Annual Report 2017-18

Virginia Partnerships for Success Grant

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Annual Report 2017-18

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Submitted to:

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Katie Gelman, Kait Markley, Ivonne Parra, Naomi Randell, Cindy Vigil, Natalie Wheeler, and Cheryl Winston from OMNI contributed to the creation of this report.

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Virginia Partnerships for Success 2017-18 Annual Report: Executive Summary

Background

In 2015, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) was awarded a Partnerships for Success (PFS) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA). The PFS grant seeks to leverage resources and funding at the state and local levels for prevention work and infrastructure building, as well as enhance state and community capacity to identify and address health disparities. Virginia provides PFS grant funds to nine communities to address opioid and heroin use among youth aged 12-25 years old.

The OMNI Institute has partnered with DBHDS as the evaluator for Virginia's PFS initiative. OMNI prepared this report to provide an update on the progress made during the latest fiscal year of the grant (October 2017 through September 2018) and on community substance use outcome data. As this is an intermediary update in the grant cycle, the data in this report are a snapshot of current status rather than a comprehensive analysis on how outcomes have changed over time.

Building Prevention Capacity

PFS funding has afforded grantee communities the opportunity to build prevention capacity and resources. These important infrastructure improvements during the initial years of the grant contribute to effective planning, implementation, and evaluation of prevention strategies.

PFS funding has strengthened the prevention workforce. By 2018, two thirds of communities felt they had enough staff with the right skills to successfully implement PFS strategies (compared to 22% in 2016).

PFS communities report significantly more capacity now than they did at the beginning of the PFS grant.

PFS communities collaborate with more than a dozen coalitions. These coalitions are highly engaged and remain critical components of PFS success.

From 2016 to 2018, there was a **45% increase in the number of active stakeholders** in PFS communities.

Implementing Prevention Strategies

From local media campaigns to trainings, PFS communities implemented a variety of strategies throughout the year to engage their communities in preventing substance use and reducing access to substances.

Community Reach

Drug Take-Back Events

More than 17 drug take-back events resulted in the collection of thousands of pounds of unused prescription medications.

Safe Storage and Disposal

Drug deactivation packets, smart pill bottles and prescription drug lock boxes were distributed to the community at more than 60 events.

Environmental Strategies

25% of all activities implemented targeted the entire community with their efforts or messaging.

REVIVE! Naloxone Trainings

105 *REVIVE!* trainings taught 850 people how to use life-saving Naloxone to reverse an opioid overdose.

Successes

1. Community partnerships have been key to achieving implementation success.
2. Media campaigns are successfully reaching target audiences and have resulted in increased demand for prevention services.
3. Youth and young adults are becoming increasingly more engaged in PFS efforts.

Challenges and Lessons Learned

1. Establishing partnerships with the medical community to promote the Prescription Drug Monitoring Program have been challenging.
2. Engaging young adults is difficult yet remains important. Young adults are vital as key informants, leaders and ambassadors.
3. Building partnerships and involvement with the Hispanic and Latino populations in PFS communities is a ongoing goal.

> *"We wouldn't be so successful without our outstanding community partners. They have assisted in every step of the SPF process."*
>
> - PFS Community

Monitoring Substance Use Patterns

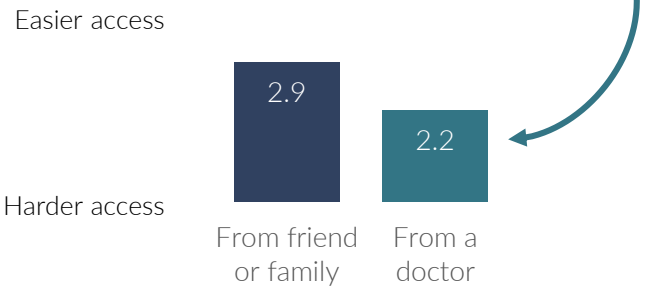
Monitoring substance use patterns over time requires a comprehensive look not only at substance use rates, but also at the causes and consequences of substance use. Throughout the PFS grant, the evaluation has monitored substance use patterns at these three levels:

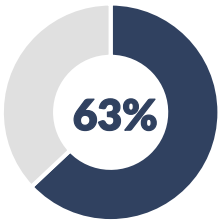
Risk and Protective Factors for Use → **Substance Use** → **Consequences of Use**

Risk and Protective Factors

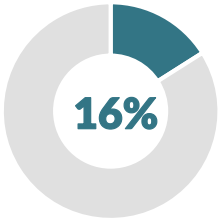
Young adults report it is easier and more common to get misused prescription drugs from friends and family members rather than a health care provider.

Virginia's young adults reported it is harder to access prescription drugs from a doctor than it is to access them from friends or family members.





of Young Adult Survey responses identify friends or family as the source for misused prescription drugs.



of responses identify health care providers as the source for misused prescription drugs.

A greater percentage of young adults think it is risky to use heroin than think it is risky to misuse prescription drugs.

Percentage of young adults who perceive great risk:

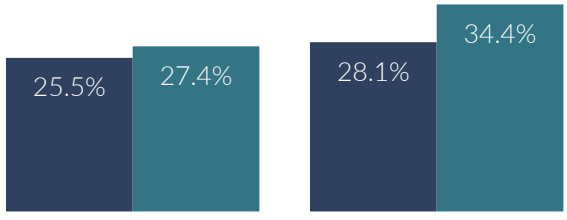
83% Heroin use

54% Prescription drug misuse

40% Binge drinking

Awareness of local prevention strategies increased significantly from 2016 to 2018.

Percentage of young adults aware of strategies:



Substance Use

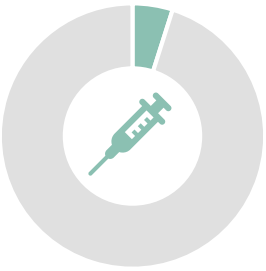
In PFS communities, 1 in 10 young adults misused prescription drugs in the past 30 days. Prescription drug misuse is less common than alcohol consumption and more common than heroin use.

Alcohol: 59%

(increase from 51% in 2016)

Prescription Drugs: 10%

(increase from 9% in 2016)



Heroin: 5%

(increase from 4% in 2016)

Consequences of Substance Use

Early results show opioid fatal overdoses remained steady in PFS communities while they trended upward in Virginia's non-PFS communities and across the nation. This is a notable prevention success. Additional years of data are needed to draw conclusions about long-term changes in consequences of substance use.

Fatal Overdoses

The rate of fatal fentanyl overdoses increased from 2015 to 2016 across Virginia.

During the same period, the rate of fatal opiate overdoses remained steady in PFS communities while it increased in non-PFS communities.

Substance Abuse Services

Admission rates to substance abuse services remained steady from 2015 to 2016.

In both years, the rates of admission to substance abuse services were higher among PFS than non-PFS communities.

Substance-Related Crimes

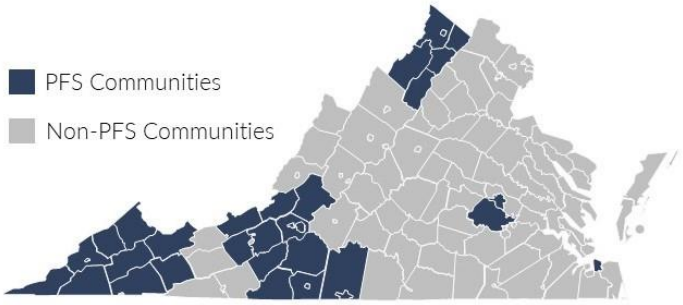
There was no change in the percentage of crimes that were substance related from 2015 to 2016.

The percentage of crimes that are prescription drug- or heroin-related is higher in PFS than non-PFS communities.

Introduction

In 2015, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) was awarded a Partnerships for Success (PFS) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goals of this grant are to (1) reduce and prevent prescription drug misuse and abuse (PDU) among White males and females, ages 12 to 25 and (2) reduce and prevent heroin use among White and Black youth and young adults, ages 15-25, with an emphasis on males. The PFS project also seeks to leverage resources and funding at the state and local levels for prevention work and infrastructure building, as well as enhance state and community capacity to identify and address health disparities.

