West Virginia

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/23/2021 9.29.54 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

NOT FINAL

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State SAPT DUNS Number

Number 618137715

Expiration Date 2/9/2018

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

Agency Name West Virginia Department of Health and Human Resources

Organizational Unit Office of the Secretary

Mailing Address One Davis Square, Suite 100 East Office of the Secretary

City Charleston

Zip Code 25301

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

First Name Elliott

Last Name Birckhead

Agency Name West Virginia Department of Health and Human Resources

Mailing Address 350 Capitol Street, Room 350

City Charleston

Zip Code 25301

Telephone (304) 352-5558

Fax 304-558-1008

Email Address elliott.h.birckhead@wv.gov

State CMHS DUNS Number

Number 618137715

Expiration Date 2/9/2018

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

Agency Name West Virginia Department of Health and Human Resources

Organizational Unit Office of the Secretary

Mailing Address One Davis Square, Suite 100 East Office of the Secretary

City Charleston

Zip Code 25301

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

First Name Christina

Last Name Mullins

Agency Name West Virginia Department of Health and Human Resources

NOT FINAL

Mailing Address 350 Capitol Street, Room 350

City Charleston

Zip Code 25301

Telephone 304-352-5837

Fax 304-558-2230

Email Address Christina.R.Mullins@wv.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Melissa

Last Name Mullins

Telephone 304-352-5608

Fax 304-558-1008

Email Address Melissa.D.Mullins@wv.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: ______________________________

Name of Chief Executive Officer (CEO) or Designee: Bill J. Crouch

Signature of CEO or Designee[1]: ______________________________

Title: Cabinet Secretary

Date Signed: ______________________________

mm/dd/yyyy

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[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Jim Justice

Governor of West Virginia

September 1, 2017

Bill J. Crouch, Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Cabinet Secretary Crouch:

This letter is to authorize you in your position as Cabinet Secretary of the West Virginia Department of Health and Human Resources to serve as my designee for the purpose of signing the combined Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) application, certifications, waiver requests, etc.

This authorization will remain in effect until further notice.

Sincerely yours,

Jim Justice
Governor

JJ:mh

Enclosure

State Capitol | 1900 Kanawha Blvd., East, Charleston, WV 25305 | (304) 558-2000

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
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3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Bill J. Crouch

Signature of CEO or Designee[1]: ______________________

Title: Cabinet Secretary

Date Signed: ______________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Jim Justice
Governor of West Virginia

September 1, 2017

Bill J. Crouch, Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Cabinet Secretary Crouch:

This letter is to authorize you in your position as Cabinet Secretary of the West Virginia Department of Health and Human Resources to serve as my designee for the purpose of signing the combined Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) application, certifications, waiver requests, etc.

This authorization will remain in effect until further notice.

Sincerely yours,

Jim Justice
Governor

JJ:mh

Enclosure

State Capitol | 1900 Kanawha Blvd., East, Charleston, WV 25305 | (304) 558-2000

State Information

Disclosure of Lobbying Activities

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

Name

Bill J. Crouch

Title

Cabinet Secretary

Organization

West Virginia Department of Health and Human Resources

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Organizational Overview of Public M/SUD System at the State and Local Level

The Bureau for Behavioral Health (BBH) is the federally designated Single State Agency (SSA) and State Mental Health Authority (SMHA) for mental health, substance use, and intellectual and developmental disabilities in West Virginia. The BBH is responsible for administering the Substance Abuse Prevention and Treatment and Community Mental Health Block Grant. Through the Block Grant and a combination of other federal grants and state funding, BBH supports comprehensive behavioral health prevention, promotion, early intervention, treatment, and recovery programs statewide. Funding is also provided for community-based behavioral health services for persons with behavioral needs, including those who are uninsured or underinsured. The BBH operates under the auspices of the West Virginia Department of Health and Human Resources (WVDHHR) which includes the Bureau for Children and Families (BCF), Bureau for Medical Services (BMS), and Bureau for Public Health (BPH). Collaboration on a variety of grants and projects occurs between BBH and each of the other Bureaus housed within WVDHHR. The BBH provides leadership, oversight, and coordination of policy, planning, development, funding, and monitoring of the public behavioral health system. Additionally, BBH is the host agency for the State Epidemiological Outcomes Workgroup.

Both the work done by the BBH and the Substance Abuse and Mental Health Services Administration (SAMHSA) share the same principles:

- Support the adoption of evidence-based practices.
- Increase access to the full continuum of services for mental and substance use disorders.
- Engage in outreach to clinicians, grantees, patients, and the public.
- Collect, analyze, and disseminate data to inform policies, programs, and practices.
- Recognize that the availability of mental and substance use disorder services is integral to everyone's health.

The mission of the BBH is to serve the people of West Virginia by working with strategic partners to advance access to and improve the quality of statewide behavioral health services so that residents feel empowered to reach their full potential. The Bureau champions wellness, resilience, and recovery of West Virginians and values the lived experiences of stakeholders, families, and communities. In the simplest of terms, we believe in the power of connection and hope.

Organizational Structure: Bureau for Behavioral Health

Previously known as the Bureau for Behavioral Health and Health Facilities, in July 2018 the Bureau was split into two separate and distinct entities under the umbrella of the West Virginia Department of Health and Human Resources (WVDHHR). The Office of Health Facilities (OHF)

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is now responsible for oversight of the state-owned and operated hospitals with long-term or acute care psychiatric functions for adults and the BBH is responsible for the statewide administration of community-based behavioral health services.

The Commissioner's Office provides direction to the Bureau and communicates the goals of WVDHHR/BBH to the community to ensure continuity of services. Underneath the Commissioner's Office are two integrated sections (Programs and Policy, and Administration and Operations), each overseen by a Deputy Commissioner.

Staff within the Programs and Policy section are charged with the development, implementation, and oversight of the statewide community-based behavioral health system of care and must ensure that individuals with mental health, substance use, or developmental disorders have meaningful treatment and support services to maximize their abilities to function as productive and stable citizens of West Virginia within the least restrictive environments suitable to their needs. Funding is provided to comprehensive community behavioral health centers and other providers to provide for a statewide continuum of care and supports for individuals in need of prevention, intervention, treatment and recovery, as well as related supports and services.

The Programs and Policy section is currently undergoing a reorganization by adding the newly to developed Office of Adult Substance Use Disorder. This Office is being formed by bringing together SUD staff from the Office of Adult Services, SOR, and adding in newly funded positions dedicated to serving pregnant and postpartum women (PPW). The reorganization should be completed by late Summer/early Fall. The Programs and Policy section is now comprised of the following Offices:

- Office of Adult Services
- Office of Adult Substance Use Disorder
- Office of Children, Youth, and Family Services
- Office of Policy, Planning, Research, and Compliance

The Office of Adult Mental Health Services ensures and provides access to services and supports to meet the mental health and co-occurring needs of adults and transitional-aged youth, enabling them to live, learn, work, and participate actively in their communities. The Office of Adult Services also establishes standards to ensure effective and culturally competent care to promote recovery. In addition, the Office of Adult Services sets policy, promotes self-determination, protects human rights, and supports mental health training and research.

The Office's priorities include development and expansion of peer and family supports, the West Virginia Leadership Academy, recovery education, housing and homeless outreach to individuals with mental health issues, coordination and delivery of services for returning veterans and their families, integrated primary care and mental health services, and operational support for the West Virginia Mental Health Planning Council. The Office provides leadership, facilitation, technical assistance, and funding to support children and adults who have intellectual/developmental disabilities, prioritizing self-advocate/family/provider awareness of and access to community

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services and supports, and developing services and supports for individuals with complex support needs.

The Office of Adult Substance Use Disorder (SUD) administers programs to promote SUD treatment and recovery within West Virginia, with a division specifically focused on providing services to pregnant and postpartum women (PPW) with SUD. The Office is also responsible for implementing the strategies, policies, and practices required to administer SUD services in accordance with federal and state programmatic regulations, requirements, and standards. This includes the statewide programs associated with the federal Substance Abuse Block Grant and the federal State Opioid Response (SOR) grant among others. The number of SUD treatment and recovery facilities has grown significantly over the past five years and has required increased collaboration with a variety of partners, both at the state and community levels. Collaborative partnerships include working with BMS to implement the SUD waiver, harm reduction services administered through BPH, offender reentry services through the Division of Justice and Community Services, as collaborative work with the Office of Drug Control Policy.

The Office of Children, Youth and Families administers programs to promote the behavioral health of children and youths in West Virginia communities through primary prevention and individualized services for mental health, substance use, and intellectual and developmental disabilities. The Office provides leadership, technical assistance, and funding to support children and youths with serious emotional disturbances (SED), young adults transitioning to adulthood with serious mental illness (SMI) or early serious mental illness (ESMH)/First-Episode Psychosis (FEP), children and youths with intellectual or developmental disabilities (I/DD), and their families. Key initiatives to build capacity include enhancing the West Virginia System of Care (WVSOC) through increased core services, such as Children's Mental Health Wraparound, Mobile Crisis Response and Stabilization, and Expanded School Mental Health. Other initiatives to support children, youths, and families with behavioral health needs include the Family Advocacy, Support, and Training (FAST) Program; Regional Youth Service Centers that include community-based mental health and substance use services, now with Family Coordinators to support the families of youths served and help create a peer network for families in the state; suicide prevention and early intervention; and substance use prevention and intervention across the lifespan, including representation of the state in the National Prevention Network (NPN).

The Office of Policy, Planning, and Research oversees the cross-Bureau functions of the Programs and Policy section of BBH. This office includes strategic planning, behavioral health workforce development; system engagement; access and consumer affairs, primarily through statewide and intermediary organizations such as the WV Behavioral Health Planning Council (WVBHPC), WV Interagency Council on Homelessness (WVICH), the Helpline (844-HELP4WV), and the Governor's Advisory Council on Substance Use Prevention Treatment (GACSUPT); program data, research, analysis, and dissemination; legislative and policy analysis; training and technical assistance; and communication, including website development.

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Staff within the Administration section are responsible for fiscal and general administrative duties for the Bureau including budgeting, reporting, and administrative policy. The *Fiscal Division* staff are responsible for allocation of grant funds to the community behavioral health centers and other community-based service providers.

The Bureau's data and technology needs are administered through the WV Department of Health and Human Resources' Office of Management Information Services (MIS). In collaboration with MIS, BBH securely collects and stores a comprehensive data set pertaining to Bureau-supported services rendered to the citizens of West Virginia. The data sets collected include not only an extensive list of key demographics of each consumer for whom services are provided, but also an in-depth set of data that describe the types of services provided, location of service provision, and any other key service identifiers determined to be relevant.

For planning and programming purposes, BBH divides the state into six regions:

Region 1: Brooke, Hancock, Marshall, Ohio, and Wetzel Counties
Region 2: Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton Counties
Region 3: Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, and Wood Counties
Region 4: Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur Counties
Region 5: Boone, Cabell, Clay, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, and Wayne Counties
Region 6: Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster, and Wyoming Counties.

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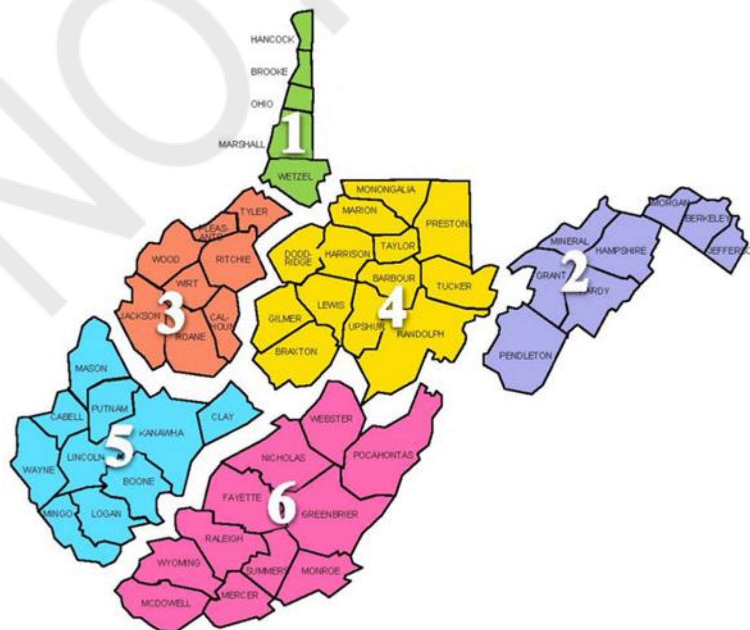

SSA/SMHA Roles and Responsibilities

- Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care,
- Integration and coordination of the public behavioral health system,
- State-level program funding decisions based on behavioral health indicators and program evaluation data,
- Prioritization and approval of all expenditures of funds received and administered by the BBH, including the establishment of rates, reimbursement methodologies, and fees,
- Oversight of the implementation of the agreed upon Hartley Consent Decree order related to community support activities, including but not limited to, expansion of Care Coordination services, expansion of group homes and residential services, and the development of additional day supports,
- Partnership with DHHR Bureaus for Children and Families, Medical Services, and Public Health on evidence-based supports for children and families and community issues, including licensure and regulation of behavioral health professionals, programs, and facilities,
- Promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services,
- Implementation of the responsibilities related to behavioral health required by state law, as referenced in West Virginia Code, Chapter 27, Article 1A *et seq*., and all applicable legislative rules.

Overview: Mental Health, Substance Use, and COVID-19 in West Virginia

West Virginia has been disproportionately devastated by SUD and has the nation's highest overdose death rate. While the state has invested in its SUD and mental health continuum of care in recent years, the present COVID-19 pandemic increased the burden on an already fragile mental health and substance use healthcare system. Behavioral health workforce shortages (social workers, psychologists, addiction medicine physicians, and counselors) in West Virginia were already common prior to COVID, but the pandemic has further exacerbated the problem. In-person service options have been significantly reduced since the start of the pandemic and many West Virginians have had to cope with anxiety, social isolation, job loss, illness, and other stressors with fewer places to turn for help. Substance use disorder treatment gaps were already common throughout West Virginia and COVID has only caused those gaps to widen.

According to the March 2021 Health Professionals Shortage Area Quarterly Report, fewer than 1 in 5 West Virginians (17%) had their mental health care needs met by professionals, while nationally, more than 1 in 4 Americans' (27%) needs were met. To remove the designation as a mental health professional shortage area, West Virginia would need to add an additional 122 practitioners. In the meantime, the rapid, increased need to use telehealth services or other alternatives to traditional are essential to maintain care. There are 101 mental health professional shortage areas in West Virginia, covering 50 of West Virginia's 55 counties, or an estimated 39.5% of the population. Adding to the behavioral health workforce shortage issue is the state's unequal

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distribution of primary care providers, as well as shortages of mid-level practitioners, a range of medical specialists, and child psychiatrists.

While the behavioral health impact of COVID-19 is still being determined, early data is starting to emerge, and the picture is grim. Estimates from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics shows a 48.4% increase in overdose deaths in West Virginia between October 2019 and October 2020. During this same timeframe, the overdose rate increase for the overall United States (U.S.) was 30.0%. West Virginia had started to see a decrease in overdose deaths beginning in 2018, but the pandemic shattered any hopes of continuing to make improvements in the lives of vulnerable West Virginians.

To make matters worse, another epidemic was added to the list of problems facing intravenous drug users (IDU) in West Virginia – an HIV outbreak in the state's largest and most populous county. Referred to by the CDC as the "most concerning" HIV outbreak in the country, Kanawha County, West Virginia has been in the national spotlight for all the wrong reasons. Over the past three years, Kanawha County has seen an increase in HIV cases linked to IDU of more than 700%. For perspective, in 2019 New York City had 36 identified case of HIV linked to IDU. During that same time, Kanawha County, which is 48 times smaller than New York City, had 35 HIV cases linked to IDU. Prior to the Kanawha County outbreak, in January 2018 a similar outbreak was first identified less than 50 miles west of Kanawha County in Cabell County, West Virginia. With the help of the CDC and the implementation of public health measures, the Cabell County HIV outbreak has been decreasing. Kanawha County will also receive the help of the CDC's Epi-Aid, but the outcome of the assistance will not be known for some time.

It may be easy to forget about the other impacts, beside physical health, that COVID-19 has had on the world, but it is important that we don't forget that many people are carrying a hidden burden. Now, even more than ever, West Virginia must develop strategies to strengthen the behavioral health support systems for both adults and children.

Behavioral Health Provider System

West Virginia's publicly funded community-based behavioral health system is anchored by 13 Comprehensive Behavioral Health Centers (CBHCs), operating full service and/or satellite offices in each of the counties located in the center's catchment area. Public behavioral health services provided by a CBHC are for all populations and all ages at risk for, or have a diagnosis of, mental illness, substance use disorder, intellectual/developmental disability, or a co-occurring/co-existing disorder. The CBHCs are charged with ensuring the following "essential services" are available and accessible in each county: screening, assessment, crisis response, outpatient services (with referral for Intensive Outpatient Programs (IOP) as may be assessed/needed), information and referral capacity, and medication management.

Most of the "essential services" are billable through third-party payors, but additional funding may be needed to ensure availability of these services at the county level. Continuum Enhancement Funds are provided by BBH to meet this need. Charity Care, which is funded through state general revenue funds are accessible so that no one is turned away for their inability to pay. As a Medicaid expansion state, the use of charity care has decreased. West Virginia's population has one of the

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highest medically insured rates in the country, thanks to Medicaid expansion. America's Health Rankings report that in 2020 only 6.7% of residents were uninsured. BBH provided $6,150,640 to pay for uncompensated care in FY 2021. The funding supports the development and provision of services and activities that are not otherwise billable through other funding streams or that exceed any approved service limits or caps. These funds may not be used for costs covered by an organization's administrative or indirect
cost plan**.**

Children, Youth, and Young Adult Behavioral Health Service System

The WVDHHR and BBH continue to expand and connect the state's System of Care (SOC) for children experiencing serious emotional disturbance (SED) and young adults experiencing serious mental illness (SMI) and co-occurring needs, along with their families. Through braided state, SAMHSA, Medicaid, and other funding sources, WVDHHR is coordinating Wraparound and other services for children and youths in their homes and communities to help them thrive and prevent unnecessary placements. New developments since the previous block grant application include the following:

- BBH was awarded the SAMHSA SOC grant which created a statewide, 24/7 Children's Crisis and Referral Line (https://www.help4wv.com/ccl) which connects families with Mobile Crisis Response, Stabilization Teams, and other community-based services; one statewide and six regional Family Coordinators to help families navigate the behavioral health system and get connected with needed supports; development of an improved data collection system for and evaluation of SOC-related programs; short-term crisis respite services for families; and a pilot youth drop-in center in Huntington, West Virginia.
- A Children with Serious Emotional Disorder (SED) 1915(c) waiver was approved through the Bureau for Medical Services (BMS). Information of the waiver can be found at https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx.
- Established a new West Virginia Behavioral Health Workforce and Health Equity Training Center through Marshall University (https://wvbhtraining.org/), which is working with the University of Maryland Institute for Innovation and Implementation to launch a state Wraparound and mobile response training system funded initially by block grant supplemental funding.
- Added more than 20 Expanded School Mental Health (ESMH) sites through state, State Opioid Response (SOR), and Project AWARE funding.

Since May 2019, the WVDHHR has been developing a plan under an agreement reached with the Department of Justice (DOJ) to reform West Virginia's child welfare system and ensure that children and youths receive mental health services in their homes and communities whenever possible to avoid unnecessary out-of-home placements. Increased availability and easier access to home- and community-based services are the aims of the plan which is set for initial implementation in late 2021. More information on the DOJ agreement can be found at https://dhhr.wv.gov/News/Documents/2019.05.14%20DOJ%20Agreement.pdf.

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Early Intervention and Prevention Services

The BBH recognizes the critical link between social and emotional wellbeing and substance misuse. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for individuals with SUD, as well as those who are at-risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. All 13 CBHCs are trained to provide SBIRT to clients. *Screening* quickly assesses the severity of substance use and identifies the appropriate level of treatment. *Brief intervention* focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. *Referral to treatment* provides those identified as needing more extensive treatment with access to specialty care.

Substance Abuse Block Grant prevention set-aside funding is allocated by the BBH to six regional Prevention Lead Organizations (PLOs) to provide regional leadership and technical support to local prevention coalitions throughout West Virginia's 55 counties. Prevention grantees use the strategic prevention framework (SPF) to identify needs and match evidence-based programs and practices using the following prevention strategies: information dissemination, prevention education, community mobilization, environmental strategies, alternatives for youth, and problem identification and referral.

As part of its required prevention efforts to maintain block grant funding, the Bureau is responsible for the coordination and implementation of Synar tobacco inspections in accordance with the Center for Substance Abuse Prevention (CSAP) and the U.S. Food and Drug Administration (FDA). West Virginia continues to comply with limiting retail sales of tobacco to minor youths. In fact, the Retailer Violation Rate (RVR) has been 10.0% or lower for the past several years. Synar inspections are conducted in cooperation with the West Virginia State Police and community partners. Since 2003, BBH has trained merchants on the *See Red?* initiative, which emphasizes not selling tobacco products to anyone whose driver's license or state I.D. has the telltale color red that indicates he or she is a minor.

In December 2020, West Virginia's Three-Year Prevention Strategic Plan was implemented. The goal of the Plan is to strengthen and support an integrated, statewide system of community-driven physical and mental health promotion, prevention of substance use, child abuse, sexual violence, suicide, and other related prevention efforts. The Plan's four priority goal areas in corporate Adverse Childhood Experiences (ACEs) data and trauma informed programs, services, and supports and include: 1. Increase, sustain, and align investments in prevention (including recruiting and retaining West Virginia's prevention workforce and advocating for policy reforms), 2. maximize cross systems planning and collaboration, 3. improve data collection, integration and use, and 4. align strategic communications, awareness and education. It has been estimated that more than half (55.8%) of West Virginia adults report at least one ACE, while 13.8% reported four or more. The most common experience reported was substance use in the household (29.0%), followed by verbal abuse (22.7%), and separation/divorce (22.6%).

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Prevention services have expanded in the state recently with an influx of SAMHSA discretionary grants and state-funded projects. In addition to the Block Grant, West Virginia supports prevention through the following discretionary SAMHSA grants:

- Partnerships for Success (PFS), which has 18 PFS coordinators around the state focusing on the prevention and reduction of underage drinking, marijuana use, and intravenous drug use of high-risk students aged 9-20.
- Prescription Drug Overdose Prevention (PDO), is a data-driven and collaborative process for preventing overdose-related deaths, emergency department visits, hospitalizations, and other overdose-related outcomes among adults in high-risk WV counties determined by overdose rates and sub recipient capacity to distribute naloxone. This has been accomplished by a phased, county-level approach that engages the counties at highest-risk of opioid/opiate overdoses. The PDO grant ends August 31, 2021.
- Strategic Prevention Framework for Prescription Drugs (SPF-Rx) to prevent and reduce prescription drug and illicit opioid misuse among youths aged 12-17 and adults 18 years of age and older and to enhance the state's SPF-based prevention infrastructure to address prescription drug misuse. Some newer prevention resources were also made possible through the SPF-Rx discretionary grant and include Help and Hope WV (https://helpandhopewv.org/), Stigma Free WV (https://stigmafreewv.org/), a safe medication disposal campaign, expansion of Students Against Destructive Decisions (SADD) initiative, and a West Virginia effective-prevention-practices guide that was released in 2019.
- State Opioid Response (SOR) funds twelve ODCP Regional Coordinators, six Regional Adult Intervention Specialists. and six Regional Family Coordinators to enhance community support services and regional collaboration to prevent overdoses and increase access to opioid use disorder (OUD) services, including evidence-based medication. In addition, prevention and early intervention programs include funding for 10 Quick Response Teams (QRT) and Harm Reduction Programs. The QRTs contact individuals who have experienced a non-fatal overdose within 24-72 hours to offer support services and offer linkage to treatment. Harm Reduction services provide HIV and Hepatitis testing and employ Peer Recovery Support Specialists to encourage and link people who inject drugs to enter treatment. SOR funds also support Teen Courts.
- SOR funding was used to expand the ability of organizations to implement adult prevention activities, as well as to produce a campaign designed to reduce stigma pertaining to medication for Opioid Use Disorder (OUD) and naloxone use.

Supplemental Block Grant funding is also supporting several prevention activities such as:

- Continued implementation of West Virginia's prevention strategic plan and meeting the goals of the West Virginia ODCP/Governor's Council on Substance Abuse Prevention and Treatment's *2020-2022 Substance Use Response Plan through* a Statewide Prevention Summit. This Prevention Summit will build upon the highly attended and well received West Virginia Statewide Prevention Summit conducted virtually in September 2020. The Summit also meets several goals and key performance indicators outlined in the *Substance Use Response Plan*: 1. maximize cross systems planning, collaboration, and integration, 2. host an annual statewide prevention summit to promote knowledge sharing, innovation,

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and commitments to shared outcomes, and 3. form a planning committee to organize, plan, and select sessions and speakers.

- Provide funding for the 56 schools implementing ESMH to purchase the evidence-based Olweus Bullying Prevention Program (OBPP). The OBPP is a comprehensive, schoolwide program that involves the entire school community in the form of schoolwide interventions, classroom activities, and individual interventions. The Program works to change the school climate and social norms with regards to bullying. Improving self-esteem and reducing bullying helps reduce two risk factors for both substance misuse and mental health issues.
- Provide funding for the Help and Hope WV website to continue to host the most relevant, up-to-date substance use prevention information for a variety of audiences. The website was originally funded by the SAMHSA Strategic Prevention Framework (SPF) for Prescription Drugs (Rx) grant, which ends in August 2021. Help and Hope WV has become a hub for important substance use prevention information, regional contacts, and events.
- Develop a statewide social media campaign targeting marijuana use among youth and pregnant women. A recent National Institutes of Health study showed a link between cannabis use and higher levels of suicidal ideation, plan, and attempt. A Canadian study found that "evidence is accumulating that warns prenatal cannabis consumption can have negative consequences on neurodevelopmental disorders…". Other states are already providing resources to the public regarding cannabis use, including Illinois and Colorado.

Treatment

In addition to providing prevention services, the SAPT Block Grant is a major source of West Virginia's SUD service continuum, allocating $6,500,000 for substance abuse early intervention, treatment, and recovery services across the state. BBH provides funding support to a continuum of treatment options, for individuals who are not otherwise covered by Medicaid, Medicare, or private insurance. Block grant funds provide for community-based recovery support services that included the expansion of best practice in peer supports and expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to live drug and/or alcohol free. Logisticare has the current contract as the state of West Virginia's Non-Emergency Medical Transportation (NEMT) manager. The organization provides rides free of charge for eligible Medicaid Members throughout the state for covered medical services. The program was put in place to alleviate transportation barriers to treatment in a rural state.

Treatment in West Virginia is supported by more than just federal SAPT Block Grant funds. Additional federal grants, such as SOR, along with state funds provide for additional support. The SOR grant supports West Virginia's response to the opioid epidemic. The grant award, from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), is administered by the WVDHHR, BBH SOR Team. SOR grantees across West Virginia are funded to expand the availability of treatment with medication and additional evidence-based services for individuals with SUD, including individuals with OUD and stimulant use disorder. This grant funding helps to identify and engage individuals with SUD by assisting with treatment and providing supports to help individuals stay in long-term recovery.

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The BBH encourages families to be involved in the treatment and recovery process and assists the family of an individual with an SUD or co-occurring mental health disorder.

Continued expansion of WVU COAT Hubs and Spokes model. In addition, through solicitation of a funding announcement, 14 treatment and peer recovery support specialist providers were selected to receive SOR funding to increase evidence-based services throughout WV. Each grantee provides after hour/weekend hour appointments and in some cases, telehealth services. In collaboration with the Bureau of Children and Families, SOR funds are used to provide subsidized childcare for individuals engaged in treatment for an SUD. Funds are also used to support a statewide grant with West Virginia Public Transit Association to provide free transportation for individuals seeking treatment and recovery services. West Virginia's three medical school receive SOR funding to provide direct services related to OUD/SUD in collaboration with healthcare graduate programs. The West Virginia Division of Corrections and Rehabilitation partners with SOR to provide two OUD treatment initiatives in correctional settings; SOR funding provides medication for OUD, naloxone, and PRSS in all ten regional jails.
More than $20,000,000 in state funding had been used over the past three years to expand residential treatment services across West Virginia. The funding is supported by the Ryan Brown Addiction Prevention and Recovery Fund as part of the state's comprehensive plan to combat the opioid epidemic.

Recovery System:

Block grant funds provide for community-based recovery support services that include expanding best practices in peer supports. The BBH has trained over 2,000 recovery coaches statewide (including 40 individuals trained as trainers) and has expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to promote stability and successful re-entry to community living. The Bureau has also led efforts to increase the capacity of recovery supports and services throughout West Virginia. These efforts include:

- Established recovery programming statewide in all regions of West Virginia, which increased recovery housing capacity between 2018 and 2021. The BBH supports 23 different agencies throughout the state who provide more than 700 recovery beds.
- Established a West Virginia affiliate of the National Alliance for Recovery Residences (NARR) known as the West Virginia Association of Recovery Residences (WVARR). During WVARR's first year of operation 34 recovery residences were certified, with several others in process for certification.
- Expanded the number of recovery beds available for women in recovery including women with children. Using both state and federal funds, BBH has been able to financially support over 160 beds.
- Increased the number of trained recovery coaches from 200 to over 2,000 between 2018 and 2021 by utilizing multiple Peer Recovery Support Specialist (PRSS) training modules. Funding for scholarships were provided by BBH. These scholarships covered the cost of

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application fees and testing fees for peer credentialing through the West Virginia Certification Board of Addiction and Prevention Professionals. By providing scholarships, the number of Board certified PRSSs increased 60.0% in West Virginia.

- Conducted nine West Virginia Learning Academy trainings between 2018 and 2021 with more than 100 participants in attendance.
- Cross-trained peer supporters and the general community in the nationally recognized Mental Health First Aid™ curriculum.
- Utilized the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Awards to deliver Whole Health Action Management (WHAM) training, promote Wellness Recovery Action Planning™ (WRAP) groups, and introduce shared decision-making concepts into behavioral health care promoting self-direction.
- Continued funding for PRSSs.
- Establishing a peer workforce training hub to provider a central location for peers to get information on continuing education, PRSS training, and peer credentialing.

There are currently eight Peer Centers located throughout West Virginia that support adults with serious mental illness (SMI) and individuals with SUD. These centers provide individual and group peer support activities, resource brokerage, linkage to the recovery community, and assist with ensuring basic needs are met (either directly or through referral). West Virginia is in the process of adding three additional Peer Centers that will serve as Recovery Community Organizations (RCO) that will focus on providing recovery supports to those with SUD. Three existing Peer Centers will also be converted into the RCO model. This will give West Virginia a network of five Peer Centers serving primarily those experiencing a SMI (with capacity to serve those experiencing co-occurring SMI and SUD), as well as six RCOs primarily serving those with SUD.

Additionally, there are 13 community-based programs that host peer supporters for mental health issues. These peer supporters maintain contact with the recovery community, provide individual and group peer support and recovery planning as well as resource brokerage and advocacy. Twenty Community Engagement Specialists (CES) can also be found throughout the state. These programs provide supports that keep individuals in the community and avoid unnecessary hospitalizations. Supports may include expedited access to a medical provider, linkage to crisis intervention, or provision of needed community support in the home.

