West Virginia

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 06/15/2023 - Expires 06/30/2026
(generated on 07/17/2024 3.12.58 PM)

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

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	YZ2HCE5SELE6

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 Unique Entity Identification

Unique Entity ID	YZ2HCE5SELE6

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	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

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	8/30/2023 3:01:13 PM
Revision Date	6/18/2024 4:13:27 PM

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: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

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 19 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, as applicable, with 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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: Sherri A. Young, DO, MBA, FAAFP

Signature of CEO or Designee[1]: _____

Title: Interim 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.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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 [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: West Virginia

Name of Chief Executive Officer (CEO) or Designee: Sherri A. Young, DO, MBA, FAAFP

Signature of CEO or Designee[1]:

Title: Interim Cabinet Secretary

Date Signed: 8/30/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Jim Justice
Governor of West Virginia

August 30, 2023

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Interim Cabinet Secretary Young:

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

This authorization will remain in effect until further notice.

Sincerely,

Jim Justice
Governor

JJ:mh

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Tara L. Buckner, Chief Financial Officer
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Ms. Buckner:

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

This authorization will remain in effect until further notice.

Sincerely,

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

SAY:bj

State Information

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

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services 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 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**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
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**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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: Sherri A. Young, DO, MBA, FAAFP

Signature of CEO or Designee[1]: _____

Title: Interim 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 your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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 [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
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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: Sherri A. Young, DO, MBA, FAAFP

Signature of CEO or Designee[1]:

Title: Interim Cabinet Secretary

Date Signed: 8/30/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Jim Justice
Governor of West Virginia

August 30, 2023

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Interim Cabinet Secretary Young:

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

This authorization will remain in effect until further notice.

Sincerely,

Jim Justice
Governor

JJ:mh

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Tara L. Buckner, Chief Financial Officer
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Ms. Buckner:

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

This authorization will remain in effect until further notice.

Sincerely,

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

SAY:bj

West Virginia
Community Mental Health Services Block Grant (MHBG)
Bipartisan Safer Communities Act (BSCA)
BSCA Funding Plan 2024
October 1, 2023 -- September 30, 2025

With the second round of BSCA supplemental funding in the amount of $440,681, West Virginia will continue to strengthen its mental health emergency preparedness and crisis response capabilities. As described in this proposal, the funding will enhance West Virginia's development of emergency preparedness plans and workflow protocols among crisis, suicide, and first response agencies to prevent, rapidly respond, and provide postvention to individuals and communities affected by behavioral health crises, suicide, natural disasters, mass shootings, and other traumatic events.

Current Resources and Activities

Multiple SAMHSA funding opportunities have helped West Virginia rapidly develop its crisis continuum of care, including a statewide 988 Suicide and Crisis Lifeline center and expansion of mobile crisis response teams for children and adults. Below are highlights of the state's resources.

A. **988 Suicide and Crisis Lifeline**. First Choice Services became the state's sole National Suicide Prevention Lifeline call center in 2017, with funding from the Bureau for Behavioral Health (BBH) through the MHBG. It now serves as the state's single 988 Suicide and Crisis Lifeline call, chat, and text center since July 16, 2022. BBH funds the WV 988 center with a combination of MHBG and SAMHSA 988 Capacity grant awards. As a companion, SAMHSA 988 Capacity Grant BSCA funding is assisting the state with marketing of 988 and development of workflow protocols between 988, public safety answering points (PSAPs), first responders, and behavioral health providers.

B. **Mobile Crisis and Quick Response Teams**. For children and young adults up to age 21 and their families, seven regional Children's Mobile Crisis Response and Stabilization teams respond in all 55 counties. These teams are currently sustained by state funding. Reimbursement through the Children with Serious Emotional Disorder (CSED) Medicaid Waiver is possible in certain circumstances, and the Bureau for Medical Services (BMS) received approval in September 2023 to implement a Medicaid state plan amendment to allow reimbursement for mobile crisis response services for individuals of all ages.

Six Adult Mobile Crisis Response teams are also available in several areas of the state with others in development through MHBG supplemental funding and direct SAMHSA funding to several behavioral health agencies.

In addition to mobile crisis response teams, quick response teams (QRTs) made up of behavioral health and other professionals contact adult individuals within 24-72 hours of an overdose to

connect them with treatment and other services. More than half of the state's 55 counties are covered by QRTs.

C. **Suicide Prevention, Intervention, and Postvention**. Prevent Suicide WV, the American Foundation for Suicide Prevention WV chapter, and a dozen BBH- and SAMHSA-funded regional youth and adult suicide intervention specialists 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. Learn more about suicide prevention efforts at https://preventsuicidewv.com/.

BBH leads and participates in several collaborative partnerships to prevent suicide, including the Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families; WV Council for the Prevention of Suicide; and WV 988 Planning Coalition.

D. **Workforce Training**. Since 2021, BBH has funded the WV Behavioral Health Workforce and Health Equity Training Center to support and expand the state's behavioral health workforce, including Peer Support Specialists and Recovery Coaches, by increasing access to high-quality, evidence-based trainings at no cost to providers. Training and technical assistance is offered specifically for mobile crisis response providers, as well as more general behavioral training on numerous topics, including several suicide prevention related trainings (e.g., Mental Health First Aid, ASIST, and Question, Persuade, Refer or QPR). Learn more about the training center at https://wvbhtraining.org/.

E. **School Safety and Threat Preparedness**. For several years, BBH and the West Virginia Department of Education (WVDE) have co-chaired the Expanded School Mental Health (ESMH) Steering Team to review and recommend policy changes and provide guidance and funding for multi-tiered support for students and schools. ESMH is a multi-tiered system of support where schools, families, and strategic community partners work together to enhance student mental health in schools. It is a framework that includes the full continuum of prevention, early intervention, and mental health treatment; serves all students; builds upon core programs/services being provided by schools; and emphasizes shared responsibility between schools, mental health providers, and community partners. BBH and WVDE provide grants to 93 schools for ESMH through state, MHBG supplemental, and SAMHSA Project AWARE funding. Read more about ESMH at https://wvesmh.org/.

Since 2021, BBH has collaborated with the WV Fusion Center of the Department of Homeland Security (DHS) to deter the escalation of threat referrals through behavioral health threat assessments and community-based mental health services and supports. BBH is using state funding to develop a uniform process to assess threats within schools and ensure students are

referred to and receive the appropriate community-based mental health services to meet their needs. This project will help meet this unmet need in schools and prevent unwarranted involvement with law enforcement due to a lack of knowledge on how to appropriately evaluate threats. BBH's efforts will complement the DHS School Safety Initiative launched in 2022. Read more at https://dhs.wv.gov/Pages/WV-School-Safety.aspx.