Virginia funds nine communities[1] to implement substance use prevention strategies targeting the two priority substances. Prevention efforts within these funded communities follow the strategic prevention framework (SPF), SAMHSA's model for planning, implementation, and evaluation of prevention work. In addition, Virginia serves as a comparison group for other PFS grantees who are targeting underage alcohol use among people 12 to 20. Because of this, Virginia is tracking data related to underage drinking, but will not implement specific strategies targeting alcohol.



In February 2016, OMNI Institute (OMNI) was selected as the evaluator for Virginia's PFS initiative. OMNI's role is to lead the design and implementation of the Commonwealth's evaluation, including the identification of measures and provision of technical assistance (TA) to funded communities on collection of these measures. OMNI's team of technical assistance providers has supported communities to: complete needs assessments to identify local prevention needs; develop logic models illustrating prevention goals; and write evaluation plans that document how evaluation data will be collected and analyzed throughout the implementation phases of the project.

The purpose of this report is to provide process data from the latest year of the PFS grant (the fiscal year spanning October 2017 through September 2018) and to update outcome data points on substance use that were included in the PFS baseline report. The data in this report are a snapshot of current status. As this is an intermediary update in the grant cycle, it does not include comprehensive analyses on how outcomes have changed over time. A full analysis of change over the PFS grant will be included in a final report at the close of the grant cycle.

In order to focus on key findings in the report, each data source is briefly introduced in the sections below for context. Details on methodology and all data sources used can be found in the appendix.

[1] There are nine PFS communities, the majority of which represent the catchment area of a Community Service Board (CSB) in Virginia. One community is comprised of a collaborative between four rural CSBs. In this report, the word community is used to reference the catchment areas targeted in the PFS grant.

Building Prevention Capacity

In addition to implementing prevention strategies, PFS communities and OMNI engaged in multiple activities to build prevention capacity across the state. These activities also serve to assess, plan, and evaluate prevention efforts, as well as monitor epidemiological data.

Statewide Initiatives

Young Adult Survey Administration: OMNI worked with communities throughout Virginia to collect survey data from both PFS and comparison non-PFS communities to monitor trends in substance use-related attitudes and behaviors.

Virginia Social Indicator Dashboard: OMNI continued to consult with state agencies and update the dashboard with new data. This work ensures the dashboard remains a current resource for data such as substance-related arrests, overdoses, and treatment.

State Epidemiology Outcomes Workgroup: OMNI facilitated Virginia's SEOW, which includes stakeholders from state agencies who contribute data and expertise in substance use prevention. The SEOW met in April 2018 to prioritize data for a state needs assessment, and again in September 2018 to identify future SEOW activities and deliverables.

SAMHSA Reporting: In coordination with the PFS Project Manager, OMNI compiled and submitted SAMHSA-required reports, including the Community-Level Instrument (community capacity and implementation progress), outcomes data, and quarterly progress updates.

Ongoing Evaluation Guidance and Support: OMNI provided ongoing technical assistance and training to PFS communities as part of Virginia's effort to build evaluation capacity across the prevention workforce. This TA and training was aligned with each of the community-level activities at right.

Community-Level Activities

Logic Models: OMNI supported each community in the development of a logic model outlining their strategies, the risk and protective factors related to their strategies, and outcomes they can measure to determine their impact.

Evaluation Plans: After logic models were completed, communities developed evaluation plans that defined how they will measure short-term outcomes for each strategy implemented.

Data Collection Plans: OMNI developed data collection plans based on communities' logic models and the strategies they planned on implementing. These plans were shared with communities to ensure strategies and data are accurately tracked for SAMHSA reporting.

Ongoing Reporting: Communities captured prevention implementation data in an online tracking system on an ongoing basis. They also completed an end-of-year report summarizing activities completed during the fiscal year and progress toward achieving the outcomes written in their logic models.

PFS Training Summit: Communities engaged in capacity-building trainings, including one focused on health disparities. OMNI provided an overview on evaluation updates and efforts during a day-long gathering.

Annual Capacity Assessment

Data in this section are self-reported by the PFS staff in each community through an annual capacity assessment. Details on this assessment (known formerly in the PFS grant as the Community-Level Instrument) are available in Appendix A.

Community capacity to implement prevention interventions has grown significantly since the start of the PFS grant.

The PFS grant has provided resources for considerable capacity-building among PFS communities. The most common capacity-building activities reported by PFS communities in 2018 were: staff training; identifying key organizational or coalition activities and goals; improving cultural competence; and coordinating or improving technical resources.

As a result of three years of PFS funding and its associated capacity-building opportunities, PFS communities agree more strongly now that they have enough capacity to implement their interventions than they did at the start of the grant. From 2016 to 2018, mean scores in this area increased from 2.41 to 3.09 (out of 4). This increase was statistically significant ($p = 0.02$).

Highest Capacity Areas

In 2018, PFS communities most strongly agreed they have enough capacity in these areas:

- Implementing relevant prevention interventions
- Collaborating with other organizations on prevention interventions
- Using data in prevention planning
- Using data in prevention evaluation

Largest Increases in Capacity

Since the beginning of the grant, PFS communities' agree that capacity has grown the most in the following areas. These increases were statistically significant ($p < 0.01$).

- Fiscal/financial resources
- Number of staff
- Staff with the right skills

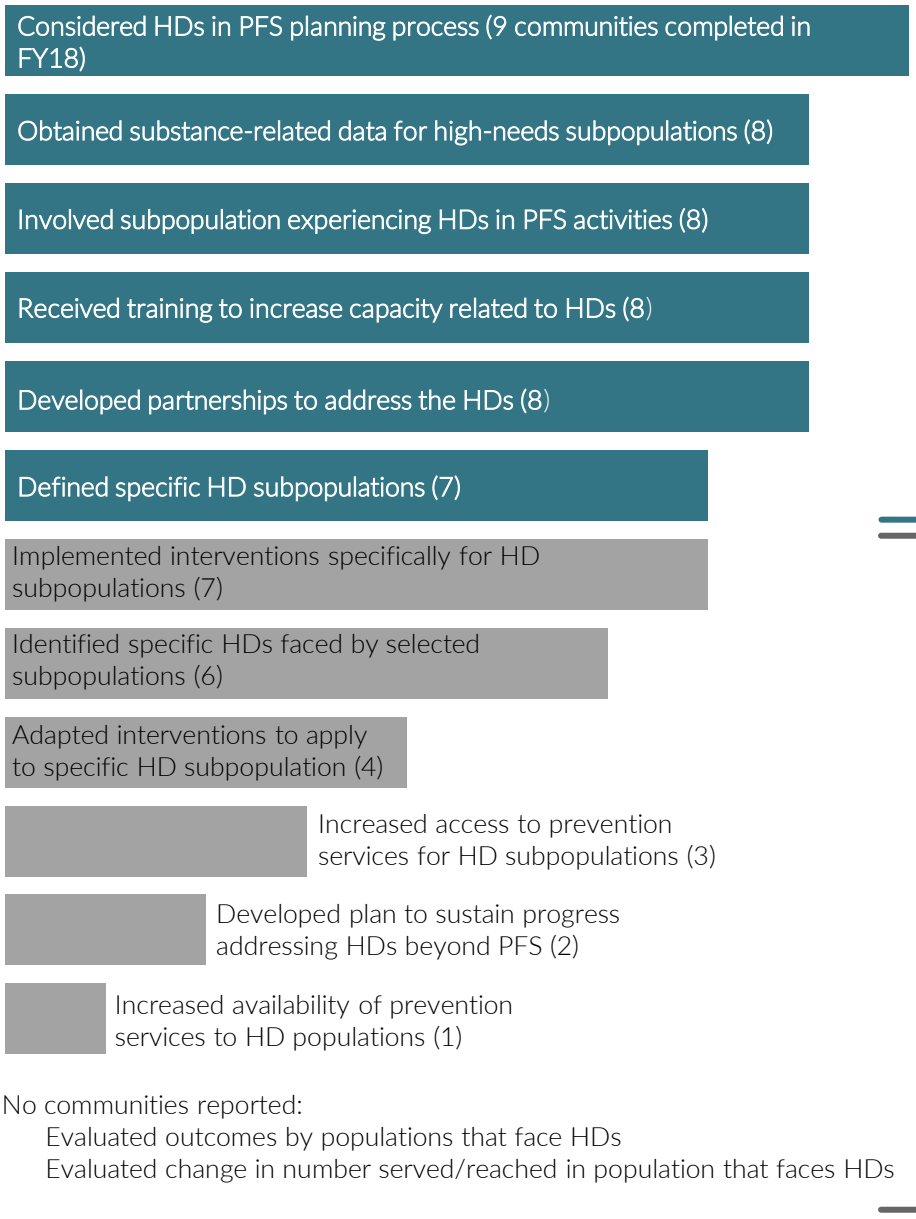
The areas with the largest increases in capacity are likely attributible to the influx of PFS grant funding, which has allowed for staff hiring and attendance at trainings. The areas with the highest capacity are closely aligned with the implementation and evaluation TA provided throughout the grant by OMNI and the PFS Project Manager. This alignment may reflect the effectiveness of the TA services that DBHDS has elected to provide to PFS communities.