The efforts of West Virginia's Peer Centers during COVID-19 have been admirable. Peer Centers have quickly adapted to providing virtual recovery supports by utilizing available technology such as telephone/video and the internet. Access to online group and individual support was also provided. A peer warmline was also established through the Help4WV call center and is available 24/7. As Peer Centers and recovery communities start to return to pre-pandemic business operations, many have noted that they will continue to offer online and telephone recovery supports because it has reached individuals who otherwise would not have received support.

The number of Peer-Operated Recovery Homes and Facilities in West Virginia has increased, providing safe housing for individuals age 18 and older who are recovering from substance use

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and/or co-occurring substance use and mental health disorders. These facilities house individuals for up to twelve months. Residents are encouraged to participate in outpatient and intensive services provided off-site so that Medicaid may pay for Medicaid reimbursable services that do not occur at the facility. Service areas provided by the facility include prevention, health promotion and wellness, and recovery support services.

Evidence-based approaches using Recovery Coaching and Peer Mentors will be implemented to serve the target populations of homeless individuals, youth, veterans and their families, pregnant women (in partnership with the Drug Free Moms and Babies programs), incarcerated individuals re-entering the community, individuals that present for services for OUD at Federally Qualified Health Centers, and individuals that present for MAT at regional medical centers. Thirty-four FTEs will be hired to serve as Recovery Coaches and/or Peer Mentors. Additionally, specialized webinars will be developed to help assure peers receive necessary training beyond their basic certification to be as knowledgeable and effective as possible with the special populations they are serving. WV BMS (Medicaid) is interested in partnering on efforts to train individuals specializing in MAT Peer Supports.

Addressing Cultural Competence

West Virginia requires all providers to follow the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) to implement culturally competent, evidence-based programming statewide. A special emphasis is placed on SAMHSA's priority populations that include pregnant women, service members, veterans and their families, transitioning-aged youths, persons who inject drugs (PWID), individuals experiencing homelessness, and individuals identifying as LGBTQ^{+}. BBH requires that these priorities be addressed in its subgrant agreements and addresses them in various trainings. All BBH grantee statements of work (SOW) include the requirement for provision of or arrangement for tuberculosis (TB) services including testing to determine presence of TB and needed treatment, including referral to another source if a person is not admitted for services.

At residential treatment facilities, priority is given to PWID, PPW, transition-aged youths, and individuals transitioning from a higher level of care. These facilities provide clinically managed, high-intensity services that feature a planned regimen of care in a safe, structured, and stable environment. Residential programming is gender specific, trauma-informed, and in coordination with day habilitation, rehabilitation, and peer supports. Some residential facilities also serve women with dependent children in a family style housing. Other target populations including homeless individuals, youth, veterans, are also considered a priority.

Specialized webinars have also been developed/procured to help ensure peers receive necessary training beyond their basic certification to be as knowledgeable and effective as possible with the special populations they are serving. This includes training on supporting the LGBTQ+ population, which was developed through a collaboration with BCF and Fairness WV.

Disaster Preparedness for Special Populations

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The BBH works with communities and a variety of organizations to develop processes, policies, plans and support annexes that are inclusive of individuals with disabilities and those who may have access and functional needs. Since disasters generally provide little or no warning having an inclusive plan in place is imperative. These inclusive plans have been incorporated as part of West Virginia's various Emergency Operations Plans and incorporates Emergency Support Function #6 (mass care, emergency assistance, temporary housing, and human services annex) of FEMA's National Response Framework. Partner organizations include, but are not limited to, the West Virginia Bureau for Public Health (BPH), the West Virginia State Red Cross Chapter, West Virginia Division of Homeland Security, State Emergency Management, and Voluntary Organizations Active in Disaster (VOAD). This strong behavioral health response is coordinated by the BBH's Disaster Coordinator who works closely with first responders, hospitals, local health departments, social services, homeland security, emergency management agencies, the faith-based community, and voluntary organizations to develop disaster response plans, continuance of operations plans and exercises across the state as needed. The BBH supports the integration of the Disaster Behavioral Health and the Disaster Spiritual Care Programs in order to meet behavioral, emotional, and spiritual care needs of impacted individuals, first responders, recovery workers, and communities. Regional CBHCs are encouraged to add trained peers to their disaster response teams to provide a more well-rounded and inclusive response.
Additional information about the BBH's disaster recovery efforts and caring for you behavioral health can be found at: https://dhhr.wv.gov/BBH/getconnected/Pages/Support-Disaster-Recovery-Efforts.aspx.

Data and Information

The West Virginia State Epidemiological Outcomes Workgroup (SEOW) is housed and led by the BBH to facilitate the use of data in policy making and program decision making for substance misuse prevention at the state, county and community level. The SEOW is comprised of 56 organizational and individual partners who serve as subject matter experts and meetings are conducted quarterly. The mission of the WV SEOW is to facilitate statewide prevention improvement by leading a systematic process to gather, review, analyze, and disseminate information about substance use and abuse in West Virginia. The goals are to:

- Establish an effective epidemiological team with the capacity to access, analyze, interpret, and disseminate data and apply in a state and regional context.
- Establish a systematic framework for ongoing monitoring of prevention needs and outcomes in the state and regions.

The purpose of SEOW is to:

- Analyze data (e.g. alcohol, tobacco, and other substance-related data such as National Outcome Measures (NOMs)) for prevention and treatment purposes.
- Assess the prevalence of substance use and related problems, including co-occurring mental health issues, within specific populations (e.g. veterans, PPW, LGBTQ$^+$, racial and ethnic minorities) across the life span.
- Determine the scope and extent of substance use and related problems in WV and perform on-going surveillance of the extent and scope of the problems.

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- Develop West Virginia's need profile, patterns of consumption, and consequences of substance use using data sources such as Vital Records, National Survey on Drug Use and Health, Uniform Crime Reports, and the Behavioral Risk Factor Surveillance System.
- Employ systematic, analytical thinking to understand the epidemiology of the causes and consequences of the use of alcohol, tobacco, and other substances.
- Coordinate with appropriate decision-making entities within West Virginia to provide data which guides effective and efficient use of prevention resources.
- Promote an ongoing, in-depth exchange of data and learning among SEOW members, state leaders, and local community leaders who have in-depth understanding of local SUD issues.

For more information on SEOW, including a list of organizations and partners, meeting recordings, presentations, etc. please visit https://dhhr.wv.gov/BBH/data/SEOW/Pages/default.aspx.

Since 2013, the BBH has developed a statewide behavioral health profile, partnered with BPH to update all 55 county-level behavioral health data sets and posted them online for dissemination to the general public, written and presented the *2016 West Virginia Overdose Fatality Analysis*, and worked on multiple initiatives to track and disseminate updated, quality West Virginia behavioral health data that meets the needs of communities. The Bureau has also contracted with West Virginia University (WVU) to conduct a needs assessment and data system review, worked with the West Virginia Board of Education to develop and analyze data from a statewide prevention study, and has been working on a West Virginia Child Welfare Study. A new data system is also being developed to better capture SOR data, report GRPA data, and provide other necessary supports to both BBH and the behavioral health network. The data system is being developed by FEi and was awarded through a competitive contract process. Since 2018, the BBH has been able to hire two FTE Behavioral Health Epidemiologists, with third FTE in the process of being hired. During 2021, BBH and SEOW will work to establish an evidence-based practices workgroup.

With support from WVU, a new behavioral health surveillance initiative called Mountain State Assessment of Trends in Community Health (MATCH) has been implemented, with their first survey period starting August 2021 and going through January 2022. This survey tool will provide county-level behavioral health data that has been reviewed and advised by national experts on how to conduct scientifically-sound surveys in rural (and population-losing) settings. The BBH works in close coordination with the West Virginia Office of Drug Control Policy, which provides a data dashboard that tracks EMS responses to suspected overdoses, hospital ER incidents related to overdoses, fatal overdoses, and naloxone administration prior to EMS. https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx

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Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:

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

While the Mountain State's mountainous topography and picturesque scenery are remarkable, the rural terrain presents challenges, including isolating residents from services and adding significant physical barriers to the most vulnerable. Consequently, the state suffers from high poverty and unemployment rates, low levels of higher education attainment and literacy, and high rates of substance use disorder.

The Bureau for Behavioral Health (BBH) provides leadership, oversight and coordination of policy, planning, development, funding and monitoring of the public behavioral health system. West Virginia's publicly funded, community-based behavioral health system is anchored by 13 regionally based Comprehensive Behavioral Health Centers (CBHCs), operating centers or satellite offices in each of the counties located in the center's catchment area.

Public behavioral health services provided by a CBHC are for all populations and all ages at-risk for, or have a diagnosis of, mental illness, substance use disorder, intellectual/ developmental disability, or a co-occurring/co-existing disorder. The CBHCs are expected to assure the following "essential services" are available and accessible in each county: Assessment, Outpatient Services (with referral for intensive outpatient services as needed), Information and Referral, and Medication Management. The majority of "essential services" are billable through third party payers, but additional funding is sometimes needed to ensure availability of these services at the county level. State Continuum Enhancement Funds are provided by the BBH to engage people where they are. Indigent care state general revenue funds are also provided to ensure that no one is turned away based on inability to pay. During the 2021 State legislative session legislation was introduced for the Department of Health and Human Resources to develop certification process to allow and encourage the CBHC's to become certified community behavioral health clinic (CCBHC). In the coming year the Bureau and partners will be defining and implementing CCBHC processes in the state.

Rural Populations, Culture and Access

West Virginia is a rural state, the only one located entirely within the Appalachian Region. Its 24,038 rugged square miles of area is home to 1.79 million people. West Virginia's population centers are small in comparison with other states. Currently West Virginia has no city with a population over 50,000. July 2019 Census estimates showed the capitol city of Charleston, the largest population center in the state, decreased from 47,215 to 46,536. The other most populated cities include Huntington (45,110), Parkersburg (29,306), Morgantown (30,549), and Wheeling (26,430)[i]. There are no federally recognized tribes in West Virginia.

Appalachian culture and values influence behavior. At the risk of overgeneralization, Appalachian culture is typically marked by self-reliance, the centrality of home place, and the preeminence of family. This strong sense of place and community also results in a robust mistrust of outsiders and "systems" that are perceived to encroach on community-based viewpoints. As a result, the most successful mental health and substance use disorder (SUD) programs are implemented on a county or regional level, where barriers to access services are reduced and individuals have developed trust with service providers and agencies.

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The racial composition of West Virginia's population reflects low ethnic diversity. White accounts for 93.5% of the population while 3.6% is African American or black, 0.8% is Asian and 1.8% is two or more races[ii]. Less than 3% of the population in West Virginia speaks a language other than English as their primary language, compared to almost 22% of the population in the United States[iii].

West Virginia is aging and losing population. From 2010 to 2019 the state has lost 3.3% of the population, while the US has gained 6.3%. Over 20% of the state's population is 65 years and over, compared to 16.5% of the nation[iv]. The aging and declining population of the state is having consequences. The state lost a US House seat in 2021 due to the decline in population. The number of births has decreased from 21,994 in 2007 to 18,136 in 2019, while deaths have increased from 21,086 to 23,404 during the same time period[v]. More people are dying in the state than being born.

While West Virginia has low racial and ethnic diversity, the LGBTQ population of the State is comparable to the nation. The State has approximately 58,000 people who identify as LGBT or 4.0% of the total population and 31% of LGBT individuals are raising children in the State compared to 4.5% of the national population identify as LGBT and 29% are raising children[vi].

Health disparities related to race exist in West Virginia and BBH welcomes opportunities to partner with organizations working to close this gap as it relates to behavioral health, and through BBH's strategic planning process. There are a variety of statewide intermediary organizations focused on supporting minority populations in West Virginia. For example, Fairness West Virginia is the statewide advocacy organization for LGBT West Virginians, and WVU's LGBTQ+ Center serves as a resource center and as the social, intellectual, and physical hub of the LGBTQ+ community at WVU, helping the University identify, monitor, and assess best practices in programming and policy to ensure an inclusive atmosphere, to help WVU establish a leadership role in the state and among peer institutions on LGBTQ+ matters. Established by Gov. Earl Ray Tomblin in March 2012, the Herbert Henderson Office of Minority Affairs is committed to advancing equality for all minorities across West Virginia and developing innovative ways to address issues affecting minorities through integrity, leadership and collaboration. Race Matters West Virginia is another resource available to the Bureau.

Mental Health

According to the 2018-2019 National Survey on Drug Use and Health (NSDUH) 5.4% of adults aged 18 or older had serious thoughts of suicide in the past year[vii]. This is a slight increase from 2016-2017 of 4.8%, which was a slight increase from 2013-2014, which estimated 4.2% or adults had serious thoughts of suicide within the past year[viii]. The West Virginia 2018-2019 percentage is also higher than the national rate of 4.6%. West Virginia also has a higher rate of suicide death than the nation. The crude rate of suicides has increased from 12.6 per 100,000 in 1999 to 18.4 per 100,000 in 2019. West Virginia also has higher rates than the nation; in 2019 the national crude rate was 14.5 per 100,000[ix].

West Virginia also has a higher rate of mental illness, 24.6%, compared to the nation, 19.9%. West Virginia also has a higher percentage of population with a serious mental illness (SMI),

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5.8% compared to 4.9% nationally, and a higher percentage of the population that had a major depressive episode in the past year, 9.3% compared to 7.5%[x]. In 2019, the Behavior Risk Factor Surveillance System (BRFSS) found that 20.2% of West Virginian's had 14 or more days out of the past 30 when mental health was not good[xi]. Sixty-three percent of those individuals also reported poor mental or physical health impacted normal activities[xii]. It is also important to note that among adults served in West Virginia's public mental health system in Fiscal Year 2020, 65.2% were not in the labor force and another 15.3% were unemployed[xiii]. The state also has the lowest workforce participation rate in the nation overall, with approximately 53.2% of the population 16 and older in the labor force compared to the national rate of 63.0%[xiv]. This may be in part due to a higher disability rate with 14.0% of people under 65 years having a disability compared to 8.6% in the nation[xv]. While the state is amid a substance use disorder (SUD) crisis, the BBH is acutely aware that mental health services are a crucial need in the state.

High Overdose Mortality and Opioid Use

Data confirms what West Virginians experience in daily life when they watch the local news or attend another funeral of a loved one whose life was cut short: no state has been as profoundly affected by the epidemic of opioid drug use as West Virginia. The state has had, for at least ten years in a row, the highest drug overdose mortality rate in the nation – more than double the rate of the United States as a whole. In 2017, the age-adjusted fatal overdose rate was 59.0 per 100,000 residents[xvi]. The next highest state was Ohio at 46.3 per 100,000 residents. Families and communities are devastated by the effects and service providers and residents are acutely aware of the need for substance abuse prevention, treatment, and recovery services. Overdose rates decreased in 2018 (51.3 crude rate) and the 2019 rate (52.1 crude rate) was comparable to the previous year providing hope that the State was making steady progress[xvii]. But then COVID-19 struck. The preliminary 2020 data indicate that more people died from an overdose in WV in 2020 than any other year[xviii]. 2017 was the highest year on record, 2020 was 30% higher, with an estimated crude rate of 74 per 100,000. Compared to 2019, 2020 was 42.5% higher. Emergency department data for suspected overdoses indicate that 2021 through the end of July is slightly higher than 2020 for the same timeframe[xix].

The entire state has been affected by the drug crisis. One of the challenges for both assessing areas with the highest level of impact as well as ensuring services in communities is the State has 55 counties, with only three with a population over 100,000 and twelve under 10,000 people. Most of the counties (44 out of 55) have less than 50,000 people. The low numbers that accompany low population make it challenging to identify geographic areas of risk in a timely manner due to instability. The southern coal fields were some of the first area's affected by the crisis and continue to be impacted by the crisis. Other population centers in the State are also showing high rates of fatal overdoses.

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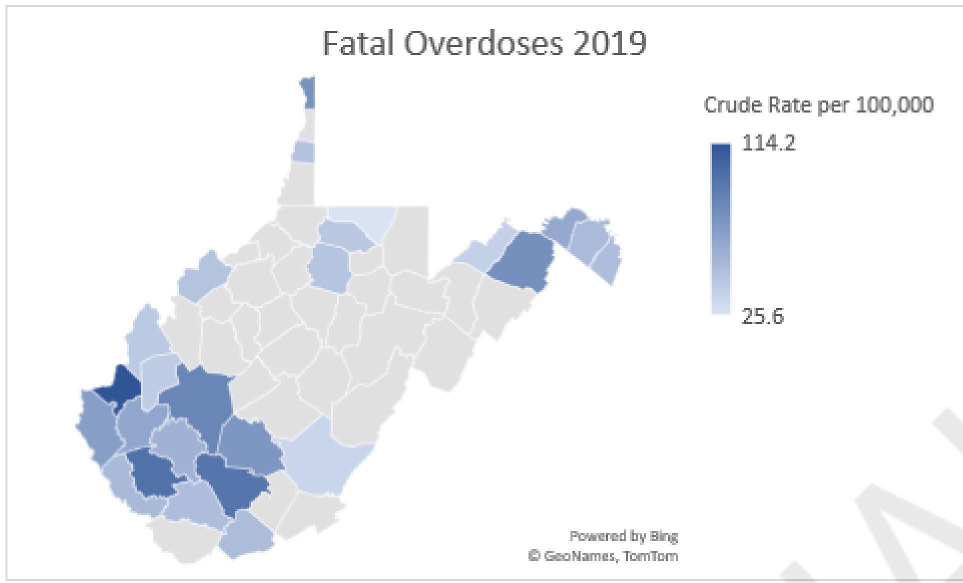
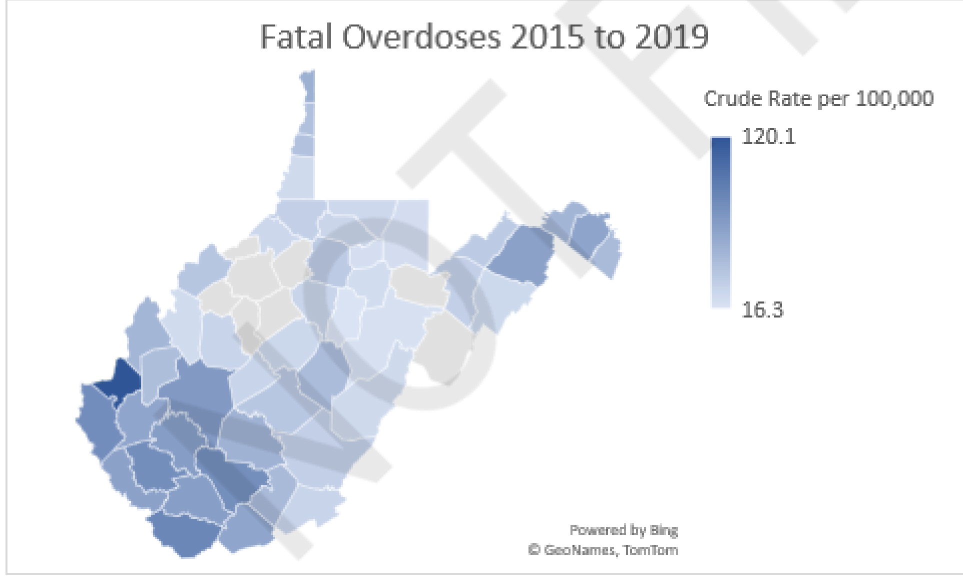


US Rate 22.7

WV Rate 52.1

Note: Overdose rates are redacted where the cell size is less than 10 due to unstable estimates. Data from 2019 is preliminary and subject to change. These data include all manners of drug overdose deaths including accidents, suicides, homicides, and those of undetermined intent among West Virginia Residents[xx].



US Rate 21.1

WV Rate 50.0

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Note: Overdose rates are redacted where the cell size is less than 10 due to unstable estimates. Data from 2019 is preliminary and subject to change. These data include all manners of drug overdose deaths including accidents, suicides, homicides, and those of undetermined intent among West Virginia Residents[xxi].

The drug crisis continues to evolve in the State. Originally prescription opioids were at the root of fatal overdoses, this evolved to heroin, and currently fentanyl contributes to approximately 75% of fatal overdoses. Another area that the state has seen substantial increases is the

contribution of methamphetamine in overdose deaths. Approximately 45% of fatal overdoses has methamphetamine present. This raises a treatment challenge.

West Virginia is not only known for high overdose death rates, but also for the number of opioid pills shipped to the state. In 2006, the state led the nation in prescribing rates at 129.9 opioid prescriptions per 100 persons. This has decreased to 81.3 in 2017. Nationally there has been a decrease in opioid prescribing too. However, West Virginia has fallen from number one to number eight, while this is still high, it shows the impact of the continued efforts to address inappropriate opioid prescribing across the state.[xxii] The State has passed legislation to address opioid prescribing in the state. Most indicators show decreases changes in prescribing practices that puts patients at risk for addiction and overdose. This is important progress in the prevention of substance use disorder. From 2014 to 2019 there was a 44% decrease in opioid prescriptions, with 15 million fewer pills dispensed from 2018 to 2019[xxiii]. The rate of multiple provider episodes (5 or more prescribers and 5 or more pharmacies in a 6-month period) has fallen from 43 per 100,000 residents in 2014 to 3 in 2019[xxiv]. Overlapping benzodiazepines and opioid prescriptions have also dropped from 33% of prescription days in 2014 with a co-prescription to 17% in 2019[xxv]. This is good news for the State, but also indicates strategies to target illicit drugs are needed.

In West Virginia there is a mortarium on opioid treatment programs (OTPs), which restricts the number of OTPs to the current nine that are operational. This limits the availability of methadone treatment across the state. Office-based medication assisted treatment (OBMAT) is another out-patient option. Practices/providers that prescribe MAT to more than 30 people must register with the Office of Health Facility Licensure and Certification. Currently there are 198 OBMATs in the state[xxvi]. Not only has the number of OBMATs increased, but in 2017 only 27 of West Virginia's 55 counties have an OBMAT, currently 41 counties have a OBMAT registered. Efforts under the STR and SOR grants have focused on expanding access to MAT via mechanisms like telehealth and hub and spoke models as well as workforce development to support individuals that may not have expertise in MAT and to encourage providers to become a waivered prescriber. From January 2019 to May 2020, there was an increase of 232 waivered providers in the state[xxvii]. This resulted in a potential 18,720 people that could have access to buprenorphine. The BBH estimates that there are approximately 150,000 residents that have a SUD. 57% of the waivered providers in the state are certified for 30 patients.

The residential treatment infrastructure has changed substantially in the past four years primarily due to two occurrences: West Virginia became a SUD waiver state [xxviii]and the state legislature created the Ryan Brown Addiction Prevention and Recovery Fund. SUD services under the wavier were phased in during 2018. The first services began on January 14, 2018. Initially services were covered under fee-for-service, on July 1, 2019 services were transferred to managed care organizations (MCOs). This has resulted in an increase in additional providers outside of the CBHCs. The BBH and the Bureau for Medical Services (BMS) have and continue to work closely to ensure treatment and services are provided during this transition and identify and address any gaps that arise. In 2017, the West Virginia legislature created the Ryan Brown Addiction Prevention and Recovery Fund. The funding associated with the act has had a substantial impact on the residential treatment infrastructure in the state by providing funding for the creation of additional facilities. In 2012, there were 281 treatment beds at the CBHCs and

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represented the treatment infrastructure. Currently, there are 1222 SUD residential treatment beds in the state (ASAM level 3.1-3.7). As of the writing of this, 28% of the treatment beds are at CBHCs. The BBH works with the ODCP to identify area's where residential treatment is needed and work with partners to access to treatment in communities occurs.

The ability to expand treatment, both out-patient and residential is dependent on available workforce. The Kaiser Foundation estimates that the state needs an additional 122 mental health practitioners to remove the health professional shortage area (HPSA) designations[xxix]. The West Virginia Rural Health Association reports that there are 224 psychiatrists in the state[xxx]. The West Virginia Board of Examiners of Psychologists report that there are 655 psychologists and school psychologists that are licensed to work in the state[xxxi]. The BBH has several initiatives to meet the behavioral health need at all levels.

IV Use and Blood-Borne Pathogens

While the origins of the States overdose crisis have its roots in prescription medications the crisis continues to evolve not only by the drugs contributing ot overdoses but also the route drugs are used. The increased misuse of drugs in West Virginia is alarming. Many of these drugs are being injected, leading to increases in blood-borne viral infections. West Virginia was one of the first states with a Hepatitis A outbreak. Rates increased from 0.3 per 100,000 in 2017 to 124.4 in 2018[xxxii]. Rates for 2019 decreased to 26.1 as the outbreak slowed and was closed in August 2020. Illicit drug use was reported in 68% of the outbreak cases, 57% had Hepatitis C co-infection, 10% had Hepatitis B co-infection, and 9% were homeless[xxxiii]. Rates of acute Hepatitis B has decreased from 14.7 per 100,000 in 2015 to 4.2 in 2019[xxxiv]. However, the State still has one of the highest rates in the nation with the national rate at 1.0 per 100,000. The State also has a high rate of acute Hepatitis C at 4.4 per 100,000 compared to the national rate of 1.3 for 2019[xxxv]. West Virginia also reported the highest rate of newly reported chronic Hepatitis C in 2019 at 201.0 per 100,000 with Alaska the next highest at 130.8[xxxvi].

West Virginia is a low HIV/AIDS incidence state. However, HIV clusters are becoming more common. The two largest have been Cabell and Kanawha Counties. West Virginia historically has seen approximately 77 new cases a year across the state (2008-2018). This jumped to nearly double, 146, in 2019. In 2020, 121 cases were reported. From 2008 to 2017, the average percent of cases indicating injection drug use was 12%, this increased to 35% in 2018, then to 57% in 2019, and 67% in 2020[xxxvii]. The CDC has referred to the increase in the State's HIV cases as the most concerning in the nation.

Low Socioeconomic Standing

West Virginia is one of the most impoverished states in the country. In 2019, the national median household income was $62,843, the median household income in West Virginia was $46,711, which is 26% below that of the nation. Per capita income in West Virginia is 22% lower than the national rate, $26,480 compared to $34,103[xxxviii].

Eighteen percent of West Virginia families with related children under age 18 have an income below the poverty level (compared to 14% for the nation). When the family has a female head of

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household (i.e., no husband present) the percent under poverty is even more pronounced with 42% of West Virginia families with a female head of household with children under age 18 years below the poverty level (compared to 34% for the United States)[xxxix].

According to Workforce West Virginia the current unemployment rate in the State is 5.4. Prior to COVID-19 the State had an unemployment rate of 5.1 compared to the national rate of 3.5. During COVID-19 it peaked to 15.6. Post COVID-19 West Virginia's rate is comparable to the nation at 5.0. While the unemployment rate has recovered to pre-COVID-19 levels, the State has a low workforce participation rate at 55.1 for 2019 compared to 63.1 for the nation[xl]. Correlated with low economic standing is low educational attainment levels, which has a direct impact on socioeconomic wellbeing. While the population with a high school degree or higher in West Virginia is comparable to that of the nation (87% and 88%, respectively), significantly fewer West Virginians hold bachelor's degrees than the United States (21% and 32%, respectively)[xli]. For the 2018-2019 school year, 52% of 11th graders were proficient at reading, and 24% were proficient at mathematics[xlii]. Even as the state embraces a diversified economy the workforce may need additional training to meet educational requirements.

An initiative born out of the Governor's office and housed at the West Virginia Department of Education has the goal of providing the appropriate training to individuals to fill workforce shortages. While anyone meeting program criteria are eligible, a target audience for participation are individuals in recovery. The BBH is supporting this initiative by providing resources when requested and has participated in training when requested. The bureau also has hope that this initiative can address some of the workforce needs related to mental health workers in the state. While the shortage of psychiatrists and psychologists is often cited, the shortage is associated with all behavioral health occupations.

Uninsured and Underinsured

With implementation of the Affordable Care Act (ACA), West Virginia saw significant improvements in its rate of insurance coverage, which continues to be maintained. In 2019, 93% of all West Virginian's had insurance, with 96% of children and 90% of adults 19-64 were insured. Before implementation of the major coverage provisions of the ACA, an estimated 20.7% of West Virginians aged 18 to 64 were uninsured.[xliii] Thus, while the state has made progress, there are still individuals without health insurance and others who have insufficient coverage to meet their healthcare needs. In West Virginia, if an individual or family is unable to access services offered through qualifying health plans, Medicaid, or the state's 13 CBHCs, they can access the BBH's state-funded charity care dollars, given that the service need is a Medicaid-eligible service. While Medicaid expansion provided first-time services for many, others who were covered by the state's charity care mechanisms were faced with co-pays for the first time, depending on the plan. Additionally, many individuals who decided to go to the Health Insurance Marketplace now have plans that have not adequately met their healthcare needs, and now find themselves underinsured for behavioral health services. The BBH has recently established a workgroup to establish policy and procedures to address the needs of the underinsured.

Criminal Justice and Law Enforcement

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The number of prisoners in West Virginia was comparable from 2018 to 2019, 6,775 compared to 6,800. There were slightly more admissions in 2019, 4,177, compared to 2018, 3,834. This appears to be due to more parole violations, 1,281 in 2018 compared to 1,841 in 2019. While new court commitments decreased from 2,316 in 2018 to 2,135 in 2019. There was a total of 4,152 releases in 2019. West Virginia has a lower imprisonment rate (379 per 100,000 residents) than the nation (435 per 100,000 residents).[xliv]

While some communities believe the solution to the drug crisis is law enforcement and judicial in nature, the state in general has taken a prevention and treatment approach. Quick Response Teams (QRTs) is an approach that engages law enforcement in prevention. These teams are typically made up of a representative of law enforcement, EMS responder, and either a peer, social worker, or other clinical professional. QRTs follow-up with individuals that have had a non-fatal overdose within 72 hours to link to care and services. Thirty-four counties in the state have a QRT. This is leading to multiple approaches and the BBH and other DHHR partners are working to assess and define what QRTs are in the state.

In December 2017, the Bureau for Public Health (BPH) released a social autopsy of people that had died from an overdose in 2016. In the year prior to death, 22% of males and 12% of females were incarcerated.[xlv] Consequently, the Department of Military Affairs and Public Safety (DMAPs) has implemented policy, and programming to increase treatment in jails across the state. Previously individuals with SUD underwent detoxification upon admission. Currently individuals that are on MAT upon admission are maintained on it, and plans are underway for naltrexone induction in jails. Programs related to peer in jails are also being implemented. The other large initiative that has occurred is the creation of a treatment unit at one of the regional jails. There are laws that pose barriers to diversion efforts, to mitigate consequences of this a treatment unit was developed. Many of these activities have been implemented with the support of STR and SOR.

Veterans

Military veterans are twice as likely to develop an opioid addiction, as well as twice as likely to overdose, when compared to the civilian population. [xlvi] In 2019, 141,341 or 8.5% of the adult population was a veteran. This is higher than the national percent of 6.8%. Almost half, 49%, of the State's veteran population is 65 year or older. Twenty-six percent of the veterans in the state are receiving disability compensation[xlvii].

