections were drawn from the Performance Based Prevention System (PBPS) and narrative data were collected through an end-of-year reporting survey completed by CSB staff.

Community Mobilization and Coalition Capacity Building

Coalitions played a key role in mobilizing the community to support prevention efforts and disseminate prevention messaging. This fiscal year, CSBs partnered with local coalitions to plan and implement prevention activities, engage in community outreach efforts, and leverage partnerships with community stakeholders to spread prevention messaging.

37 CSBs
led or facilitated coalitions

66
active coalitions

1,920
Coalition members

"Our community has grown in reaching more youth due to kids learning virtually and other community members working from home and having extra time to be able to attend the meetings. The community has really come together during this pandemic to help each other. We have strong relationships with other organizations in the community"
-Dickenson County Behavioral Health Services

The ongoing COVID-19 pandemic brought both challenges and opportunities to CSBs and coalitions to adapt and sustain their prevention efforts.
Though the pandemic limited their capacity to hold in-person meetings, coalitions maintained and grew their membership by recruiting additional community members who had increased availability to attend virtual meetings, including youth and individuals working from home. Further, many coalitions reported higher participation and engagement of their membership due to the shift to virtual meetings. Coalitions saw success in leveraging virtual and other media platforms to promote prevention messaging, including TV commercials, radio ads, local news segments and virtual events.

The pandemic also presented challenges that required coalitions to be flexible with planning and communication efforts. Several communities reported increased stress and isolation related to COVID-19, especially in youth. As a response to the stress, coalitions strengthened community connections by providing tailored resources and events to help those most impacted by the pandemic.

Stakeholder participation was critical in addressing community needs and spreading prevention messaging. Coalitions leaned on partnerships with local businesses, schools, and agencies to promote their prevention messaging and engage community members. Data from the end-of-year survey shows that across coalitions, the following sectors had the highest engagement in BG activities: business community, youth groups/representatives; schools/school districts, other youth serving organizations, and mental health professionals/agencies. Some of the sectors that were least engaged in BG activities were tribal groups, military, and organizations serving the LGBTQ community.

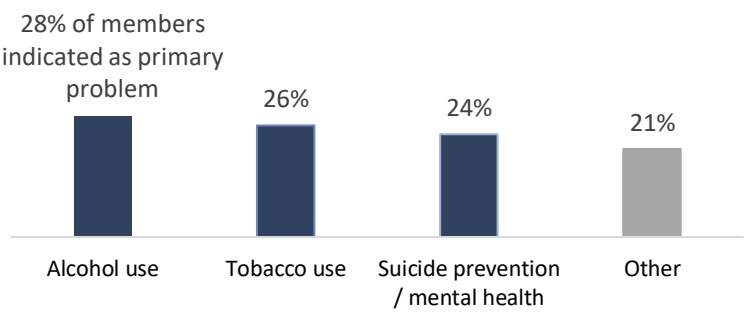
Image from the Rural Substance Abuse Awareness Coalition promoting an Overdose Awareness Virtual Walk.

In the 2020-21 fiscal year, 30 CSBs implemented a Coalition Readiness and Effectiveness Assessment. A total of 333 members across 36 coalitions assessed their coalition across 8 dimensions on a scale of 1 to 4 (with 1 indicating low readiness and 4 indicating high readiness).

Coalition members reported the highest levels of readiness in the domains of leadership and context, reflecting confidence in their leaders and the ability of their coalitions to address their community's most critical issues. The lowest ranked domain of coalition readiness was institutionalization, suggesting that coalitions are still building community connections and working to been seen as an authority on their priority areas.

Domains of Coalition Readiness and Effectiveness	Average score (out of 4)
Context: To what extent is the coalition working on a critical issue that affects the community?	3.53
Structure: To what extent does the coalition have effective norms, information, support, and representative membership?	3.28
Leadership: To what extent do members perceive leadership to be effective, collaborative, knowledgeable, and skilled with communication, management, and problem-solving?	3.40
Membership: To what extent do members effectively work together and have a strong commitment to the coalition?	3.08
Process: To what extent does the coalition value member opinions and make effective decisions?	3.24
Results: To what extent has the coalition set specific, measurable goals and achieved them?	3.12
Maintenance: To what extent does the coalition revise plans and share information and results with members and the larger community?	3.18
Institutionalization: To what extent is the coalition integrated into the larger community, recognized, and consulted as an authority on the topic of focus by other organizations, legislative bodies, or government entities?	2.94

Coalition members indicated alcohol use, tobacco use, and suicide prevention as the primary problems addressed by their coalition, showing strong alignment with state priorities.