Proposed Uses of BSCA MHBG Funding

This funding will enhance West Virginia's existing resources and activities described above as follows:

1. **Development and implementation of a statewide mental health emergency preparedness and response plan and team focused on behavioral health**. In late 2022, BBH formed a 988/Crisis/Disaster steering team that includes BBH and BMS program leadership, a regional NAMI representative, the director of Prevent Suicide WV, and the WV 988 agency's CEO and program director. Membership of this team can be expanded to include DHS, first responders, and threat preparation professionals. This funding will provide for continued contractual assistance from an experienced agency, Community Access, Inc.,[1] to facilitate the steering team meetings and assist with implementation of the statewide mental health emergency preparedness and response plan in development from the previous round of MHBG BSCA supplemental funding and then annual updates to the plan.

- **Funding amount-- $275,000**, which exceeds the five-percent crisis set-aside for this supplement (i.e., $22,034.05).

2. **Training of agencies and providers identified in the statewide plan.** Following development of the statewide mental health emergency preparedness and response plan, BBH will have the Behavioral Health Workforce and Health Equity Training Center or another training entity provide training recommended in the statewide plan and team to mobile crisis response teams, regional threat assessment teams, West Virginia Voluntary Organizations Active in Disaster (WV VOAD), the West Virginia Council of Churches, first responders, and others identified in the plan. Funding will be used for trainings that may include therapeutic crisis intervention, de-escalation, debriefing, and protocols among entities.

- **Funding amount-- $100,000**, which exceeds the five-percent crisis set-aside for this supplement (i.e., $22,034.05).

3. **Coordination with First Episode Psychosis (FEP) providers, Medicaid, and Public Health on awareness and screenings-- including Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-- to identify, prevent, intervene, or lessen the impact of psychotic**

[1] The Community Access agency has a history of expertise with implementation of large projects on a variety of timelines and has worked with a variety of government agencies including BBH, the WV Department of Education, the WV Developmental Disabilities Council, and the WV Division of Rehabilitation Services. The agency provides continuity, logistical, and subject matter expertise, and responsiveness regarding both relationships and processes at the regional and state level in WV, including with families with lived experience through the WV Behavioral Health Planning Council.

disorders or serious emotional disturbances (SEDs) in youth and young adults. West Virginia is coordinating an EPSDT Workgroup with contractual support by Community Access for meeting facilitation and plan development. This workgroup will help connect multiple emerging efforts both within WV state government and with partner organizations around EPSDT and FEP screening. BBH has identified the coordination of these efforts as an emerging priority to avoid duplication of effort and funds and to streamline messaging as much as possible to avoid confusing families and providers. The workgroup will bring together teams working on the goal of sustainable and widespread EPSDT across the state to provide access to comprehensive mental health services for children and youth diagnosed with serious emotional disturbances (SEDs).

Led by Rebecca Roth, BBH Director of the Office of Policy, Planning, and Research, the WV EPSDT Workgroup may include the following members:

- Amy Saunders, Marshall University Research Corporation. Marshall (or MURC) is pursuing a pilot opportunity that came out of recently awarded federal funds and a brainstorming session with Region 5 SAMHSA Administrator Jeffrey Cody. MURC's interests aligned with Jeffrey Cody's interest in working towards the prevention specialist recognition as a workforce category from the U.S. Dept. of Labor. MURC plans to pilot its initiative with a Medicaid managed care organization (MCO) in West Virginia on billing for prevention, likely through EPSDT, as a prevention/early intervention activity within that benefit. MURC is also reviewing similar work occurring in Pennsylvania.
- Tahnee Bryant, Program Manager II, WV Bureau for Behavioral Health. Tahnee oversees BBH Block Grant sub-grantee prevention grants, with statewide coverage through the Prevention Lead Organizations (PLOs). She also serves on the Mental Health Shortages-Think Tank with colleagues across education, higher education, and behavioral health sectors and is a strong proponent for increasing the number of West Virginians with a preventionist credential and ongoing training. She also has a critical eye for understanding conversations covering the interplay between co-occurring mental health prevention and substance use disorder (SUD) prevention issues in youth.
- Josh VanBibber, Program Manager I, who oversees the BBH FEP grants and provides technical assistance to the regional FEP providers funded by the MHBG, which is collectively known as Quiet Minds WV.[2] Josh will bring the Children's Crisis and Referral Line and the Statewide Family Advisory Board to conversations.
- A DHHR deputy secretary or bureau commissioner. A report commissioned by WV Governor Jim Justice, by the consulting firm McChrystal Group, and released to the WV Legislature in November 2022, recommended a Deputy Secretary for Access and Eligibility.[3] Should that deputy secretary position be named, this position may co-lead the workgroup.
- Jim Jeffries, Director, Office of Maternal Child and Family Health, WV Bureau of Public Health. Jim's office is responsible for providing annual training on EPSDT for primary

[2] Read more about Quiet Minds at https://quietmindswv.com/.
[3] Read the McChrystal report at https://governor.wv.gov/Documents/DHHR%20Report.pdf.

care providers. Children's mental health care transformation at DHHR has led to additional focus on CQI related to the mental health aspect of the EPSDT.

- Cynthia Parsons, Director, Office of Behavioral Health and Long-term Care, WV Bureau of Medical Services. Cynthia takes a lead role in WV Medicaid's work related to behavioral health and the State Medicaid Plan and other amendments, waivers, service delivery and payment systems in WV. Cynthia's expertise in this arena is especially notable as WV is currently working on a Certified Community Behavioral Health Clinic (CCBHC) state plan amendment and has an 1115 SUD waiver renewal application in review as of this writing, aspects of which are similar to California's 1115 SUD waiver.[4]
- Kathy Szafran, MA, LPC, Executive Director, Aetna, Mountain Health Promise. Aetna oversees the Mountain Health Trust contract, which includes WV CHIP, and the Mountain Health Promise contract, for all WV children in foster care. Kathy is a founding member of the WV ACEs Coalition.
- Dr. Lisa Costello, MD, MPH. Dr. Costello is assistant professor of pediatrics at West Virginia University (WVU) School of Medicine and medical lead for the State's Joint Interagency Task Force Information Center and is a citizen member of WV Children's Health Insurance Program (CHIP).
- Kevin Junkins, MD, Chief Medical Officer-Behavioral Health, Community Care. Dr. Junkins grew behavioral health services by 600% at Community Care's 8 county-FQHC and School Based Health Center footprint in WV. He is board-certified in child and adolescent psychiatry.