Aging Population and Older Adults with SMI

Where once the median age of a West Virginia resident was nearly identical to the median age in the U.S., West Virginia's median age in 2019 was over four years greater than the U.S. (42.9 years compared to 38.5 years). [xlviii] By 2056 the population of U.S. adults aged 65 years and older is projected to become larger than the population aged 17 years and younger. The West Virginia Health Statistics Center (HSC) projects that this event will occur about the year 2029 for West Virginia, much earlier than for the rest of the country.[xlix]

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The 2019 BRFSS found that in West Virginia people 65 and older were less likely to report 14 or more poor mental health days, 10.9%, than 18-64-year old's, 24.9% for 18–24-year-olds, 25.8% for 25–44-year-old, and 21.8% for 45–64-year-old[l]. However, as the population continues to age this age group will require greater surveillance. This is a priority population about which BBH needs additional state-specific data.

The aging population not only poses potential challenges associated with treatment and programming, but also has implications for the number of mental health professionals in the workforce. As mentioned previously West Virginia has a shortage of mental health professionals, as the population ages and leaves the workforce this has the potential to increase the deficit already present in the state.

Pregnant Women and Infants

Nationally, neonatal abstinence syndrome (NAS) is surveilled with hospital discharge data. However, there is a long data lag associated with this data source. Furthermore, in 2009 the Office of Maternal, Child and Family Health sponsored a cord blood study and found that nearly 20% of cord blood samples tested were positive for at least one substance, which was higher than estimates based on discharge data.[li] Due to these limitations, NAS surveillance was implemented by leveraging an existing risk assessment tool, the Birth Score. The Birth Score is a tool that identifies infants at risk of mortality in the first year of life and is completed for each infant born at a West Virginia birthing facility. Surveillance was implemented in October of 2016. In addition to NAS, intrauterine substance exposure is also collected, which allows the identification of infants with potential consequences of substance exposure, and not just those that went through withdrawal. In 2020, 6.6% of infants born in West Virginia were diagnosed with NAS, and 14.2% had intrauterine substance exposure. [lii] This data has also illustrated that different consequences of the drug crisis have distinct geographic patterns and why it is crucial to look at multiple data points and not overdoses alone.

To meet the needs of the pregnant women with SUD, the West Virginia Perinatal Partnership started the Drug Free Mom and Babies Project (DFMB) with funding from BBH with additional support from BPH and the Benedum Foundation. The project is a comprehensive and integrative medical and behavioral health program, and provides prevention, early intervention, treatment, and recovery support services. Initial evaluation has shown promising outcomes and the program has expanded. Currently there are 16 sites which are often affiliated with birthing centers, which is over 50% of the birthing facilities in the state. An evaluation of the original four pilot sites found that 71.5% of women enrolled in the program remained in the program until they gave birth. Positive drug screens dropped from 80.9% during the first trimester to 21.9% during the third trimester[liii].

Expansion of treatment facilities that accepts pregnant and post-partum women as well as their children is also underway. There are currently seven facilities that serve the PPW population with another underdevelopment.

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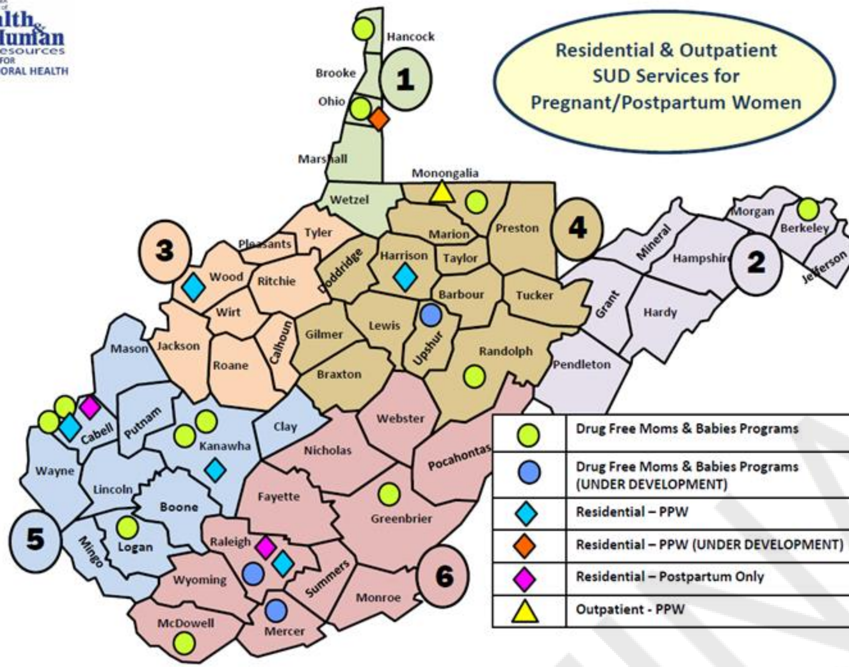

Children, Youth, and Families

Children and Youths with SED.
In 2018-2019, 14.05% of 12-17 adolescents had at least one major depressive episode. This is higher than the adult rate of 8.52%. [liv] Over a third of high schoolers, 36%, reported they felt sad or hopeless for 2 or more weeks and as a result stopped doing some usual activities[lv]. In 2019, of high school students in West Virginia surveyed 21% seriously considered suicide, 14% made a plan to attempt suicide, 11% had attempted suicide, and 4% had a suicide attempt that resulted in injury[lvi]. However, prevention and early intervention needs to occur prior to high school.

Research shows that "...repeated trauma exposure tends to produce a cumulative detrimental effect with loss of resilience and increased vulnerability to future trauma exposure" [lvii]. The youth of West Virginia face a variety of primary and secondary traumatic experiences, often at higher rates when compared with other youth in the nation. In 2019, 6,673 children were confirmed by child protective services as victims of maltreatment (19 per 1,000)[lviii]. Almost 10% of West Virginia high school students have been physically forced to have sexual intercourse at least once in their lives, 9% percent have experienced physical dating violence (including being hit, slapped, or physically hurt by their boyfriend or girlfriend), and 7.3% have experienced sexual dating violence[lix].

According to the U.S. Department of Health and Human Services Administration for Children and Families' most recent report, Child Welfare Outcomes, the statistics for West Virginia's children ranked the state among the most challenged for child welfare outcomes[lx]:

- The 2019 entry rate for foster care is 14.0 percent, the highest rate in the U.S.

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- In 2019 the number of child maltreatment victims was 6,727.
- In West Virginia, 19.6% of the child maltreatment victims are under one year of age.
- In 2019, 84% of the maltreatment of children was physical abuse, 66.1% was emotional abuse, 42% was neglect, 5.7% was medical neglect, and 3.7% was sexual abuse.
- In 2019, the median length of stay in foster care was 14.6 months.
- In 2019, there were 2,577 children awaiting adoption. A total of 1,675 children were adopted.
- In 2019, there were 17 child fatalities, a rate of 4.7 per 100,000.

The August 2021 point in time Foster Care Placement Report indicates that 53% of foster children had a kinship/relative placement, 29% were in therapeutic foster care, 10% were in group residential care, and 1% were in a long-term psychiatric facility. Nearly 7000 (6,908) children were in care during August. This number is comparable to rolling year average[lxi].

The BBH is part of a statewide collaboration under the guidance of the West Virginia Department of Health & Human Resources. The collaboration is tasked to develop a plan that has three goals: prevent children with serious mental health conditions from being needlessly removed from their family homes in order to obtain treatment, prevent those children from unnecessarily entering Residential Mental Health Treatment Facilities; and transition children who have been placed in these settings back to their family homes. The overarching strategy to achieve these goals is to provide a full continuum of supports to strengthen families and fortify community-based services across systems. Safe at Home (SAH) is one program that was developed to help keep families unified. As of July 1st, 2019, 3,435 youth have been enrolled in SAH. West Virginia has returned 107 youth from out-of-state residential placement back to West Virginia, 281 youth have stepped down from in-state residential placement to their communities, and 53 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 2,289 at-risk youth. The BBH programs Children's Mental Health Wraparound, Children's Mobile Crisis, and Positive Behavior Support Program are anticipated to be part of the continuum of care across systems. During the pilot period for Children's Mobile Crisis 445 children and youths received Mobile Crisis services with the following outcomes: 379 of the 445 of the children and youth, or 85%, were maintained safely in their homes; and of the children for which follow-up information was available, 324 of 335 of the children and youth, or 97%, were not involved with the legal system. Children's Mental Health Wraparound receives approximately 100 referrals per fiscal year, with about half of the referrals resulting in Wraparound services. In the original two-year pilot, of the 75 families served, 46% of the children were aged 11 or younger, 39% were adopted or in the care of a relative or other legal guardian, 30% had a parent who had been incarcerated or was currently incarcerated, and 75% had no new involvement with the judicial system.

The children mental health prevention and treatment landscape is evolving and expanding across the state. In addition to the expansion of Children's Mental Health Wraparound, and Children's Mobile Crisis to state-wide programs, the expansion of Enhanced School Mental Health (ESMH) programs is also underway. Additionally, the BMS recently received a Children with Serious Emotional Disorder Waiver. Services under the waiver include case management, in-home family support, in-home family therapy, peer parent support, specialized therapy, independent living/skills building, respite care, non-medical transportation, assistive equipment, job

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development, supported employment, and community transition. The waiver is designed to serve 500 youth in year one, 1,000 youth in year two, and 2,000 youth in year three. The 2018-2019 National Survey of Children's Health indicated that 23.8% of children 3-17 with a mental/behavioral condition that needed treatment had somewhat difficulty receiving it, another 8.3% was very difficult to receive, and 2.7% but did not receive it[lxii]. It is anticipated that the expansion and implementation of these programs will increase children receiving services.

Adverse Childhood Experiences, commonly referred to as ACEs, higher scores are associated with substance use disorders and depression, as well as other physical diseases, and are linked to criminal justice system involvement and homelessness. While 45.5% of West Virginia adults report zero ACES, the average was 1.4. In West Virginia, the most common ACE was household substance abuse, followed by separation/divorce, verbal abuse, mental illness, domestic violence, physical abuse, sexual abuse, and incarceration of a household member. Approximately 21% or 271,996 West Virginia adults would be considered high risk for having or developing health problems based on having three or more ACEs.[lxiii]

Youth and Grandparents

There are 40,529 grandparents living with their own grandchildren under 18 years in West Virginia. Of these grandparents 54% are responsible for the grandchildren. Nationally, 33% of grandparents living in households with their grandchildren are responsible for the children[lxiv]. And while kinship care can cover many family members, it is important to note the large percentage (53% for July 2021) of children in foster care that are in a kinship placement. It appears this family structure is becoming more common in the state.

Homeless Individuals

In 2020, an estimated 1,341 people experienced homelessness in the state on any given day. Approximately 13% of people experiencing homelessness in the state are chronically homelessness. Veterans' make-up 7.8% of the homeless population in the state. These are estimates are based on point in time count, which likely is an under representation of the extent of homelessness in the state and does not capture those with unstable housing. [lxv]The Department of Education also tracks students experiencing homelessness. The definition that is used allows for children that are living in potentially unstable locations to be included, such as hotel/motels and with other families. West Virginia had 10,522 students that were homeless. The majority of these children, 87%, were "doubled-up" (e.g. living with another family). An additional 8% were in shelters, transitional housing, awaiting foster care, with 3% unsheltered, and the remaining 2% primarily living in a hotel/motel[lxvi].

Leadership Change

In September 2018 the Secretary of the Department of Health Human Resources appointed a new commissioner with the primary goal to apply public health approaches to behavioral health. The bureau now has two epidemiologists to support data driven decision making. The bureau has also increased the internal workforce and has split what was referred to as the Adult Office into two offices, one to focus on substance use disorder and the other to focus on mental health. This will

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allow primary focus on both topics, while the collaborative nature of the bureau allows for cross cutting approaches too.

In addition to the change in leadership at the bureau, there have been changes at the ODCP too. The ODCP and the BBH have common goals and work closely together and consequently this has also impacted the bureau.

ATLAS (formerly known as Shatterproof)

West Virginia is one of the five pilot states to participate in an assessment of quality of care of SUD treatment. This project is in the beginning stages but has ambitious deadlines. Participation has sparked discussion about what is the state's SUD treatment infrastructure. It has also illustrated how abstinence-based programs can be hard to fit into medical models of treatment. The state continues to participate in ATLAS.

COVID-19

Early in the pandemic West Virginia was identified as the most at risk state due the high rate of various risk factors found in the population. The most recent Household Pulse Survey (Week 34) found that 45% of West Virginian adults reported at least several days of feeling nervous, anxious, or on edge. While report of anxiety has decreased from earlier in the pandemic a high, consistent percentage of the state's adult population are still experiencing anxiety. Rates of report of feeling down, depressed, or hopeless were the same for Week 34, 45%[lxvii]. There is no doubt that the sustained high rates of anxiety and depression, along with the other stressors that came with the pandemic will continue to have consequences. The BBH has worked with community partners, as well as those within DHHR to ensure continuity of services could be maintained.

State Epidemiological Outcomes Workgroup (SEOW)

The SEOW meets quarterly and is comprised of representatives from across the agency, both data and programmatic, academia, and community partners, especially those that are charged with prevention (for more details see Step 1). The SEOW brings together individuals with different skill sets and needs. Epidemiologists across the agency have the opportunity to share data that is not always public facing, and prevention organizations get to hear the most current data on topics they are addressing. At the most recent SEOW people were introduced to a new survey with a primary focus on behavioral health topics the BBH and the Bureau for Medical Services is sponsoring in collaboration with West Virginia University. The survey is anticipated to be fielded in the fall of 2021. One of the primary goals is to meet a need that is often expressed at the SEOW be able to have county level data. If possible, the presentations are shared after the SEOW to be used as resource documents. In fact, a presentation on overdose deaths has turned into a go-to document when working on a tight deadline and was used to inform this document.

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[i] https://data.census.gov/cedsci/

[ii] https://www.census.gov/quickfacts/WV

[iii] https://www.census.gov/quickfacts/WV

[iv] https://www.census.gov/quickfacts/WV
[v] https://wonder.cdc.gov/
[vi] https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density
[vii] https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates
[viii] https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates
[ix] https://wonder.cdc.gov/
[x] https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates
[xi] https://nccd.cdc.gov/weat/#/analysis
[xii] https://nccd.cdc.gov/weat/#/analysis
[xiii] https://wwwdasis.samhsa.gov/dasis2/urs.htm
[xiv] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates
[xv] https://www.census.gov/quickfacts/WV
[xvi] West Virginia Health Statistics Center, Vital Statistics System, Drug Overdose Database.
[xvii] https://wonder.cdc.gov/
[xviii] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[xix] https://essence.syndromicsurveillance.org/
[xx] https://wonder.cdc.gov/
[xxi] https://wonder.cdc.gov/
[xxii] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention
[xxiii] https://dhhr.wv.gov/vip/county-reports/Documents/2019%20CSMP%20Reports/2019%20County%20Profiles-Summary.pdf
[xxiv] https://dhhr.wv.gov/vip/county-reports/Documents/2019%20CSMP%20Reports/2019%20County%20Profiles-Summary.pdf
[xxv] https://dhhr.wv.gov/vip/county-reports/Documents/2019%20CSMP%20Reports/2019%20County%20Profiles-Summary.pdf
[xxvi] https://ohflac.wvdhhr.org/Apps/Lookup/FacilitySearch
[xxvii] DEA Waivered Provider list
[xxviii] https://dhhr.wv.gov/bms/Programs/WaiverPrograms/Pages/Substance-Use-Disorder-(SUD)-Waiver-.aspx
[xxix] https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[xxx] http://portals.ncahd.org/wvhdp/
[xxxi] https://psychbd.wv.gov/license-info/License-Search/Documents/2021-8-16%20Verification%20of%20Licensure.pdf
[xxxii] https://www.cdc.gov/hepatitis/statistics/2019surveillance/pdfs/2019HepSurveillanceRpt.pdf
[xxxiii] https://oeps.wv.gov/ob_hav/pages/default.aspx#box
[xxxiv] https://www.cdc.gov/hepatitis/statistics/2019surveillance/pdfs/2019HepSurveillanceRpt.pdf
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[xxxviii] https://data.census.gov/cedsci/
[xxxix] https://data.census.gov/cedsci/
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[xli] https://www.census.gov/quickfacts/fact/table/US,WV/PST045219
[xlii] https://zoomwv.k12.wv.us/Dashboard/dashboard/7301
[xliii] https://www.kff.org/state-category/health-coverage-uninsured/?state=WV
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https://dhhr.wv.gov/bph/Documents/ODCP%20Reports%202017/2016%20West%20Virginia%20Overdose%20Fatality%20Analysis_004302018.pdf
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[xlvii] https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_West_Virginia.pdf
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[l] https://nccd.cdc.gov/weat/#/analysis
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[lii] West Virginia Office of Maternal, Child and Family Health & WVU Birth Score
[liii] https://secureservercdn.net/198.12.144.78/k0l.ef0.myftpupload.com/wp-content/uploads/2019/10/DFMB-Pilot-Prog-Results_PMR-Journal.pdf
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[lxii] https://www.childhealthdata.org/browse/survey
[lxiii] West Virginia Health Statistics Center
[lxiv] https://data.census.gov/cedsci/
[lxv] https://endhomelessness.org/wp-content/uploads/2019/08/WV-fact-sheet-2019.pdf
[lxvi] https://www.usich.gov/homelessness-statistics/wv/
[lxvii] https://www.census.gov/programs-surveys/household-pulse-survey/data.html

NOT FINAL

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Comprehensive Adult Mental Health Services

Priority Type: MHS

Population(s): SMI, Other (Rural, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Improve access to a full continuum of community mental health services

Strategies to attain the goal:

1. Establish the adult crisis response system statewide.
2. Coordinate existing CES provider efforts to leverage impact across the continuum of care.
3.Collaborate with the WV Behavioral Health Workforce and Health Equity Training Center, or similar entity, to develop training initiatives to enhance behavioral health workforce as related to services for older adults.
4. Ensure Comprehensive Behavioral Health Centers establish and maintain offices in each of the rural counties in West Virginia.
5. Expand Rapid Rehousing (RRH) Services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number adult mobile crisis and stabilization teams in the State

Baseline Measurement: 0

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 4

Data Source:

Provider reporting

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of psychiatric urgent care centers in the State

Baseline Measurement: 0

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

Grantee reporting

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis.

Data issues/caveats that affect outcome measures:

NOT FINAL

None

Indicator #: 3

Indicator: Increase the number of referrals from Psychiatric Hospitals to CES

Baseline Measurement: 1724

First-year target/outcome measurement: 1810

Second-year target/outcome measurement: 1896

Data Source:

BBH CES Program Manager

Description of Data:

Reports of program staff activities and training records

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Increase the number of discharge planning meetings CES attended

Baseline Measurement: 1295

First-year target/outcome measurement: 1360

Second-year target/outcome measurement: 1425

Data Source:

CSDR Reporting

Description of Data:

BBH's client level data reporting system

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Training initiative to enhance behavioral health workforce services for older adults

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

Training Records

Description of Data:

Training records of the trainings provided by WV Behavioral Health Workforce and Health Equity Training Center

Data issues/caveats that affect outcome measures:

None

NOT FINAL

Indicator #: 6

Indicator: Release and Implementation of SOR Rapid Rehousing (RRH) Awards

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: Release SOR RRH funds via the Announcement of Funding Availability (AFA) Process

Second-year target/outcome measurement: All 4 Continuum's of Care (CoC) in West Virginia will be providing SOR RRH Services

Data Source:

BBH Allocation Chart

Description of Data:

The allocation chart shows every organization funded by BBH.

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Comprehensive Children's Mental Health Services

Priority Type: MHS

Population(s): SED, ESMI, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Children/Youth at Risk for BH Disorder, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase access to community-based child and family services to prevent unnecessary removals or hospitalizations of children and youths.

Strategies to attain the goal:

1. Continue to enhance availability and access to statewide Wraparound services for children with serious emotional disturbance (SED) or youths with serious mental illness (SMI) through the new assessment pathway developed as part of DHHR's agreement with the Department of Justice
2. Continue to enhance availability and access to statewide Children's Mobile Crisis Response and Stabilization Services through the 24/7, statewide Children's Crisis and Referral Line
3. Incrementally increase the number of schools with Expanded School Mental Health, or three tiers of student support
4. Increase family peer support, referrals to resources, and input in systemic improvement through regional six Family Coordinators and a dedicated staff person in the BBH Office of Children, Youth, and Families.
5. Continue implementation and expansion of First Episode Psychosis (FEP)/ESMI "Quiet Minds" (https://quietmindswv.com/) coordinated specialty care services at six regional centers for statewide coverage
6. Continue implementation and expansion of First Episode Psychosis (FEP)/ESMI "Quiet Minds" (https://quietmindswv.com/) coordinated specialty care services at six regional centers for statewide coverage
7. Work with provider associations to adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among clients receiving care for mental or substance use disorders.
8. Prepare for the transition of the National Suicide Prevention Lifeline to 988 and anticipated increase in call/chat/text volume in July 2022

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children receiving Wraparound services statewide

Baseline Measurement: Establish number of children receiving Children's Mental Health Wraparound and Children with Serious Emotional Disorder (CSED) Waiver Wraparound services annually prior to October 1, 2021

First-year target/outcome measurement: 10 percent increase

Second-year target/outcome measurement: 20 percent increase

Data Source:

BBH Grantee Reporting, BMS CSED Waiver data, Interim Services process in the DOJ pathway (post-October 2021)

Description of Data:

NOT FINAL

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis. The Bureau for Medical Services (BMS) also tracks the number of children and youths approved for the Children with Serious Emotional Disorder Waiver. After DHHR's assessment pathway is implemented (tentatively in October 2021), the interim services process will also be a data source for children with SED and youths with SMI served with Wraparound services.

Data issues/caveats that affect outcome measures:

None

Indicator #:	2
Indicator:	Number of counties participating in the pilot Children's Mobile Crisis initiative
Baseline Measurement:	Current number of counties participating
First-year target/outcome measurement:	10 percent increase
Second-year target/outcome measurement:	20 percent increase

Data Source:

BBH Grantee Reporting (both Mobile Crisis Response and Stabilization grants and First Choice Services for the Children's Crisis and Referral Line)

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis.

Data issues/caveats that affect outcome measures:

None

Indicator #:	3
Indicator:	Number of schools with Expanded School Mental Health
Baseline Measurement:	64 schools with Expanded School Mental Health
First-year target/outcome measurement:	74 schools with Expanded School Mental Health
Second-year target/outcome measurement:	84 schools with Expanded School Mental Health

Data Source:

BBH Grantee Reporting and the West Virginia Department of Education (WVDE)

Description of Data:

All BBH and WVDE Project AWARE grantees must report on programmatic activities and client level information on individuals served on a quarterly basis. The WVDE is a collaborative partner on this project.

Data issues/caveats that affect outcome measures:

None

Indicator #:	4
Indicator:	Increase the number of young adults receiving First Episode Psychosis (FEP)/ESMI "Quiet Minds" coordinated specialty care services
Baseline Measurement:	Current number of individuals receiving FEP services
First-year target/outcome measurement:	10 percent increase
Second-year target/outcome measurement:	20 percent increase

Data Source:

BBH Grantee Reporting

NOT FINAL

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis. https://quietmindswv.com/

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Maintain Regional youth and adult suicide intervention specialists to assist with suicide prevention screening, assessment, referral, safety-planning, discharge-planning, and follow-up

Baseline Measurement: 6

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 6

Data Source:

BBH Grantee Reporting

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis.

Data issues/caveats that affect outcome measures:

None

Indicator #: 6

Indicator: Work with provider associations to adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among clients receiving care for mental or substance use disorders.

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: Draft policies and procedures

Second-year target/outcome measurement: Implement policies and procedures

Data Source:

BBH Staff

Description of Data:

Documentation of policies and procedures

Data issues/caveats that affect outcome measures:

None

Indicator #: 7

Indicator: Prepare for the transition of the National Suicide Prevention Lifeline to 988 and anticipated increase in call/chat/text volume in July 2022

Baseline Measurement: Number of calls answered in state by the state's National Suicide Prevention Lifeline call center (First Choice Services)

First-year target/outcome measurement: Increase in call volume while maintain more than 80 percent of calls, chats, and texts answered in state

NOT FINAL

Second-year target/outcome measurement: Increase in call volume while maintain more than 80 percent of calls, chats, and texts answered in state

Data Source:

First Choice Services and National Suicide Prevention Lifeline/988 reports

Description of Data:

Call level information

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Quality Behavioral Health Systems

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Improve quality of behavioral health services

Strategies to attain the goal:

1. Increase opportunities for professional development for the behavioral health workforce due to workforce shortages in behavioral health.
2. Expand participation of Statewide Epidemiological Outcomes Workgroup (SEOW) and educate SEOW members on county and statewide products as meeting topics or special committee meetings.
3. Expand, capture, and more fully automate data reporting ability of Management Systems (CSDR Expansion)
4. Measure number of completed referrals, call volume, and implement screening/assessment tool via the 24/7 statewide behavioral health call-line.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of providers participating in the annual Appalachian Addiction & Prescription Drug Abuse Conference

Baseline Measurement: 500 Participants

First-year target/outcome measurement: 5 percent increase

Second-year target/outcome measurement: 5 percent increase

Data Source:

Appalachian Addiction & Prescription Drug Abuse Conference

Description of Data:

Appalachian Addiction & Prescription Drug Abuse Conference

Data issues/caveats that affect outcome measures:

Due to COVID-19 precautions, this event will be held virtually.

Indicator #: 2

Indicator: SEOW Membership

Baseline Measurement: 39 Members

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 3

NOT FINAL

Data Source:

WV State Epidemiological Outcomes Workgroup (SEOW)

Description of Data:

WV SEOW membership records and meeting minutes

Data issues/caveats that affect outcome measures:

None

Indicator #:	3
Indicator:	Number of CSDR Participants
Baseline Measurement:	12 CBHC Provider participants
First-year target/outcome measurement:	Development of CSDR portal for independent providers
Second-year target/outcome measurement:	Pilot portal at 2 independent provider sites

Data Source:

WV DHHR MIS

Description of Data:

MIS programmers are working to expand the CSDR system to all BBH providers. Currently, the CBHC's are the only entities to utilize this data portal. Other providers currently utilize spreadsheets to report service data.

Data issues/caveats that affect outcome measures:

None

Indicator #:	4
Indicator:	Number of calls for statewide behavioral health call-line
Baseline Measurement:	20,388
First-year target/outcome measurement:	5 percent increase
Second-year target/outcome measurement:	5 percent increase

Data Source:

First Choice Health Systems

Description of Data:

First Choice manages the statewide behavioral health call-line and tracks this measure and reports to BBH.

Data issues/caveats that affect outcome measures:

None

Priority #:	4
Priority Area:	Comprehensive Substance Use Disorder Services
Priority Type:	SAT
Population(s):	PP, Other (Adolescents w/SA and/or MH, Students in College, Rural)

Goal of the priority area:

Improve access to a full continuum of substance use disorder services

NOT FINAL

Strategies to attain the goal:

1. Expand access to Medication Assisted Treatment (MAT) through increasing the number of wavered prescribers.
2. Expand the utilization of Quick Response Teams (QRT) statewide.
3. Increase the number of West Virginia Alliance of Recovery Residences (WVARR) certified recovery residences statewide.
4. Increase the number of peer operated recovery beds statewide

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of MAT waivered prescribers

Baseline Measurement: 450

First-year target/outcome measurement: 10 percent increase

Second-year target/outcome measurement: 10 percent increase

Data Source:

West Virginia Office of Health Licensure and Certification (OHFLAC), SAMSHA

Description of Data:

WV OHFLAC tracks this number and reports to the MAT coordinator housed in BBH. SAMHSA website also provides information on the number of MAT waivered prescribers.

Data issues/caveats that affect outcome measures:

Training opportunities could be impacted by COVID-19, which could impact the number of waivered prescribers added annually.

Indicator #: 2

Indicator: Number of QRT encounters statewide

Baseline Measurement: 10,500

First-year target/outcome measurement: 10 percent increase

Second-year target/outcome measurement: 10 percent increase

Data Source:

BBH, Bureau for Public Health (BPH), ODCP

Description of Data:

BBH, BPH, and ODCP all report and share information on QRT activity statewide.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of WVARR certified recovery residences.

Baseline Measurement: 3

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 9

Data Source:

WVARR, BBH

Description of Data:

WVARR supplies BBH with data regarding certified recovery residences as requested, but at a minimum of once a month. Data shows

NOT FINAL

number of certified recovery residences and the number of residences in process for certification.

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of Peer Operated Recovery Beds

Baseline Measurement: 750

First-year target/outcome measurement: 10 percent increase

Second-year target/outcome measurement: 10 percent increase

Data Source:

BBH Grantee Reporting

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis.

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Primary Prevention

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Create communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and prevent or reduce substance misuse or use disorder through universal, selective, and indicated prevention strategies for individuals of all ages.

Strategies to attain the goal:

1. Maintain regional Prevention Lead Organizations (PLOs), which will provide support and technical assistance to county prevention coalitions
2. Ensure implementation of effective and evidence-based prevention strategies through prevention training (e.g., Prevention Ethics and Substance Abuse Prevention Skills Training or SAPST) and selection of evidence-based strategies using the strategic prevention framework (SPF)
3. Implement a safe medication disposal campaign with print materials and safe disposal kits in collaboration with senior centers, long-term care facilities, funeral homes, and other places where older adults may be reached.
4. Involve older adults in prevention coalitions and planning to help plan and inform prevention initiatives focused on older adults.
5. Obtain available data, including through the State Epidemiological Outcomes Workgroup (SEOW), to inform the needs and overall SPF process to focus prevention efforts for older adults.
6. Support youth-led peer support and leadership initiatives, such as Youth Move to promote protective factors and positive alternatives to substance use
7. Collaborate with schools and other initiatives (e.g., Expanded School Mental Health, Collegiate Initiative to Address High-Risk Substance Use, and the W.Va. Department of Education's ReClaim WV) to implement effective prevention strategies with schools and community partners.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of prevention professionals trained in Prevention Ethics and SAPST

Baseline Measurement: 50

First-year target/outcome measurement: 100

Second-year target/outcome measurement: 200

NOT FINAL

Data Source:

BBH Prevention Lead Organizations (PLO)

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis.

Data issues/caveats that affect outcome measures:

None

Indicator #:	2
Indicator:	Total number of direct prevention materials distributed and number of community organizations reached.
Baseline Measurement:	No Baseline – New Initiative
First-year target/outcome measurement:	Distribute 50,000 direct prevention materials and reach out to 50 community organizations.
Second-year target/outcome measurement:	Distribute 100,000 direct prevention materials and reach out to 100 community organizations.

Data Source:

BBH Grantee Reporting

Description of Data:

All BBH grantees must report on programmatic activities and groups served.

Data issues/caveats that affect outcome measures:

None

Indicator #:	3
Indicator:	Number of meetings focused on SPF process and prevention efforts for older adults.
Baseline Measurement:	No Baseline – New Initiative
First-year target/outcome measurement:	5
Second-year target/outcome measurement:	16

Data Source:

BBH Prevention Data Portal

Description of Data:

All BBH grantees must report on programmatic activities and groups served.

Data issues/caveats that affect outcome measures:

None

Indicator #:	4
Indicator:	Usage/views of Help and Hope WV, Stigma Free WV, and social media campaigns
Baseline Measurement:	170,000
First-year target/outcome measurement:	10 percent increase
Second-year target/outcome measurement:	10 percent increase

Data Source:

NOT FINAL

BBH Prevention Data Portal

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a quarterly basis. The Prevention Data Portal captures all prevention data.