> "Through our involvement with the Drug Task Force, we regularly attend community awareness events at churches, schools, and libraries, where we join forces with law enforcement, treatment, recovery, and another prevention coalition to provide information and resources. Community contacts and invested citizens connect with [our coalition] at these events and often become more involved with local efforts." [2]

[2] All quotes throughout this report are from PFS communities' prevention leadership, via qualitative interviews with the OMNI evaluation team or written PFS reports.

PFS communities have significantly increased activities to address health disparities.

On the annual capacity assessment, communities are asked to report which of 14 activities that address health disparities they completed. During FY18, PFS communities completed an average of 8 of the health disparity-related activities listed in the survey. This was a significant increase ($p < 0.01$) from the average of two activities reported in 2016, and a positive indicator that the TA and trainings on health disparities provided by the PFS Project Manager are effective.



The most commonly completed activities across PFS communities addressed health disparities with capacity-building, planning, and data collection activities.

As the latter half of the PFS grant cycle occurs, communities may shift focus to address health disparities in implementation, evaluation, and sustainability activities.

No communities reported:

- Evaluated outcomes by populations that face HDs
- Evaluated change in number served/reached in population that faces HDs

HD = health disparity

Stakeholder involvement is up across PFS communities.

Engaging community stakeholders is an essential part of the PFS grant. PFS communities have reported success in building their stakeholder networks from a variety of community sectors.

The average number of active stakeholders in each PFS community grew significantly from

41 active stakeholders in 2016 ***to*** **60** active stakeholders in 2018.

45% increase in the mean number of active stakeholders

The largest numbers of stakeholders come from these sectors:

1. Youth groups/representatives
2. Law enforcement agencies
3. Health care professionals/agencies
4. Substance use disorder prevention organizations

These four sectors also showed the greatest increases in average number of stakeholders from 2016 to 2018. These sectors are well-aligned with many current PFS interventions, such as installing prescription drug drop boxes in law enforcement buildings and encouraging use of Virginia's Prescription Drug Monitoring Program.

PFS communities are actively planning for the sustainability of prevention activities beyond the PFS funding cycle.

All PFS communities engaged in some activities during FY18 to ensure sustainability of intervention activities and outcomes after the conclusion of the PFS funding. The average number of activities each community completed was three, with the most common activity being the leveraging of funding or in-kind resources.

Sustainability activities	# of communities who engaged in the activity
Leveraged, redirected, or realigned other funding sources or in-kind resources (for example, used the success of the PFS efforts to secure other funds)	6
Incorporated prevention intervention activities into the missions/goals and activities of other organizations (for example, schools and law enforcement)	5
Implemented local level laws, policies, or regulations to guarantee the continuation of prevention intervention activities or outcomes	5
Developed a partnership structure that will continue to function beyond the end of the PFS grant period	4
Folded prevention staff positions into other organizations (for example, school districts and community agencies)	4
Gained formal adoption of prevention activities into other organizations' practices (for example, school curriculum or organizational policy change)	4

Coalition Capacity

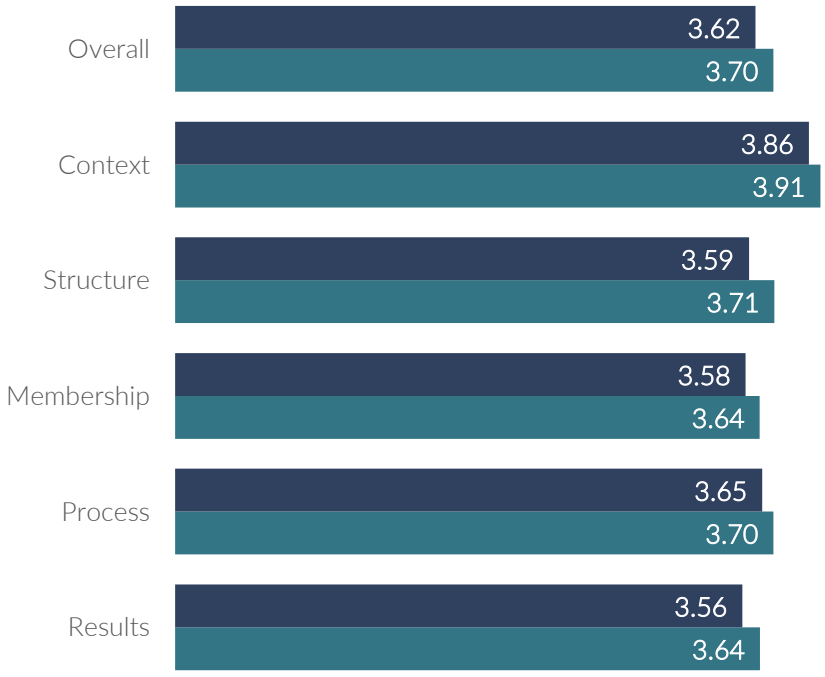
A coalition's capacity is measured by surveying all coalition members on aspects of the coalition's structure and function. Data in this section represent the combined results from all PFS coalitions. More details on the Coalition Readiness Assessment are available in Appendix A and a copy of the assessment is available from OMNI.

Coalition members are satisfied with how their coalitions function, and they indicate PFS-associated coalitions are well-positioned to address community substance use issues.

PFS communities work closely with more than a dozen local coalitions to understand community priorities and support intervention implementation. Across all PFS coalitions, coalition members feel their coalitions are effective and functional bodies. In particular, coalition members scored their coalitions highest in the area of coalition context, which is an indicator of alignment between community needs and the issues the coalition is addressing.

Coalition members rate their coalitions very highly. These high ratings were given in both the 2016 and 2018 administrations of the survey.

2016: n=170 2018: n=207 (Scores can range from 1 to 4.)



"Our community workgroups continue to be highly focused, engaged and active."

Implementing Strategies

Reach and Engagement

From local media campaigns to trainings, PFS communities implemented a variety of strategies throughout the year to engage their communities in preventing substance use and reducing access to substances.

Drug Take-Back Events

More than 17 drug take-back events resulted in the collection of thousands of pounds of unused prescription medications.

Safe Storage and Disposal

Drug deactivation packets, smart pill bottles and prescription drug lock boxes were distributed to the community at more than 60 events.

Environmental Strategies

25% of all activities implemented targeted the entire community with their efforts or messaging.

Community Prevention Messaging

33% of strategies involved distribution of prevention messaging, such as media campaigns.

Leveraged Funding

99% of PFS activities leveraged at least one other funding source, amplifying their reach and impact.

REVIVE! Naloxone Trainings

105 *REVIVE!* trainings taught 850 people how to use life-saving Naloxone to reverse an opioid

Comprehensive Approaches

More than 20% of PFS activities targeted young adults' peers and families, reflecting the multi-dimensional nature of prevention.

Legislative Roundtables

Legislators and stakeholders attended two roundtable discussions to raise their awareness of substance use and prevention issues across Virginia.

"[There is] strong support from our local partners [to begin] stigma reduction around opioid abuse, and the community [is] starting to come together to address an epidemic in our community that left few untouched."

Community Experiences and Feedback

Through anecdotal sharing and the collection of qualitative data from PFS communities, several common themes on implementation successes have emerged.

Community partnerships have been key to achieving implementation success.

"Community partners played a role in inviting us to different events that they were hosting so as to ensure our task was completed."

"We wouldn't be so successful without our outstanding community partners. They have assisted in every step of the SPF process. They were instrumental with the distribution of our Deterra drug deactivation pouches throughout the county. We are pleased with the continued growth of the Heroin Task Force. Every month we add new contacts to our member list."