Funding for contracted facilitation and report writing for the proposed WV EPSDT Workgroup will be as follows:

- **Total amount-- $65,681**, which exceeds the ten-percent FEP/Early Serious Mental Illness set-aside for this supplement (i.e., $44,068.10).

[4] California's waiver notes that, in order to comply with EPSDT requirements, early intervention services, regardless of diagnosis, are available for Medicaid enrollees under age 21. See https://www.chcf.org/wp-content/uploads/2022/05/TreatingStimulantUseDisorderCalAIMsContingencyMgmtPilot.pdf.

West Virginia
Community Mental Health Services Block Grant (MHBG)
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- **Funding amount-- $275,000**, which exceeds the five-percent crisis set-aside for this supplement (i.e., $22,034.05).

2. **Training of agencies and providers identified in the statewide plan.** Following development of the statewide mental health emergency preparedness and response plan, BBH will have the Behavioral Health Workforce and Health Equity Training Center or another training entity provide training recommended in the statewide plan and team to mobile crisis response teams, regional threat assessment teams, West Virginia Voluntary Organizations Active in Disaster (WV VOAD), the West Virginia Council of Churches, first responders, and others identified in the plan. Funding will be used for trainings that may include therapeutic crisis intervention, de-escalation, debriefing, and protocols among entities.

- **Funding amount-- $100,000**, which exceeds the five-percent crisis set-aside for this supplement (i.e., $22,034.05).

3. **Coordination with First Episode Psychosis (FEP) providers, Medicaid, and Public Health on awareness and screenings-- including Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-- to identify, prevent, intervene, or lessen the impact of psychotic**

[1] The Community Access agency has a history of expertise with implementation of large projects on a variety of timelines and has worked with a variety of government agencies including BBH, the WV Department of Education, the WV Developmental Disabilities Council, and the WV Division of Rehabilitation Services. The agency provides continuity, logistical, and subject matter expertise, and responsiveness regarding both relationships and processes at the regional and state level in WV, including with families with lived experience through the WV Behavioral Health Planning Council.

disorders or serious emotional disturbances (SEDs) in youth and young adults. West Virginia is coordinating an EPSDT Workgroup with contractual support by Community Access for meeting facilitation and plan development. This workgroup will help connect multiple emerging efforts both within WV state government and with partner organizations around EPSDT and FEP screening. BBH has identified the coordination of these efforts as an emerging priority to avoid duplication of effort and funds and to streamline messaging as much as possible to avoid confusing families and providers. The workgroup will bring together teams working on the goal of sustainable and widespread EPSDT across the state to provide access to comprehensive mental health services for children and youth diagnosed with serious emotional disturbances (SEDs).

Led by Rebecca Roth, BBH Director of the Office of Policy, Planning, and Research, the WV EPSDT Workgroup may include the following members:

- Amy Saunders, Marshall University Research Corporation. Marshall (or MURC) is pursuing a pilot opportunity that came out of recently awarded federal funds and a brainstorming session with Region 5 SAMHSA Administrator Jeffrey Cody. MURC's interests aligned with Jeffrey Cody's interest in working towards the prevention specialist recognition as a workforce category from the U.S. Dept. of Labor. MURC plans to pilot its initiative with a Medicaid managed care organization (MCO) in West Virginia on billing for prevention, likely through EPSDT, as a prevention/early intervention activity within that benefit. MURC is also reviewing similar work occurring in Pennsylvania.
- Tahnee Bryant, Program Manager II, WV Bureau for Behavioral Health. Tahnee oversees BBH Block Grant sub-grantee prevention grants, with statewide coverage through the Prevention Lead Organizations (PLOs). She also serves on the Mental Health Shortages-Think Tank with colleagues across education, higher education, and behavioral health sectors and is a strong proponent for increasing the number of West Virginians with a preventionist credential and ongoing training. She also has a critical eye for understanding conversations covering the interplay between co-occurring mental health prevention and substance use disorder (SUD) prevention issues in youth.
- Josh VanBibber, Program Manager I, who oversees the BBH FEP grants and provides technical assistance to the regional FEP providers funded by the MHBG, which is collectively known as Quiet Minds WV.[2] Josh will bring the Children's Crisis and Referral Line and the Statewide Family Advisory Board to conversations.
- A DHHR deputy secretary or bureau commissioner. A report commissioned by WV Governor Jim Justice, by the consulting firm McChrystal Group, and released to the WV Legislature in November 2022, recommended a Deputy Secretary for Access and Eligibility.[3] Should that deputy secretary position be named, this position may co-lead the workgroup.
- Jim Jeffries, Director, Office of Maternal Child and Family Health, WV Bureau of Public Health. Jim's office is responsible for providing annual training on EPSDT for primary

[2] Read more about Quiet Minds at https://quietmindswv.com/.
[3] Read the McChrystal report at https://governor.wv.gov/Documents/DHHR%20Report.pdf.

care providers. Children's mental health care transformation at DHHR has led to additional focus on CQI related to the mental health aspect of the EPSDT.

- Cynthia Parsons, Director, Office of Behavioral Health and Long-term Care, WV Bureau of Medical Services. Cynthia takes a lead role in WV Medicaid's work related to behavioral health and the State Medicaid Plan and other amendments, waivers, service delivery and payment systems in WV. Cynthia's expertise in this arena is especially notable as WV is currently working on a Certified Community Behavioral Health Clinic (CCBHC) state plan amendment and has an 1115 SUD waiver renewal application in review as of this writing, aspects of which are similar to California's 1115 SUD waiver.[4]
- Kathy Szafran, MA, LPC, Executive Director, Aetna, Mountain Health Promise. Aetna oversees the Mountain Health Trust contract, which includes WV CHIP, and the Mountain Health Promise contract, for all WV children in foster care. Kathy is a founding member of the WV ACEs Coalition.
- Dr. Lisa Costello, MD, MPH. Dr. Costello is assistant professor of pediatrics at West Virginia University (WVU) School of Medicine and medical lead for the State's Joint Interagency Task Force Information Center and is a citizen member of WV Children's Health Insurance Program (CHIP).
- Kevin Junkins, MD, Chief Medical Officer-Behavioral Health, Community Care. Dr. Junkins grew behavioral health services by 600% at Community Care's 8 county-FQHC and School Based Health Center footprint in WV. He is board-certified in child and adolescent psychiatry.

Funding for contracted facilitation and report writing for the proposed WV EPSDT Workgroup will be as follows:

- **Total amount-- $65,681**, which exceeds the ten-percent FEP/Early Serious Mental Illness set-aside for this supplement (i.e., $44,068.10).

Below is a **table with the breakdown of funding**, including required MHBG set-asides.