Data issues/caveats that affect outcome measures:

None

Priority #: 6

Priority Area: Pregnant Women and Women with Dependent Children (PWWDC)

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Improve behavioral health outcomes for pregnant women and women with dependent children.

Strategies to attain the goal:

1. Increase the availability of PWWDC recovery beds.
2. Establish new PWWDC program in Region 2

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of beds statewide specifically available for PWWDC.

Baseline Measurement: 110

First-year target/outcome measurement: 10 percent increase

Second-year target/outcome measurement: 10 percent increase

Data Source:

BMS, BBH

Description of Data:

Weekly Residential Adult Services, SUD Facilities Report – Approved report. Report is generated by BMS and shared with BBH.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: New PWWDC program in BBH Region 2

Baseline Measurement: 1

First-year target/outcome measurement: Release of Announcement of Funding Availability (AFA)

Second-year target/outcome measurement: Fund 1 new PWWDC program in BBH Region 2

Data Source:

BBH AFA Records

Description of Data:

BBH will utilize its AFA process to solicit applications for this program in Region 2.

NOT FINAL

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Improve behavioral health outcomes for persons who inject drugs (PWID)

Strategies to attain the goal:

1. Improve health outcomes among PWID in West Virginia by utilizing the SOR program to fund harm reduction programs that request funding, meet the West Virginia Legislature's rule on harm reduction programs, and emphasize linkage to care.
2. Increase access to naloxone through the BBH initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SOR funded harm reduction programs.

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

SOR data

Description of Data:

SOR program and financial reports.

Data issues/caveats that affect outcome measures:

The new West Virginia Legislative rule may impact the number of harm reduction programs that are funded by SOR.

Indicator #: 2

Indicator: Number of Naloxone kits distributed

Baseline Measurement: 20,000

First-year target/outcome measurement: 10 percent increase

Second-year target/outcome measurement: 10 percent increase

Data Source:

BBH, University of Charleston

Description of Data:

Distribution reports from the University of Charleston.

Data issues/caveats that affect outcome measures:

West Virginia's PDO grant has ended. This may impact the number of naloxone kits that can be purchased and distributed.

NOT FINAL

Priority #: 8

Priority Area: Persons with or at risk of tuberculosis (TB) who are receiving SUD Treatment Services

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Improve behavioral health outcomes for persons with or at risk of tuberculosis who are receiving SUD Treatment Services (TB)

Strategies to attain the goal:

1. 1 All SUD Treatment Service provider grant agreements include specific requirements for TB screening and referrals and will be actively monitored to ensure compliance with the priority area. Continue collaboration efforts with the WV Bureau for Public Health, Division of Tuberculosis Elimination and providers to strengthen protocols for identification of those individuals who are at high risk of TB. Provide technical assistance for providers through monitoring efforts with maintaining and improving their policies and procedures regarding TB screening and referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: TB Grant Compliance

Baseline Measurement: 100% Provider Compliance

First-year target/outcome measurement: 100% Provider Compliance. All SUD grantee providers will submit their policies and procedures relating to TB screening and referrals for all individuals seeking services for SUD.

Second-year target/outcome measurement: 100% Provider Compliance. All SUD grantee providers will maintain and submit all updated policies and procedures for TB screening and referral for all individuals seeking SUD services.

Data Source:

BBH Statements of Work (SOW)

Description of Data:

BBH SOW's outline specific requirements in the grant agreements between BBH and the provider mandating TB compliance. BBH requires that providers use a TB risk assessment for individuals using SUD services.

Data issues/caveats that affect outcome measures:

None

NOT FINAL

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021   Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$9,487,666.00		$0.00	$60,848,192.00	$8,762,427.00	$0.00	$0.00		$5,784,019.00	$3,413,099.00
a. Pregnant Women and Women with Dependent Children[c]	$997,500.00				$5,501,800.00					
b. All Other	$8,490,166.00			$60,848,192.00	$3,260,627.00				$5,784,019.00	$3,413,099.00
2. Primary Prevention[d]	$2,530,044.00		$0.00	$20,000,000.00	$1,530,000.00	$0.00	$0.00		$1,820,000.00	$910,160.00
a. Substance Abuse Primary Prevention	$2,530,044.00			$20,000,000.00	$1,530,000.00				$1,820,000.00	$910,160.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$0.00									
5. Early Intervention Services for HIV	$0.00									
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$632,511.00			$5,000,000.00	$245,762.00				$300,000.00	$227,540.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$12,650,221.00**	**$0.00**	**$0.00**	**$85,848,192.00**	**$10,538,189.00**	**$0.00**	**$0.00**	**$0.00**	**$7,904,019.00**	**$4,550,799.00**

NOT FINAL

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]		$0.00								
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$587,799.00						$500,000.00		$388,938.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care		$0.00								
8. Ambulatory/Community Non-24 Hour Care		$4,702,396.00	$20,395,666.00	$6,800,000.00	$103,509,655.00			$2,660,000.00		$3,111,504.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$293,900.00			$497,067.00			$143,493.00		$194,469.00
10. Crisis Services (5 percent set-aside)[g]		$293,900.00			$3,117,352.00			$1,200,000.00		$194,469.00
11. Total	**$0.00**	**$5,877,995.00**	**$20,395,666.00**	**$6,800,000.00**	**$107,124,074.00**	**$0.00**	**$0.00**	**$4,503,493.00**	**$0.00**	**$3,889,380.00**

NOT FINAL

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	92	19
2. Women with Dependent Children	3,091	612
3. Individuals with a co-occurring M/SUD	5,674	1,330
4. Persons who inject drugs	2,168	528
5. Persons experiencing homelessness	629	163

NOT FINAL

Please provide an explanation for any data cells for which the state does not have a data source.

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Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$6,325,111.00	$5,784,019.00	$2,559,824.00
2 . Primary Substance Use Disorder Prevention	$1,686,696.00	$1,820,000.00	$682,620.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$421,674.00	$300,000.00	$170,655.00
6. Total	**$8,433,481.00**	**$7,904,019.00**	**$3,413,099.00**

NOT FINAL

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	A	B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$129,299	$143,780	$53,927
	Selective			
	Indicated			
	Unspecified			
	Total	**$129,299**	**$143,780**	**$53,927**
2. Education	Universal	$265,145	$294,840	$110,584
	Selective			
	Indicated			
	Unspecified			
	Total	**$265,145**	**$294,840**	**$110,584**
3. Alternatives	Universal	$52,374	$58,240	$21,844
	Selective			
	Indicated			
	Unspecified			
	Total	**$52,374**	**$58,240**	**$21,844**
4. Problem Identification and Referral	Universal	$19,640	$21,840	$8,191
	Selective			
	Indicated			
	Unspecified			
	Total	**$19,640**	**$21,840**	**$8,191**
	Universal	$790,524	$879,060	$329,705

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5. Community-Based Process	Selective			
	Indicated			
	Unspecified			
	Total	**$790,524**	**$879,060**	**$329,705**
6. Environmental	Universal	$379,714	$422,240	$158,369
	Selective			
	Indicated			
	Unspecified			
	Total	**$379,714**	**$422,240**	**$158,369**
7. Section 1926 Tobacco	Universal	$50,000		
	Selective			
	Indicated			
	Unspecified			
	Total	**$50,000**	**$0**	**$0**
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,686,696**	**$1,820,000**	**$682,620**
Total SABG Award[3]		**$8,433,481**	**$7,904,019**	**$3,413,099**
Planned Primary Prevention Percentage		**49.67 %**	**53.00 %**	**122.74 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$1,686,696	$1,820,000	$682,620
Universal Indirect			
Selective			
Indicated			
Column Total	**$1,686,696**	**$1,820,000**	**$682,620**
Total SABG Award[3]	**$8,433,481**	**$7,904,019**	**$3,413,099**
Planned Primary Prevention Percentage	**20.00 %**	**23.03 %**	**20.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☐	☐
Heroin	☑	☐	☐
Inhalants	☑	☐	☐
Methamphetamine	☑	☐	☐
Bath salts, Spice, K2)	☑	☐	☐
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☑	☑
Rural	☑	☑	☑

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Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems				$500,000.00	
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation					
7. Training and Education					
8. Total	**$0.00**	**$0.00**	**$0.00**	**$500,000.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

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[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 10/01/2021 MHBG Planning Period End Date: 09/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support						
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)	$49,500.00	$0.00	$0.00	$49,500.00	$0.00	$0.00
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education						
8. Total	**$49,500.00**	**$0.00**	**$0.00**	**$49,500.00**	**$0.00**	**$0.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.
SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]
One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

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partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

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[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **https://www.samhsa.gov/find-help/disorders**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating,_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

West Virginia behavioral health services are integrated into Medicaid managed care. Since the MCOs are responsible for managing the physical and behavioral health services provided to the vast majority of enrollees, they have been able to integrate mental health and SUD treatment services with physical health treatment services. This integration has also moved West Virginia toward value-based purchasing for both physical and behavioral health services. Under this program, the Bureau has contracts with three Managed Care Organizations (MCOs) for the provision of medically necessary services currently provided by the State, with the exception, most notably, of pharmacy, long term care, and non-emergency medical transportation services.

Goals of the MCO program include: Providing a medical home to every member, increasing use of primary and preventive care, Improving compliance with immunization schedules and well-child visits, Improving birth outcomes, Enhancing member satisfaction with the program, Containing the escalating costs of Medicaid, Reducing inappropriate use of services, Increasing competition, Improving quality, Improving population health, and developing a person centered system of care. School-Based Health Centers (SBHCs) are health clinic sites sponsored and managed by Community Health Centers. A range of services are offered to children, adolescents and the school community. SBHCs are housed within a school site. The SBHC provides preventive and immediate care, behavioral health services, health education, and sometimes dental care. Most SBHC services are provided during the school day. Referrals to other health care providers are available as needed.

As of the fall of 2018, school based health services are available to a school -age population of over 84,000 children in 40 counties. Expanded School Mental Health (ESMH) refers to programs that build upon the core services typically provided by schools. It is a three-tiered framework that includes the full continuum of behavioral health services, including: Tier 1- Universal - Prevention/MH Promotion for all = 80 to 90% of students; Tier 2 -Targeted – Early Intervention for the 5-15% of at-risk students; and, Tier 3 - Intensive – Treatment for the 1-5 % of high-risk students. ESMH is a partnership between the school, community, and local mental health providers.

West Virginia is making significant progress in integration of mental health into community health with its system of community behavioral health centers. As of this writing, there are 5 SAMHSA-grant funded start-ups of Certified Community Behavioral Health Centers in West Virginia: Prestera, Westbrook, Seneca, FMRS, and Southern Highlands. West Virginia BBH has also requested federal stimulus funding through SAMHSA's Block Grant mechanism to further support CCBHC start-up. In addition, WV BHH is working collaboratively with its sister bureau, Bureau for Medical Services (WV Medicaid) on a proposal to CMS (SUPPORT Act 1003 Demonstration Project to Increase Substance Use Provider Capacity, that proposes, among other things, a change in payment mechanism and service delivery to support a Center of Excellence model that requires integration of physical and mental health.

NOT FINAL

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

West Virginia is making significant progress in integration of mental health into community health with its system of comprehensive behavioral health centers. As of this writing, there are 5 SAMHSA-grant funded start-ups of Certified Community Behavioral Health Centers in West Virginia: Prestera, Westbrook, Seneca, FMRS, and Southern Highlands. BBH has also requested federal stimulus funding through SAMHSA's Block Grant mechanism to further support CCBHC start-up. In addition, BBH is working collaboratively with its sister bureau, Bureau for Medical Services (WV Medicaid) on a proposal to CMS (SUPPORT Act 1003 Demonstration Project to Increase Substance Use Provider Capacity, that proposes, among other things, a change in payment mechanism and service delivery to support a Center of Excellence model that requires integration of physical and mental health.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ◉ Yes ○ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The WV Office of the Insurance Commissioners (OIC)

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ◉ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

SSA/SMHA involvement is primarily limited to education and linkage to support, specifically, educating people about their rights under parity via questions and information on the BBH website, and linkage via the WV Insurance Commissioner's Office for complaints and questions.

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

NOT FINAL

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

Item	Response
a) Race	(●) Yes ( ) No
b) Ethnicity	(●) Yes ( ) No
c) Gender	(●) Yes ( ) No
d) Sexual orientation	( ) Yes (●) No
e) Gender identity	( ) Yes (●) No
f) Age	(●) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (●) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (●) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (●) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes (●) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (●) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Behavioral Health (BBH) has funded the Marshall University Research Corporation (MURC) to pilot the WV Behavioral Health Workforce and Health Equity Training Center (https://wvbhtraining.org/) to increase behavioral health workforce excellence by providing training in evidence-based practice statewide and to reduce behavioral health disparities related to mental health and substance misuse and increase health equity for marginalized populations. MURC will also support BBH in establishing a Statewide Training Advisory Council, which will be comprised of a variety of stakeholders and provide recommendations to guide the state's vision of professional development in the behavioral health workforce. This project is funded by the Substance Abuse and Mental Health Services Administration through the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant.

Under the SAMHSA Partnerships for Success (PFS) grant, Marshall is assisting BBH with IRB-reviewed focus groups of higher-risk students, including those who are LGBTQ+, on how to improve prevention and other service provision in the state.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

NOT FINAL

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

NOT FINAL

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ◉ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

NOT FINAL

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Eligibility criteria includes:
• 15 and 25 years of age, and their families, who are experiencing a first episode of psychosis
• Residents of West Virginia
• DSM-5 diagnostic criteria: schizophrenia, schizoaffective disorder, and schizophreniform disorder, as well as other specified/unspecified schizophrenia spectrum and other psychotic disorders
• Individuals having experienced psychotic symptoms lasting at least one week but less than two years
• Individuals who have had not more than 18 months of prior cumulative treatment with anti psychotic medication

Rule outs include:
• substance/medication-induced psychotic disorder
• psychotic disorder due to another medical condition
• bipolar disorder with psychosis

• depressive disorders with psychotic features • serious or chronic medical illness significantly impairing function independent of psychosis • intellectual disability evidenced by an IQ of less than 70

Service types: • coordination/case management services
• supported employment/education
• low dose medication treatment
• individual therapy
• social skills training
• peer support
• family support/education services
• specialized services such as trauma therapy and multifamily therapy will be offered
• physical health is emphasized and encouraged

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The Quiet Minds program has had successful integration in the community by a well-rounded Advisory committee. There has also been extensive training offered to ready the workforce and team of practitioners that serve individuals. The Evidence Based Practice (EBP) includes trauma-informed care, suicide assessment and prevention, motivational interviewing, cultural competence, and person-centered care along with other training to include Recovery from First Episode Psychosis, Schizophrenia and other psychotic disorders, and family focused assessment and care. They have created a network in addition to complete the Coordinated Specialty Care (CSC) model including psychiatrist, therapist, employment, education, housing, peer supports, and case management. This network is designed to create a referral system, capture early episodes, and have rich community resources.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ◉ Yes ○ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Our model emulates OnTrak NY. We have teams to include psychiatrist, therapist, supportive employment, supportive education, Recovery coaching/ youth peer supports, and case management and family psycho-education. The goal is to facilitate early identification and treatment of psychosis in a collaborative, recover-oriented approach involving individuals experiencing first episode psychosis, therefore reduce the disruption to the young person’s functioning and psychosocial development.
Model Components used include outreach, assessment, treatment, community resources, supportive employment, education, health promotion, and advocacy.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

WV will continue it's media campaign utilizing TV commercials, special and interview, billboards, banners, and brochures. We will also be expanding our services this year and will include the following: age expansion- 14-30 years of age and we will be adding a crisis component to the regular services ensuring quick response to those who are experiencing a mental health crisis and are in need of immediate services. This will be utilized to help reduce hospitalizations. These expansion will begin October 1, 2021.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Client level data:
• number of inquiries and referrals made to the central referral unit
• the number of individuals served by the Quiet Minds program
• the services received by each
• the number of families participating in the program
• employment/education information • living situation
• relationship with family
• hospitalizations
• the number of individuals referred who do not meet admission criteria and how these individuals were linked with alternative services

10. Please list the diagnostic categories identified for your state's ESMI programs.

Eligibility criteria includes:
• 15 and 25 years of age, and their families, who are experiencing a first episode of psychosis
• Residents of WV
• DSM-5 diagnostic criteria: schizophrenia, schizoaffective disorder, and schizophreniform disorder, as well as other specified/unspecified schizophrenia spectrum and other psychotic disorders
• individuals having experienced psychotic symptoms lasting at least one week but less than two years
• Individuals who have had not more than 18 months of prior cumulative treatment with antipsychotic medication

Rule outs include:
• substance/medication-induced psychotic disorder

NOT FINAL

• psychotic disorder due to another medical condition
• bipolar disorder with psychosis
• depressive disorders with psychotic features • serious or chronic medical illness significantly impairing function independent of psychosis
• intellectual disability evidenced by an IQ of less than 70

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

West Virginia has a number of existing statewide programs for people with disabilities, including people with mental health issues, which emphasize self-direction, including the state Medicaid agency's three Home and Community-Based Waivers (IDD, TBI and Aged and Disabled) and Money Follows the Person/Take Me Home WV program for people transitioning from nursing facilities, the Ron Yost state funded personal care service program, and the Bureau of Senior Services' Lighthouse in home service program.

4. Describe the person-centered planning process in your state.

BBH has long supported consumer, family and provider training and development in the use of evidenced based approaches, such as Motivational Interviewing, Wellness Recovery Action Planning (WRAP) and Positive Behavior Supports (PBS). BBH state has sponsored trainings and conferences that include seminars and workshops on Motivational Interviewing, has provided financial support for people in recovery to become WRAP trainers, and has awarded grant funding to the WVU Center of Excellence for operation of their statewide Positive Behavior Support (PBS) Program.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ◉ Yes ○ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ◉ Yes ○ No
3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

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Footnotes:

NOT FINAL

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   West Virginia does not have any federally recognized tribes.

2. What specific concerns were raised during the consultation session(s) noted above?

   N/A

3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

NOT FINAL

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? — (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) — (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [x] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [x] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

Each of the six WV Regions, which cover all 55 counties, receive formula based funding based on high risk needs and population. The Strategic Prevention Framework model is utilized to determine needs at the local level as well as county profiles developed by the Bureau for Behavioral Health in coordination with the WV SEOW

If no, (please explain) how SABG funds are allocated:

NOT FINAL

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ◉ Yes ○ No

If yes, please describe

The WV Certification Board for Addiction & Prevention Professionals (WVCBAPP) currently is the sole credentialing body for professionals working in the substance use prevention field. WVCBAPP currently credentials Levels I and II Prevention Specialists. One of the state's regional prevention lead organizations has a prevention specialist that currently serves on the WVCBAPP board. All six Prevention Lead Organizations (PLOs) provide routine capacity building trainings to increase the certified prevention workforce. PLOs provide trainings on prevention ethics, prevention certification competencies, strategic prevention framework, social norms, stigma, and evidence-based programs and practices. Trainings to community members and stakeholders are determined by community needs that reflect identified risk factors.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ◉ Yes ○ No

If yes, please describe mechanism used

All grantees have the same requirements within their statements of work that outlines to them as to the mandatory trainings they must meet annually for their prevention workforce

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

If yes, please describe mechanism used

Community readiness assessments are completed on a routine basis. Community capacity is determined through the Strategic Prevention Framework model

NOT FINAL

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Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ◉ Yes ○ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

See attached strategic plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ◉ Yes ○ No ○ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

a) ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds

b) ☑ Timelines

c) ☑ Roles and responsibilities

d) ☑ Process indicators

e) ☑ Outcome indicators

f) ☑ Cultural competence component

g) ☑ Sustainability component

h) ☑ Other (please list):

i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ○ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

An Evidence-Based Workgroup has been established that reviews evidence-based programs and strategies per their IOM level of prevention; universal, selective, and indicated. The group consists of membership from each of the prevention lead organizations, BBH, certified preventionists, and other state prevention stakeholders.

NOT FINAL

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Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Health Fairs, Drug Take Back Events, Naloxone Training Events, Community Forums, Prevention Guide training and distribution, Rack Cards, Brochures, Food Banks, WV Students Against Destructive Decisions, Social media campaigns, Job fairs, Tobacco Free Days, Loved Ones, Prom Promise, Red Ribbon Week, Prevention Week activities, Blessing Boxes, Save a Life Day, Overdose Awareness events

b) Education:

WV Substance Use Trends, Synar Trainings, Training for Intervention Procedures (TIPS), Fetal Alcohol Spectrum Disorders, Marijuana trainings/workshops, Hidden in Plain Sight, Generation Rx, Teen Court Trainings, Underage Drinking, Synthetic Drugs, Parent 360 Rx, Current Drug Trends, PDMP Trainings, SBIRT, Risk and Protective Factors, Stigma Trainings, Keep a Clear Mind, Alcohol True Stories, All Stars, Health Alternatives for Little Ones, Too Good For Drugs, Too Good for Violence, PAX Good Behavior Game, Signs of Suicide, Not on Tobacco, Matrix Model, Positive Action, Botvin Life Skills, Second Step, Mind Yeti, Parents as Teachers, Healthy Grandfamilies, Strengthening Families, Change Company Journaling, Mind Up, Everfi, Journey of Hope, Ripple Effects, Project Alert,

c) Alternatives:

The Empty Chair, Students Against Destructive Decisions (SADD), Loved Ones, Youth Coalitions, Kidding Around Yoga,

NOT FINAL

Mindfulness, Drug Free All Stars, Youth Move and Hidden in Plain Sight

d) Problem Identification and Referral:

Teen Courts, Juvenile Drug Courts, Synar Compliance Checks, Alcohol Compliance Checks, and Expanded School Mental Health

e) Community-Based Processes:

Community Resource Meetings, Family Resource Network Meetings, Regional Coalition Meetings, State Prevention Steering Committee, SADD Conference, Health Children and Families Meetings, Youth Move, Collaborations with colleges, WV Collegiate Initiative Against Substance Use (WVCIA), Tobacco Prevention Coalition Meetings, Head Start Policy Council Meetings, Prevention Consortiums, Community Readiness assessments, Needs Assessments, and Strategic Action Planning

f) Environmental:

Drug Take Back Boxes, Deterra Bags, Drug Testing Kits, Social Hosting Ordinance, Naloxone Events

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ◉ Yes ○ No

If yes, please describe

Recommendations are made through the Governor's Substance Use Prevention Committee.
A state epidemiological workgroup continues to enhance data systems and is working on the development of an evaluation plan to evaluate prevention efforts outlined in the current Strategic Prevention Plan. The workgroup is also identifying gaps to address future needed prevention strategies

NOT FINAL

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm
- **c)** ☑ Disapproval of use

NOT FINAL

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

NOT FINAL

Footnotes:

NOT FINAL

WEST VIRGINIA
Prevention Strategic Plan

2021–2023

NOT FINAL

NOT FINAL

This draft document is intended to summarize key discussions and decisions of the Prevention Strategic Plan Workgroup. To learn more about prevention in West Virginia and make public comments on the plan, please visit https://helpandhopewv.org/.

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Acknowledgements

It takes a village to create a positive environment in which people can thrive, and so is true with the diverse stakeholders who came together to draft West Virginia's Three-Year Prevention Strategic Plan. The development of this plan is a result of a collaborative process among various bureaus within the West Virginia Department of Health and Human Resources (DHHR), West Virginia Department of Education, and local, public, and private prevention organizations throughout the state. Through the implementation of this Strategic Prevention Plan, West Virginia can continue to build the prevention infrastructure and the health and wellness of individuals, families, schools, and communities within our great state.

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Introduction

In April 2020, DHHR's Bureau for Behavioral Health (BBH) launched a strategic planning process to develop a unified, comprehensive, statewide prevention plan that will help strengthen and sustain West Virginia's current prevention infrastructure. Due to the COVID-19 pandemic, in-person meetings were replaced with a series of facilitated, virtual planning sessions with prevention allies and partners to develop a shared vision, core values, and three-year strategic priorities, objectives, and outcomes.

The West Virginia Strategic Prevention Plan builds upon and aligns with existing prevention plans currently being implemented by our partners. These plans include the *West Virginia 2020-2022 Substance Use Response Plan* through DHHR's Office of Drug Control Policy (ODCP) and the *State Rural Health Plan 2018-2022* through DHHR's State Office of Rural Health. The Governor's Council on Substance Abuse Prevention and Treatment (Council) will act as the main oversight entity for the plan. A subcommittee of the Governor's Council, the Prevention Committee, will work in tandem with the current Prevention Steering Team to implement and evaluate this plan.

The intended audience for this plan includes legislators and other policy makers, governmental agencies, community-based prevention organizations/coalitions, primary and secondary schools, higher education institutions, media, businesses, law enforcement, civic and volunteer groups, youth-serving organizations, and funding partners. The West Virginia Strategic Prevention Plan will be launched December 1, 2020 and overseen by the Governor's Council Prevention committee and the currently in place Prevention Steering Team through BBH.

Throughout the planning process, the importance of building, understanding, and using common language and terminology was noted. The definitions of various prevention terminologies can be found in *Appendix 1: Glossary of Terms*.

The Strategic Prevention Framework (SPF) provided by the Substance Abuse Mental Health Services Administration (SAMHSA) was the overall planning framework utilized for the development of this plan. SAMHSA is the agency within the U.S. Department of Health and Human Services designated to lead public efforts to advance the behavioral health of the nation. Congress established SAMHSA in 1992 to make substance use and mental disorder information, services, and research more accessible.

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(https://www.slideserve.com/qamra/strategic-prevention-framework)

The following key elements comprise the SPF and contribute to more meaningful strategic plans:

- *Getting Started*: Initiate the process;
- *Capacity*: Mobilizing our state system and building capacity;
- *Assessment*: Assess our state's needs, resources, readiness, and gaps;
- *Planning*: Develop a strategic prevention plan;
- *Implementation*: Implement evidence-based prevention strategies;
- *Reporting and Evaluation*: Evaluate and monitor results, change as necessary;
- *Cultural Competence*: Ensure that we operate in consideration of diverse communities; and
- *Sustainability*: Identify new funding sources and resources and sustainable service delivery.

In addition to the SPF, theoretical or conceptual frameworks that support the premise of the West Virginia Strategic Prevention Plan include the following:

- Social Ecological Model;
- Social Determinants of Health;
- SAMHA's Eight Dimensions of Wellness;
- Theory of Change; and
- Lifelong impact of Adverse Childhood Experiences (ACEs).

The theoretical and conceptual frameworks of the Strategic Prevention Plan are discussed in Chapter One.

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CHAPTER ONE: EXECUTIVE SUMMARY

Section 1:1 Overview of Prevention

What is prevention? Merriam-Webster defines prevention as the act of preventing or hindering.[1] What is meant by *Prioritizing Prevention in West Virginia*? This overview will answer this question and discuss the delivery of effective evidence-based programs and prevention strategies for substance use, suicide, child abuse, sexual violence, and domestic violence.

According to SAMHSA, prevention is one component of the continuum of behavioral healthcare (the promotion of mental health, resilience, and well-being), along with promotion, treatment, and recovery. Prevention helps individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors related to substance use/misuse prevention, suicide prevention, and mental health promotion.[2] The prevention field relies heavily on research and practice working in concert within local communities to effectively create positive outcomes in building healthy families and communities.

The Institute of Medicine (IOM) categorizes prevention into three categories in relation to substance use/misuse. Universal prevention strategies address the entire population and are not directed at a specific risk group. Selective prevention focuses on subpopulations that are at increased risk for substance use/misuse due to exposure to identified risk factors. Indicated prevention targets those already using or engaged in other high-risk behaviors to prevent heavy or chronic use.[3] Service strategies and classification of strategies are based on service delivery method and targeted populations. After the strategies and classifications are determined, evidence-based programming selection begins. IOM notes evidence-based programming is defined as conceptually sound, internally consistent, reasonably well implemented and evaluated.

[1] Merriam-Webster. (n.d.). Prevention. In *Merriam-Webster.com dictionary*. Retrieved August 23, 2020, from https://www.merriam-webster.com/dictionary/prevention
[2] Learn About Prevention, Prevention Action Alliance. (n.d.) Retrieved August 23, 2020 from https://preventionactionalliance.org/learn/about-prevention/.
[3] Institute of Medicine (IOM) Classifications for Prevention. Retrieved August 23, 2020 from http://mh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf

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According to the Centers for Disease Control and Prevention (CDC), public health works to prevent disease and promote health rather than diagnose and treat diseases. This form of prevention is related to an individual's physical health. The public health approach to prevention is also categorized into three levels:

- Primary prevention aims to reduce risk factors to prevent disease onset;
- Secondary prevention screens to identify diseases in the earliest stages, before the onset of signs and symptoms; and
- Tertiary prevention is managing disease post-diagnosis to slow or stop the disease progression.[4]

PREVENTION		
Primary	Secondary	Tertiary
Before condition occurs	During development of condition	After condition has occured

An example of a public health approach to prevention in these stages would be education on the harms of tobacco use (primary), routine screenings for disease due to tobacco use (secondary), and managing disease to stop or delay progression due to tobacco use (tertiary).

Prevention in relation to intimate partner abuse, child abuse, rape, and victimization also use the terms primary, secondary, and tertiary prevention. Primary prevention interventions occur before abuse takes place and is delivered to all populations. Secondary prevention interventions focus on subpopulations that are at higher-risk and have fewer protective factors in place. Tertiary prevention interventions seek to prevent further incidences of abuse/sexual violence from happening again with individuals or families where it has already happened.

Universal, selective, and indicated prevention interventions can be integrated into an overall public health approach in primary healthcare settings, schools, work sites, churches, and other community settings.[5] Studies have shown the benefits of integrated primary and behavioral healthcare. The links between mental illness and physical illness are well documented, as risk factors for poor health outcomes are also the same risk factors for substance use/misuse and behavioral health disorders. Prevention is an important piece of this continuum of care, and preventionists can work together to deliver interventions in a coordinated way, especially during the COVID-19 pandemic which could adversely affect individuals, families, and communities. Understanding the interconnections of individual prevention interventions as a system

[4] Center for Disease Control. Prevention. Retrieved on August 23, 2020 from https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

[5] Institute of Medicine (US) Committee on Prevention of Mental Disorders; Mrazek PJ, Haggerty RJ, editors. Reducing Risks for Mental Disorders. Frontiers for Preventive Intervention Research. Washington (DC): National Academies Press (US); 1994. 2, New Directions in Definitions. Available from: https://www.ncbi.nlm.nih.gov/books/NBK236318/.

and how a systematic perspective works is critical as West Virginia moves forward to build and strengthen its prevention infrastructure.

Prevention work in the state is based on data and the implementation of proven, evidence-based programs and practices. The application of local, regional and state data applies to universal, selective, indicated levels of prevention and primary, secondary, and tertiary levels of prevention. Evidence-based programs are programs that have been rigorously tested in controlled settings, proven effective, and translated into practice models that are widely available to community-based organizations.

The Health Policy Institute of Ohio defines "evidence-based practice" and "evidence-based public health" as broad terms, often used interchangeably, that refer to the process of using scientific evidence to identify health problems and effective health improvement strategies.[6] Evidence-based practice involves making prevention decisions on the best available scientific evidence and data; applying program and planning frameworks; engaging the community in the decision-making and implementation; conducting sound evaluation; and disseminating what is learned. Federal funders, such as SAMHSA and CDC, require grantees to utilize evidence-based programs and practices in prevention, treatment, and recovery services and programs.