"Partnering with [organizations] aided in our success in completing our short-term outcomes... Partnering with [the] DEA and [our local] police department also contributed to the collection of 612 pounds of prescription drugs during our April 2018 Drug Take-Back Event."

Media campaigns are successfully reaching target audiences and have resulted in increased demand for prevention services.

"We have several locations in the law enforcement community and private service providers who are interested in having a local drop box."

"*REVIVE!* Trainings have been the most beneficial trainings provided to communities this past year. The demand for this training was created by two social norms campaigns."

"The ads have been very well received and were even retweeted by the doctor who is the head of Physicians Against Opiate Abuse."

"Our media campaigns went very well and were good enough that the state of Tennessee wants to use them. We got free advertising from radio stations and the local Comcast office."

"The Take-Back events [are] always well-received by the community and our media partner support."

"The Young Adult Survey provided great feedback particularly around the reach of our social media campaign, our multimedia campaigns and perception of harm/usage."

Youth and young adults are becoming increasingly more engaged in PFS efforts.

"[Our] Young Adult Action Team helped develop a press release for use in recruiting new members. We were featured on a local TV station due to this effort."

"High school students contacted us to participate in a town hall meeting on heroin/prescription drugs. We are working directly with high school students to update our 6th grade drug curriculum."

Challenges and Lessons Learned

Feedback from PFS communities on the annual capacity survey and from their quarterly progress reports identified several challenges they have faced in implementing strategies. This section of the report provides details on these barriers. Both the Commonwealth and PFS communities may take findings from this section to inform training, TA, and strategy development for the remaining years of the PFS grant.

Despite the differences in priority areas and strategies across PFS communities, they report similar implementation barriers in their communities.

On the annual capacity assessment, each community identified which barriers had an impact on their prevention activities and how impactful it was (low, moderate, or high). The commonalities across communities, and the fact that there is significant overlap between the most common and most impactful barriers, provide direction for future TA and trainings that will help communities address these challenges.

Most Common Barriers

In 2018, all nine PFS communities reported these factors may have introduced barriers to implementing prevention activities:

- Easy access to prescription drugs for nonmedical use
- High poverty rates/low socioeconomic status
- Lack of drug-free activities for area youth
- Lack of supervision for area youth

Highest Impact Barriers

PFS communities rated the following barriers as having the greatest impact on prevention activities:

- Easy access to prescription drugs for nonmedical use
- High poverty rates/low socioeconomic status
- Lack of drug-free activities for area youth
- Not enough funds for prevention interventions

Establishing partnerships with the medical community to promote the Prescription Drug Monitoring Program have been challenging.

"It surprised us that the hospital system was not willing to work with us to train physicians in our southern counties. We encountered resistance from our hospital system, and in response we created [window] clings to give to doctors' offices that say they check the PDMP or if they don't as a way to start the conversation. We also developed posters for doctors' offices that show all the pain medications and asked patients to talk to doctors about the addictive nature of these pills."

"Our biggest challenge was around trying to get permission to do training for doctors around the PDMP through our local medical center. They were not willing to allow us to do the training and wanted us to have another coalition do it that isn't within our partnership."

Engaging young adults is difficult yet remains important. Young adults are vital as key informants, leaders and ambassadors.

"Accessing the 18-25-year-old group of young adults continues to be a challenge; lots of possible work but not enough volunteers/staff to engage in all of it."

"Colleges have been reluctant to allow us to administer the [Young Adult Survey] on campus. We are seeking opportunities to reach out to the population identified for the survey."

Building partnerships and involvement with the Hispanic/Latino populations in PFS communities is a goal.

"The Hispanic community has been reluctant to join our efforts because of stigma that being part of our group may identify them as users. Also, *REVIVE!* trainings have a registration process that many Hispanics are reluctant to fill out because it is entered in a database."

"There seems to be an underreporting by the Hispanic community for fear of deportation. We are working with law enforcement through community [distribution] of Heroin Treatment Resource Cards and are utilizing our Multicultural Liaison for our media campaign."

Monitoring Substance Use Patterns

Risk and Protective Factors for Use | **Substance Use** | **Consequences of Use**

Monitoring substance use patterns over time requires a comprehensive look not only at substance use rates, but also at the causes and consequences of substance use. Throughout the PFS grant, the evaluation has monitored substance use patterns at three levels:

- Risk and protective factors. These variables are best described as individual, social, and environmental factors that make an individual more or less susceptible to engaging in substance use. A risk factor is one that makes an individual more likely to use substances, while a protective factor is one that makes an individual less likely to use substances.
- Substance use. This data captures past 30-day use and lifetime use of the substances of interest, based on self-reported data.
- Consequences of use. Consequence measures - such as substance-related criminal offenses, fatal overdoses, and utilization of behavioral health services - provide a better understanding of the impact of substance use on a community. These are sometimes referred to as the societal costs of substance use. The reduction of these costs are long-term goals of the PFS funding.

The majority of prevention interventions implemented with PFS funding aim to address risk and protective factors for use. The focus on these factors is based on literature that shows impacting risk and protective factors can impact substance use rates and thus the consequences of use. The data in this section are drawn from a variety of sources and, where possible, provide insight on how data have changed since the beginning of the grant.

Risk and Protective Factors

Most risk and protective factor data come from the Young Adult Survey administered by PFS communities in 2016 (n = 3,899) and 2018 (n = 3,111). Responses come from a convenience sample so the participants may not be representative of the full young adult population in these communities. In addition, the young adults who completed the survey were different in 2018 than those who completed it in 2016, and these results do not control for differences between the two groups. Thus, rather than being changes in true risk, the changes in data from 2016 to 2018 may be driven by factors such as: changes in the representation of each community within the full sample; the ways participants were recruited; or the characteristics of those who elected to complete the survey. More information about the Young Adult Survey can be found in Appendix A.

In 2018, the Young Adult Survey was administered by seven non-PFS communities in Virginia to provide comparison data for the PFS communities. Selected results from the non-PFS communities (n = 960) are available in Appendix B.

Where possible, data from the National Survey on Drug Use and Health (NSDUH) are also presented as an additional source for evaluating the state of substance use in Virginia. More information about the NSDUH can be found in Appendix A.

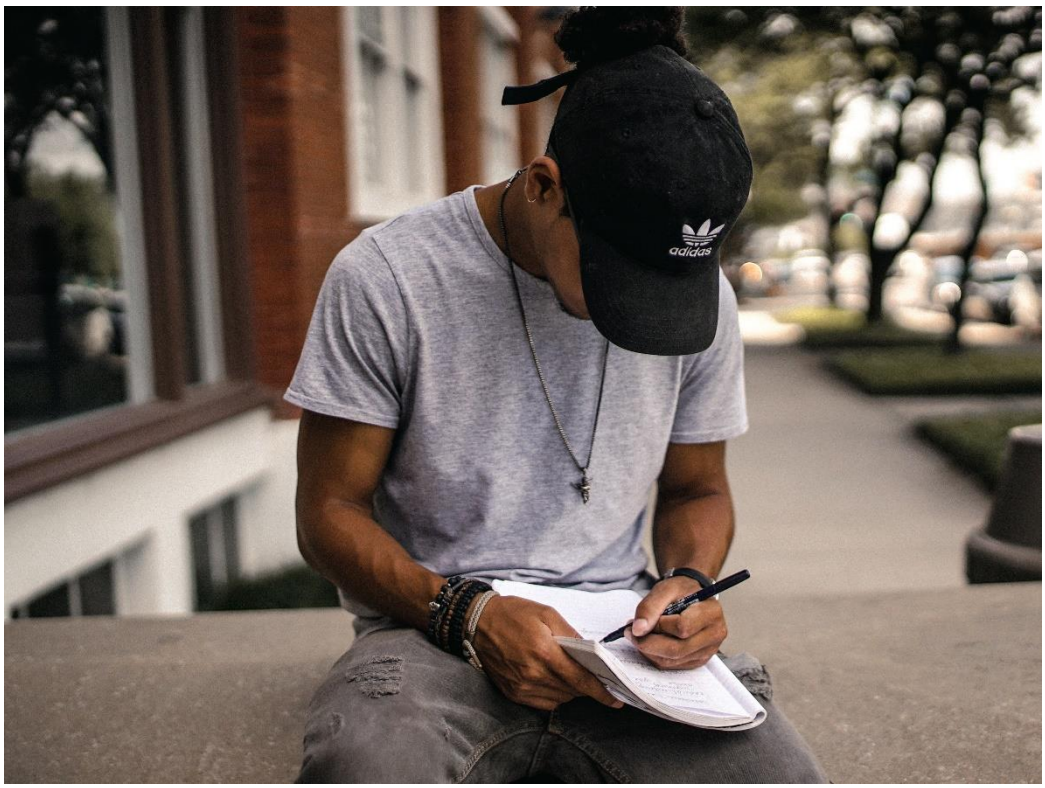
Young adults report that the substances which were the biggest issues in their community in 2016 remain the biggest issues in 2018.