Activity	Year 1	Year 2	Required set-aside	Two-Year Total
Development and Implementation of statewide mental health emergency preparedness and response plan and team focused on behavioral health	$275,000	$275,000	5-percent crisis set-aside. Exceeds minimum of $22,034.05 per year	$550,000
Training of agencies and providers identified in the statewide plan	$100,000	$100,000	5-percent crisis set-aside. Exceeds minimum of $22,034.05 per year	$200,000

[4] California's waiver notes that, in order to comply with EPSDT requirements, early intervention services, regardless of diagnosis, are available for Medicaid enrollees under age 21. See https://www.chcf.org/wp-content/uploads/2022/05/TreatingStimulantUseDisorderCalAIMsContingencyMgmtPilot.pdf.

FEP/EPSDT Workgroup	$65,681	$65,681	10-percent FEP/ESMI set-aside. Exceeds minimum of $44,068.10 per year	$131,362
Totals	$440,681	$440,681		$881,362

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

Sherri A. Young, DO, MBA, FAAFP

Title

Interim Cabinet Secretary

Organization

West Virginia Department of Health and Human Resources

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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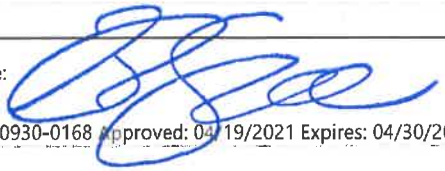
Signature: 

Date: 8/30/2023

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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 (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

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. BBH is responsible for administering the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and Community Mental Health Services Block Grant (MHBG). Through the block grants and a combination of other federal grants and state funding awarded to about 130 providers through 470 grants, 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. Additionally, BBH is the host agency for the Statewide Epidemiological Outcomes Workgroup (SEOW).

The mission of the BBH is to serve the people of West Virginia by working with strategic partners to advance access quality of statewide behavioral health to empower each West Virginian to reach their potential. The Bureau champions wellness, resilience, and recovery and values the lived experiences of stakeholders, families, and communities; BBH believes in the power of connection and hope.

In 2023 the WV Legislature passed House Bill 2006, which reorganized the WV Department of Health and Human Resources (WVDHHR) into three agencies, effective as of January 2024: the Department of Health,which will include the Bureau of Public Health; the Department of Human Services; and the Department of Health Facilities, which will be responsible for oversight of the state-owned and operated hospitals with long-term or acute care psychiatric functions for adults. BBH will operate under the auspices of the West Virginia Department of Human Services (DHS), which will include the Bureau for Child Support Enforcement, Bureau for Family Assistance, Bureau for Medical Services (BMS, the State Medicaid agency), Bureau for Social Services, and Office of Drug Control Policy. BBH collaborates extensively on a variety of grants and projects with each of the other Bureaus housed within the new Department of Human Services, the other new Departments, and other state, regional, and community agencies.

Organizational Structure: Bureau for Behavioral Health

The Commissioner’s Office provides direction to BBH 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 a statewide continuum of care and support for individuals in need of prevention, intervention, treatment and recovery.

The Programs and Policy section is comprised of the following Offices:

- Office of Adult Mental Health Services
- Office of Adult Substance Use Disorder
- Office of Children, Youth, and Families
- Office of Policy, Planning, and Research

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 Behavioral 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 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 (the State Medicaid agency) to implement the SUD 1115 waiver, harm reduction services administered through BPH, offender reentry services through the Division of Justice and Community Services, and 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 youth in West Virginia communities through primary prevention and individualized services for mental health, substance use, and intellectual and developmental

disabilities. Charged with overseeing the prevention set-aside of the SUPTRS Block Grant (including the Synar program) and the crisis and First Episode Psychosis (FEP)/Early Serious Mental Illness (ESMI) set-asides of the MHBG, the Office provides leadership, technical assistance, and funding to support children and youth with serious emotional disturbances (SED), young adults transitioning to adulthood
with serious mental illness (SMI) or FEP/ESMI), children and youth with intellectual or developmental disabilities (I/DD), and their families. The Office also leads collaboration on the 988 Suicide & Crisis Lifeline. Key initiatives to build capacity include enhancing the state's system of care (SOC) and Kids Thrive Collaborative (https://kidsthrive.wv.gov/ through increased core services, such as:

- Children's Mental Health Wraparound,
- Children'sMobile Crisis Response and Stabilization,
- Positive Behavior Support,
- 24/7 Children's Crisis and Referral Line of 844-HELP4WV, and
- Expanded School Mental Health.

Other initiatives to support children, youth, 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 youth 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), program data, research, analysis, and dissemination; legislative and policy analysis; training and technical assistance; and communication, including website development.

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.

To read more about the WV Bureau for Behavioral Health, please see the website, https://dhhr.wv.gov/bbh/, which may change as part of the reorganization of the Department.

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.

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 Family Assistance, Social Services, Medical Services, and Public Health on evidence-based supports for children, families, and communities, 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.

Behavioral Health Provider System

Currently 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 Continuum Enhancement Funds are provided by BBH to meet the remaining need to ensure availability of these services at the county level. Charity Care, which is funded through state general revenue funds, is 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. BBH has amplified the WV Medicaid agency and WV Navigator messages and efforts to encourage Medicaid beneficiaries to update their contact information and complete their Medicaid redetermination process, for example, in sub-grantee calls and Bureau e-blasts that reach 1,000+ West Virginians.

BBH provided $6,123,784 to pay for uncompensated care in FY 2023-24. 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.

West Virginia's behavioral health system has been intentionally preparing to offer Certified Community Behavioral Health Clinics (CCBHC) . Of the 13 current Comprehensive Behavioral Health Centers (CBHC) in WV, 4 received SAMHSA CCBHC expansion grants between 2020-2023, as well as 2 clinics that had not previously served in the state comprehensive behavioral health role. WV Senate Bill 247, passed in the 2022 WV legislative session, provided that WV develop a system of CCBHCs in the state. In 2023 BBH became one of 15 states awarded a SAMHSA Planning Grant to develop the CCBHC system in West Virginia. Being awarded the planning grant allows BBH to apply for a CCBHC demonstration grant. There will be 10 awardees for the demonstration grant. The demonstration grant would give WV an increased federal match rate. BBH and BMS, in coordination with the WV Behavioral Health Provider Association, are currently working on creating criteria for CCBHCs. Additional development is currently occuring in the creation of a CCBHC application process and in the drafting of a State Plan Amendment (SPA), to allow for CCBHC certification.

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 youth 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.