Evidence-based programs must also subject their evaluations, after rigorous testing, to critical peer review. This means that experts in the prevention field exam the evaluation methods and agree with the conclusions about the program's effects.

Implementing an evidence-based program is widely considered a "best practice" strategy for community health promotion/prevention. Evidence-based programs add value in many ways:[7]

- Positively impacting the health of the program participants is more likely with an evidence-based program;
- Funders increasingly demand that programming be based on solid evidence;
- Agency leaders want to concentrate limited resources on proven programs;
- Program managers can concentrate their efforts on program delivery rather than program development, allowing them more time to reach a larger population and have a greater impact;
- Older adults are savvy and want to invest their time and money in programs that have been proven to work; and
- The demonstrated outcomes of evidence-based programs are attractive to community members and potential partners, facilitating community buy-in and the formation of partnerships.

It is important to note the distinction between "Research-Based" and "Evidence-Based." It is a common misconception that programs based in research fit the criteria to be an

[6] Health Policy Institute of Ohio. Guide to evidence-based prevention. Retrieved from https://nnphi.org/wp-content/uploads/2015/08/GuideToEvidence-BasedPrevention.pdf.
[7] Enhance. What is an Evidence-Based Program. Retrieved from https://projectenhance.org/what-is-an-evidence-based-program/.

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evidence-based program, but just because a program contains research-based content, or was guided by research, that does not mean the program itself has been proven effective. As noted above, the program must be tested and shown to be effective to qualify as an evidence-based program.

Section 1:2 Risk and Protective Factors

Risk and protective factors help explain why a problem exists and are the framework upon which prevention research and practice are based. These factors suggest why certain individuals or groups are likely or unlikely to become victims of crime, abuse, neglect, poor health outcomes, mental illness, suicide, or substance use/misuse.

According to SAMHSA, protective factors are characteristics associated with a lower likelihood of negative health outcomes or that reduce a risk factor's impact. Therefore, helping an individual to build protective factors reduces the risk of developing a risky health behavior or for an existing high-risk behavior to worsen. Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.[8]

An initial first step the Strategic Prevention Planning Team completed was comparing identified risk and protective factors across all the strategic plans submitted to the planning team. This process permitted the team to identify shared risk and protective factors across systems. While not an exhaustive list of all factors, the chart below identifies some common protective and risk factors.

Protective Factors	Risk Factors
• Strong family unit • Active/positive involvement with schools • Positive peer relationships/role models • Resiliency and coping skills • Economic security • Stable home • Health needs met • Social-emotional learning skills • Positive Behavioral Interventions and Supports (PBIS) • Trauma-informed schools • Community support/connectedness • Coordination of resources and services among community agencies	• Poverty • Anxiety • Depression • Current mental health diagnosis • Adverse childhood experiences (ACEs) • Substance use/misuse • Child abuse • Academic issues • Lack of parental involvement/monitoring • Bullying, • Lack of employment opportunities • Lack of institutional support from police and judicial system • Weak health

[8] Substance Abuse and Mental Health Service Administration. Risk and Protective Factors. Retrieved on August 24, 2020 from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf.

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• Access to mental health and substance misuse services • Affiliation with pro-social peers	• Economic • Gender • Educational and social policies • High levels of crime and other forms of violence • Family environment characterized by physical violence and conflict • Adherence to traditional gender role norms

Risk and protective factors can have influence throughout a person's lifespan. For example, risk factors such as poverty and family dysfunction can contribute to the development of obesity, heart disease, high blood pressure, and mental or substance use disorders. The impact of risk factors also affects the community. Risk factors tend to be positively correlated with one another and negatively correlated to protective factors, which means individuals experiencing some risk factors have a greater chance of experiencing more risk factors.[9]

Working in collaboration with communities around shared risk and protective factors is an effective way to stretch limited funding, strengthen partnerships, and increase reach. Understanding risk and protective factors helps to identify appropriate interventions and methods to build protective factors. The more protective factors an individual has decreases risk factors. The essence of prevention practice is to decrease risk and increase protection by creating positive individual and community change. Working collaboratively across sectors helps build these protective factors for individuals, families, and communities.

Section 1:3 Adverse Childhood Experiences

The CDC-Kaiser Permanent Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being. Conducted from 1995 to 1997 with two waves of data collection, the study included more than 17,000 health maintenance organization (HMO) members receiving physical exams in southern California who completed confidential surveys regarding their childhood experiences and current health status and behaviors.[10] The study found that adverse childhood experiences (ACEs), or potentially traumatic events that occur in childhood, are aspects of the child's environment that can undermine their sense of safety, stability, and bonding.[11] ACEs include the following:

[9] Substance Abuse and Mental Health Service Administration. Risk and Protective Factors. Retrieved on August 24, 2020 from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf.
[10] Centers for Disease Control and Prevention. Retrieved August 24, 2020 from https://www.cdc.gov/violenceprevention/acestudy/about.html.
[11] Centers for Disease Control and Prevention. Retrieved August 24, 2020 from https://www.cdc.gov/violenceprevention/acestudy/about.html.

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- Experiencing violence, abuse, or neglect;
- Witnessing violence in the home or community;
- Having a family member attempt or die by suicide;
- Substance use in the home;
- Mental health problems; and
- Parental separation or household members being in criminal justice system.

Researchers estimate that 55.8 percent of West Virginia adults report at least one ACE, while 13.8 percent reported four or more. The most common experience reported was substance use in the household at 29 percent, followed by parental separation/divorce at 26.6 percent and verbal abuse at 22.7 percent.[12]

It is important to note, however, that having a high number of ACEs does not mean that a person will necessarily develop correlating physical and mental health problems.[13] It simply means they are at a greater risk. Moreover, while ACEs can impact the development of the brain, the effect is not irreversible. Parts of the brain can grow and new pathways can be developed.

ACEs are counteracted by resiliency, which is the individual's ability to overcome adversity and continue normal development.[14] The single most important factor that influences a child's resiliency is having the support of at least one stable and committed relationship with a parent, caregiver, or other adult. The American Psychological Association also suggests the following for promotion of resiliency in children:[15]

- Teach children how to make friends, and build a strong family network;
- Introduce child to a belief/faith system;
- Teach child to help others;
- Maintain a daily routine;
- Encourage play;
- Teach child self-care, including eating properly, exercising, and getting adequate rest;
- Teach child to set reasonable goals;
- Nurture a positive self-view

[12] Charleston Gazette-Mail. Traumatic childhood events common in WV, report says. February 10, 2018, https://www.wvgazettemail.com/news/health/traumatic-childhood-events-common-in-wv-report-says/article_7efb3d3b-9940-51c9-9ba1-4f162656ba7e.html

[13] Adverse Childhood Experiences (ACEs) and Their Impact on Brain Development. Maryland Coalition of Families. Blog. May 11, 2018. http://www.mdcoalition.org/blog/adverse-childhood-experiences-aces-and-their-impact-on-brain-development

[14] Adverse Childhood Experiences (ACEs) and Their Impact on Brain Development. Maryland Coalition of Families. Blog. May 11, 2018. http://www.mdcoalition.org/blog/adverse-childhood-experiences-aces-and-their-impact-on-brain-development

[15] Resilience guide for parents and teachers. American Psychological Association. August 26, 2020. https://www.apa.org/topics/resilience-guide-parents

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- Keep things in perspective and maintain a hopeful outlook
- Look for opportunities of self-discovery
- Accept change

America's Health Rankings by the United Health Foundation has provided an analysis of national health on a state-by-state basis for 30 years. The foundation evaluates a historical and comprehensive set of health, environmental and socioeconomical data to determine national benchmarks and state rankings. Data obtained from West Virginia's Health Rankings is valuable in guiding prevention work.

The following tables show ACEs for West Virginia as ranked by America's Health Rankings by the United Health Foundation.

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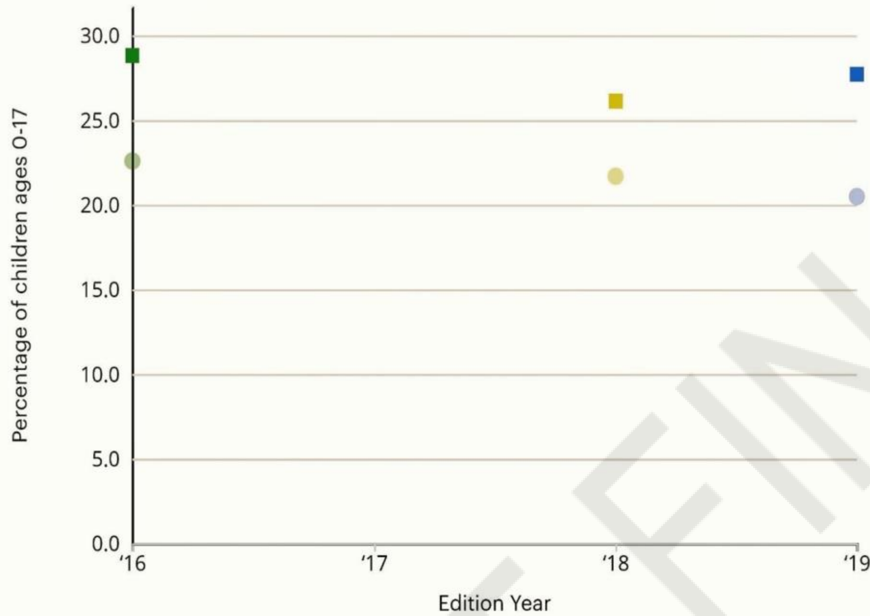
Trend: Adverse Childhood Experiences, West Virginia, United States, 2019 Health Of Women And Children Report



Percentage of children ages 0-17 who experienced two or more of the following: economic hardship; parental divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to race/ethnicity; or death of parent (2-year estimate)

Percentage of children ages 0-17 who experienced two or more of the following: economic hardship; divorce/parental separation, lived with someone who had an alcohol or drug problem; victim or witness of neighborhood violence; lived with someone who was mentally ill or suicidal; domestic violence witness; parent served time in jail; treated or judged unfairly due to race/ethnicity; or death of parent (pre-2016 NSCH redesign)

Percentage of children ages 0-17 who experienced two or more of the following: economic hardship; parental divorce or separation; lived with someone who had an alcohol or drug problem; victim or witness of neighborhood violence; lived with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served time in jail; treated or judged unfairly due to race/ethnicity; or death of parent (1-year estimate)

■ West Virginia ● United States

SOURCE:

- U.S. HHS, HRSA, Maternal and Child Health Bureau (MCHB), Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health Indicator Data Set, Data Resource Center for Child and Adolescent Health
- Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Data Resource Center for Child and Adolescent Health

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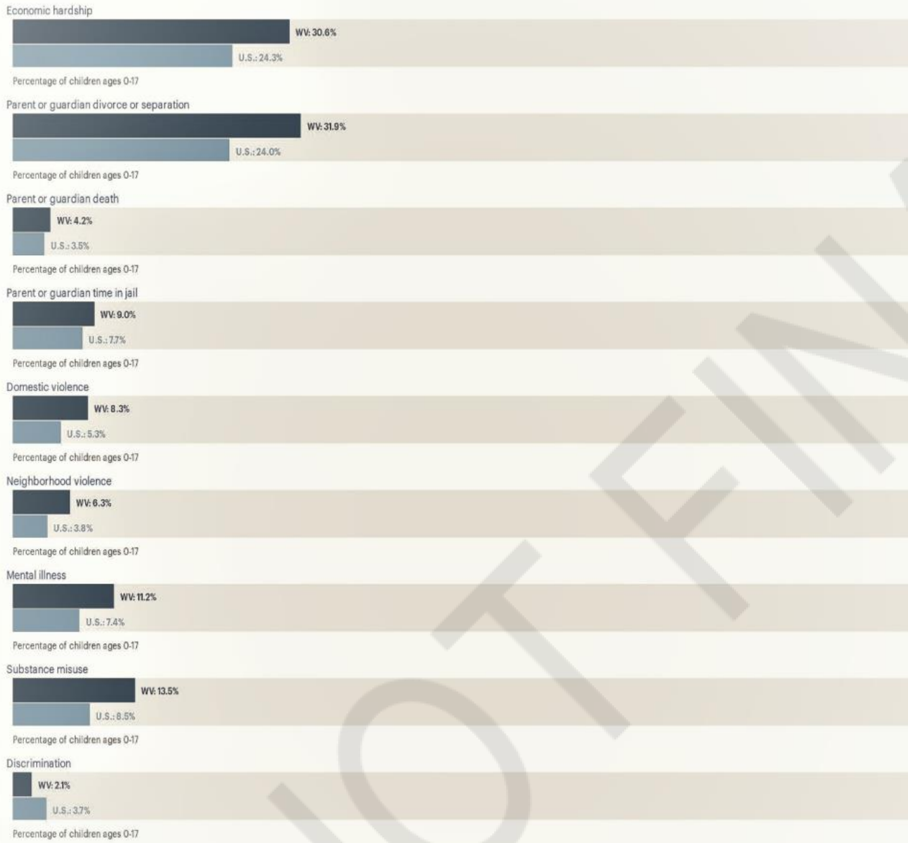
Subpopulations: Adverse Childhood Experiences, West Virginia, United States, 2019 Health Of Women And Children Report

Adverse Childhood Experiences Measures



Data suppression rules are as defined by the original source.

Race and ethnicity populations are as defined by the original source.

SOURCE:

- U.S. HHS, HRSA, Maternal and Child Health Bureau (MCHB), Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health Indicator Data Set, Data Resource Center for Child and Adolescent Health, 2016-2017

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ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood, and they also negatively affect education and job opportunities. However, ACEs can be prevented and mitigated.[16] Understanding of ACEs helps guide prevention work and ensures the appropriate interventions are selected and delivered to meet the individual's needs.

Section 1:4 Strategic Prevention Framework

For communities to establish and implement effective plans to address substance misuse, they must first understand that prevention must begin with an understanding of the complex behavioral health problems within their complex environmental contexts.[17] Research and experience have proven this to be the most effective means to provide substance misuse prevention strategies and program.

To facilitate this understanding, SAMHSA developed the Strategic Prevention Framework (SPF). The five steps and two guiding principles of the SPF provide a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing states and communities.[18]

The SPF includes these five steps:

1. Assessment: Identify local prevention needs based on data (e.g., What is the problem?)

2. Capacity: Build local resources and readiness to address prevention needs (e.g., What do you have to work with?)

3. Planning: Find out what works to address prevention needs and how to do it well (e.g., What should you do and how should you do it?)

4. Implementation: Deliver evidence-based programs and practices as intended (e.g., How can you put your plan into action?)

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[16] America's Health Rankings. United Health Foundation. Retrieved from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/WV

[17] A Guide to SAMHSA's Strategic Prevention Framework. June 2019. Substance Abuse Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.

[18] A Guide to SAMHSA's Strategic Prevention Framework. June 2019. Substance Abuse Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.

5. Evaluation: Examine the process and outcomes of programs and practices (e.g., Is your plan succeeding?)

The SPF is also guided by two cross-cutting principles that should be integrated into each of the steps that comprise it:

- Cultural competence: The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.

- Sustainability: The process of building an adaptive and effective system that achieves and maintains desired long-term results.

Section 1:5 Social Ecological Model

The Social Ecological Model is a theory-based framework, endorsed by the CDC, for understanding how the social determinants of health influence and maintain health and health-related issues.[19] The Social Ecological Model moves beyond a focus on individual behavior and towards an understanding of the wide range of factors that influence health outcomes. The model illustrates how factors influence each other at different levels.[20]

Commented [VSM1]: Already spelled out on page 7.

1. Societal (e.g., laws, systems, the media, and widespread social norms)
2. Community (e.g., neighborhoods, schools, faith communities, and local organizations)
3. Individual (e.g., a person's attitudes, values, and beliefs)
4. Relationship (e.g., relationships with family, partners, friends, and peers)

The Social Ecological Model is used within prevention frameworks to understand the multiple contexts in which risk and protective factors exist. Individuals have biological and physical characteristics that can put them at greater risk or protect them from the effects of emotional, mental, and behavioral health problems:

- Risk and protective factors exist within relationships such as peers, partners, family members, and colleagues;
- Community factors occur within schools, workplaces, and neighborhoods; and
- Societal factors exist in cultural norms of communities.

[19] Increasing Our Impact by Using a Social Ecological Approach. March 2015. Retrieved from https://www.healthyteennetwork.org/wp-content/uploads/2015/06/TipSheet_IncreasingOurImpactUsingSocialEcologicalApproach.pdf.
[20] Centers for Disease Control and Prevention. (2019). The social-ecological model: A framework for prevention. Retrieved from https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html

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This figure illustrates the five levels of the model:

- Individual/intrapersonal: The individual characteristics that influence behavior, including knowledge, skills, motivation, and personality traits.

- Interpersonal: Relationships with others and effects on social identity.

- Organizational/Institutional: Rules and regulations of organizations and institutions that can impact behavior.

- Community: Availability and location of resources that promote health, social networks, and social norms.

- Policy: Local, state, and federal policies and laws that impact health.

The Social Ecological Model explains factors affecting behavior and provides guidance for developing successful programs through social environments. Furthermore, the model emphasizes multiple levels of influence and the idea that behaviors both shape and are shaped by the social environment. The principles of the model are consistent with social cognitive theory concepts, which suggest that creating an environment conducive to change is important to making it easier to adopt health behaviors.[21]

Section 1:6 Social Determinants of Health

Social determinants of health (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[22]

Research by the CDC on SDOH topics expands the scientific evidence that will help build the pathway to health equity. Based on specified criteria, the following categories have been published by Healthy People 2020 utilizing a place-based framework to

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[21] Social and Behavioral Theories. e-Source Behavioral and Social Sciences Research. Retrieved from http://www.esourceresearch.org/Default.aspx?TabId=736.
[22] Social Determinants of Health. Healthy People 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

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identify SDOHs.[23] Each of these five determinant areas reflects a number of key issues that make up the underlying factors in the arena of social determinants of health:

- Economic stability (employment, food insecurity, housing instability, and poverty);
- Education (early childhood education and development, enrollment in higher education, high school graduation, lifelong learning, and language and literacy);
- Social and Community Context (civic participation, discrimination, incarceration, and social cohesion);
- Health and Healthcare (access to healthcare, access to primary care, and health literacy); and
- Neighborhood and Build Environment (access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing).

As noted in *Creating a Culture of Health in Rural West Virginia: State Rural Health Plan 2018-2022*, many health issues in West Virginia are a product of cultural and socioeconomic factors outside of the control of the healthcare delivery system. Social and cultural factors in rural West Virginia lead to increased likelihood for residents to pick up unhealthy behaviors. These behaviors include tobacco use, lack of physical activity, and substance misuse. Generational poverty, income level, and low priority on education can often span generations. Many children are now being raised by grandparents, other extended family members, or foster parents due to substance use/misuse, overdoses, or incarceration. These social and cultural factors are the areas that can be hardest to change but are the most changeable factors.[24]

Healthy communities involve many facets that will work together to promote a high quality of life. Culture, education, economy, and ecology are all part of healthy communities. This idea correlates with the ideas of SDOH. Promoting these ideas involves a broader group of stakeholders to encourage positive change. General areas of concern noted in *Creating a Culture of Health in Rural West Virginia: State Rural Health Plan 2018-2022* include the following:

- Alcohol, substance, and tobacco dependence/misuse;
- Insufficient physical activity;
- Poor nutrition (food access, diet choices, income);

[23] Social Determinants of Health: Know What Affects Health. CDC Research on SDOH. Retrieved from https://www.cdc.gov/socialdeterminants/research.html?Sort=Article%20Date%3A%3Adesc&Category=Economic%20Stability.
[24] Department of Health and Human Resources State Office of Rural Health. Creating a Culture of Health in Rural West Virginia; State Rural Health Plan 2018-2022. Retrieved from https://wvrha.org/wp-content/uploads/2017/08/2018-State-Rural-Health-Plan-Final.pdf.

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- Risky sexual behaviors; and
- Violence (child abuse, intimate partner abuse).

This Strategic Prevention Plan aligns with the Rural Health Plan in promoting positive health behaviors by West Virginians through promotion, awareness, education, problem identification and referral, information dissemination, and implementation of evidence-based programs and practices.

The 2017 West Virginia Behavioral Risk Factor Surveillance System Report notes the following for SDOH in West Virginia:

- Approximately 14.5% of West Virginia adults reported being unable to pay bills in the past year;
- Approximately 12.9% of West Virginia adults reported that they did not have enough money to make ends meet at the end of the month;
- Approximately 8.2% of West Virginia adults reported that they considered their neighborhood to be unsafe;
- Approximately 23.4% of West Virginia adults reported that they had been food insecure in the past year;
- Approximately 24.3% of West Virginia adults reported that they could not afford to eat balanced meals at times in the past year; and
- Approximately 18.6% of West Virginia adults reported that they were stressed all or most of the time in the past month.[25]

Section 1:7 Theory of Change

Theory of Change (TOC) describes how and why a desired change is expected to happen and connects intervention activities with the expected outcomes. Interventions that are based on theory are more likely to be effective and thus recommended by SAMHSA.[26] TOCs also facilitate program evaluation because the important outcomes are explicitly defined.

SAMHSA developed a Theory of Change to guide work to support the development and implementation of innovations in behavioral health service delivery. Interventions that are based on theory are more likely to be effective and thus recommended by SAMHSA. TOCs also facilitate program evaluation because the important outcomes are explicitly defined.

The TOC depicts how innovations can move through stages of development through widespread adoption. SAMHSA's TOC has provided the conceptual foundation for

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[25] Department of Health and Human Resources State Office of Rural Health. Creating a Culture of Health in Rural West Virginia; State Rural Health Plan 2018-2022. Retrieved from https://wvrha.org/wp-content/uploads/2017/08/2018-State-Rural-Health-Plan-Final.pdf.

[26] SAMHSA's Theory of Change. Retrieved from https://www.tn.gov/content/dam/tn/mentalhealth/documents/Theory%20of%20Change.pdf.

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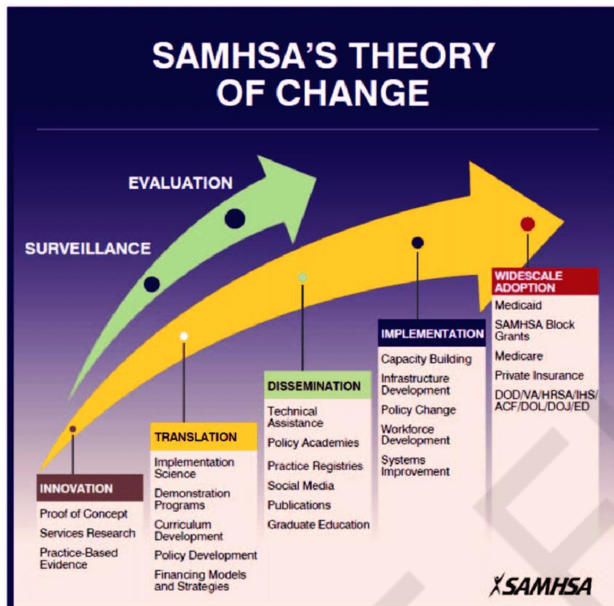
efforts to promote wide-scale adoption of the system of care approach to serving children, youth, and young adults with mental health challenges and families.[27]



https://www.researchgate.net/figure/The-Substance-Abuse-and-Mental-Health-Services-Administration-SAMHSA-model-for_fig1_312926682 **Section 1:8 SAMHA's Eight Dimensions of Wellness**

Wellness is a broad concept. Merriam-Webster defines wellness as the quality or state of being in good health especially as an actively sought goal. The Cambridge Dictionary defines wellness as the state of being healthy. Dictionary.com defines wellness as an approach to healthcare that emphasizes preventing illness and prolonging life, as opposed to emphasizing treating diseases.

SAMHSA has a wellness initiative that pledges to promote wellness for those with behavioral health conditions by motivating individuals, organizations, and communities to act and work toward improved quality of life, heart, health, and increase years of life.[28] SAMHSA's eight dimensions of wellness are emotional, physical, occupational, intellectual, financial, social, environmental, and spiritual.[29] SAMHSA defines wellness as being healthy in these eight mutually interdependent dimensions. Each aspect of

[27] Substance Abuse and Mental Health Services Administration (SAMHSA). Applying SAMHSA's Theory of Change to Systems of Care: Summary of Expert Panel Meeting July 2015.
[28] J. Flowers Health Institute. 8 Dimensions of Wellness. Retrieved from https://jflowershealth.com/8-dimensions-of-wellness/.
[29] Creating a Healthier Life. A Step-by-Step Guide to Wellness. Substance Abuse Mental Health Services Administration (SAMHSA). Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4958.pdf.

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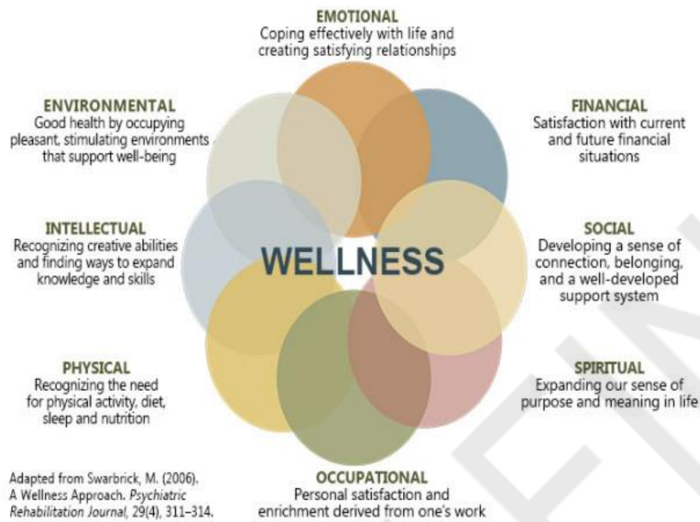
these dimensions of wellness can affect overall quality of life. The following illustration of the eight dimensions of wellness shows them as being in multiple circles overlapping one another, as each aspect of wellness can affect another aspect of wellness in the circle.



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CHAPTER TWO: STRATEGIC PLAN

Section 2:1 Setting the Context

The West Virginia Strategic Prevention Plan was informed by the preceding frameworks, models, and theories; a horizontal view of current state prevention plans; a review of key data indicators; and input from partners on key planning themes through an electronic feedback process. The information gathered provided a decision-making framework to develop key components of the strategic plan, including a shared vision, core values, and strategic priorities.

Through partnerships, the West Virginia Strategic Prevention Plan strengthens and supports an integrated state-wide system of community-driven physical and mental health promotion, substance-use prevention, suicide prevention, prevention of child abuse, sexual violence prevention, and other related prevention efforts. Key opportunities and challenges identified throughout the planning process are noted as follows:

Opportunities	Challenges
• Increase collaboration and communication at the community and state levels • Streamline and align our programs and interactions with the school system to create a comprehensive, singular approach within the education system (include local coalitions to help with the delivery of prevention services) • Integrate evidence-based prevention services within current service systems • Create unified, consistent messaging and build upon asset-based positive community norms • Bridge/braid funding and share resources and training. Braided funding is the combination of 2 or more funding sources to support a program/initiative • Seek private-public partnerships, especially toward sustainable funding opportunities	• Lack of consistent and reliable community-level data and current data around core measures • Funding – overreliance on federal dollars • Buy-in and support from policy makers and other stakeholders in making prevention a priority • Sigma across all environments • The impact of COVID-19 • Health literacy levels • A sense of complacency at the community level • The use of one size-fits all programs – not all programs can work in all localities – some have limited capacity • Silos and duplication within provider organizations and organizations themselves

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• Encourage prevention screenings and cross-training opportunities within prevention workforce • Develop and fund a statewide data collection infrastructure to ensure that research, policy, and practice inform each other in a bidirectional manner • Partner to support families and caregivers in building social and emotional competence of children • Provide preventive and supportive services at the community level to strengthen families • Collaborate to address workforce retention and recruitment • Coordinate statewide education for communities about substance use disorders, and stigma • Explore expansion of the Icelandic Model to every county	

While planning the West Virginia Strategic Prevention Plan, stakeholder involvement emphasized the importance of building, understanding, and using common language. Based on this, the following has been included in this strategic plan:

- A crosswalk of common terms and definitions of prevention to be used include universal, selective, and indicated (tier one, tier two, tier three; primary, secondary, tertiary in addition to defining public health approach doses); and
- Clearly defined and included definitions of risk and protective factors.

The Strategic Prevention Planning Committee met on the following dates during the development phase of the plan with specific purposes for each meeting.

SESSION	PURPOSE	DATE
Session I	Organize, imagine, and launch the comprehensive prevention strategic planning process by addressing key “planning the plan” questions.	April 15, 2020
Session II	Build upon current prevention plans to align and inform the development of our	May 20, 2020

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SESSION	PURPOSE	DATE
	comprehensive prevention strategic plan.	
Session III	Using the Strategic Prevention Framework, review key data assessment findings as we continue to develop a comprehensive plan to strengthen and sustain WV's prevention system.	June 4, 2020
Session IV	Reach agreement on shared vision concepts, strategic priorities, and expected results as we continue to develop our comprehensive, unified plan to strengthen and sustain WV's prevention system.	June 24, 2020
Session V	Building upon our strengths and opportunities, identify current and additional strategies to achieve our strategic outcomes and priorities.	July 8, 2020
Session VI	Building upon our strengths and opportunities, review and reach agreement on strategic objectives and timeframes for implementation.	July 30, 2020
Session VII	Discuss and reach agreement on implementation and monitoring recommendations to launch the strategic plan.	August 27, 2020
Session VIII	Provide feedback on the initial strategic plan draft utilizing the Six Thinking Hats process.	September 11, 2020

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Section 2:2 Current Prevention Landscape

Shared values that emerged from Session I were to honor, support, and build upon the current efforts of prevention partners. As a starting point, there was agreement to review existing plans to inform and align development of the comprehensive prevention plan.

The following organizations or strategic prevention plan focus areas were identified by partners and reviewed for additions. As part of discussion, two additional plans were added to the list for a total of 21 strategic plans: the West Virginia Drug Intervention Institute and the Mountains of Hope State Cancer Prevention Plan.

ACES Coalition	Prevent Child Abuse WV
Family First Prevention	Icelandic Model Collaborative
Mountains of Hope State Cancer Prevention Plan	Office of Drug Control Policy
Overdose to Action	Prevention First
Problem Gambling	Reclaim WV
Sexual Violence	State Opioid Response Prevention
SPF Prescription Drug Overdose	Suicide Prevention
Teen Pregnancy/THINK	Tobacco Prevention
Underage Drinking	WV Domestic Violence
WV Domestic Violence	WV Drug Intervention Institute
WV Rural Health Association	

Partner organizations submitted their respective strategic plans to Basecamp and completed a summary template of their plan to inform the review process. Template informational areas include the following:

- Prevention Plan Sector;
- Specific Population Addressed;
- Focus Area (statewide, regional, or local)
- Funding Streams;
- Timeline of Implementation;
- Data or Assessments Available Which Can Be Shared;
- Risk and Protective Factors the Plan Addresses; and
- Levels of Social Ecology the Plan Addresses.

Using information gathered from submitted strategic plans, the following common themes, opportunities, and challenges were identified.