These substances are presented below with the percentage of young adults who feel they are an issue in their community. The comparison group in 2018 identified the same top three issues in the same order. These data suggest that, while the PFS grant is focused on opioid and heroin outcomes, addressing risk and protective factors common to all forms of substance use is critical.

Underage drinking (61%)

Marijuana abuse (57%)

Prescription drug abuse (43%)

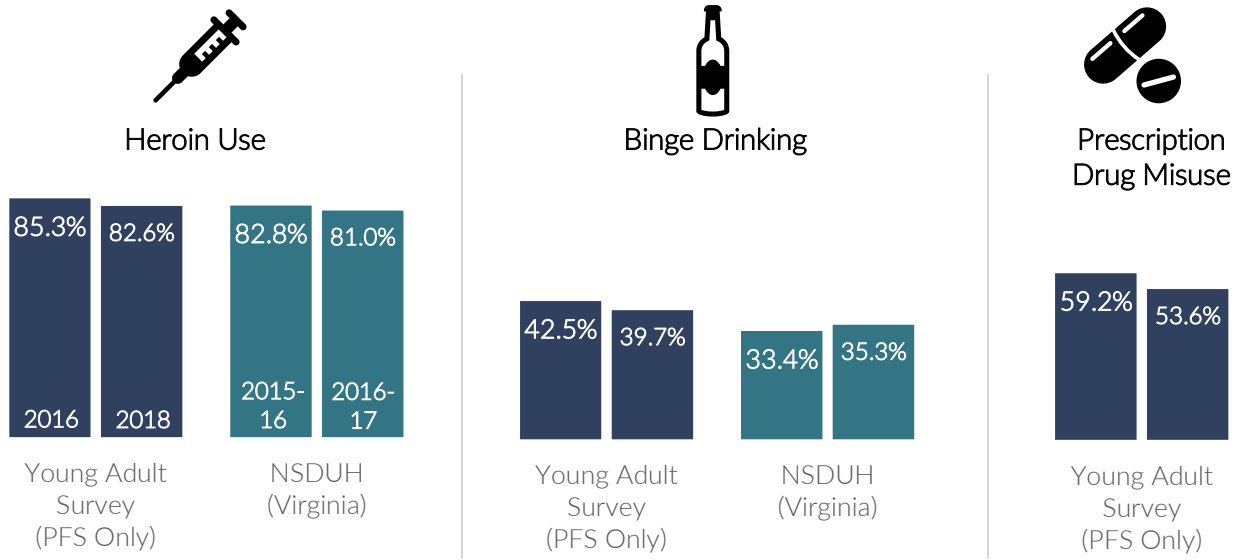


Compared to other substance use behaviors, a greater proportion of young adults believe heroin use poses a great risk.

In both 2016 and 2018, the Young Adult Survey data show that the percentage of young adults in PFS communities who believe that heroin use poses a "great risk" is much larger than the percentage who believe there is "great risk" for other substance behaviors. Data from the National Survey on Drug Use and Health on young adults from across Virginia also support this finding.

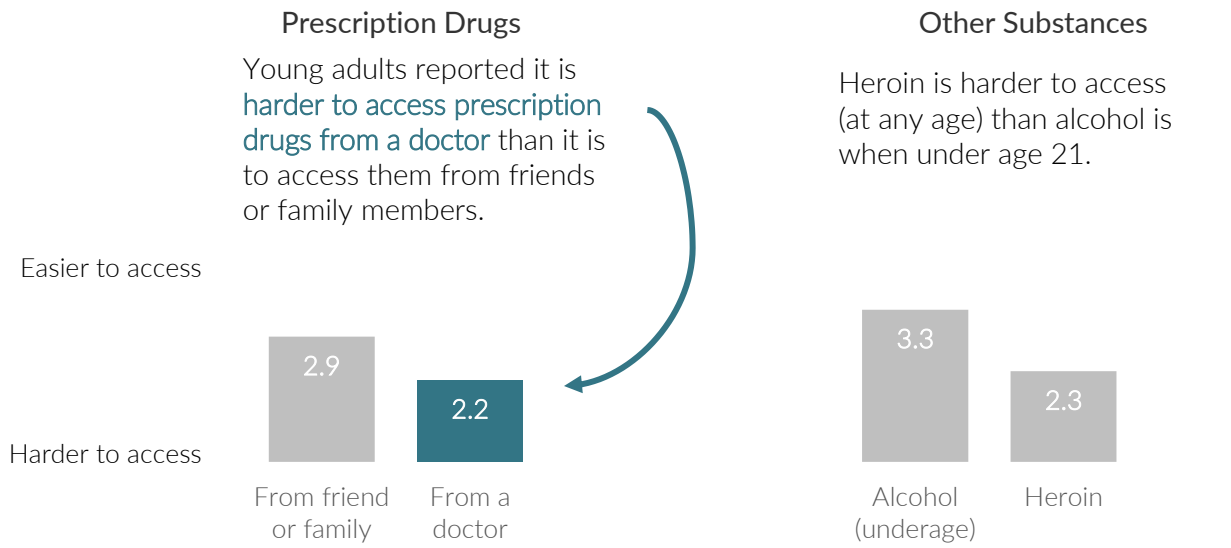
From 2016 to 2018, Young Adult Survey data revealed small but statistically significant shifts in perceived risk of heroin use, binge drinking, and prescription drug misuse. A slightly smaller percentage of young adults surveyed in 2018 think there is "great risk" of engaging in these behaviors compared to the percentage of young adults surveyed in 2016 who thought there was "great risk." More data is needed to draw a conclusion about the long-term trends of perceived risk, but this is an area to watch, as lower perceived risk is a risk factor for substance use.

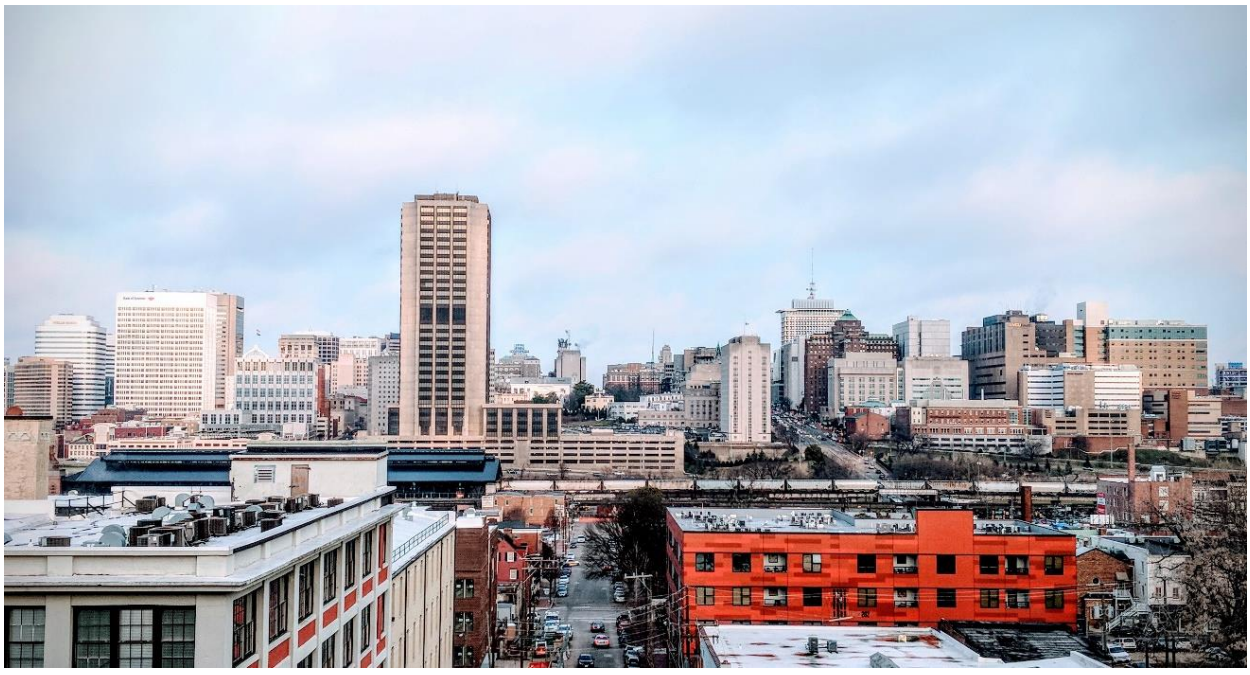
Percentage of young adults in Virginia who perceive "great risk" of...