Lock and Talk Suicide Prevention and Awareness

CSBs implemented Lock and Talk efforts to prevent suicide by limiting access to lethal means and spreading suicide prevention awareness through merchant and community education and media messaging. A key component of Lock and Talk includes distributing devices such as gun trigger and cable locks as well as medication lock boxes to reduce access to guns, medications and other dangerous items. Some CSBs delivered devices directly to gun merchants along with suicide prevention education while others distributed devices through community partners and during outreach events. All media and community messaging focused on recognizing and responding to the warning signs of suicide, the importance of normalizing talking about suicidal thoughts, and locking away lethal means.

37 CSBs implemented Lock & Talk

15,141 devices distributed

2.9M impressions/ reach

"We continue to weave this strategy into existing infrastructures in our community. For example, a local pharmacy that mostly serves older residents uses our materials to help people lock up their medications and dispose of them properly. Goochland Schools provides these materials to parents and encourages safe storage of guns. Ambulance drivers who routinely see people who have high risk provide these materials."
-Goochland-Powhatan CSB

COVID-19 restrictions hindered Lock and Talk efforts, but CSBs leveraged partnerships and found ways to adapt. Many CSBs could not visit gun retailers in their area, attend events, train staff, or provide trainings in their communities during parts of the fiscal year. Therefore, many CSBs focused on spreading information virtually via social media and television ads. When CSBs had the ability to safely meet in-person they worked with partner organizations, such as healthcare providers, pharmacies, schools, law enforcement, gun shops, and faith communities to distribute devices and suicide prevention resources. Some examples of partnerships include CSB staff distributing materials during Feeding America events and working with pharmacies to distribute drug deactivation kits, lock boxes, and suicide prevention materials to adults picking up prescription medications.

Lock and Talk media campaign messaging images from the Lock and Talk Virginia Facebook page

Mental Health Promotion and Suicide Prevention Trainings

All 40 CSBs implemented suicide prevention trainings in their communities, with many adapting from in-person to virtual trainings. Due to the COVID-19 pandemic, most CSBs chose to adapt their trainings to be delivered virtually. Some CSBs were still able to safely offer trainings in-person at various points in the fiscal year, while others utilized blended approaches. CSBs were required to offer one of the following three suicide trainings to meet this grant requirement: Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA), or Question. Persuade. Refer. (QPR). In addition, CSBs could opt to implement other evidence-based trainings in their community, such as Safe TALK, More Than Sad, and Talk Saves Lives.

40 CSBs conducted trainings

422 trainings

6,960 people trained

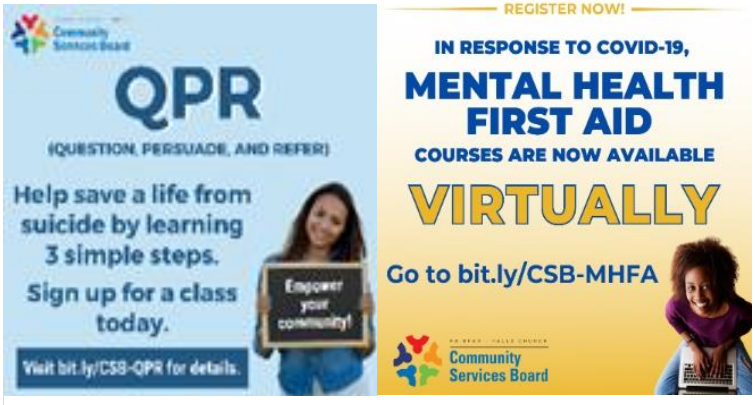
"We saw an increased demand for MHFA trainings and have expanded availability of those trainings to meet that demand, primarily with the virtual model of MHFA."—New River Valley Community Services

"We greatly expanded our MHFA reach by teaching virtually." –Chesterfield CSB

CSBs implemented seven different suicide prevention trainings, with Mental Health First Aid standing out as the most-delivered training.