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Prevention plans reviewed on 5/20/2020	Common themes identified across plans	Opportunities on the horizon for cross-collaboration	Issues holding us back/slowing us down
Office of Drug Control Policy Sexual Violence Problem Gambling SPF RX Plan Family First WV Prevention First SOR Teen Pregnancy /THINK Tobacco Prevention	Except for THINK, these plans have a statewide **focus** (THINK teen pregnancy plan focuses efforts in 21 counties) Reviewed plans are **environmentally focused** Several plans focus on **policy and community and are individually focused** The target populations are **school-age children, youth, and high-risk populations** (several plans reviewed also target college-age groups) **Screening** is encouraged Several plans are working with **families to strengthen structure and access** to needed services and supports **Common risk factors** were noted in several plans and included: poverty, anxiety, depression, MH diagnosis, ACES, family use/RX of substance use/misuse, abuse, academic issues, lack of parental involvement/monitoring, bullying, <u>A risk factor that is often missing across plans is the sense of hopelessness</u> **Protective factors** Present include strong family unit, active/positive involvement with schools, positive peer relationships/role-models, resiliency and coping skills, economic security, stable home, health needs	Many plans focus on partnering with the school system – **there is an opportunity to streamline our interactions with school systems and align after-school and summer programing, and combine efforts to create a comprehensive, singular approach within the education system** **Sexual violence socioecological framework** would be a good vertical comparison for horizontal comparison across plans **All plans require assessment and ongoing data collection and measurement collection - this could allow us to determine pockets of resistance and resilience** to help us understand what communities are doing well and to apply similar efforts to the communities that need additional assistance to succeed There is an opportunity to **bridge/ braid and align funding and to share resources and training opportunities.** There is an opportunity to **increase collaboration at** the **local or community level** so that the	**There is no mechanism for local level data or plans** to address identified issues in communities. **Local planning and local data are needed at the forefront = more local control.** This will permit a process that is consistent. Need to encourage local data collection but acknowledge limitations. There is **a lack of consistent and reliable community level data** **Up-to-date solid data is not available around core measures**, especially regarding the youth's experience in substance use **Funding** is limited, especially for tobacco prevention **Buy-in and support** from partners, legislature and other policy makers is another challenge. Although prevention is recognized as important at the state level, it is not made a priority There is **a sense of complacency** at the community level The **use of one size-fits all programs** – not all programs can work

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Prevention plans reviewed on 5/20/2020	Common themes identified across plans	Opportunities on the horizon for cross-collaboration	Issues holding us back/slowing us down
	met, social-emotional learning skills, Positive Behavioral Interventions and Supports, and trauma-informed schools **Community level data** is often not referenced or is missing across plans The importance of **empowering and training adults to be positive role models and to share consistent messaging** is another missing component across plans **Youth led prevention efforts** in tobacco prevention have been shown to be an effective strategy It appears that most plans are **federally funded which impacts sustainability**	community can identify where braiding should occur since they are best to identify their needs - collect **local data** and divide results by region There is an opportunity to **create unified, consistent messaging/**develop a social norm campaign/find new ways to delivering messaging in the current environment (embed messaging in tele-health) and to use non-traditional ways to get the message to youth in the new environment There is an opportunity to **provide prevention services and supports to children in the foster care system and other high-risk populations** to prevent out-of-home placements **Expanding education and communication** across providers/organizations was identified as an additional opportunity to collaborate Due to workforce issues in our state, there is an opportunity **to collaborate our efforts help address workforce shortages across the prevention field**	in all localities – some have limited capacity. **Confidentiality** is an additional constraint **The COVID-19 Pandemic** has hindered implementation and the need to shift to new innovative means of service delivery through electronic means **Workforce issues/shortages** continue to impact services and delivery **Health Literacy** level of populations being served **Stigma s**urrounding individuals across all socio-economic levels

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Prevention plans reviewed on 5/20/2020	Common themes identified across plans	Opportunities on the horizon for cross-collaboration	Issues holding us back/slowing us down
		Encourage screening and cross-training for co-occurring issues	

The following considerations and questions emerged regarding the current prevention landscape in West Virginia:

- *The importance of incorporating mindfulness practices into the schools by a statewide group, Mindful WV, is having a substantial impact.*
- *How will West Virginia shift to prevention, which is employee-heavy, in comparison to residential types of treatment?*
- *It appears that most funding for prevention is federal. How does this hold us back? How do we identify and collaborate with private and state-level funding partners and policy makers to make prevention a priority? State funds could be matched with federal funds.*
- *Systemic and collaborative efforts are needed to garner additional prevention funding that would support statewide data collection at the community level.*
- *There is an analysis for cost savings if evidence-based programming is implemented with fidelity. Nationally, for every $1 invested in prevention, there is a $17-$27 return on investment. What other prevention services around the state could help show there is a cost savings associated with effective prevention?*
- *How can we grow economically if our children are not healthy physically and mentally?*
- *Who are our Prevention Champions who can help facilitate the changes and who else would we want to involve?*

The Strategic Prevention Planning Committee agreed that all the above questions and considerations were important to the development of an overall prevention strategic plan for the state. The key opportunities and issues identified are as follows:

Opportunities	Issues Holding Us Back
Streamline and align our programs and interactions with the school system	Lack of consistent and reliable community-level data
Collaborate to address workforce shortages	Funding – overreliance on federal dollars
Bride/braid funding and share resources and training	Buy-in and support from policy makers and other stakeholders in making prevention a priority
Create unified, consistent messaging	Stigma across all environments

Section 2:3 Health Disparities in West Virginia

A health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. According to the CDC, health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

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Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.[30]

Health disparities result from multiple factors, including:

- Poverty;
- Environmental threats;
- Inadequate access to healthcare;
- Individual and behavioral factors; and
- Educational inequalities.

Good health is associated with academic success. Individuals with less education are more likely to experience health risks, such as obesity, substance misuse, and intentional or unintentional injury, compared to individuals with more education. Good health is associated with academic success.

Additionally, higher levels of protective health behaviors and lower levels of health risk behaviors are associated with higher academic grades among high school students. Health risks such as teen pregnancy, poor dietary choices, inadequate physical activity, physical and emotional abuse, substance misuse, and gang involvement have a significant impact on how well students perform in school.[31]

Statistics about the population of West Virginia[32]

US Census 2018, Vintage 2018

Age (% > 65 years)	**19.4%**
Race (% white)	**93.6%**
Ethnicity (% Hispanic)	**1.6%**
Disability (% < 65 years)	**14.4%**
Median household income	**$44,061**
Proportion in poverty	**19.1%**
High school graduate	**85.9%**

Why are these statistics important?

Statistics like age, sex, income and education are part of the Social Determinants of Health.

These factors have been shown to affect a person's health outcomes. Understanding these factors can help organizations like the West Virginia Bureau for Public Health improve health for each citizen of our state.

[30] Centers for Disease Control and Prevention. Adolescent and School Health. Health Disparities. Retrieved from https://www.cdc.gov/healthyyouth/disparities/index.htm.
[31] Centers for Disease Control and Prevention. Adolescent and School Health. Health Disparities. Retrieved from https://www.cdc.gov/healthyyouth/disparities/index.htm.
[32] West Virginia Department of Health and Human Resources Division of Health Promotion and Chronic Disease. Helping Prevention and Manage Chronic Disease. Retrieved from https://dhhr.wv.gov/hpcd/data_reports/pages/fast-facts.aspx.

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Each year since 1984, the West Virginia Behavioral Risk Factor Surveillance System (BRFSS) has measured a range of risk factors that can affect West Virginians' health. The most recent report presents state survey results for the year 2018 as well as county data combined for the latest available five years (2013 through 2018).

The information in this report serves as a resource for governments, business leaders, schools, and community groups, all of which are helping to shape the health of West Virginia. The following tables represent data related to health disparities for West Virginia for 2018.

Health Status	Healthcare Access	Weight Status
West Virginia ranked 2nd highest nationally in the prevalence of general health of adults as either fair or poor.	The prevalence of no healthcare coverage among West Virginia adults aged 18-64 was at an all-time low of 9.3%, compared to 14.1% nationally.	The prevalence of obesity in West Virginia was 37.7%, which was 1st highest in the nation.
More than one-fourth of West Virginia adults (26.3%) considered their health to be either fair or poor.	The prevalence of no healthcare coverage among those aged 18-64 was highest in Barbour and Logan counties.	The prevalence of obesity was significantly higher in Fayette, Logan, and McDowell counties than in the rest of the state
Fair or poor health was most common among groups of adults aged 55-64, those with less than a high school education, and those who have an annual household income of less than $15,000.	Nearly half of West Virginia adults have private insurance (45.1%), followed by Medicare (24.3%) and Medicaid (15.9%).	More than two-thirds (70.9%) of West Virginia adults were overweight or obese, the 2nd highest in the U.S.
The prevalence of fair or poor health was highest in Boone, Fayette, Lincoln, Logan, McDowell, Mercer, Mingo, and Wyoming counties.	Nearly one-fifth of all adults do not have a personal doctor or healthcare provider (19.5%).	The prevalence of overweight or obese was highest among men, those aged 45-54, those with a high school education, and those with an annual household income of $50,000-$74,999.
West Virginia ranked 1st highest in the nation for the prevalence of poor physical health, poor mental health, and activity limitations due to poor physical or mental health.	Approximately 14.6% of West Virginia adults could not afford needed medical care in the past year.	
	More than one-fifth of West Virginia adults did not have a routine checkup in the past year (21.4%).	

Physical Activity	Sugar-Sweetened Beverages	Cardiovascular Disease
More than one-fourth of West Virginia adults (28.5%) did not participate in leisure-time physical activity or exercise, West Virginia 11th highest in the nation.	More than one-fourth of West Virginia adults (28.8%) consume soda or pop on a daily basis.	West Virginia ranked 1st highest in the nation in the prevalence of heart attack (7.5%) and coronary heart disease (8.0%).

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Physical Activity Continued

The prevalence of physical inactivity was significantly higher among females than males.

Physical inactivity was highest among those aged 65 and older, those with less than a high school education, and those with an annual household income of less than $15,000.

The prevalence of physical inactivity was significantly higher in Grant, Logan, McDowell, Mercer, Mingo, Webster, and Wyoming counties than the rest of the state.

Sugar-Sweetened Beverages Continued

The prevalence of daily soda or pop consumption was highest among men, those aged 25-34, and those with less than a high school education.

The prevalence of daily consumption of sugar-added beverages was highest among males, those aged 18-24, and those with a high school education or less.

Approximately 39.2% of West Virginia adults consume either soda, pop, or a sugar-added beverage daily.

Nearly one in five West Virginia adults (19.1%) consume sugar-added beverages on a daily basis.

Menu Labeling

Nearly half of West Virginia adults (47.2%) use calorie information provided on menus.

The prevalence of using calorie information on menus was highest among women, college graduates, and those with an annual household income of $75,000 or more.

Cardiovascular Disease Continued

West Virginia ranked the 7th highest in the nation in the prevalence of stroke (4.4%).

The prevalence of cardiovascular disease was highest among men, those aged 65 and older, those with less than a high school education, and those with an annual household income less than $15,000.

The prevalence of cardiovascular disease was significantly higher in Grant, Logan, McDowell, Mingo, and Wyoming counties than the state.

More than half of West Virginia adults (50.8%) are currently watching or reducing their sodium intake.

Cancer

Approximately 7.4% of West Virginia adults had ever had skin cancer and 8.1% had ever had some other type of cancer.

About 1 in 7 West Virginia adults had been diagnosed with cancer, but were still living (14.0%), which ranked West Virginia the 3rd highest for overall cancer prevalence.

Cancer prevalence was highest among adults aged 65 and older and those with an annual household income of $25,000-$34,999.

Cancer Screening

The prevalence of had a mammogram in the past 2 years among women aged 50-74 was 77.8%, similar to the U.S. prevalence.

The prevalence of had a Pap test in the past 3 years among women aged 21-65 was 79.5%, similar to the U.S. prevalence.

West Virginia men aged 40+, 52.9% discussed advantages of prostate specific antigen (PSA) test with a doctor, 31.8% discussed the advantages of the prostate specific

Diabetes

More than 1 in 10 West Virginia adults had diabetes (15.0%), which ranked West Virginia the 2nd highest nationally.

The prevalence of diabetes was highest among those aged 65 and older, those with less than a high school education, and those with an annual household income of less than $15,000.

The prevalence of diabetes was significantly higher in Grant, Logan, McDowell, and Wayne counties than the state as a whole.

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Cancer Continued

Among cancer survivors, 35.4% received a written summary of all cancer treatments and 4.9% participated in a clinical trial.

Among cancer survivors, 63.9% received instructions about routine cancer check-ups after treatment and 76.2% of those were written instructions.

Cancer Screening Continued

antigen (PSA) test with a doctor, 31.8% discussed the disadvantages of the PSA test with a doctor, 52.5% had a doctor who recommended having the PSA test, and 42.7% had a PSA test in the past 2 years.

Among adults aged 50-75, 10.0% had a Fecal Occult Blood Test (FOBT) test in the past year and 16.8% had a FOBT test in the past 3 years.

Among adults aged 50-75, 63.3% had a colonoscopy in the past 10 years, similar to the U.S. prevalence.

More than two-thirds of West Virginia adults aged 50-75 had at least one of the recommended colorectal cancer screenings (67.0%), which was similar to the U.S. prevalence.

Diabetes Continued

Among West Virginia adults with diabetes, 24.3% had 2 or more A1C test in the past year and 48.0% have taken a diabetes self-management class.

Approximately 11.0% of West Virginia adults had pre-diabetes.

The prevalence of borderline or pre-diabetes was highest among those aged 65 and older and those with less than a high school education.

Diabetes Testing

Among West Virginia adults who do not have diabetes, 62.9% have had a diabetes test in the past 3 years.

The prevalence of had a diabetes test in the past 3 years was highest among those aged 65 and older, college graduates, and those with an annual income of $25,000-$34,999.

Comorbidities

Approximately 1 in 6 West Virginia adults (17.3%) were both obese and had arthritis.

About 1 in 6 West Virginia adults (14.8%) had arthritis and did not exercise.

Respiratory Diseases

Approximately 16.2% of West Virginia adults have ever been diagnosed with asthma and 11.8% of West Virginia adults currently had asthma.

Women had significantly higher prevalence of both lifetime and current asthma than men.

Tobacco Use

Nearly one-fourth of adults (24.8%) currently smoke cigarettes every day or some days, which ranked West Virginia the 2nd highest nationally.

The prevalence of current smoking was highest among those aged 25-34, those with less than a high school education, and those with an annual household income of less than $15,000.

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Comorbidities Continued	Respiratory Diseases Continued	Tobacco Use Continued
About 1 in 8 West Virginia adults (12.9%) were obese and did not exercise.	The prevalence of both lifetime asthma and current asthma was highest among those with less than a high school education and those with an annual household income of less than $15,000	The prevalence of current cigarette smoking was highest in Calhoun and Wyoming counties.
About 1 in 11 West Virginia adults (9.2%) were obese and had diabetes.	The prevalence of current asthma was significantly higher in Harrison and McDowell counties than the rest of the state.	Approximately 54.7% of current smokers had tried to quit smoking in the past year, which was the 46th highest (equating to 9th lowest) in the nation.
Approximately 1 in 20 West Virginia adults (5.3%) had both cardiovascular disease and diabetes.	The prevalence of chronic obstructive pulmonary disease or COPD in West Virginia was 13.9%, which was 1st highest in the nation.	West Virginia ranked the 2nd highest in the nation in the prevalence of smokeless tobacco use (8.5%) among adults.
About 1 in 11 West Virginia adults (8.7%) were current smokers who had depression.	The prevalence of COPD was highest among adults aged 55-64, those with less than a high school education, and those with an annual household income of less than $15,000.	The prevalence of smokeless tobacco use was highest in Grant and Lincoln counties.
	The prevalence of COPD was significantly higher in Fayette, Lincoln, Logan, McDowell, Mercer, and Mingo counties than the rest of the state	The prevalence of respondents who currently use e-cigarettes was 4.7%, similar to the U.S. prevalence, and was highest among adults aged 18-24.

Section 2:4 Data Assessment and Gaps

Prevention research has underscored the importance of strategically using data to inform efforts to reduce problems related to substance use/misuse, mental, emotional, and behavioral disorders. SAMHSA has funded State Epidemiological Outcomes Workgroups (SEOWs) to assist states, jurisdictions, tribal entities, and communities to adopt and implement the Strategic Prevention Framework (SPF)[33].

SEOWs are a network of people and organizations that bring analytical and other data competencies to prevention. Their mission is to integrate data about the nature of substance use and Mental Emotional Behavioral (MEB) disorders and related consequences into ongoing assessment, planning, and monitoring decisions at state and community levels.

The West Virginia SEOW is housed and led by the West Virginia Bureau for Behavioral Health in order to facilitate the use of data in policymaking and program decision-

[33] Substance Abuse Mental Health Services Administration (SAMHSA). Data-Based Planning for Effective Prevention: State Epidemiological Outcomes Workgroups. Retrieved from; https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4724.pdf.

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making for substance use prevention at the state and community level. The SEOW is comprised of 26 organizations and individual partners, listed below, who serve as subject matter experts.[34]

CAMC Center for Health Services & Outcomes Research	WV Coalition to End Homelessness
WV Bureau for Children and Families	WV Division of Corrections
WV Bureau for Medical Services	WV Department of Education, Office of Healthy Schools
WV Bureau for Public Health, Health Statistics Center	WV Department of Education, Office of Research
WV Bureau for Public Health, Epidemiology and Prevention Services	WV Healthcare Authority
WV Bureau for Public Health, Office of Maternal Child and Family Health	WV National Guard
First Choice Services, Inc.	WV Poison Center
Governor's Highway Safety Program	WV Division of Motor Vehicles
WV Higher Education Policy Commission	WV State Police
WV Coalition Against Domestic Violence	WV Supreme Court of Appeals
CAMC Center for Health Education & Research Institute	WV Division of Justice & Community Services, Office of Research & Strategic Planning & Justice Center for Evidence Based Practice
WV Statistical Analysis Center	WV Rural Health Association
CAMC Health Education & Research Institute	WV Controlled Substances Monitoring Program – WV Board of Pharmacy

Tammy Collins, PhD., COS, OCPC and Lead Evaluator &Family Scientist, Marshall Center of Excellence and Recovery gave an overview of key data findings to help provide data assessment and identify gaps in current state data in the third planning session. Sources Dr. Collins utilized included national surveys and monitoring efforts, state surveys, and state and local administrative data. The following are excerpts from her presentation which include consumption data, risk factors, and consequence data.

[34] WV Department of Health and Human Resources: Bureau for Behavioral Health. Data: West Virginia State Epidemiological Outcomes Workgroup. Retrieved from: https://dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Pages/DataResearch.aspx.

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Substance Use of Middle & High Schoolers

Annual Averages Based on 2016 and 2017 NSDUHs - Percentages	US	WV	WV School Climate Survey Item Equivalent
Alcohol Use in the Past Month among individuals aged 12 to 17	9.54	10.1	12.21
Binge Alcohol Use in the Past Month among individuals aged 12 to 17	5.06	5.67	6.41
Marijuana Use in the Past Month among individuals aged 12 to 17	6.46	5.45	6.61
Alcohol Use and Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20	19.5	20.38	

West Virginia youth talked with at least one parent or guardian about the dangers of tobacco, alcohol, or drug use in the 12 months prior to the survey. *(School Climate Survey 2018-19)*

How much do people risk harming themselves physically and in other ways when they do the following?	
Drink alcohol occasionally	50.2%
Have five or more drinks of an alcoholic beverage once or twice a week	77.2%
Smoke marijuana occasionally	56.2%
Smoke marijuana once or twice a week	65.0%
Use prescription drugs that are not prescribed to them	84.3%

Solutions to address this problem focus on improving alcohol and drug prevention education and creating healthier school environments. The 2016 West Virginia School Health Profiles indicated the percentages of West Virginia high schools that implemented the following policies and practices:[35]

90% of schools require alcohol and drug prevention courses for students.
36% of schools have lead health teachers who received prevention training in the past 2 years.
36% of schools provide parents with alcohol/drug prevention information.
29% of schools have programs using community members as role models/mentors.

[35] West Virginia Department of Education, 2017 Youth Risk Behavior Survey, 2016 Health Profiles. Retrieved from https://www.wvfree.org/wp-content/uploads/high-school-yrbss-data.pdf

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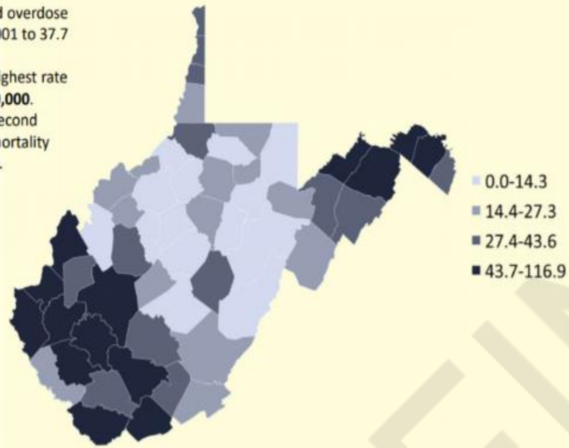
Geographic

WV Resident Opioid-Related Overdose Mortality Rate, 2018*

Crude Rate per 100,000

The statewide opioid-related overdose mortality rose from 8.4 in 2001 to 37.7 in 2018.

- Cabell County had the highest rate in 2018 at **114.8 per 100,000**.
- Boone County had the second highest opioid-related mortality rate at **82.0 per 100,000**.



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*2018 data are preliminary and subject to change. Rates calculated for counties with fewer than 10 overdose deaths are unreliable and subject to large fluctuations.
Source: WV Health Statistics Center, Vital Statistics System, December 2019.

Overdose Morbidity & Mortality

Statewide EMS Overdose Data	
Month and Year	Number
January 2019	630
February 2019	441
March 2019	608
April 2019	648
May 2019	651
June 2019	655
July 2019	582
August 2019	461
September 2019	528
October 2019	584
November 2019	608
December 2019	633
January 2020	704
February 2020	534
March 2020	550
Total to Date	**8,817**
Overdoses by Age Group	

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0-19	708
20-29	1,879
30-39	2,396
40-49	1,580
50-59	1,023
60-69	634
70+	426
Unknown	171
Overdoses by Sex	
Females	3,638
Males	4,962
Unknown	217
Naloxone (Narcan) Given	
Yes	4,017
No	4,800

Statewide Emergency Room Overdose Data	
Month and Year	Number
January 2019	529
February 2019	499
March 2019	617
April 2019	601
May 2019	596
June 2019	576
July 2019	520
August 2019	609
September 2019	615
October 2019	561
November 2019	525
December 2019	550
January 2020	582
February 2020	566
March 2020	550
Total to Date	**8,496**
Overdoses by Age Group	
0-19	1,252
20-29	1,819
30-39	2,056
40-49	1,359
50-59	960
60-69	602
70+	446
Unknown	1-6
Overdoses by Sex	
Females	4,070
Males	4,349
Unknown	77

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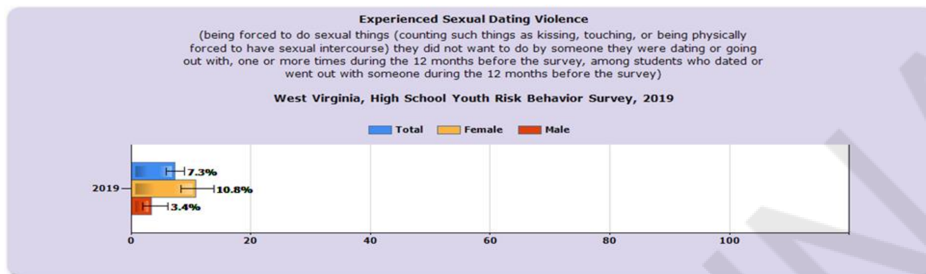
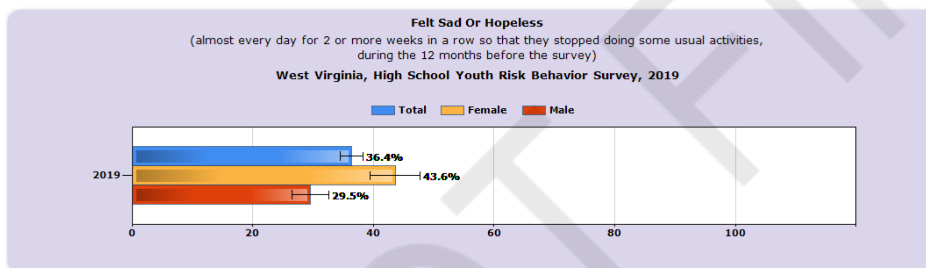
The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults including:

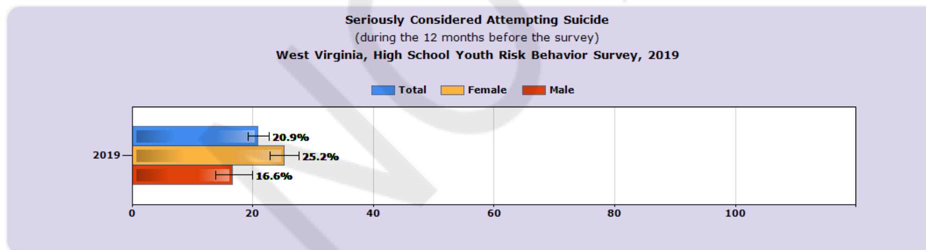
- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

YRBSS is a system of surveys. It includes a national school-based survey conducted by the CDC and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.[36]

The West Virginia Youth Risk Behavior Survey/School Health Profiles for High School 2018 provide the following data related to sexual behaviors, suicidal behaviors, feeling of sadness, and lack of sleep which is linked to both physical and mental health.[37]







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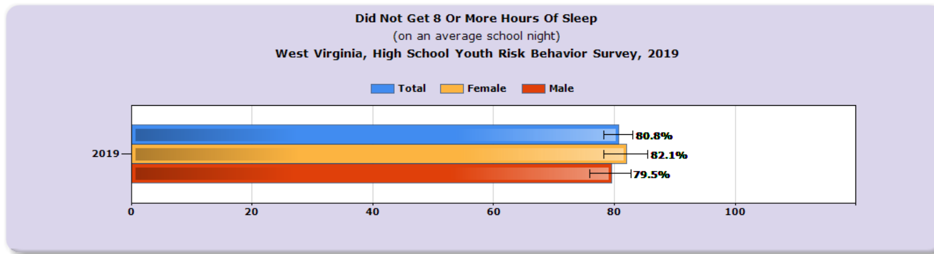
[36] Centers for Disease Control and Prevention. Adolescent and School Health YRBSS. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/index.htm.
[37] Centers for Disease Control and Prevention. High School YRBS. West Virginia 2019 Results. Retrieved from https://nccd.cdc.gov/youthonline/App/Results.



Following the presentation, committee members had a discussion around two focus questions:

- *What is the data or information telling us that demands change (gaps, needs, challenges)?*
- *Where is the greatest moment or opportunity for prevention work?*

The following summarizes this discussion:

What is the data or information telling us that demands change (gaps, needs, challenges)?	***Where is the greatest moment or opportunity for prevention work?***
Everything is connected. Nutrition, economy, mental health – they all connect to each other and need addressed for one another. Data collected through ACES does have good representation, but it needs overlaid to create visual representation. Social norms need to be addressed and deinstitutionalization pursued. College students, for instance, are not all partakers of risky behaviors although they are publicized as doing so. This has become a social norm that is not accurate. Social norm messaging is necessary. Need to work on not sensationalizing use – this can have unintended consequences in relation to social norms. We don't have enough data on what is effective In WV – we normally just see the data for what works in larger cities. This means we cannot compare apples to apples for our population.	Be more efficient with our resources to help collaborate and play to our strengths but not duplicate. Share strategies and evidence-based practices – develop a collective knowledge base. Examine how to evaluate programs in WV and in the areas of WV. WV tends to do program evaluation to prove that the program works versus using it to see what needs adjusted and how to use data for improvement – need is as a process improvement. Make sure we are willing to adjust to needs as they come. Increase comfort levels with sharing data across agencies (data sharing agreements?). Need to be more willing especially non-state entities.

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We need to find what works for WV – we see things that work in other areas but not if it works here (evaluation is needed but that requires resources). We have made progress in some key indicators as a state; however, our risk factors are overwhelming – there are also increases in marijuana use and vaping rates in young adults – we need to proactively address these increases and consider the impact of legalizing medical marijuana. There needs to be more of a focus on the family unit/use of the social ecological framework and universal prevention in the schools, in addition to social norms and perceptions. Social-emotional learning is critical – people are resilient in WV, but they need the right tools. A dose of prevention is needed at every developmental stage: target ages 18 – 25. Lack of transportation. Lack of a sustainable workforce. Disparities regarding technology and access to broadband. High level policies are not supportive of actual needs, i.e., strict guidelines of allowable purchases for food – basic needs must be met before people will listen to change. Sustainability of prevention efforts – as noted in the last session, most funding is federal/no state dollars – policy makers and legislators need to be educated about the importance to invest in prevention if we can explain it. Historically, we have not done a good job	We need to engage people to become change agents – the infrastructure needs to be developed at the community level through youth-led coalitions – infrastructures are a force multiplier, specifically in educating legislators on the importance of investing in prevention. Expand certified prevention specialist as a true profession/grow the profession. Develop a social norms media campaign. Understand and use the data to improve our work and make decisions. Take a proactive approach on risk factors – everyone will be at-risk coming out of the pandemic. With the election, there will be new players entering the field which provides a good opportunity to get the message/need out to legislators and policy makers. We need to change the narrative…WV does not have a drug problem – WV has an addiction problem. Good, solid, reliable local level and state level data is needed that can paint the story that is analytical, anecdotal, and pictorial. In other words, the narrative must be consumable based on the population that it is presented. Legislators think in terms of money….so how prevention costs can demonstrate a positive return and can decrease costs related to treatment and recovery services.

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explaining and advocating for the role of prevention.	

Section 2:5 Mission, Shared Vision, and Core Values

Mission:

The mission or purpose of the unified plan is to strengthen and sustain West Virginia's prevention system. To guide the plan, a shared vision of the future was agreed upon to focus possibilities and lead collaborative efforts. A set of core values was also affirmed.

Shared Vision:

We envision a proud West Virginia comprised of healthy, resilient communities, where all individuals are supported, purposeful and hopeful throughout their lifespan.

Core Values:

Implementation of the strategic plan is guided by the following set of core values.

We believe and are dedicated to:

- Cross-sector collaboration and building upon current planning efforts
- Community engagement
- Evidence-based practices, policies, and programs
- Sustainability
- Data-driven and stakeholder driven decision-making
- Cultural competency (race, ethnicity, age, ability, language, gender, socio-economic status, sexual orientation, gender identity, nationality, religion)
- Strengths, assets and protective factors

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Section 2:6 Strategic Goals and Objectives

Based upon the current prevention landscape, strategic goals and objectives were identified, in addition to expected results to be achieved over the next three years. Successful strategies from current strategic plans being implemented by partners were also shared.