Perceived ease of access did not change from 2016 to 2018.

The fact that prescription drugs from a doctor were the hardest to access of these substances may reflect success in PFS initiatives that target prescribers, such as encouraging use of Virginia's Prescription Drug Monitoring Program. These data also suggest an ongoing need to target social access to prescription drugs. PFS communities may want to strategically address this need over the remaining PFS grant period.

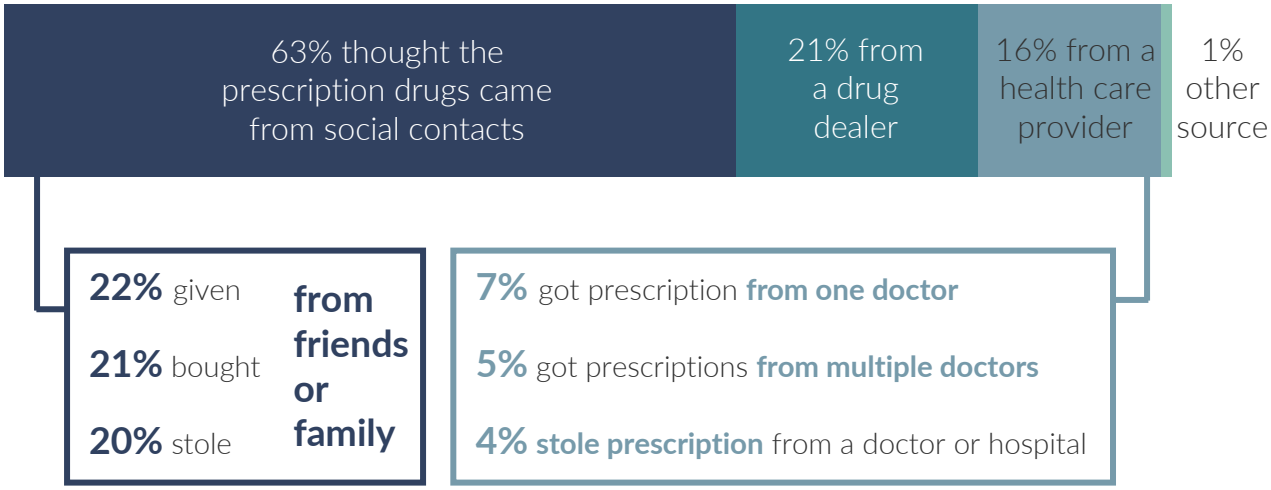




Friends and family members are the most commonly cited source for misused prescription drugs.

Consistent with 2016 data, in 2018, young adults believe the most common sources of misused prescription drugs are social sources (friends and family). These findings align with SAMHSA data on sources of misused prescription drugs and emphasize the importance of restricting the supply of opioids acros the entire community, not just the populations that demonstrate the highest rates of prescription drug misuse. PFS communities' interventions targeting peers and families of young adults are thus key components of a successful prevention strategy.

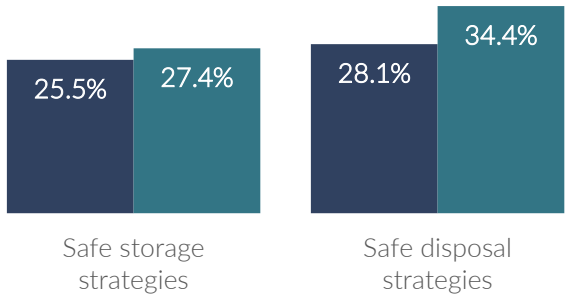
When young adults were asked the source of misused prescription drugs...



Awareness of prevention strategies in PFS communities increased significantly from 2016 to 2018, with drug take-back events generating the most awareness among young adults.

There were significant increases from 2016 to 2018 in the percentage of young adults who said they had heard of safe storage and safe disposal strategies in their community. In 2018, there were also several young adults who recalled hearing about local substance use prevention coalitions. These are encouraging findings which are indicative of the success of PFS communities in raising awareness of their prevention strategies.

Percentage of young adults aware of strategies in 2016 and 2018



Most Recalled Strategies

When asked to name prevention strategies they could recall hearing about in their community, young adults most commonly mentioned:

- Safe disposal/drug take-back events
- Coalitions and their associated CSBs
- Rehab programs, including methadone clinics

> "In speaking to community members, there is a greater awareness that unwanted medications need to be disposed of and other medication needs to be monitored and stored under lock and key."

Substance Use

Substance use data from the Young Adult Survey of PFS communities is presented on this page and serves as a snapshot of the substance use patterns of the older portion of the PFS target demographic. Significant changes occurred from the 2016 survey are noted. On the following page, substance use data from high schoolers across Virginia is included. These data come from the 2017 Virginia Youth Survey and provide insight on the younger portion of the PFS target demographic.

For alcohol, prescription drugs, and heroin, there were significant increases in the percentage of young adults who reported using these substances in the past 30 days.

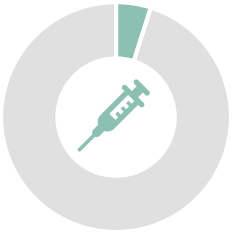
Percentage of young adults who used each substance in the past 30 days:

Alcohol: 59%

(increase from 51% in 2016)

Prescription Drugs: 10%

(increase from 9% in 2016)



Heroin: 5%

(increase from 4% in 2016)

More than a quarter of young adults report ever having misused prescription drugs. This is a small, but statistically significant increase since the 2016 Young Adult Survey.

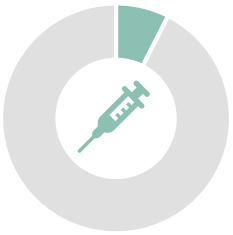
Percentage of young adults who have ever used each substance:

Alcohol: 85%

(81% in 2016)

Prescription Drugs: 27%

(increase from 26% in 2016)



Heroin: 8%

(7% in 2016)

A quarter of high school students reported drinking alcohol in the past 30 days and five percent reported misusing prescription drugs.

Percentage of Virginia high schoolers who used each substance in the past 30 days:

Alcohol: 25%

(23% in 2015)

Prescription Drugs: 5%

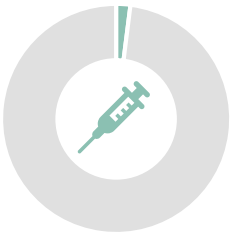
(2015 data not available)

In their lifetime, 13% of high school students reported misusing prescription medicine and two percent reported ever using heroin.

Percentage of Virginia high schoolers who have ever used each substance:

Prescription Drugs: 13%

(16% in 2015)



Heroin: 2%

(2% in 2015)

Consequences of Substance Use

The consequence measures being tracked over the course of this grant are related to alcohol, heroin, prescription drug use, and fentanyl[3]. Data for each of the consequence measures can be found on the Virginia Social Indicator Dashboard. For each of the data sources and indicators below, the statistics for PFS communities and non-PFS communities are presented, as well as notes on how the data have changed since the last report. Regression analysis was used to calculate change over time. In cases where the indicator significantly changed over time, the direction of change is noted. This information should be interpreted cautiously, as changes or lack of changes over time cannot be directly tied to PFS activities and may be related to other contextual factors. Note that due to lags in data collection and release by state agencies, this section includes data from the first two fiscal years of PFS funding (2015 and 2016).

In PFS communities, the percentage of crimes that are prescription drug- or heroin-related is higher than in non-PFS communities, but still lower than alcohol-related crimes.

Across all substances, and for both PFS and non-PFS communities, there was not a statistically significant change in the percentage of substance-related crimes from 2015 to 2016.