Mental Health First Aid (MHFA)- Adult	205 Trainings
Mental Health First Aid (MHFA)- Youth	119 Trainings
Question. Persuade. Refer. (QPR)	66 Trainings
Talk Saves Lives	14 Trainings
More Than Sad	9 Trainings
Safe TALK	6 Trainings
Applied Suicide Intervention Skills Training (ASIST)	3 Trainings

COVID-19 restrictions and staff limitations posed challenges for training delivery. Multiple CSBs reported that they were unable to implement ASIST and Safe TALK trainings, which required in-person participation. In response to these limitations, many CSBs reported training additional staff to deliver QPR instead. Some CSBs reported reduced ability to host trainings due to a lack of trainers and staff turnover.



Suicide Prevention Training Messaging from Fairfax-Falls Church CSB

All CSBs implemented mental health promotion and suicide prevention awareness activities through media campaigns. Though the COVID-19 pandemic limited mental health and suicide prevention trainings, several CSBs responded by increasing their focus on media campaigns and virtual events. CSB staff shared suicide prevention messaging through social media, CSB and coalition websites, TV and radio public service announcements, and community events targeting youth and adults.

40 CSBs
implemented campaigns

3.8M
impressions/ reach

"…ESCSB developed a 'Pizza Box' initiative with 15 local pizza restaurants (and more joining!) in which the ESCSB provides exclusively designed pizza boxes with information about suicide prevention on the box for the restaurants to distribute. The restaurant staff are provided education on identifying signs and symptoms of depression and suicide. The ESCSB also provides drink coasters to local dine in and take out restaurants and bars that provides information on the national suicide prevention hotline and signs and symptoms of depression and suicide."
–Eastern Shore Community Services

CSBs launched innovative efforts and leveraged new and existing partnerships to spread their messaging. CSBs found the most success by collaborating with other organizations. Some of the main partnerships included schools, law enforcement, first responders, and local business and non-profits. Eastern Shore CSB engaged with local restaurants owners and their staff by providing education about mental health and suicide prevention. In addition to discussions, they provided pizza boxes and drink coasters with suicide prevention messaging. Chesterfield CSB partnered with their local school system and the American Foundation for Suicide Prevention to deliver More Than Sad trainings to parents. Horizon CSB reported working with their local Criminal Justice Academy to deliver trainings, collaborating with a local college to host mental health awareness presentations, and partnering with their local coalition to host a virtual Taking the Lead Youth Summit with a focus on mental health. Norfolk CSB implemented information dissemination strategies where bags filled with suicide prevention messaging, helpline information, and other resources were dropped at recreation and community centers as well as senior communities.

Regional collaboration helped expand the reach of suicide prevention messaging through virtual programming. Several CSBs from the Eastern region (Region 5) of Virginia reported participating in the fifth annual "Shatter the Silence" Regional Prevention and Awareness Conference which was hosted virtually for the first time. Region 5 CSBs also collaborated through a Regional Suicide Prevention Task Force to disseminate regional media campaigns for Talk Saves Lives. CSBs from the Central region (Region 4) of Virginia also partnered to offer resources and training via the BeWellVA suicide prevention training plan and website.

Promotional image for the Shatter the Silence Regional Suicide Prevention Conference presented by the Region 5 Prevention Council

Counter Tools Youth Retail Tobacco Prevention and Merchant Education

Though merchant education visits were not feasible for all CSBs due to COVID-19 restrictions, prevention staff continued both planning and implementation efforts. Prior to the COVID-19 pandemic, all Virginia CSBs participated in merchant education visits to tobacco and nicotine retailers across the communities they serve. Educating retailers reduces the amount of access underage youth have to tobacco and nicotine. Due to COVID-19 restrictions there was wide variation in the amount of merchant visits that were completed this fiscal year, with many CSBs visiting most or all tobacco retailers in their area and other CSBs unable to visit any merchants.