There was consensus that over the next three years, prevention partners will seek to focus collaborative efforts in four priority goal areas:

1. Increase, sustain and align investments in prevention (including recruiting and retaining our prevention workforce and advocating for policy reforms)
2. Maximize cross systems planning and collaboration
3. Improve data collection, integration and use
4. Align strategic communications, awareness and education

Strategic objectives and suggested timeframes for implementation are outlined as follows:

Strategic Goal 1: Increase, sustain and align investments in prevention (including strengthening our prevention workforce and advocating for policy reforms)			
2021 - 2024 Strategic Objectives	**2021**	**2022**	**2023**
1.1 Develop a consistent updated method for coalition funding distribution.		**x**	**x**
1.2 Coordinate talking points across systems for legislators/policymakers.	**x**	**x**	**x**
1.3 Form a professional statewide Prevention Association (warehouse) that can support advocacy and policy change, workforce, training, credentialing. Steps: Information Gathering: what organizations exist, what training exists, what credentialing exists, what education level and training is required to do work, identify mentors within each area of prevention, establish a prevention collaborative virtual workspace/library, and identify gaps. Form a committee to do this.	**x**		

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1.4 Establish cross-system training opportunities related to prevention. Hold 3-4 annually.	x	x	x
1.5 Identify and engage Prevention Champions within medical fields, recovery, legislative, etc.	x	x	x
1.6 Continue to identify opportunities to collaborate, braid funding, share resources among prevention organizations/efforts. The Prevention Steering Team is a good source to do this.	x	x	x
The same committee would also start the process of information gathering for 1.2, 1.4, 1.5 and 1.6 for all FY21 objectives and aligning structures within prevention organizations.			
Long-term expected results, achievements or outcomes we hope to accomplish: 1. State-level funding for prevention will be increased through a dedicated line item in the State Budget. 2. A Professional Prevention Association that can also serve as a clearinghouse for best practices/theories/trainings/resources will be created. 3. Criteria for how prevention will continue to progress and build infrastructure will be developed, include recruitment and retention. 4. Opportunities to braid funding and increase collaboration among prevention sectors will be advanced. Identify a minimum of 2-3 opportunities to braid funding.			

Strategic Goal 2: Maximize cross systems planning, collaboration, and integration			
2021 - 2024 Strategic Objectives	**2021**	**2022**	**2023**
2.1 Inform and shape prevention policy and practices by building upon research, proven models such as the CDC Knowledge to Action framework and meaningful data. • Identify and research proven models.	X	X	X
2.2 Formalize an infrastructure of prevention stakeholders (state organizations, local non-profits, behavioral health organizations, Prevention Lead Organizations, coalitions, Department of Education, et.al.) across systems to lead integration of prevention efforts, mobilize resources, enhance communication, and to set the expectation that collaboration is the norm. (Prevention Steering Team) • Survey members to ensure we have everyone at the table to make sure every aspect of prevention is represented.	X		

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• Develop a partnership agreement to define roles and expectations.			
2.3 Clarify the roles of community-based coalitions to create stronger linkages, maximize funding, and increase understanding and access to a continuum of prevention programs.		X	
2.4 Align and streamline interactions with the school system. • Identify and build upon existing relationships. • Assess partnership readiness.	X		
2.5 Create a state-level clearinghouse of promising practices, tools, and win-win opportunities to support collaborative learning processes. • Identify where clearinghouse where be housed and what platform would be used. • Review existing guides and toolkits and streamline/align into a comprehensive document.	x		
2.6 Expand and translate current prevention curriculum and programs to alternative delivery modes. (It should be noted that all evidence-based prevention programs are not allowed to be delivered virtually at this time.) • Review what curriculum is being transferred to online and lessons learned (be open to meeting schools where they are and being patient to identify where we might "fit" and how components can be delivered). • Explore opportunities to expand train-the-trainer opportunities/component. • Build our capacity to utilize technology and online platforms to deliver programming (identify and promote use of best practice guidelines that are being used to deliver programs online).	X	x	x
2.7 Host an annual statewide prevention summit to promote knowledge sharing, innovation, and commitments to shared outcomes.	x	x	x
Long-term expected results, achievements or outcomes we hope to accomplish: 1. Evidence-based practices and indicators will be identified and promoted. 2. There will be an increased recognition at the local level that prevention work aligns and interfaces across multiple levels. 3. Major gaps and redundancies in programming will be eliminated. 4. Best practices and lessons learned will be shared and built upon. 5. Internal and external communications across partners will be enhanced. 6. Local planning efforts will be built upon.			

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7. A formalized infrastructure will be created to reduce silos and increase collaboration.

Strategic Goal 3: Improve data collection, integration, and use at the regional level to track progress and promote shared accountability			
2021 - 2024 Strategic Objectives	**2021**	**2022**	**2023**
3.1 Data will be used to develop/utilize evidence-based resources and needed prevention programming based upon regional needs.	**X**	**X**	**X**
3.2 Centralize data collection through designated regional coordinators.		**X**	**X**
3.3 Improve multi-agency data sharing.	**X**	**X**	**X**
3.4 Develop a data sharing process for regional and statewide needs assessment collaboration and use.		**X**	
3.5 Create and maintain a data assessment task force to review and continually evaluate regional data collectively, and plan prevention work accordingly.	**X**	**X**	**X**
3.6 Identify data sources and fill data gaps across the continuum of care and systems and improve data collection processes.	**X**		
3.7 Identify, secure, and analyze data resources to build capacity for prevention support and data resource dissemination.	**X**		
Long-term expected results, achievements or outcomes we hope to accomplish: 1. Data will be accessible. 2. Data will inform and improve quality, policy, changes, and decisions. 3. Data will be shared across the continuum of care and systems.			

Strategic Goal 4: Align strategic communications, awareness and education			
2021 - 2024 Strategic Objectives	**2021**	**2022**	**2023**
The following principles undergird the following objectives: • Individual/community acceptability,			

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• Data-driven, • Best or promising practices • Culturally relevant and inclusive			
4.1 Convene a Prevention Internal Marketing Team to coordinate prevention education and media campaigns across regions/sectors *(ex. DHHR, WVDE, Prevention First, non-governmental entities).*	**x**		
4.2 Develop a common language to speak with one voice by using social norm messaging to develop consistent, unified language that is inclusive, culturally competent and stigma free.	**x**		
4.3 Develop prevention messaging that targets the social ecological model *(Individual, Interpersonal, Organizational, Community, Public Policy)* and can be customized for local campaigns, coalitions, and audiences *(i.e., youth vs. law enforcement).*	**x**		
4.4 Develop standardized communication designed to reach vulnerable subpopulations identified for increased risk. Why is this important? Host stakeholder meetings of target populations to develop/disseminate messaging. *(Selected media channels need to be accessible to priority populations - ex. TikTok and YouTube vs. billboards and newspapers.)*	**x**	**x**	**x**
4.5 Utilize Data from Goal 3 to drive consistent prevention messaging, media campaigns, and promotion of success stories *(ex. WV Kids Count - ability to tell story and outcomes; Icelandic Model project - data and stories).*	**x**	**x**	**x**
4.6 Utilize Prevention Champions and community stakeholders identified in Goal 1 as trained Media Messengers *(inclusive and culturally competent).* Include Youth voice/champions. Provide media/communication training.	**x**	**x**	**x**
4.7 Provide media and communication training to prevention staff and organizations and media messengers *(ex. how to use local data to tell a story; how to cultivate relationships with media; how to select appropriate imagery and language).*	**x**	**x**	**x**
4.8 Host Annual Prevention Day at the Legislature	x		
Need to add Behavioral Change Strategies, separate out public health media campaigns/marketing principles - different "products."	x		

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Engage and utilize university staff and students.	x		

Long-term expected results, achievements or outcomes we hope to accomplish:

1. Sectors and stakeholders will collaborate to align data driven prevention education and messaging.
2. Consistent messaging across sectors will be enhanced through a clearing house and protocols will be developed.
3. Public understanding and awareness will be increased through universal media campaigns and materials.

Section 2:7 Implementation

The committee makes the following recommendations for implementation of the Prevention Strategic Plan:

Who should oversee implementation?	The Governor's Council on Substance Abuse and Prevention will formally oversee the Strategic Prevention Plan. Prevention Steering Committee, which consists of the same partnering organizations identified in the plan will form subgroups that will assist with the oversight of the plan throughout the state. BBH will also have a lead role to help ensure implementation, evaluation, and leveraging resources/funding.
How should workgroups and organizations leads be established?	Workgroups should be established around the 4 plan goals. The workgroups should be part of the Prevention Steering Committee.
Who will be responsible for developing plans and timelines?	Sub-groups from the Prevention Steering Team, BBH, and local input from vested stakeholders.
How will the work be communicated (types and frequency?)	Bi-monthly and/or quarterly and communicated from BBH.

The need for funding to implement this plan is recognized by the committee. Discussions included utilizing Block Grant funds and braided funding opportunities with other bureaus. However, the committee believes continuing support for services

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provided by each partnering agency/organization, coupled with working collaboratively on state-level strategies, will contribute to the overall collective impact.

The implementation of strategies includes workgroup implementation and maintenance of action plans. Each workgroup will be responsible for ensuring the completion of action plans aligned with the four priority areas identified in the plan, as well as following up with local coalitions to review action items as accomplished.

Through the oversight of the Governor's Council, the Strategic Planning Committee will continue to work with work groups to to identify and engage new partners in implementation workgroup action items and the strategic prevention plan. Each year, the plan will be reviewed and the Action Plans updated as needed to make sure that goals are being met.

The planning committee recognizes that this plan will be used as the foundation for ongoing planning. It is important to continue to review, analyze, and update the strategies within this plan as needed to meet the most relevant needs at that time. The first year of the plan will focus on the development of the specific actions plans for each of the strategies.

Section 2:8 Evaluation

The committee recommends working in tandem with the West Virginia SEOW to select the best measures available that provide points from which we can monitor progress of the plan.

The Strategic Prevention Planning Committee recommends that the West Virginia SEOW partner with the Prevention Steering Team to conduct an assessment of the needs, resources, and gaps of state substance use, mental health disorders, sexual violence, suicide, and child abuse using state level data.

Several data sets are utilized to obtain relevant data for prevention efforts in West Virginia. These data sets provide information on social impact indicators, as well as local community and service level data. Due to the complexities of the various funding allocation methods used by state agencies and the focus of services being delivered, the committee is not able to combine all service data collection systems. The committee recognizes the need for a uniformed database that can function as a warehouse for state level data.

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CHAPTER THREE: APPENDICES

1. List of Acronyms and Abbreviations

ACES	Adverse Childhood Experiences
BBH	Bureau for Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Center for Disease Control
COS	Chief of Staff
COVID	Corona Virus
CSAP	Center for Substance Abuse Prevention
DHHR	West Virginia Department of Health and Human Resources
FY	Fiscal Year
IC & RC	International Certification & Reciprocity Certification
IOM	Institute of Medicine
MEB	Mental, Emotional, and Behavioral
MH	Mental Health
NSDUH	National Survey on Drug Use and Health
OCPC	Ohio Certified Prevention Certification
ODCP	Office of Drug Control Policy
PhD	Doctor of Philosophy
PLO	Prevention Lead Organization
RX	Prescription
SAMHSA	Substance Abuse Mental Health Services Administration
SEM	Social ecological Model
SEOW	State Epidemiological Outcomes Workgroup
SOC	System of Care
SPF	Strategic Prevention Framework
TOC	Theory of Change
WVDE	West Virginia Department of Education
YRBSS	Youth Risk Behavioral Surveillance System

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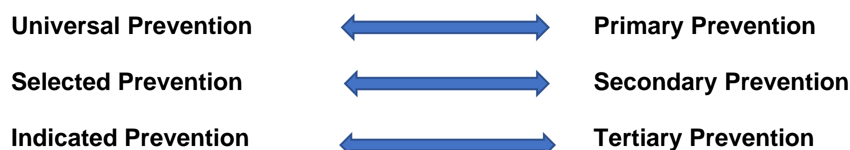
2. Prevention Terminology Crosswalk



The Institute of Medicine (IOM) categorizes prevention into three categories in relation to substance use/misuse.

- Universal prevention targets the entire population and is not directed at a specific risk group.
- Selective prevention targets subpopulations that are at increased risk for substance use/misuse due to exposure to identified risk factors.
- Indicated prevention targets those already using or engaged in other high-risk behaviors to prevent heavy or chronic use.[38]

Service strategies and classification of strategies are based on service delivery method and targeted populations. After the strategies and classifications are determined, evidence-based programming selection begins. The IOM notes evidence-based programming is defined as conceptually sound, internally consistent, reasonably well implemented and evaluated.

According to the CDC, public health focuses on prevention of disease and health promotion rather than the diagnosis and treatment of diseases. This form of prevention is most familiar as it is related to an individual's physical health. The public health approach to prevention is also categorized into three levels.

- Primary prevention targets risk factors to prevent disease onset.
- Secondary prevention screens to identify diseases in the earliest stages, before the onset of signs and symptoms.

[38] Institute of Medicine (IOM) Classifications for Prevention. Retrieved August 23, 2020 from http://mh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf

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- Tertiary prevention is managing disease post diagnosis to slow or stop the disease progression.[39]

3. Strategic Planning Team Members

We would like to thank the following partner organizations and individuals for their participation in this collaborative planning process, and for sharing their expertise and insights. Your commitment to achieving our shared goals is greatly appreciated.

Bruce Adkins, Director, DHHR Bureau for Public Health, Office of Community Health Systems and Health Promotion

Laura Sperry-Barno, Director, Family First Implementation, DHHR Bureau for Children and Families

Dr. Susan Bissett, President, West Virginia Drug Intervention Institute, Inc.

Tahnee Bryant, Program Manager II, DHHR Bureau for Behavioral Health

Lori Garrett-Bumba, Director of Prevention Services, Youth Services System Inc.

Elizabeth Coffey, Director, State Opioid Response, DHHR Bureau for Behavioral Health

Dr. Tammy Collins, PhD, Certified Prevention Specialist Lead Evaluator & Family Scientist, Marshall University Center of Excellence in Recovery

Kathy Danberry, Tobacco Cessation Program Manager, DHHR Bureau for Public Health

Dr. Geri Dino, Professor and Director, WV Prevention Research Center Department of Social and Behavioral Sciences WVU School of Public Health

Lisa Ertl, Director, DHHR Bureau for Children and Families Division of Early Care and Education

Logan Fiengold, Opioid Response VISTA Office of Drug Control Policy

Barri Faucett, Director, Prevent Suicide, Prestera Center

Brian Gallagher, Chairman, Governor's Council on Substance Abuse Prevention and Treatment and Chief of Government Relations, Marshall University

Robert Hansen, Director, DHHR Office of Drug Control Policy

Stephanie Hayes, Coordinator, West Virginia Department of Education

[39] Center for Disease Control. Prevention. Retrieved on August 23, 2020 from https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

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Nancy Hoffman, State Coordinator, West Virginia Foundation for Rape Information and Services

Susan Jackson, CBCAP State Lead, Children and Families Commissioner's Office

James Kerrigan, HHR Program Manager II, Division Director, DHHR Bureau for Public Health Office of Community Health and Health Promotion

Jonnie Kifer, Region 4 Partnerships for Success Project Lead, WV Prevention Solutions

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Jim McKay, State Coordinator, Prevent Child Abuse West Virginia

Laurie McKeown, Executive Director, TEAM for West Virginia Children

Jo Anne McNemar, Project Director, Partnerships for Success Grant, HHR Specialist Senior, DHHR Bureau for Behavioral Health

Martha Minter, Assistant Director, Community Access, Inc.

Shelly Mize, Prevention Coordinator, Westbrook Health Services

Kelli Mordecki, Coordinator, School of Mental Health, WV Department of Education, Office of Student Support and Well-Being

Greg Puckett, Executive Director, Community Connections

Anna Sabb, WVU Intern, DHHR Bureau for Behavioral Health

Lydia Sadd, State Opioid Response Program Coordinator, DHHR Bureau for Behavioral Health

Elizabeth Shahan, Executive Director, WV Prevention Solutions

Kimberly Shoemake, Regional Prevention Coordinator, Prestera Center

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Jessica Smith, Prevention Program Manager, DHHR Office of Drug Control Policy

Nikki Tennis, Office Director, DHHR Bureau for Behavioral Health

Josh VanBibber, Program Manager, DHHR Bureau for Behavioral Health

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

West Virginia's publicly-funded community based behavioral health system is anchored by thirteen (13) Comprehensive Behavioral Health Centers (CBHC's), operating full service and/or satellite offices in each of the counties located in the center's catchment area. Public behavioral health services provided by a CBHC are for all populations and all ages at risk for, or have a diagnosis of, mental illness, substance abuse, intellectual/developmental disability, or a co-occurring/co-existing disorder. CBHC's are charged with ensuring the following "essential services" are available and accessible in each county: Screening, Assessment, Crisis Response, Outpatient services (with referral for Intensive Outpatient Services (IS) as may be assessed/needed), Information and Referral capacity, and Medication Management.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	● Yes ○ No
b)	Mental Health	● Yes ○ No
c)	Rehabilitation services	● Yes ○ No
d)	Employment services	● Yes ○ No
e)	Housing services	● Yes ○ No
f)	Educational Services	● Yes ○ No
g)	Substance misuse prevention and SUD treatment services	● Yes ○ No
h)	Medical and dental services	● Yes ○ No
i)	Support services	● Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	● Yes ○ No
k)	Services for persons with co-occuring M/SUDs	● Yes ○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

BBH funds each of the 13 regional Comprehensive Behavioral Health Centers (CBHCs) and a number of independent community agencies to provide community based supports to people with mental health issues, substance use disorders and nonwaiver funded individuals with intellectual developmental disabilities. Indigent Care funds are available to support people who are uninsured and/or underinsured seeking Medicaid eligible treatment services from the 13 regional CBHCs

3. Describe your state's case management services

BBH uses State general revenue funds to support Community Engagement Specialists (CES) at both the CBHCs and independent providers. Community Engagement is a service which identifies, connects and/or provides personal and community supports to individuals with a diagnosis of mental illness, substance use, or co-occurring disorders, and who are committed, have a history of commitment, or are in danger of commitment to a state psychiatric, private diversion facility, or correctional facility. Engagement and integrated community supports are necessary for individuals to achieve and sustain recovery in the community.

The Community Engagement program is intended to support all individuals who have a history of and/or are at risk of involuntary

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commitment such that they can live in local communities of their choosing. This program's work is supported by CES staff who serve as the stewards of the programs implementation efforts. The CES are the brokers and facilitators of a wide range of community based and collaborative efforts and strategies designed and intended to support the varying needs of those served.

The CES works in the community to assist individuals with serious mental illness, substance use, co-occurring or co-existing disorder(s) that are at risk of psychiatric hospitalization or are currently committed. Any individual at risk who resides in or is from the grantee's area is eligible for assistance from the CES; individuals do not have to be an active consumer of the grantee to be eligible for this service as a significant focus is placed on identification and engagement. The CES engages and collaborates with all available community resources to prevent the need for involuntary commitment, improve community integration, and promote recovery by addressing the often complex needs of eligible individuals.

4. Describe activities intended to reduce hospitalizations and hospital stays.

BBH funds multiple programs whose primary goal is to reduce hospitalizations. These programs include the previously mentioned CES program, BBH's primary programmatic approach to reducing hospitalizations. Other key programs include group homes, day support programs, Peer Centers, and Permanent Supportive Housing Programs.

Additionally, BBH is in the process of funding pilot projects for Adult Crisis Response. The initial program types will be Adult Mobile Crisis and Stabilization Teams and Psychiatric Urgent Care Centers which will further reduce hospitalization.

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Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

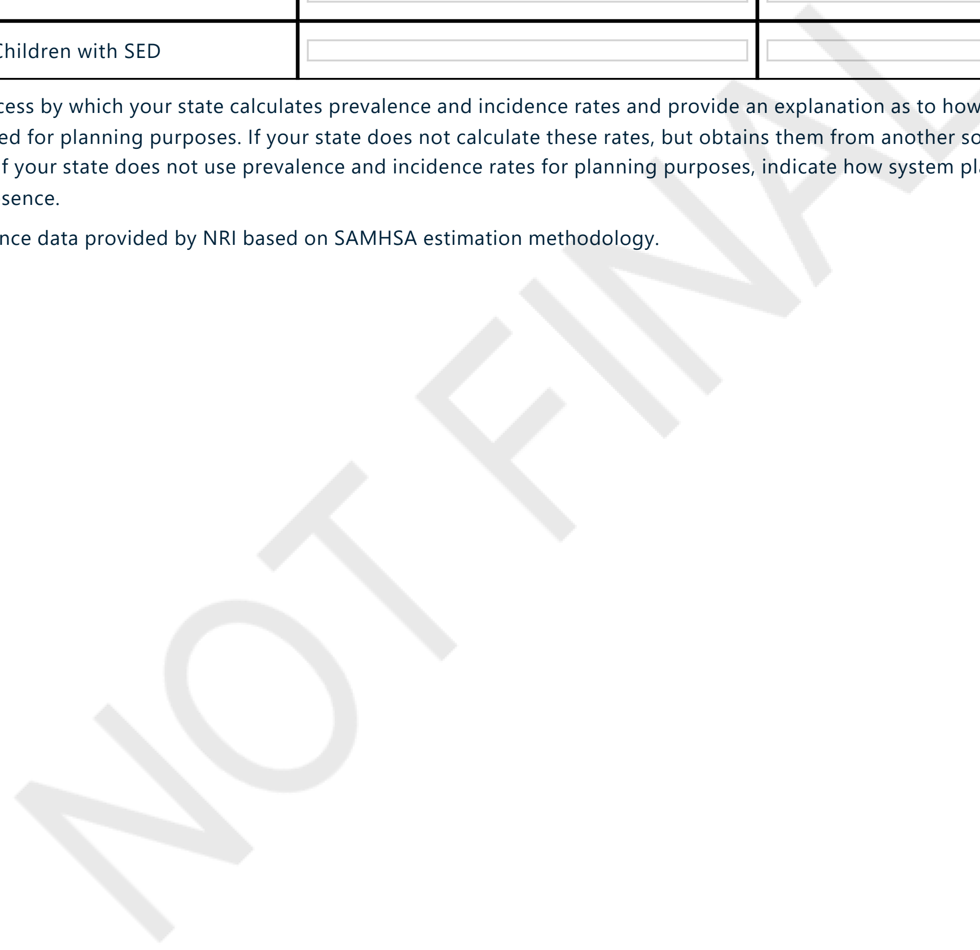
Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI		
2.Children with SED		

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

BBH uses prevalence data provided by NRI based on SAMHSA estimation methodology.



Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	◉ Yes ○ No
b)	Educational services, including services provided under IDE	◉ Yes ○ No
c)	Juvenile justice services	◉ Yes ○ No
d)	Substance misuse preventiion and SUD treatment services	◉ Yes ○ No
e)	Health and mental health services	◉ Yes ○ No
f)	Establishes defined geographic area for the provision of services of such system	◉ Yes ○ No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

West Virginia is a rural State and is the only State that is entirely considered part of Appalachia by the Appalachian Regional Commission. West Virginia's rural nature has meant that rural services are part of every behavioral health system. However, additional steps have been taken to ensure that services are targeted to rural areas. Transportation is part of BBH grant budgets and CBHC's maintain offices in each of WV's 55 counties. Mobile services are provided to reach particularly isolated mountain areas.

b. Describe your state's targeted services to the homeless population.

PATH
BBH receives the annual Projects for Assistance in Transition from Homelessness (PATH) grant. All 6 regions of the state have a PATH provider in addition to the WV Coalition to End Homelessness who oversees the Balance of State. Each Continuum of Care (CoC) is represented in the program. BBH emphasizes outreach and case management in the PATH program.

Continuums of Care (CoC)
West Virginia utilizes the Continuum of Care (CoC) model. These are groups of individuals, organizations, and policymakers who gather under a formal structure to develop local systems and strategies for delivering housing and services. The overall approach is based on the concept that homelessness is more than a lack of shelter, but involves a variety of underlying, unmet physical, economic, and social needs. West Virginia's model is administered through four regional organizations: Cabell-Huntington-Wayne CoC, Kanawha Valley Collective CoC, Northern Panhandle CoC, and Balance of State CoC.

West Virginia Coalition to End Homelessness (WVCEH)
BBH directly funds the WVCEH to support their statewide mission of ending homelessness. In addition to functioning as the Balance of State CoC, WVCEH provides an array of services for individuals experiencing homelessness and coordinates the statewide management of the Homeless Management Information System (HMIS).

Integrated Behavioral Health Care Project
BBH funds West Virginia Health Right to provide integrated behavioral health care services in Charleston as a part of their free clinic's service array. People experiencing homelessness are a priority population for this project and West Virginia Health Right maintains a location at Covenant House specifically targeted for homelessness services.

WV Interagency Council on Homelessness
Governor Tomblin revitalized the West Virginia Interagency Council on Homelessness through Executive Order No. 9-13. The Council is charged with the development and implementation of a plan to prevent and end homelessness in the State of West Virginia.

Children's Homeless Outreach Program (CHOP)
The Children's Homeless Outreach Program (CHOP) provides a secure healthy environment, case management, life skills education, brief counseling, referrals and linkage to community services and supports for children and their families who are experiencing homelessness and are residing in one of the homeless shelters.

c. Describe your state's targeted services to the older adult population.

Older adults with serious mental illness have access to all services available to adults with serious mental illness. West Virginia's Bureau for Senior Services is responsible for services including transportation, meals, exercise classes, and in-home services. BBH partners with the Bureau for Senior Services to assist with analysis of need and consultation with development of services. BBH funds mental health services for older adults who are unable to travel to their local behavioral health center that require in-home services.

NOT FINAL

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

ADMINISTRATION

BBH includes two interrelated sections which are Programs and Policy, and Administration. Administration is responsible for fiscal management, technology and shared data systems. Programs and Policy provides oversight and coordination of planning, development, funding, and monitoring of community behavioral health services and supports. BBH engages in contractual grant agreements with each provider who receives Block Grant funding.

DISASTER PREPAREDNESS FOR SPECIAL POPULATIONS

BBH is working with various groups, such as the Bureau for Public Health (BPH), the West Virginia State Red Cross Chapter, West Virginia Division of Homeland Security, State Emergency Management, and West Virginia Voluntary Organizations Assisting in Disasters (VOAD), to develop processes, policies, plans and annexes for inclusion of those with access and functional needs in the State's various Emergency Operations Plans and for the activities listed in The National Response Framework (NRF) under Emergency Support Function #6. This includes mass care, sheltering, housing and human resources, as well as the transition into the Health and Human Resources Recovery Support Function under the National Recovery Support Framework.

BBH employs a fulltime Disaster Coordinator who collaborates for a strong behavioral health response with first responders, hospitals, local health departments, social services, homeland security and emergency management agencies, faith based community, and voluntary organizations to develop disaster response plans, continuance of operations plans and to conduct table top and other exercises across the State. The BBH supports the WV VOAD Disaster Behavioral Health and the Disaster Spiritual Care Programs in order to meet behavioral, emotional, and spiritual care needs of the affected individuals, responders and recovery workers, and the communities as a whole. BBH encouraged the CBHCs to add trained peers to their disaster response teams.

NOT FINAL

Footnotes:

Statewide Prevalence and Incidence data is provider by SAMHSA.

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	◉ Yes ○ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/social)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Services for special populations:

Targeted services for veterans?	◉ Yes ○ No
Adolescents?	◉ Yes ○ No
Other Adults?	◉ Yes ○ No
Medication-Assisted Treatment (MAT)?	◉ Yes ○ No

NOT FINAL

Criterion 2

NOT FINAL

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ◉ Yes ○ No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ◉ Yes ○ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ◉ Yes ○ No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ◉ Yes ○ No

5 Has your state identified a need for any of the following:

- **a)** Open assessment and intake scheduling ◉ Yes ○ No
- **b)** Establishment of an electronic system to identify available treatment slots ◉ Yes ○ No
- **c)** Expanded community network for supportive services and healthcare ◉ Yes ○ No
- **d)** Inclusion of recovery support services ◉ Yes ○ No
- **e)** Health navigators to assist clients with community linkages ◉ Yes ○ No
- **f)** Expanded capability for family services, relationship restoration, and custody issues? ◉ Yes ○ No
- **g)** Providing employment assistance ◉ Yes ○ No
- **h)** Providing transportation to and from services ◉ Yes ○ No
- **i)** Educational assistance ◉ Yes ○ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The majority of behavioral health services in West Virginia are provided by the 13 CBHC's who give priority consideration to PWWCD. In addition, West Virginia has numerous independent behavioral health providers, some of whom provide services to this high-risk population. West Virginia has worked during the past several years to recruit more providers for these specialty services and has provided statewide training on the clinical aspects of care for PWWCD. Those whom the state as funded for these services are given a detailed statement of work (SOW) detailing all expected performance and outcome measures. All pregnant and Post-Partum women are given precedence in the screening, assessment and admission process. West Virginia also have a specialty screening instrument call the Prenatal Risk Screening Instrument (PRSI) that is recommended for all pregnant women. In addition, Screening, Brief Intervention and Referral to Treatment (SIBIRT) is promoted throughout the state to identify all (including pregnant women) those who are at risk for developing substance use disorders. When bed availability for PWWCD is limited, providers are required to make a referral and follow up with other service providers in the state. Providers are required to report any admission problems to the Bureau of Behavioral Health who will help work through any barriers to receiving services for this population.

NOT FINAL

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

		Yes	No
a)	90 percent capacity reporting requirement	●	○
b)	14-120 day performance requirement with provision of interim services	●	○
c)	Outreach activities	●	○
d)	Syringe services programs, if applicable	○	●
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	●	○

2. Has your state identified a need for any of the following:

		Yes	No
a)	Electronic system with alert when 90 percent capacity is reached	○	●
b)	Automatic reminder system associated with 14-120 day performance requirement	○	●
c)	Use of peer recovery supports to maintain contact and support	●	○
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	●	○

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

West Virginia works closely with the Bureau of Public Health Infectious Disease Surveillance Unit to monitor issues related to the incidence of infectious disease in West Virginia. There is a BBH staff person assigned to each grant who is responsible for monitoring compliance with all aspects of these services. All Statements of Work include language that consumers who inject drugs is a high priority in West Virginia in terms of screening and treatment. All providers are required to provide report screening results to local health department. Any issues related to the breakdown of identification, screening and treatment of infectious is addressed immediately in coordination with the Bureau of Public Health.

Tuberculosis (TB)

		Yes	No
1.	Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?	●	○

2. Has your state identified a need for any of the following:

		Yes	No
a)	Business agreement/MOU with primary healthcare providers	●	○
b)	Cooperative agreement/MOU with public health entity for testing and treatment	●	○
c)	Established co-located SUD professionals within FQHCs	●	○

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Required training for all SUD providers is directed by the Statement of Work (SOW), and requires that all staff are required to be trained in infectious disease. The manager at each provider location, is required to assure that those under his/her supervision understands the importance of these requirements. Compliance issues with these requirements are given the highest attention and, the provider is placed on notice that their grant could be in jeopardy due to non-compliance and that corrective action is to be taken immediately.