Substance Related Crime, 2015-2016		Percentage of Crimes (FY 2015)	Percentage of Crimes (FY 2016)	Change from 2015 to 2016
Alcohol-Related Crime (Ages 12-25)	PFS Communities	7.66%	7.15%	No change
	Non-PFS Communities	8.98%	7.68%	No change
Prescription Drug-Related Crime[4] (Ages 12-25)	PFS Communities	1.00%	0.93%	No change
	Non-PFS Communities	0.77%	0.86%	No change
Heroin-Related Crime (Ages 15-25)	PFS Communities	0.91%	0.95%	No change
	Non-PFS Communities	0.61%	0.69%	No change

[3] See Appendix C for further information on fentanyl and why it is included in this report.
[4] There is not a single category for prescription drug-related arrests. A prescription drug category was created which included arrests coded as involving morphine, other narcotics, other stimulants, barbiturates, other depressants, or other drugs. This categorization may include some arrests involving non-prescriptions drugs, such as bath salts, and exclude some arrests involving prescription drugs such as Adderall.

In both PFS and non-PFS communities, the rate of fatal fentanyl overdoses more than doubled between 2015 and 2016. Opiate prescription drug overdoses remained steady in PFS communities during this period.

In both 2015 and 2016, overdose rates were higher in PFS communities than in non-PFS communities. The rate of opiate prescription drug overdoses significantly increased in non-PFS communities; there were 3.24 opiate prescription drug overdoses per 100,000 people in 2015 and 4 opiate prescription drug overdoses per 100,000 people in 2016. Considering the trend in non-PFS communities in Virginia and nationwide, the fact that the opioid overdose rate remained steady in PFS communities should be considered a prevention accomplishment.

In both PFS and non-PFS communities, the rate of fentanyl overdoses more than doubled between 2015 and 2016. This increase was statistically significant and warrants attention from the commonwealth's prevention workforce.

Fatal Overdoses, 2015-2016		Rate per 100,000 (2015)	Rate per 100,000 (2016)	Change from 2015 to 2016
Alcohol[5] Overdoses	PFS Communities	2.11	3.07	No change
	Non-PFS Communities	1.63	2.15	No change
Opiate Prescription Drug[6] Overdoses	PFS Communities	6.19	7.44	No change
	Non-PFS Communities	3.24	4.00	↑ Increased
Heroin Overdoses	PFS Communities	4.83	6.48	No change
	Non-PFS Communities	3.53	4.58	No change
Fentanyl Overdoses	PFS Communities	3.42	8.54	↑ Increased
	Non-PFS Communities	2.24	6.45	↑ Increased

"We saw an increase [in] engagement from school partnerships with school social workers and nurses due to three high school student overdose deaths related to opioids. We heard from our EMS partners that one of the participants in a *REVIVE!* training used the Narcan they received from our community training to reverse an opioid overdose."

[5] Death involved a blood alcohol concentration >0.08%.
[6] One or more opiate prescription drugs caused or contributed to death (codeine, hydrocodone, hydromorphone, methadone, morphine-no-heroin, oxycodone, oxymorphone, tramadol).

There were no changes in the admission rates to substance abuse services from 2015 and 2016. The admission rates remain higher in PFS communities than non-PFS communities across Virginia.

In both 2015 and 2016, the rates of admission to substance abuse services were higher among PFS communities than non-PFS communities. Across all substances, and for both PFS and non-PFS communities, there was no change in the rate of admission to substance abuse services between 2015 and 2016.

Admission to Substance Abuse Services, 2015-2016		Rate per 10,000 (2015)	Rate per 10,000 (2015)	Change from 2015 to 2016
Alcohol	PFS Communities	22.11	20.98	No change
	Non-PFS Communities	20.78	17.63	No change
Heroin	PFS Communities	9.94	11.06	No change
	Non-PFS Communities	5.43	5.83	No change
Other Opiate/Synthetic	PFS Communities	17.26	17.94	No change
	Non-PFS Communities	5.48	5.15	No change
Other Amphetamine/Stimulant	PFS Communities	0.73	0.84	No change
	Non-PFS Communities	0.71	0.61	No change
Benzodiazepine	PFS Communities	5.36	5.23	No change
	Non-PFS Communities	1.37	1.36	No change

The rate of seizures of fentanyl rose from 2015 to 2016, especially in non-PFS communities, where the increase was statistically significant.

In 2015, the average drug seizure rate for PFS communities was higher than the average drug seizure rate for non-PFS communities for all substances except fentanyl. In 2016, the average drug seizure rate was higher in PFS communities compared to non-PFS communities for all substances. From 2015 to 2016, the rate of fentanyl seizures significantly increased in non-PFS communities from 5.82 to 16.93 fentanyl seizures per 100,000 people.

Similar to drug arrest rates, drug seizure rates are likely more attributable to law enforcement strategies rather than drug use rates in a given community. As such, caution should be used when using this measure to evaluate prevention and intervention initiatives because changes on this measure could be due to a change in law enforcement efforts rather than a change in drug use in the community.

Drug Seizures, 2015-2016		Rate per 100,000 (2015)	Rate per 100,000 (2016)	Change from 2015 to 2016
Opiate Prescription Drug[7] Seizures	PFS Communities	137.60	123.64	No change
	Non-PFS Communities	45.37	47.15	No change
Heroin Drug Seizures	PFS Communities	95.56	98.46	No change
	Non-PFS Communities	50.65	56.12	No change
Fentanyl Drug Seizures	PFS Communities	5.78	20.46	No change
	Non-PFS Communities	5.82	16.93	↑ Increased

[7] Drug seizure cases involving at least one prescription opioid painkillers, such as Vicodin and OxyContin.

Appendix

A. Methodology and Data Sources

Methodology

This report includes a variety of process data reported by PFS communities as well as outcome data collected from the external agencies. This is intended to be an update to the PFS baseline report produced in 2017. It builds on the data included in that report by adding trend data collected since that report was produced, allowing for a preliminary look at the progression of communities since the beginning of the PFS grant. This report is designed to provide an intermediary look at progress in communities. Where appropriate, statistical tests were used to determine whether changes since the baseline report are statistically significant. OMNI intends to produce intermediary reports such as this annually, followed by a final report at the end of the PFS grant that will allow for a more comprehensive and in-depth look at the outcomes of the five-year grant.

Data Sources

Annual Capacity Assessment (formerly the Community-Level Instrument)

The Community-Level Instrument (CLI) was a SAMHSA-required reporting tool for the first two years of the PFS grant. It was administered every six months, starting in 2016 and ending with the last administration completed at the end of 2017. SAMHSA discontinued use of the CLI in 2018. OMNI and the PFS project management team identified select questions from the CLI that were important to continue measuring for evaluation of the project and administered a shortened version of the CLI to PFS communities in October 2018. These questions, now referred to as the Annual Capacity Assessment will be administered to communities through the end of the grant.

Coalition Readiness Surveys

PFS communities administer a 29-item survey to their coalition members to assess the coalition's readiness to address the substance use issues the PFS grant work is targeting. The readiness assessment provides scores in the following areas: coalition context, coalition structure, coalition members, coalition process, and coalition results. The communities administered the survey in 2016 (n = 170) at the beginning of the grant and re-administered the survey in 2018 (n = 208) to assess change in readiness since then. This report includes data from both timepoints.

Drug Seizures

Data provided by the Virginia Department of Forensic Science via the National Forensic Laboratory Information System reflects cases in which drugs were seized and tested by law enforcement agencies throughout the commonwealth. When multiple drug samples of the same type of drug were submitted as part of the same case, they were only counted a single time. When multiple samples of different drug types were submitted as part of the same case, they were counted as a single case for each included drug type. Data presented in this report represent drug seizure rates of PFS communities and non-PFS communities for prescription opioids, heroin, and fentanyl.

Fatal Overdoses

Drug mortality data are provided through the Virginia Medical Examiner Database System (VMEDS). VMEDS is an internal agency database which contains detailed information on all deaths reported to the Office of the Chief Medical Examiner (OCME). Data include accepted cases of either full autopsy or external exams, accidental and undetermined fatal drug overdoses. Due to the nature of law enforcement and OCME death investigation, all deaths are based upon locality of occurrence and not residential status of the decedent.