21 CSBs provided education

1621 merchants visited

> "We are extremely proud and pleased to share that even through the extraordinary challenges of the COVID-19 Global Pandemic that we continued to effectively implement our Counter Tools Strategy throughout the MPNN Communities."
> **– Middle Peninsula-Northern Neck CSB**

With restrictions limiting merchant education visits, many CSBs supplanted these activities by:

- completing coverage mapping assessments of the tobacco retailer landscape in catchment areas
- increasing youth involvement with training, hiring interns, and partnering with youth-serving organizations
- managing and auditing CSB Counter Tools data
- hiring and training new CSB staff in merchant education implementation
- increasing tobacco prevention media presence (print, radio, and social media)
- maintaining merchant relationships, building new partnerships, and identifying local tobacco use trends and "hotspots"

State and national changes to the minimum age for tobacco sales shifted prevention messaging. In July 2019, the commonwealth raised the state minimum age of sale of tobacco products from 18 to 21 years of age, in part to address the rapid growth of vaping among teens. Shortly after, in December 2019, the minimum age was raised to 21 at the federal level. This change in legislation required CSBs to receive and disseminate new materials and signage bearing the new 21 minimum age in their retailer visits. OMNI and OBHW will continue to monitor the impact of the new law on youth tobacco prevention in Virginia.

Merchant education materials used by CSBs during retailer visits this fiscal year

Adverse Childhood Experiences (ACEs) Trainings

CSBs provided ACE Interface trainings to bring awareness to the impact of ACEs on health and behavior, share the science of resilience, and support the statewide goal of building self-healing communities. The ACE Interface curriculum teaches participants about the biological, health, and social impacts of ACEs as well as strategies to support the health and well-being of community members. This fiscal year, many CSBs reported that additional prevention staff underwent the ACEs instructor training to increase capacity to offer trainings across their catchment areas. By increasing staff capacity, CSBs were able to provide in-person ACEs trainings, modified in-person trainings, or virtual ACEs trainings to accommodate COVID-19 precautions. CSBs also worked to increase community awareness of ACEs through community conversations and media campaign messaging, such as public service announcements and social media campaigns.

32 CSBs conducted trainings

295 trainings

7,927 people trained

"The Virtual ACEs Collaborative is a great example of shifting to meet the needs of communities across the state. The Prevention Services Coordinator is grateful to be a part of that group and to train with folks from across the state. The shift to the virtual platform allowed for greater access to all of our communities and an increase in training numbers overall." **-Valley CSB**

Some CSBs worked together to address COVID-19 restrictions, staffing challenges, and gaps in training access by forming the Virtual ACEs Collaborative. The Virtual ACEs Collaborative helped CSBs connect and share the workload of offering trainings which enabled greater numbers of people throughout the state to be trained due to the virtual format. The collaborative group grew from five to 12 CSBs during this fiscal year and provided 31 virtual collaborative trainings to 1,954 people.

CSBs also leveraged community partnerships to train parents, school staff, health care service providers, and youth. Many CSBs reported working with local school districts to train teachers and school counselors, while others reported partnerships with medical professionals, Department of Social Services workers, non-profits, and probation/parole professionals. Harrisonburg-Rockingham CSB partnered with Futuro Latino, a local community coalition serving Latino youth, for a multi-series event (with Spanish translation support) discussing ACEs and resilience with parents and youth.

Image of a Virtual ACE Interface presenter cohort hosted by OBHW with support from Rappahannock Area CSB, Rockbridge Area CSB, and Southside CSB

In August 2020, OMNI and OBHW updated the ACEs Training Evaluation survey and distribution process to improve the quality of the data CSBs collect from participants. CSBs started using the updated survey (available in English and Spanish) for all ACEs trainings via the survey platform Qualtrics. The survey collects information on the training experience, training follow-up, and demographics. A total of 1,888 participants completed the evaluation form across 153 trainings during the 2020-21 fiscal year. Not all training participants completed the evaluation form, and the data below includes trainings funded by both block grant and the State Opioid Response grant.

The majority of participants who completed the post-training survey identified as white and female, highlighting an opportunity for CSBs to engage more diverse audiences in ACEs trainings. Most participants were between ages 45-64 and reported working in schools/school districts as well as occupations like social services and health care.

- 93% of participants identified as White, 4% identified as Hispanic
- 86% of participants identified as Female
- 53% of participants selected schools/school districts for occupation and affiliation
- 47% of participants were between ages 45-64

After ACEs trainings, participants indicated high levels of learning and a desire to expand their knowledge and participation in ACEs efforts in their communities.