Early Intervention Services for HIV (for "Designated States" Only)

		Yes	No
1.	Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?	○	○

2. Has your state identified a need for any of the following:

		Yes	No
a)	Establishment of EIS-HIV service hubs in rural areas	○	○

NOT FINAL

b) Establishment or expansion of tele-health and social media support services — ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? — ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? — ○ Yes ◉ No

   If yes, plese provide a brief description of the elements and the arrangement

NOT FINAL

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — ( ) Yes (●) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

NOT FINAL

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ◉ Yes ○ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements — ◉ Yes ○ No

   b) Training on responding to requests asking for acknowledgement of the presence of clients — ◉ Yes ○ No

   c) Updating written procedures which regulate and control access to records — ◉ Yes ○ No

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ◉ Yes ○ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ◉ Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   60

3. Has your state identified a need for any of the following:

   a) Development of a quality improvement plan — ○ Yes ◉ No

   b) Establishment of policies and procedures related to independent peer review — ○ Yes ◉ No

   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ○ Yes ◉ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ○ Yes ◉ No

   If Yes, please identify the accreditation organization(s)

   i) ☐ Commission on the Accreditation of Rehabilitation Facilities

   ii) ☐ The Joint Commission

   iii) ☐ Other (please specify)

NOT FINAL

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ● No
2. Has your state identified a need for any of the following:
   - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ● No
   - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ● No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   - a) Recent trends in substance use disorders in the state ● Yes ○ No
   - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ● Yes ○ No
   - c) Performance-based accountability: ● Yes ○ No
   - d) Data collection and reporting requirements ● Yes ○ No
2. Has your state identified a need for any of the following:
   - a) A comprehensive review of the current training schedule and identification of additional training needs ● Yes ○ No
   - b) Addition of training sessions designed to increase employee understanding of recovery support services ● Yes ○ No
   - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ● Yes ○ No
   - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ● Yes ○ No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   - a) Prevention TTC? ● Yes ○ No
   - b) Mental Health TTC? ● Yes ○ No
   - c) Addiction TTC? ● Yes ○ No
   - d) State Targeted Response TTC? ● Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   - a) Allocations regarding women ○ Yes ● No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   - a) Tuberculosis ○ Yes ● No
   - b) Early Intervention Services Regarding HIV ○ Yes ● No
3. Additional Agreements
   - a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ● No
   - b) Professional Development ○ Yes ● No

NOT FINAL

c) Coordination of Various Activities and Services ○ Yes ● No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Http://ohflac.wvdhhr.org/laws.html

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ◉ Yes ○ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ◉ Yes ○ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ◉ Yes ○ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ◉ Yes ○ No
5. Does the state have any activities related to this section that you would like to highlight.

   Trauma-informed practice is reenforced in West Virginia by grant agreements, employed peers, collaborative strategic plans, ongoing provider training, and outreach campaigns:
   A. Statements of work. The WV Bureau for Behavioral Health includes in its grantees' statements of work that their staff be trained in trauma-informed and person-centered care.
   B. Employed peers. Peers are employed across licensed behavioral health agencies, recovery residences, and the statewide, 24/7 Help4WV (https://www.help4wv.com/) mental health and substance use helpline, which includes a peer warm line. The Family Coordinators housed at the six Regional Youth Service Centers help parents and families navigate the behavioral health system

NOT FINAL

and connect with other needed supports to help the families thrive.
C. Strategic planning and state law. The Bureau is part of the collaboration with the West Virginia Governor's Council on Substance Abuse Prevention and Treatment, Office of Drug Control Policy and other partners who developed a two-year Substance Use Response strategic plan (https://dhhr.wv.gov/office-of-drug-control-policy/news/Documents/FINAL%20-%20West%20Virginia%202020_2022%20Council%20Substance%20Use%20Plan_January%2020,%202020%20(as%20filed).pdf) that includes the activity of implementing evidence-based practices to address children with or at risk of adverse childhood experiences (ACEs) involving a collaborative effort of state agencies and community organizations. Incorporated into this plan is the Bureau's Prevention Strategic Plan (https://helpandhopewv.org/docs/WV%20Prevention%20Strategic%20Plan%20-%20FINAL.pdf), which includes a section on ACEs and explanation of risk/protective factors and social determinants of health. In 2020, the West Virginia Legislature passed House Bill 4773, Creating a workgroup to investigate and recommend screening protocols for adverse childhood trauma in the state (http://www.wvlegislature.gov/Bill_Status/bills_history.cfm?INPUT=4773&year=2020&sessiontype=RS) The state's ACEs Coalition (https://www.wvaces.org/) is working on this task.
D. Training. The new BBH- and SAMHSA-funded Behavioral Health Workforce and Health Equity Training Center (https://wvbhtraining.org/) offers a series of free virtual trainings related trauma, ACEs, health equity, and related topics. In addition to the new Training Center, the Bureau provides several training opportunities on this topic, including Trauma 101, Trauma-Informed Positive Behavior Support (PBS), and prevention and early intervention evidence-based practices (EBPs) implemented in communities and schools throughout the state, including more than 60 Expanded School Mental Health (https://wvesmh.org/) sites and six Regional Youth Service Centers that house Family Coordinators and Youth Suicide Intervention Specialists. Peers receive ongoing training through SOR and Opioid Response Network (ORN).
E. Outreach campaigns. The Bureau has worked on reducing the stigma of mental health and substance use disorder, which includes an understanding of ACEs and building upon individual, family, and community protective factors across the social ecology. Campaigns for stigma reduction include Stigma Free WV (https://stigmafreewv.org/) and Back to Life WV (https://backtolifewv.org/

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1.	Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?	◉ Yes ○ No
2.	Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?	◉ Yes ○ No
3.	Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?	◉ Yes ○ No
4.	Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?	◉ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

The West Virginia Governor's Council on Substance Abuse Prevention and Treatment, Office of Drug Control Policy, Bureau for Behavioral Health, and collaborative partners developed a two-year Substance Use Response strategic plan (https://dhhr.wv.gov/office-of-drug-control-policy/news/Documents/FINAL%20-%20West%20Virginia%202020_2022%20Council%20Substance%20Use%20Plan_January%2020,%202020%20(as%20filed).pdf) that includes the goal to "Construct pathways to employment, housing, transportation, health, and behavioral health services for individuals with substance use disorders and criminal records." Resulting projects have included Jobs & Hope WV (https://jobsandhope.wv.gov/) and grants from the Bureau for Behavioral Health's State Opioid Response (https://dhhr.wv.gov/BBH/about/SOR/Pages/default.aspx) programs and other sources to provide treatment (including medication assisted treatment or MAT), transportation, employment, housing, peer, and other needed supports.

The WV 988 Planning Coalition is preparing for the launch of 988 in July 2022, with proposed legislation, outreach to first responders, and marketing planning for public awareness to increase diversion of individuals experiencing mental health and co-occurring behavioral health crises to 988 and community behavioral health services from 911, the criminal justice system, and

emergency departments.

The West Virginia Legislature passed Senate Bill 562 (http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB562%20SUB1%20enr.htm&yr=2021&sesstype=RS&i=562) in its 2021 regular session to improve juvenile competency procedures, including evaluation, remediation services, and linkages to needed behavioral health services.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? — (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? — (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? — (●) Yes ( ) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? — (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

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[61] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   - a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☐ Psychiatric Advance Directives
   - c) ☑ Family Engagement
   - d) ☑ Safety Planning
   - e) ☑ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☑ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) ☐ Assessment/Triage (Living Room Model)
   - b) ☐ Open Dialogue
   - c) ☑ Crisis Residential/Respite
   - d) ☑ Crisis Intervention Team/Law Enforcement
   - e) ☑ Mobile Crisis Outreach
   - f) ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) ☑ Peer Support/Peer Bridgers
   - b) ☑ Follow-up Outreach and Support
   - c) ☑ Family-to-Family Engagement
   - d) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
   - e) ☑ Follow-up crisis engagement with families and involved community members

NOT FINAL

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Children's Crisis Response and Stabilization Services are now available across West Virginia through the statewide Children's Crisis and Referral Line (https://www.help4wv.com/ccl), which connects families with Mobile Crisis Response and Stabilization Teams and other community-based services. The Children's Crisis and Referral Line is funded by the state's SAMHSA System of Care (SOC) grant, which also provides for a peer warm line component to Help4WV; a statewide and six regional Family Coordinators to help families navigate the behavioral health system and get connected with needed supports; development of an improved data collection system for and evaluation of SOC-related programs; short-term crisis respite services for families; and a pilot youth drop -in center in Huntington, West Virginia. While Children's Mobile Crisis Response and Stabilization services are largely provided with state funding at this time, West Virginia received a Children with Serious Emotional Disorder (SED) 1915(c) waiver through the Bureau for Medical Services (BMS) (https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx) to fund crisis response services for children and youths with serious emotional disturbance (SED) or serious mental illness (SMI) up to age 21. BMS is also exploring increased reimbursement for mobile response services across the lifespan with the CMS option to provide Medicaid coverage for qualifying community-based mobile crisis intervention services with up to 85 percent Federal Medical Assistance Percentage (FMAP) for these services.

With supplemental block grant funding, the Bureau is working to pilot adult mobile crisis response services and add mobile capabilities to its existing First Episode Psychosis (FEP) Quiet Minds WV (https://quietmindswv.com/) community-based services. The WV 988 Planning Coalition is preparing for the launch of 988 in July 2022, with proposed legislation, outreach to first responders, and marketing planning for public awareness to increase diversion of individuals experiencing mental health and co-occurring behavioral health crises to 988 and community behavioral health services from 911, the criminal justice system, and emergency departments.

Finally, BBH is in the process of launching Adult Crisis Response pilot projects for Adult Mobile Crisis Response and Stabilization teams and Psychiatric Urgent Care. After establishing initial pilots, the program will be expanded statewide utilizing a competitive funding announcement.

Please indicate areas of technical assistance needed related to this section.

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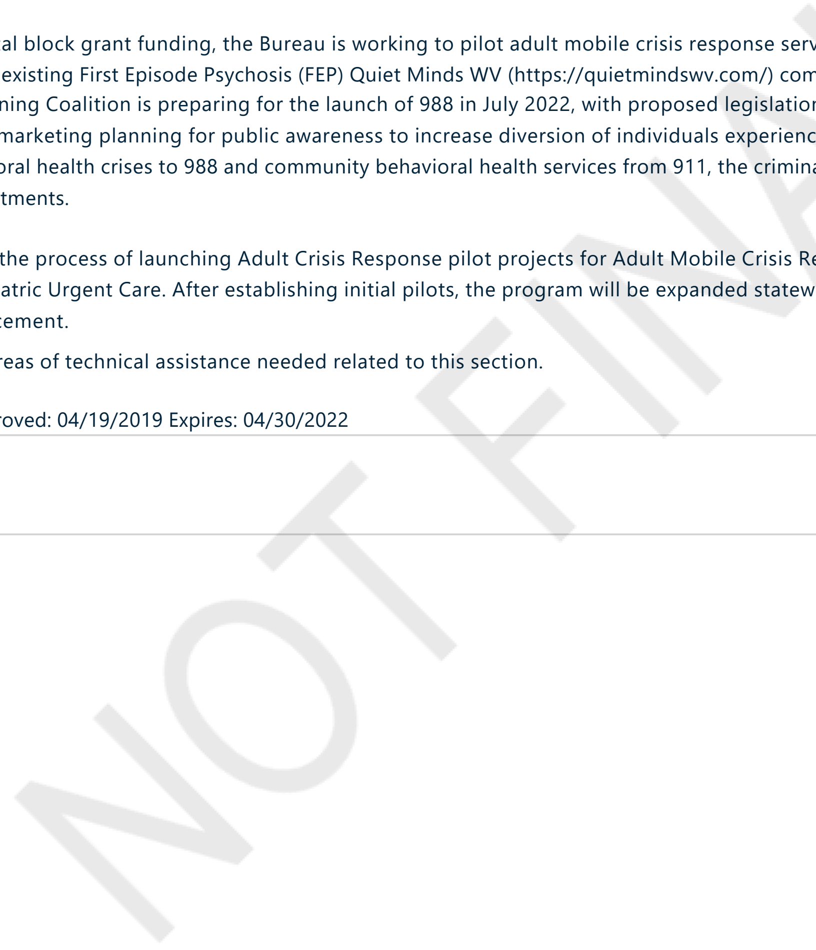
Footnotes:



Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

NOT FINAL

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ◉ Yes ○ No

b) Required peer accreditation or certification? ○ Yes ◉ No

c) Block grant funding of recovery support services. ◉ Yes ○ No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ◉ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ◉ Yes ○ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

There are eight (8) Peer Centers located throughout West Virginia that support adults with SMI. These centers provide individual and
group peer support activities, resource brokerage, linkage to the recovery community, and assists with basic needs being met either
directly, or by a community referral. In addition to the Peer Centers, there are seven (7) community based programs that host peer supporters for mental health related issues. These peer supporters maintain contact with the recovery community, provide individual and group peer support and recovery planning as well as resource brokerage and advocacy.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Peer Centers also serve those individuals with a SUD. West Virginia is currently enhancing this network to include 3 additional centers that will serve as Recovery Community Organizations (RCOs) that will focus on recovery supports for those experiencing a SUD. Also part of the planning will include converting 3 of the existing Peer Centers into a RCO model. This will give WV a network of 5 Peer Centers serving primarily those experiencing a SMI (with the capacity to serve those experiencing a co-occurring SMI & SUD) as well as a network of six (6) RCOs primarily focusing on serving those experiencing a SUD (also with with the capacity to serve those experiencing a co-occurring SMI & SUD issue). In addition there are thirteen (13) programs in the community providing community based recovery coaching. These supports include individual coaching, advocacy, linkage to recovery communities, and assistance with recovery planning.

Through a demonstration waiver WV Medicaid began reimbursing for peer support with individuals experiencing a SUD and/or co-occurring disorder. This has been successful in increasing the availability of peer support for SUD in WV. WV Medicaid has also announced plans to require credentialing through the state credentialing board in order to receive reimbursement for SUD peer support.

5. Does the state have any activities that it would like to highlight?

West Virginia has maintained a commitment to funding and supporting recovery supports. Continuing to fund Peer Recovery Support Specialists (PRSS) even with WV Medicaid reimbursing for SUD peer support is one primary example. BBH has worked with
our WV Medicaid to ensure we have strong recovery supports while not duplicating efforts. The efforts of our Peer Centers during the pandemic was admirable. The Peer Centers adapted quickly to virtual recovery supports, and provided telephonic and online supports throughout 2020 and into 2021. The Peer Centers not only provided access to online group supports, but individual supports as well. WV has also established a peer warmline though our Help4WV call center that is available 24/7. Many have continued to offer online and telephone options for recovery supports because it reached some individuals that otherwise would not have been reached. BBH has committed to setting up a peer workforce training hub that will be a central location for peers to get information on continuing education, PRSS training, or peer credentialing. We have made it possible to scholarship our peer credential to allow individuals who could not participate due to the application and exam fees to become credentialed.

Moving into 2022 we are establishing RCOs and enhancing our recovery support network to meet individuals where they are at. We also recently acquired a National Association of Recovery Residences (NARR) State Affiliate known as the WV Association of Recovery Residences (WVARR) to certify recovery residences in WV.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	◉ Yes ○ No
Home and community based services.	◉ Yes ○ No
Peer support services.	◉ Yes ○ No
Employment services.	◉ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◉ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

https://www.wvdhhr.org/oig/olmstead.html

NOT FINAL

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

NOT FINAL

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ◉ Yes ○ No

b) The recovery and resilience of children and youth with SUD? ◉ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Juvenile justice? ◉ Yes ○ No

c) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

West Virginia has been integrating its system of care for children and youths with serious emotional disturbance (SED), serious mental illness (SMI), and co-occurring behavioral health needs through the Bureau for Behavioral Health's SAMSHA System of Care grant and the state's agreement with the Department of Justice (https://dhhr.wv.gov/News/Documents/2019.05.14%20DOJ%20Agreement.pdf) to improve its system of care for children and youths with SED and SMI to ensure that children and youths receive behavioral health services in their homes and communities whenever possible to avoid unnecessary out-of-home placements. Increased availability and easier access to home- and community-based services are the aims of the plan to be implemented initially in late 2021. Read more about the DOJ agreement implementation plan and activities at https://childwelfare.wv.gov/Pages/default.aspx.

7. Does the state have any activities related to this section that you would like to highlight?

New developments since the last block grant application include the following:
• BBH's receipt of the SAMHSA System of Care grant, which has generating several projects, including creation of a statewide, 24/7 Children's Crisis and Referral Line (https://www.help4wv.com/ccl) connecting families with Mobile Crisis Response and Stabilization Teams and other community-based services; a statewide and six regional Family Coordinators to help families navigate the behavioral health system and get connected with needed supports; development of an improved data collection system for and evaluation of SOC-related programs; short-term crisis respite services for families; and a pilot youth drop-in center

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in Huntington, West Virginia;
• an approved Children with Serious Emotional Disorder (SED) 1915(c) waiver through the Bureau for Medical Services (BMS) (https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx);
• a new WV Behavioral Health Workforce and Health Equity Training Center through Marshall University (https://wvbhtraining.org/), which is working with the University of Maryland Institute for Innovation and Implementation to launch a state Wraparound and mobile response training system funded initially by block grant supplemental funding; and
• added more than 20 Expanded School Mental Health (ESMH) sites through state, State Opioid Response (SOR), and Project AWARE funding.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Suicide prevention is a priority in West Virginia (WV), where several entities have forged strong partnerships to provide a culturally competent, caring, comprehensive, and sustainable suicide prevention, intervention, and postvention system of care. With leadership from the WV Bureau for Behavioral Health (BBH), which recognized the state's myriad prevention programs (e.g., suicide, substance use, child abuse, sexual and domestic violence, teen pregnancy) shared similar risk and protective factors and evidence-based programs, WV created an overarching state prevention strategic plan in 2020 that includes suicide prevention, which also has a more detailed, stand-alone plan.

Components of the state's suicide prevention system of care include the following:
• A community-based suicide prevention workforce with Prevent Suicide WV, the American Foundation for Suicide Prevention WV chapter, and a dozen regional youth and adult suicide intervention specialists who undertake multiple suicide prevention, intervention, and postvention initiatives and directives throughout the state. These professionals collaborate with communities, schools, hospitals, behavioral health professionals, law enforcement, and other prevention professionals on several evidence-based practices and programs, including Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Counseling Access to Lethal Means (CALM), More than Sad, Signs of Suicide Prevention Program (SOS), Lifelines, and It's Real: College Students and Mental Health.
• Community-based behavioral health services that include 13 comprehensive behavioral health centers, 46 expanded school mental health sites, six regional youth service centers, six first episode psychosis (FEP) providers, and more than 100 community engagement specialists who assist individuals with serious mental illness, substance use, co-occurring, or co-existing disorders who are at risk of psychiatric hospitalization or are currently committed; and
• Crisis services. For children and young adults up to age 21 and their families, six regional mobile crisis response teams and a statewide children's crisis and referral line are available 24/7 to help interrupt crises and help them thrive in their homes, schools, and communities. For adults, the state has 172 crisis stabilization unit (CSU) beds and several quick response teams (QRTs) to follow up with individuals who have accidentally or intentionally overdosed.

First Choice Services, which became the state's sole National Suicide Prevention Lifeline call center in 2017, is also the call center for several complementary lines supporting youth and adult mental health:
• the state's 24/7 mental health and substance use helpline, Help4WV, which links people of all ages with behavioral health services and children and youths up to age 21 with mobile crisis response and stabilization services;
• a 24/7 SAMHSA/FEMA-funded Crisis Counseling Program line for pandemic-related stress, the Help304 Emotional Strengthline;
• WV211, to help people locate social services in their communities;
• Jobs & Hope WV, to link West Virginians in recovery with opportunities to obtain career training and meaningful employment;
• the Problem Gambling Network of WV, a 24/7 helpline for referrals to gambling addiction specialists and support groups; and
• the Tobacco Quitline.
First Choice Services call agents are cross-trained on its multiple lines, so callers get connected with the services they need regardless of the line they initially contact. With a combination of state and federal funding, the WV Bureau for Behavioral Health (BBH) funds the National Suicide Prevention Lifeline, Help4WV, Help304, and the Problem Gambling Network of WV; the WV Bureau for Public Health (BPH) funds the Tobacco Quitline the WV Office of Drug Control Policy and other state agencies support Jobs & Hope WV; and WV211 is a partnership with the United Ways of WV. The new 9-8-8 number will be a welcome addition to this family of call-line services.

Through the SAMHSA Garrett Lee Smith Youth Suicide Prevention and Early Intervention Grant, the Bureau for Behavioral Health, Prevent Suicide WV, and six regional Youth Suicide Intervention Specialists provide a wide array of services to youths and young

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adults aged 10-24, working to ensure young West Virginians are not lost to a preventable death. The program works towards producing a statewide infrastructure for culturally competent, caring, comprehensive, sustainable suicide prevention, intervention, and follow-up system of care. Work to reduce the rate of suicidal ideation, suicide attempts and suicide deaths in WV is completed through the development and implementation of a collaborative and coordinated statewide prevention and intervention strategies that are integrated into the existing public and private service delivery system. Specifically, the work aspires to: 1. Increase the number of youth-serving organizations able to identify and work with youths at risk of suicide; 2. Increase the capacity of clinical service providers to assess, manage, and treat youth at risk of suicide; 3. Improve continuity of care and follow-up of youths identified to be at risk for suicide, including those discharged from emergency department and inpatient psychiatric units; 4. Promote suicide prevention as a core component of health services; and 5. Integrate, institutionalize and sustain system-level change of effective suicide prevention, intervention, and postvention practices and policies in statewide youth-serving systems and agencies.

West Virginia also has a team participating in the SAMHSA and United States Department of Veterans Affairs (VA) Governor’s Challenge to Prevent Suicide Among Service Members, Veterans, and their Families to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

In addition to the Governor’s Challenge, West Virginia formed a 988 Planning Coalition to prepare for the transition of the National Suicide Prevention Lifeline to 988 in July 2022. The Planning Coalition is planning proposed legislation, outreach to first responders, and marketing for public awareness to increase awareness of 988 for individuals of all ages experiencing mental health and co-occurring behavioral health crises.

Please indicate areas of technical assistance needed related to this section.

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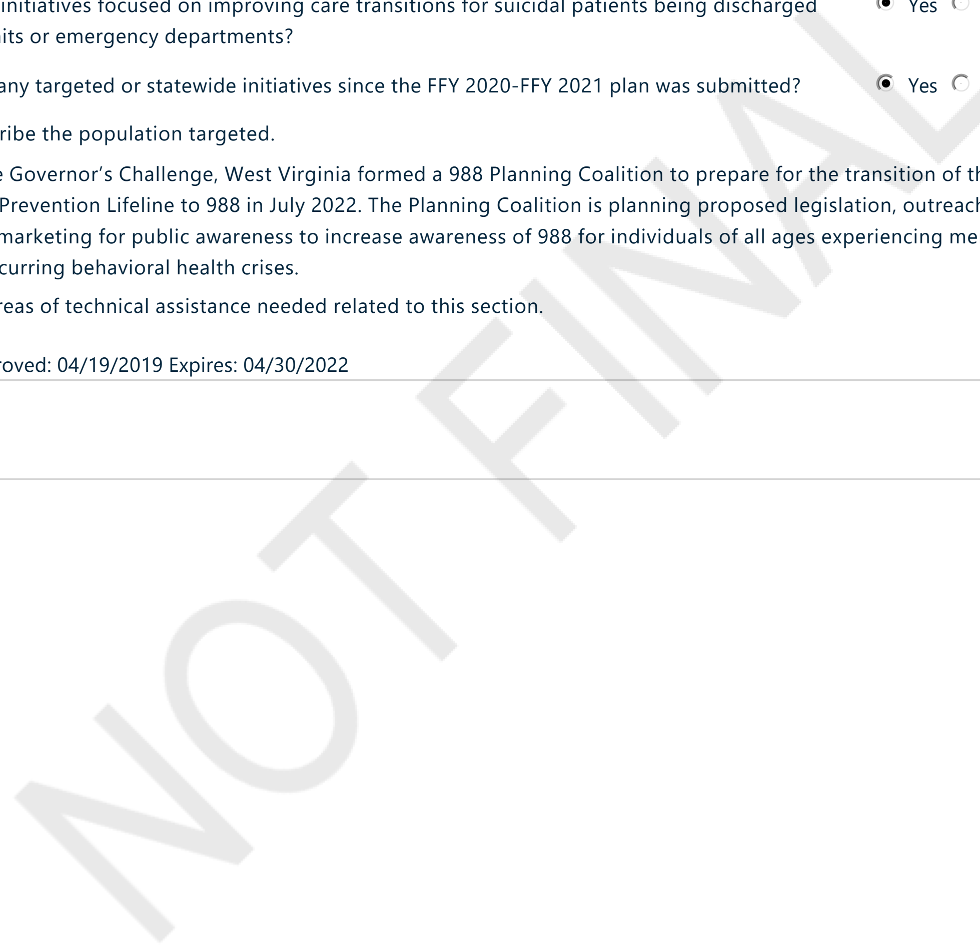
Footnotes:



Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No
2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

   If yes, with whom?

   WV Joint Interagency Task Force for COVID-19 Vaccine (JIATF)
   Child Welfare Collaborative (https://childwelfare.wv.gov/)

   Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Governor Jim Justice signed Executive Order No. 22-18 on December 3, 2018 rescinding the Governor's Advisory Council on Substance Abuse (GACSA) and replacing it with the Governor's Council on Substance Abuse Prevention and Treatment (The Council) The Council is to assist the work of the West Virginia Office of Drug Control Policy (ODCP) which was created in 2017 with the charge to create a state drug control policy; facilitate the exchange of data and issues across state government; establish and maintain a central repository of information related to the opioid drug crisis; and to create a plan to expand the number of treatment beds throughout the state. Membership is designated in the Executive Order to be persons who have education, experience or special interests regarding substance use disorders; including, but not limited to prevention, early intervention, treatment, employment, social services, behavioral health, law enforcement, or recovery, as follows:
(a) Fifteen (15) members who shall serve at the will and pleasure of the Governor and shall appointed by the Governor; and
(b) The following non-voting ex-officio members:
(I) The Secretary of the West Virginia Department of Health and Human Resources or his or her designee;
(2) The Secretary of the West Virginia Department of Military Affairs and Public Safety or his or her designee;
(3) The State Superintendent of Schools or his or her designee;
(4) The Commissioner of the Bureau for Behavioral Health or his or her designee;
(5) The Commissioner of the Bureau for Public Health;
(6) The Chief Medical Examiner or his or her designee;
(7) The Dean of the Joan C. Edwards School of Medicine at Marshall University or his or her designee;
(8) The Executive Dean of the West Virginia University School of Medicine or his or her designee;
(9) The Vice President for Academic Affairs and Dean of the West Virginia School of Osteopathic Medicine or his or her designee;
(I0) The Chair of the Senate on Health and Human Resources;
(11) The Chair of the House Committee on Health and Human Resources; and
(12) The United States Attorney for the Southern District of West Virginia.
(c) Such additional members as the Governor, at his or her discretion, may from time to time appoint

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, ◉ Yes ○ No

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suburban, urban, older adults, families of young children)?

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The mission of the West Virginia Behavioral Health Planning Council (WVBHPC) is to improve the behavioral health service system and advocate for positive change. The WVBHPC is federally mandated to review and comment on the State mental health plan, monitor, review, and evaluate allocation and adequacy of mental health block grant services, and advocate for services for individuals with mental illness and co-occurring substance abuse issues. The members of the WVBHPC and its subcommittees, including the Executive, Membership, Children and Families Services, Adult Services, Housing and Olmstead Committees, work collaboratively with the member state agencies to solicit input from the applicable stakeholders and provide input on agency priorities and plans, including but not limited to the Combined Block Grant application. The WVBHPC accomplishes this by: meeting at least quarterly in different areas of the State; developing strategies to accomplish Council goals pursuant to the federal mandate; actively participating in a wide range of state and local initiatives that impact behavioral health, homelessness, and community services; and, partnering with the BBH to assure the availability of person centered, high quality behavioral health services throughout the State and conducting independent assessments of need which are reported to the BBH.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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West Virginia Behavioral Health Planning Council

P.O. Box 8885 • South Charleston, WV 25303

WVBHPC.org

9 August 2021

Ms. Christina Mullins, Commissioner
Bureau for Behavioral Health
350 Capitol Street, Room 350
Charleston, WV 25301

Commissioner Mullins:

The Bureau of Behavioral Health personnel is working on the combined federal block grant for the next funding cycle.

The Bureau is requesting that members of the West Virginia Behavioral Health Planning Council (WVBHPC) and other interested citizens review the draft of the document and send their recommendations of corrections and additions to incorporate into the final product. We are looking forward to reviewing it.

Personnel from the Bureau will take the time to review each suggestion and use them as appropriate in the grant application. The Bureau is invited to each WVBHPC quarterly meetings to discuss and explain the information in regards to the Federal Block grant and other programs/grants that are happening around the state.

The members of the council wish to commend the Bureau for demonstrating the importance of seeking input from all regions of the State when planning for Behavioral Health Services. The WVBHPC is committed to working and strengthening the working relationship with the Bureau.

Respectfully

Joyce Floyd

Joyce Floyd, Chair
West Virginia Behavioral Health Planning Council

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Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Elliott Birckhead	State Employees	WV DHHR- Bureau for Behavioral Health		
Ardella Cottrill	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Holly Crookshanks	Providers			
Sandra De Laet	Providers			
Nancy Deming	Persons in recovery from or providing treatment for or advocating for SUD services			
Carmen Easter	State Employees			
Joyce Floyd	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Heather Hoelscher Garcia	Providers			
Tammy Ketchem	Providers			
Brenda Lamkin	Providers			
J.K. McAtee	Parents of children with SED/SUD			
Aaron Morris	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Donna Moss	Parents of children with SED/SUD			
Jason Parmer	Providers			
Cynthia Parsons	State Employees	WV DHHR - Bureau for Medical Services (Medicaid)		
Linda Pauley	Persons in recovery from or providing treatment for or advocating for SUD			

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	services			
Phil Reed	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Cathy Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
James Ruckle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
David Sanders	State Employees	WV DHHR- Bureau for Behavioral Health		
Nate Siggers	Persons in recovery from or providing treatment for or advocating for SUD services			
Patrick Tenney	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Deanna Thomas	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Vanessa Vangilder	Providers			
Rich Ward	State Employees	WV Department of Vocational Rehabilitation		
Wesley Wood	Persons in recovery from or providing treatment for or advocating for SUD services			

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Footnotes:

Note- Carmen Easter (State Employees) is the Housing Representative. A WebBGAS error is preventing adding her agency (Kanawha Housing Authority) beside her name above at this time.

Note 2 - Education, Social Services, and Criminal Justice memberships are vacant at this time due to staff turnover at the various agencies.

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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**40**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	10	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	4	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**24**	**60.00%**
State Employees	5	
Providers	7	
Vacancies	4	
Total State Employees & Providers	**16**	**40.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The combined Block Grant application project manager presented the current application to the WVBHPC on July 15, 2021 and invited members to give feedback both individual and collectively. A mechanism for providing ongoing recommendations outside of the formal application period was also discussed,

The draft application was sent to the WVBHPC August 2021 for recommendations. All recommendations of the WVBHPC will be attached to the application.

NOT FINAL

Footnotes:

West Virginia does not collect racial, ethnic, or LGTBQ demographic information from planning council members.

NOT FINAL

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

- **a)** Public meetings or hearings? — (●) Yes ( ) No
- **b)** Posting of the plan on the web for public comment? — (●) Yes ( ) No

  If yes, provide URL:

  https://dhhr.wv.gov/BBH/getconnected/Pages/SAMHSA-Block-Grants.aspx
- **c)** Other (e.g. public service announcements, print media) — (●) Yes ( ) No

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Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

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End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

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- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:
West Virginia does not fund Syringe Services (SSP) with SABG funding.

NOT FINAL

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes:

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NOT FINAL