National Survey on Drug Use and Health (NSDUH)

The NSDUH is an annual survey administered by SAMHSA that measures consumption rates of several substances, perceived risk of substance use, and prevalence of mental health and substance use disorders. NSDUH data are also used to "identify the extent of substance use and mental illness among different sub-groups, estimate trends over time, and determine the need for treatment services."[8]

Performance Based Prevention System (PBPS)

PFS communities are required to report process data (numbers served and reached) in the PBPS on an ongoing basis. OMNI provides regular technical assistance to communities to ensure accurate data entry in the PBPS, which is a site managed by Collaborative Planning Group. At the end of the fiscal year, OMNI also conducted an audit of the PFS data to ensure accuracy.

Quarterly Reports from Communities

All PFS communities complete a quarterly progress report that was designed jointly by the PFS Project Manager and the OMNI team. In these reports, communities identify activities completed, accomplishments, and technical assistance needs that arose over the past quarter. This report includes qualitative data gathered from the 2017-18 fiscal year quarterly reports.

Substance Abuse Services Admissions

Data on admissions to substance abuse services are provided by the Virginia Department of Behavioral Health and Developmental Services from the Community Consumer Submission 3 (CCS3) dataset. This dataset collects information on the number and characteristics of individuals receiving substance abuse services from CSBs. Data reflect information collected at admission to care and may be duplicated across individuals receiving multiple episodes of care over the time period. Geographic data (PFS/non-PFS) reflects place of service provision, not residence of the individual seeking services. The table in this report presents admission rates for alcohol, heroin, other opiate/synthetics, other amphetamine/stimulants, and benzodiazepines. Prescription drug misuse is likely to be captured across the latter three categories of substances.

Substance-Related Crime

Crime data was provided by the Virginia Department of Criminal Justice Services Research Center from the Virginia Uniform Crime Reports (UCR). Virginia UCR data are submitted by local law enforcement agencies to the Incident-Based Crime Reporting Repository, administered by the Virginia Department of State Police. Substance use-related crime includes producing, distributing, buying, using, or possessing controlled substances. Percentages were calculated for the specific

[8] National Survey on Drug Use and Health, SAMHSA, U.S. Department of Health and Human Services. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

age group of interest (12-25 for alcohol and prescription drugs, 15-25 for heroin) by taking the number of substance related crimes divided by the total number of crimes in that region.

It is worth noting that drug arrests are a nuanced consequence measure because they can be reflective of many other contextual factors. More specifically, these rates are likely more reflective of local law enforcement strategies rather than reliable estimates approximating drug use in a given community. It is possible for a community with a high drug use rate to have a low drug arrest rate due to limited law enforcement resources or different priorities in the area. Similarly, a community with a low drug use rate could have a high arrest rate if law enforcement resources are being allocated toward drug monitoring and control in that community. Therefore, changes in this measure over time should be interpreted with caution since they may not illustrate changes in drug use, but rather changes in drug enforcement.

Virginia Youth Survey

The Virginia Department of Health administers the Virginia Youth Survey (VYS) to collect data on youth health risk behaviors. Topics assessed include: tobacco use, alcohol and other substance use, physical activity, dietary habits, and mental health indicators. The survey is administered every odd year in randomly selected Virginia public schools. More information is available from the Department of Health at http://www.vdh.virginia.gov/livewell/data/surveys/youthsurvey/home.html.

Young Adult Survey

The Young Adult Survey was written by OMNI in conjunction with the Virginia State Epidemiological Outcomes Workgroup (SEOW) in 2016. The target population for this survey is young adults in Virginia between the ages of 18 and 25, and each PFS community is responsible for administering the survey in their catchment area. The survey includes questions about attitudes, perceptions and behaviors related to substance use, and is administered every other year throughout the PFS grant. This report includes data from two administrations: 2016 (n=3,899) and 2018 (n=3,111). In addition to the survey limitations provided on page 19, it should be noted that the representation of PFS communities within the sample was different at the two timepoints, as shown in the table below.

Community	2016		2018	
	# of respondents	percent of sample	# of respondents	percent of sample
Blue Ridge	200	5%	227	7%
Chesterfield	740	19%	296	9%
Danville-Pittsylvania	275	7%	189	6%
New River Valley	133	3%	594	19%
Norfolk	142	4%	58	2%
Northwestern	1,202	31%	1,139	37%
Piedmont	62	2%	120	4%
Richmond	365	9%	344	11%
Southwest Collaborative	780	20%	144	5%
TOTAL:	3,899	100%	3,111	100%

In 2018, in addition to the nine PFS communities who administered the survey, seven non-PFS communities across Virginia administered it to provide a comparison data source. These seven communities were chosen based on comparability to PFS communities on a variety of factors. DBHDS provided each comparison community funds to cover the cost of administration and incentives for survey participants. Because these comparison sites are not a scienctific comparison group and there was a large difference in sample size between PFS communities (n = 3,111) and non-PFS communities (n = 960), there is limited ability to make comparisons between the two groups.

B. Comparison Data for the Young Adult Survey

The data in this section come from the 960 survey responses collected by the non-PFS comparison communities in 2018. The seven comparison communities are the catchment areas of these CSBs: Alexandria, Alleghany-Highlands, District 19, Fairfax-Falls Church, Horizon, Rappahannock-Rapidan, and Southside.

Top Substance Use Issues in the Community

When asked what the top issues in their community are, the substances below were most commonly identified by young adults in the comparison sample.


Underage drinking (73%)


Marijuana abuse (70%)


Prescription drug abuse (40%)

Perceived Ease of Accessing Substances

Mean Ease of Access (out of 4):	
Alcohol underage	3.2
Prescription drugs from a friend or family member	2.9
Prescription drugs from a doctor	2.2
Heroin	2.2

Perceived Risk of Substance Use

Percentage of respondents who perceive great risk of...	
Heroin use	81%
Prescription drug misuse	57%
Binge drinking	47%

Sources of Misused Prescription Drugs

Awareness of Prevention Strategies

Percentage of respondents who have seen or heard information in the last 12 months about:	
Safe disposal strategies	29%
Safe storage strategies	26%

Percentage of Young Adults who Used Substances in the Past 30 Days

Alcohol: 45%

Binge Drinking: 25%

Prescription Drugs: 6%

Heroin: 3%

C. Note about Fentanyl Data

Fentanyl is a powerful synthetic opioid drug that is 50-100 times more potent than morphine. It is manufactured legally as a medical prescription painkiller, and is also produced illicitly and sold on the illegal drug market. It can be used as a stand-alone drug; however, fentanyl is most often mixed with heroin without the user's knowledge, or sold as tablets that mimic other less potent opioids. Fentanyl is cheaper to make than heroin and much more potent, which equates to more doses per batch at a lower cost compared to other drugs.

The reason fentanyl is being included in this report is because illicitly manufactured fentanyl is the main driver of the recent increase in overdose deaths involving synthetic opioids at both the national and commonwealth level. From 2010 to 2015, annual overdose deaths involving opioids in the United States increased by nearly 57%. This notable rise in deaths was attributed to synthetic opioids other than methadone, which rose from 3,007 to 9,580, an increase of 219%.[9] From 2010 through 2013, the rate of synthetic opioid overdose deaths in Virginia was about 1 per 100,000. Then from 2013 to 2015, the rate more than tripled, reaching 3.1 per 100,000 people.[10]

Data from the Drug Enforcement Agency's National Forensic Laboratory Information System (NFLIS) indicate that drug submissions testing positive for fentanyl (fentanyl reports) rose dramatically in Virginia from 42 in 2010 to 557 in 2015.[11] Prescribing rates for pharmaceutical fentanyl in Virginia remained stable between 2010 and 2015, at a prescription rate of about 17 per 1,000 people. These figures demonstrate the increasing role that illicitly produced fentanyl plays in the opioid epidemic in Virginia, and the importance for its inclusion in this report examining consequences associated with substance use.

[9] Centers for Disease Control and Prevention (2017). Prescription Behavior Surveillance System: Issue Brief. https://www.cdc.gov/drugoverdose/pdf/pbss/PBSS-Report-072017.pdf
[10] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2015 on CDC WONDER Online Database, released 2016.
[11] Centers for Disease Control and Prevention (2017). Prescription Behavior Surveillance System: Issue Brief. https://www.cdc.gov/drugoverdose/pdf/pbss/PBSS-Report-072017.pdf