83% agreed or strongly agreed that they want to seek more information and guidance regarding trauma-informed practice.

79% agreed or strongly agreed that they want to learn more about the causes and effects of ACEs.

78% indicated they *learned a lot* about identifying and addressing ACEs and ACEs' impact on brains and behavior.

68% indicated they *learned a lot* about why their community needs to get organized and mobilized to identify and address ACEs.

Over 90% of participants agreed or strongly agreed that they planned to incorporate their knowledge of ACEs into their daily interactions with family, friends, and their work. Participants also listed an action or behavior they planned to do as a result of the training; selected quotes are to the right.

"I think that this training will help me to better modify, cater, and think through interactions with clients, both pediatric and adult, as well as families."

"[I will] consider students' behaviors as a form of communication and consider what is going on in their life and how best I can support them."

"I will be mindful of the fact that many of my clients have high ACE scores. This will inform the compassion that I display towards them and the options for treatment offered."

Prevention Outcomes

Through their planning, capacity building, and implementation efforts, all Virginia CSBs worked toward common goals set by OBHW through the strategic planning process and the 2020-25 statewide logic model. In the first year of this five-year funding period, CSBs focused on implementing the five required strategies and achieving short-term outcomes associated with those efforts. As the funding period progresses, CSBs will continue to monitor progress towards mid-term and long-term outcomes. Desired long-term outcomes at the state level are presented below, along with the most recent data available related to those outcomes.[6]

Desired Outcomes	Current Indicators
Alcohol	
Decrease in youth alcohol use Decrease in young adult binge drinking	25.4% of VA high school youth report drinking alcohol in the past 30 days 24.6% of VA young adults report binge drinking in the past month
Tobacco/Nicotine	
Decrease in youth tobacco/nicotine use Decrease in adult tobacco/nicotine use	5.5% of VA high school youth report smoking cigarettes in the past 30 days 19.9% of VA high school youth report using a vaping product in the last 30 days 17.9% of VA adults report cigarette use in the past month
Mental Health/Suicide	
Decrease in youth suicide attempts Decrease in youth deaths by suicide Decrease in adult deaths by suicide	7.0% of VA high school youth have attempted suicide in the past year 14.3 per 100,000 youth and young adults ages 15-24 died by suicide in VA in 2019 13.3 per 100,000 individuals aged 15+ died by suicide in VA in 2019

[6] Data on high school youth from the 2019 Virginia Youth Survey. Data on adult substance use from the 2018-2019 National Survey on Drug Use and Health. Data on suicide rates from the Centers for Disease Control and Prevention.

Sustainability

Nearly all CSBs said they worked on developing a partnership structure that will continue to function into the future. In the end-of-year report, all 40 CSBs reported that they are working in one or more ways to ensure that prevention intervention activities and outcomes can be sustained in their communities. In addition to the important effort of developing partnership structures (39 CSBs working on this), 34 CSBs reported they worked to ensure that prevention intervention activities are incorporated into the missions/goals and activities of other organizations. Less frequently reported activities were working to implement local level laws, policies, or regulations (13 CSBs) and working to ensure that prevention staff positions are folded into other organizations (e.g., school districts, etc.) (19 CSBs).

Worked to develop a partnership structure that will continue to function into the future (39 CSBs)

Worked to ensure prevention intervention activities are incorporated into the missions/goals and activities of other organizations (34)

Leveraged, redirected, or realigned other funding sources or in-kind resources (27)

Worked to gain formal adoption of prevention intervention activities into other organizations' practices (23)

Worked to ensure that prevention staff positions are folded into other organizations (19)

Worked to implement local level laws, policies, or regulations to guarantee continuation of intervention (13)

Other work was done (8)

Additional ways that CSBs worked to support sustainability were related to efforts to collaborate across sectors and with local government, capacity-building of staff or community partners related to prevention, identifying additional funding opportunities, and building social media presence in the community.

"Our prevention team established a workgroup to plan, coordinate, develop, and implement virtual prevention activities in collaboration with cross-sector representatives."
– Arlington CSB

Appendix A: Virginia Block Grant Logic Model 2020-25