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 the 20-percent prevention set-aside of the SUPTRS Block Grant, the Bureau is responsible for the coordination and implementation of the Synar Program, which requires states to enforce laws prohibiting the sale and distribution of tobacco products to minors. The BBH Synar Program coordinator oversees tobacco retailer education on state and federal laws leading into annual tobacco compliance inspections conducted in cooperation with the WV State Police and community partners, in accordance with the SAMHSA Center for Substance Abuse Prevention (CSAP). Even through the COVID-19 pandemic, West Virginia has conducted the annual inspections and maintained a Retailer Violation Rate (RVR) well below the 20-percent violation threshold. West Virginia has not yet passed legislation to increase the age to purchase tobacco from 18 to 21 (often called “Tobacco 21”), which is now the age in federal law. Bills introduced each year in the state legislature have died. BBH also has the state’s contract for the FDA Family Smoking Prevention and Tobacco Control Act that can enforce the federal Tobacco 21 law. The Synar and FDA programs complement each other to prevent youth and young adults from purchasing tobacco products.

In December 2020, West Virginia’s last Three-Year Prevention Strategic Plan was implemented. Stakeholders will be convening in the fall to work on the next Prevention Strategic Plan. 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%). Read the Prevention Strategic Plan at https://helpandhopewv.org/prevention-works.html.

Prevention services have expanded with 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. PFS has helped grow youth leadership initiatives such as Youth MOVE.
- 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, 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 supporting several prevention activities such as: Continued implementation of West Virginia's prevention strategic plan and meeting the goals of the Governor's Council on Substance Abuse Prevention and Treatment (Governor's Council). The Governor's Council tasked the WV Office of Drug Control Policy in the provision of administrative support and resources to the Council. The Statewide Prevention Summit meets several goals and key performance indicators outlined in the ODCP Substance Use Response Plan https://dhhr.wv.gov/office-of-drug-control-policy/gov-council/Pages/2020-2022-WV-Substance-Use-Response-Plan.aspx: 1. maximize cross systems planning, collaboration, and integration, 2. host an annual statewide prevention summit to promote knowledge sharing, innovation, and commitments to shared outcomes, and 3. form a planning committee to organize, plan, and select sessions and speakers. In 2023 virtual town hall meetings will provide an overview of this year's progress and solicit feedback regarding updates to the plan for 2024.
- West Virginia is proud of its Expanded School Mental Health (ESMH) program which provides a multi-tiered system of support where schools, families, and strategic community partners work together to enhance student mental health, and serve all students, in schools. The ESMH framework includes the full continuum of prevention, early intervention, and mental health treatment; builds upon core programs/services provided by schools; and emphasizes shared responsibility between schools, mental health providers, and community partners. ESMH is currently being implemented in 82 WV schools.
- Provide funding for WV 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. As of late June 2023, there are 19 WV schools that have committed to training and implementation and at least 3 more schools have met with representatives to determine fit. Marshall University School Health TA Center currently has 10 signed school agreements to implement the program and 9 additional schools with agreements pending board signature. Multiple schools have begun the training and implementation process in earnest.

- 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. Help and Hope WV has become a hub for important substance use prevention information, regional contacts, and events.

Treatment

In addition to providing prevention services, the SUPTRS 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 include the expansion of best practice in peer support 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.

The state works with several partners on addressing transportation as a barrier to treatment in a largely rural state. 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. 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. SOR provides support for transportation for individuals not eligible for the NEMT Medicaid program; in 2023, BBH also started a pilot transportation project with Block Grant funds for individuals seeking treatment who found transportation to be a barrier and were neither eligible for NEMT or the SOR transportation project.

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. 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 support to help individuals stay in long-term recovery.

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

Continued expansion of West Virginia University (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 Family Assistance, SOR funds are used to provide subsidized childcare for individuals engaged in treatment for an SUD. West Virginia's three medical schools 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 Peer Recovery Support Specialists (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.

The residential treatment infrastructure has changed substantially in the past several years primarily due to two occurrences: West Virginia became a SUD 1115 waiver state and the state legislature used opioid settlement funds to create the Ryan Brown Addiction Prevention and Recovery Fund. SUD services under the waiver (including residential treatment, peer support, and methadone) were phased in during 2018. Initially 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 WV Bureau for Medical Services (BMS) is seeking CMS approval to renew WV's section 1115 SUD waiver (2017-2022) for another five years, which could be announced as early as March 2024. In addition to the current 1115 waiver services, BMS is seeking to expand services offered; the TRUST Model (focused on treating stimulant use disorder) is named among these services.

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 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.

In West Virginia there is a moratorium on opioid treatment programs (OTPs), which restricts the number of OTPs to the current nine. This limits the availability of methadone treatment across the state. MOUD expansion efforts continue to focus on Office-based medication assisted treatment (OBMAT). While the end of the DATA 2000 Act and the implementation of the MATE Act have lowered some barriers nationally to prescribe MOUD, in WV 2016 legislation W. Va. Code R. § 69-12-7 further regulates Office Based Medication to treat Addiction Treatment

(OBMAT). As a result, for example, practices/providers that prescribe MAT to more than 30 people must register with the Office of Health Facility Licensure and Certification. Currently there are 219 OBMATs in the state. 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.

Recovery System: Block grant funds provide for community-based recovery support services that include expanding best practices in peer supports. The BBH has trained more than 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 2023. 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. As of July 31, 2023, 111 recovery residences were certified. The number of Peer-Operated Recovery Homes in West Virginia has increased, providing safe housing for individuals age 18 and older who are recovering from substance use 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.
- 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 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 support that keep individuals in the community and avoid unnecessary hospitalizations. Support may include expedited access to a medical provider, linkage to crisis intervention, or provision of needed community support in the home. Peer Centers in West Virginia quickly adapted to providing virtual recovery support by utilizing available technology such as telephone/video and the internet. Access to online group and individual support continues to be provided. A peer warmline through the Help4WV call center is available 24/7.
- 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.

- 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 your behavioral health can be found at: https://dhhr.wv.gov/BBH/getconnected/Pages/Support-Disaster-RecoveryEfforts.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; the invitation list includes more than 200 people. 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 West Virginia's 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 lifespan.
- 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.
- 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 presented behavioral health data via a variety of ways, including: 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. A new data system is also being developed to better capture SOR data, report GRPA data, and provide other necessary support to both BBH and the behavioral health network. The data system is being developed by FEi and was awarded through a competitive contract process.

BBH continues to strengthen its data and research workforce pipeline. Since 2018, the BBH has been able to hire two FTE Behavioral Health Epidemiologists, with a third FTE in the process of being hired. One Epidemiologist II has been promoted to Epidemiologist III.

In 2023 BBH launched the BBH Clearinghouse, an online database of evidence-based practices to help individuals, families, providers, schools, communities, and other partners make informed decisions about selecting effective prevention, early intervention, treatment, and recovery services. Approximately two years in the making, the BBH Clearinghouse was created through extensive research by subject matter experts, graduate assistants, and Marshall University faculty; feedback from a collaborative advisory workgroup; and coordination by BBH staff, Community Access, and Terzetto Creative. Originally commissioned to review behavioral health services for children, youth, and young adults, the Clearinghouse accepts requests to review services for people of all ages.
https://clearinghouse.helpandhopewv.org/request-program-review/.

With support from WVU, a new behavioral health surveillance initiative called Mountain State Assessment of Trends in Community Health (MATCH) was implemented, with the 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 first findings were published in May 2023.

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/officeof-drug-control-policy/datadashboard/Pages/default.aspx

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 systems, 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 behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

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

Unmet Needs

- 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 overdose epidemic 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. 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 US contribution of methamphetamine in overdose deaths. Approximately 45% of fatal overdoses have methamphetamine present. Like the nation, West Virginia is concerned about xylazine. In 2019, it was present in just six fatal overdoses but has increased to 158 in provisional 2022 data, which is 12% of fatal overdoses. 2022 provisional data suggests that the surge in overdoses the state experienced as a result of COVID 19 has ended, but WV is still higher than pre-pandemic rates.

- Many substances are being injected, leading to increases in blood-borne viral infections; WV has some of the highest rates of Hepatitis B and C in the nation. West Virginia is a low HIV/AIDS incidence state. However, HIV clusters are becoming more common. For the first time since 2018, Kanawha County HIV rates, referred to by the CDC as the "most concerning" HIV outbreak in the country, declined in 2023, with the help of the CDC and the implementation of public health measures. Over the past several years, Kanawha County (home to the state's capital) had seen an increase in HIV cases linked to injection drug use of more than 700%.

- According to the 2021 National Survey on Drug Use and Health (NSDUH), West Virginia is comparable to the nation, with 4.8% of of adults aged 18 or older having had serious thoughts of suicide in the past year. It is the crude rate of suicides, however, in which West Virginia has continued to climb: from 12.6 per 100,000 in 1999 to 18.4 per 100,000 in 2019, (compared with the national 14.5 per 100,000 in 2019). In 2022, the provisional crude rate in West Virginia is 18.7 while the national average is 13.8. In addition, suicide among youth is a concern: suicide is the second leading cause of death, behind accidents, in 15-24 and 25-34 year olds in West Virginia.

  West Virginia also has a higher rate of mental illness, 23.9%, compared to the nation, 22.8%. West Virginia also has a higher percentage of population with a serious mental illness (SMI), 6.4% compared to 5.5% nationally, and a higher percentage of the population that had a major depressive episode in the past year, 9.0% compared to 8.3%.

- In 2021, the Behavior Risk Factor Surveillance System (BRFSS) found that 19.3% of West Virginians had 14 or more days out of the past 30 when mental health was not good; 61.4% of those individuals also reported poor mental or physical health impacted normal activities.

- The Trevor Project 2022 National Survey on LGBTQ Youth Mental Health in West Virginia found that 50% of WV LGBTQ youth seriously considered suicide in the last year, 14% attempted suicide, 81% experienced anxiety, 62% experienced symptoms of depression, 58% who wanted mental health care were not able to get it (often because they were afraid to share their concerns), and 80% endured discrimination based on sexual orientation or gender identity. The GLSEN 2021 National School Climate Survey indicated that WV schools were not safe for most LGBTQ+ secondary school students and that many LGBTQ+ students did not have access to important school supports. In March 2023, the WV State Legislature passed House Bill 2007 to limit gender-affirming healthcare for transgender minors; its impact on diverse youth mental health will be monitored.

- Black youth in WV are more likely to be arrested, detained, adjudicated, and placed in secure residential facilities, and they are less likely to receive diversions or to be placed on probation. They are also experiencing increases in suicide rates, according to the 2019 Congressional Black Caucus (CBC) Emergency Taskforce on Black Youth Suicide and Mental Health report, Ring the Alarm: The Crisis of Black Youth Suicide in America. A November 2021 report from the Centers for Disease Control and Prevention (CDC) indicated that nationally the suicide rate for black girls and women aged 10 to 24 increased more than 30% in 2020, and by 23% among black boys and men the same age. According to the MATCH survey 17% of people who are Black scored as having serious psychological distress compared to 14% of people who are White. Of even more concern, and a trend that is emerging in other measures, is that people who identify as multi-racial or other race fare even worse, with 25% having serious psychological distress.

Workforce Gaps

While the state has invested in its SUD and mental health continuum of care in recent years, and has seen some gradual improvements, West Virginia has been disproportionately devastated by SUD, and the 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 further exacerbated the problem. 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 June 2023 Health Professionals Shortage Area Quarterly Report, an estimated 1 in 8 West Virginians (13%) 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 90 practitioners. In the meantime, the rapid, increased need to use telehealth services or other alternatives to traditional services are essential to maintain care. There are 111 mental health professional shortage areas in West Virginia, covering 50 of West Virginia's 55 counties, and only 13% of need is met. Adding to the behavioral health workforce shortage issue is the state's unequal distribution of primary care providers, as well as shortages of mid-level practitioners, a range of medical specialists, and child psychiatrists.

Data-Informed Service Needs

Given West Virginia's workforce status, finding data-informed and focused solutions to address the behavioral health of West Virginians becomes even more critical. The first findings of a new behavioral health surveillance initiative called Mountain State Assessment of Trends in Community Health (MATCH) were published in May 2023.

- Responses indicated that the highest proportion of adults with poor mental health and highest ratios of people to mental health providers live in the southwest portion of the state.
- Individuals 18 to 34 had the highest need to see a mental health care provider and highest share that did not see a provider because of expense.
- Black respondents made up the highest share of individuals who did not see a mental health care provider citing discomfort talking to a mental health provider.
- Overall, MATCH 1.0 has confirmed the need for more accessible - and low barrier - behavioral health treatment services.
- MATCH findings on economic hardship underline the need for removing financial barriers to treatment.
- MATCH findings on stigma indicate that this continues to be an area of concern, especially as regards access to care.
- MATCH confirmed workforce shortages as a need.
- MATCH results underscore the importance of teasing out the details of barriers to care. Despite listing out options that included childcare and transportation, 1/3 of respondents listed "other" as a barrier to care.

MATCH 2.0 is anticipated to provide additional detail so BBH can be more responsive to data-informed West Virginia needs. MATCH 2.0 is also expected to provide information to Prevent Suicide WV and other grantee partners (such as First Choice with 9-8-8) on how lack of connection and needed suicide risk prevention can be addressed and focused across age and veteran status. At least 88,000 surveys will be mailed to randomly selected households in West Virginia starting August 2023. Those selected to participate will receive an invitation to complete

the survey online, by mail, or by phone. To learn more about the MATCH survey, visit wvmatchsurvey.org.

Service Gaps

An environmental scan of crisis services completed by the University of Connecticut in preparation for mobile crisis training showed that WV has gaps in crisis stabilization services for children and youth. Another service gap that continues to be difficult to fill is implementation of intensive outpatient and crisis respite services for children and youth with SED or SMI. Along with pervasive stigma and a “culture of sending kids to residential (placement),” these gaps could contribute to children with behavioral health crises presenting at emergency departments.

Several state initiatives over the past several years have attempted to tackle the overreliance on juvenile or criminal justice and out-of-home placements for youth and young adults, as well as behavioral health disparities, including these:

In 2015, WV collaborated with the Pew Charitable Trusts on juvenile justice reform to reduce the placement of low-level youth offenders in state-funded facilities and steer resources toward community-based sanctions and services that cost less and are more effective at reducing recidivism.

High rates of out-of-home placement for children and youth with serious emotional disturbance/disorder (SED) or serious mental illness (SMI) led to WV entering an agreement with the U.S. Department of Justice (DOJ) in 2019 to improve its mental health system to ensure that children can receive appropriate mental health and social services in their homes, schools, and communities. A June 2022 West Virginia University Children’s In-Home and Community-Based Services Improvement Evaluation Baseline System and Community-Level Findings and Visualization Report completed as part of the DOJ agreement found gaps in availability, accessibility, and awareness of community-based services for children, youth, and young adults with SED or SMI.

Population Level Considerations for Person-Centered Needs

The Mountain State’s topography presents challenges, including isolating residents from services, infrastructure, and adding physical barriers to the most vulnerable. The state experiences high poverty and unemployment rates, low levels of higher education attainment and literacy, and high rates of substance use disorder. With a total of 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. 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 data instability. As a result of its small population centers, 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.

West Virginia is aging and is losing population. More people are dying in the state than being born. From 2010 to 2019 the state lost 3.3% of the population, while the US gained 6.3%. Over 20% of the state's population is 65 years and over, compared to 16.5% of the nation. The number of births 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. Consequences of the aging and reduction of West Virginia's population include that the state lost a US House seat in 2021 due to the decline in population.

The state 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%. 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.

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. There are no federally recognized tribes in West Virginia. 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.

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 who identify as LGBT and 29% are raising children. One of the reasons the MATCH survey was implemented was because some of the data from national sources, while valuable and crucial for benchmarking to the nation, had a disconnect with impressions from the field. MATCH found that 7.4% of the state's population identified as LGBT. Moving forward the bureau will continue to understand similarities and differences between different data sources. However, this has direct implications in the number of residents at risk for health disparities due to sexual orientation. In fact, 28% of people who identified as LGBTQ scored as having serious psychological distress, compared to 13% of non-LGBTQ people.

BBH has efforts underway to more intentionally include people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality, so that WV behavioral health systems address the needs of underserved communities.

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 for the University. As part of West Virginia's Transformation Transfer Initiative (TTI) with the National Association of State Mental Health Program Directors (NASMHPD), BBH staff outreach in 2023 has included leadership within the Appalachian American Indians of West Virginia; the WVU Program for Native American Studies; the WV Committee on Native American Ministries; and both existing and emerging leaders in the African American community. The TTI Initiative has also emphasized leadership within state government, such as the Herbert Henderson Office of Minority Affairs.

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. 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 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).

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. Correlated with low economic standing is low educational attainment levels, which has a direct impact on socio economic 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).

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 is eligible, a target audience for participation are individuals in recovery. 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. In 2019, 93% of all West Virginians had insurance, with 96% of children and 90% of adults 19-64 insured. Before implementation of the major coverage provisions of the ACA, an estimated 20.7% of West Virginians aged 18 to 64 were uninsured. 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. Individuals using the Health Insurance Marketplace may have plans that have not adequately met their healthcare needs, and now find themselves underinsured for behavioral health services. State staff meet as requested with grantees concerned about potential changes in the Medicaid unwind to problem solve, and the BBH email listserv has sent multiple blasts to amplify information of partners and Medicaid colleagues for individuals and providers to know what to do if an individual needs to update their Medicaid or other coverage information.

Criminal Justice and Law Enforcement

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. https://dhhr.wv.gov/bph/about/Documents/2016%20West%20Virginia%20Overdose%20Fatality%20Analysis_004302018.pdf In the year prior to death, 22% of males and 12% of females were incarcerated. 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 with MAT upon admission are maintained on it. 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. Related evolving activities have been implemented with the support of 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. In 2019, 141,341 or 8.5% of West Virginia's 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 years or older. Twenty-six percent of the veterans in the state are receiving disability compensation. In 2023, WV participated in the Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families with partners including the U.S. Department of Veterans Affairs (VA) and the Substance Use and Mental Health Services Administration (SAMHSA).

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 more than four years older than the U.S. (42.9 years compared to 38.5 years). 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. 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. However, as the population continues to age, different support may be needed. 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, which increases as the population ages and leaves the workforce.

Pregnant Women and Infants

Nationally, neonatal abstinence syndrome (NAS) data is gathered at hospital discharge. However, there is a long data lag associated with this data source, and it is limited to infants who with noticeable withdrawal symptoms. 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. In order to gain more timely data, WV leverages an existing risk assessment tool called 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, first 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. In 2020, 6.6% of infants born in West Virginia were diagnosed with NAS, and 14.2% had intrauterine substance exposure. This data has also illustrated different consequences of substance use by

demographics 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. State Medicaid leveraged DFMB to develop a sustainable billing mechanism via the Maternal Opioid Misuse (MOM) Model. (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 positive drug screens dropped from 80.9% during the first trimester to 21.9% during the third trimester.

Children, Youth, and Families Children and Youths with SED

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. 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:

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. In 2020 BMS 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 development, supported employment, and community transition. 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.

Youth and young adults in WV are experiencing low income, foster care, housing instability, disabilities, or mental illness, as indicated in a Mountain State Spotlight article from May 2023: "New data shows racial, economic disparities persist in West Virginia school discipline practices." The WV Department of Education shared school discipline data in May 2023 reflecting discipline disparities for students in these populations, as well as an initial plan to address them.

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 . 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 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. lxvThe 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/motell.

Leadership and Structural 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 is growing its data team 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 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.During the 2023 legislative session the Department of Health and Human Resources passed legislation to split the agency. On January 1, 2024 the BBH will become part of the Department of Health Services. The commissioner that had started in 2018 is now a Deputy Secretary with the agency, bringing public health approaches to additional aspects of State health and human services, and a new commissioner has joined the team.

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 reports of anxiety have decreased from earlier in the pandemic, a high and consistent percentage of the state's adult population still experience anxiety and depression, along with the other stressors that came with the pandemic, which 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 composed of representatives from across the agency, including data and programmatic, as well as from academia and community partners, especially those that are charged with prevention. The SEOW brings together individuals with different skill sets and needs. Epidemiologists across the agency have the opportunity to share data, and prevention organizations get to hear the most current data on topics they are addressing. At the most recent SEOW meeting, people were introduced to the MATCH survey, which, as noted earlier, is a new survey with a primary focus on behavioral health topics that the BBH and the Bureau for Medical Services is sponsoring in collaboration with West Virginia University.

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

Goal of the priority area:

Improve access to a full continuum of community mental health services for adults with serious mental illness (SMI)

Strategies to attain the goal:

1. Establish and implement the Certified Community Behavioral Health Center (CCBHC) model.
2. Increase adult mobile crisis teams.
3. Promote best practice for serving older adults in Comprehensive Behavioral Health Centers.
4. Expand permanent supported housing programs.
5. Complete a comprehensive study on homelessness in WV

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of comprehensive behavioral health centers participating in the WV CCBHC program

Baseline Measurement: 3

First-year target/outcome measurement: 9

Second-year target/outcome measurement: 12

Data Source:

The West Virginia CCBHC advisory committee.

Description of Data:

Progress reporting

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 2

Indicator: The number of adult mobile crisis teams

Baseline Measurement: 3

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 9

Data Source:

BBH Program Reporting

Description of Data:

Providers will report as their mobile crisis team projects are fully implemented.

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Number of older adult best practice trainings

Baseline Measurement: 0

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

WV Behavioral Health Training Center

Description of Data:

Project reporting and copies of the presentations

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 4

Indicator: Number of permanent supported housing programs

Baseline Measurement: 6

First-year target/outcome measurement: 7

Second-year target/outcome measurement: 8

Data Source:

BBH Compliance and Data Reporting. BBH Allocation Chart

Description of Data:

Program and financial reporting to show the increase in programs

Data issues/caveats that affect outcome measures:

Indicator #: 5

Indicator: Comprehensive homelessness study

Baseline Measurement: No Baseline, New Initiative

First-year target/outcome measurement: Draft Plan

Second-year target/outcome measurement: Final Plan

Data Source:

Community Access

Description of Data:

Community Access is the provider who will be coordinating the project. They will provide updated progress reporting and the draft and final plans.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 2

Priority Area: Comprehensive Substance Use Disorder Services

Priority Type: SUT

Population(s): PP, Other

Goal of the priority area:

Ensure West Virginians have access to SUD treatment services.

Strategies to attain the goal:

1. Expand access to Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD) by increasing the number of providers.
2. Develop a training initiative to enhance and support the Quick Response Teams (QRT), increase success, and improve data collection.
3. Increase the number of Intensive Outpatient Programs (IOPs) statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of MAT prescribers.

Baseline Measurement: 475

First-year target/outcome measurement: Increase by 5%

Second-year target/outcome measurement: Increase by 5%

Data Source:

WV Office of Health Licensure and Certification (OHFLAC), SAMHSA

Description of Data:

WV OHFLAC publishes the number of MAT prescribers to their website. The SAMHSA website also provides information on the number of MAT prescribers.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of training opportunities to enhance QRT skills and data collection.

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

BBH, Bureau for Public Health (BPH), Office of Drug Control Policy (ODCP)
QRT Summit November 2023

Description of Data:

BBH, BPH, and ODCP data/information on QRT activity statewide.
QRT Summit November 2023

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of Intensive Outpatient Programs (IOPs)

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: Develop a system to accurate track IOPs in WV.

Second-year target/outcome measurement: Increase number of IOPs by 1

Data Source:

OHFLAC, BMS data, BBH, ODCP

Description of Data:

Partner with OHFLAC, BMS, and ODCP to develop a system to track all IOPs in WV and maintain the list. It is currently estimated that there are 28 IOPs in the state, but that data cannot be verified for accuracy.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 3

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

1. Increase the number of residential treatment beds available to PWWDC.
2. Provide opportunities for pregnant women with SUD to obtain prenatal and other healthcare/behavioral health services, in addition to treatment.
3. Educate SUD providers on the intersection of SUD and domestic violence (DV)/intimate partner violence (IPV).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of beds statewide specifically available for PWWDC.

Baseline Measurement: 175

First-year target/outcome measurement: Increase by 5%

Second-year target/outcome measurement: Increase by 5%

Data Source:

BBH, BMS

Description of Data:

Weekly residential adult service reports from BMS.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of new PWWDC who receive services through a Drug Free Moms and Babies Program

Baseline Measurement: 500

First-year target/outcome measurement: Increase by 10%

Second-year target/outcome measurement: Increase by 10%

Data Source:

BBH, WV Perinatal Partnership (Drug Free Moms and Babies Program)

Description of Data:

Data received from WV Perinatal Partnership's Drug Free Moms and Babies Program on number of new women enrolled.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of trainings for SUD treatment providers on the intersectionality of SUD and DV/IPV.

Baseline Measurement: No Baseline – New Initiative

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

BBH, partnership with National Center for Mental Health, Trauma, and Domestic Violence, WV Coalition Against Domestic Violence, WV Perinatal Partnership

Description of Data:

Data form a variety of partners on work being done to educate SUD treatment providers on the complexities of SUD and DV/IPV.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Comprehensive Mental Health and Substance Use Treatment Services for Children, Youth, Young Adults, and Families

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Increase access to community-based mental health and substance use services for children, youth, young adults, and their families to help them thrive in their homes, schools, and communities.

Strategies to attain the goal:

1. Continue to enhance availability and access to statewide Wraparound and Children with Serious Emotional Disorder (CSED) Medicaid Waiver 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 for diverse individuals to the statewide Children's Mobile Crisis Response and Stabilization Services through the 24/7, statewide Children's Crisis and Referral Line (844-HELP4WV) and the 988 Suicide & Crisis Lifeline.
3. Incrementally increase the number of schools with Expanded School Mental Health, or three tiers of student support and services (https://wvesmh.org/)
4. Increase family and youth peer support, referrals to resources, and input in systemic improvement through regional six Family Coordinators; a dedicated staff person in the BBH Office of Children, Youth, and Families; Regional Transition Navigators (https://rtn.cedwvu.org/); and youth peer support specialists at the Regional Youth Service Centers that provide outpatient mental health and substance use services.
5. Continue implementation and expansion of First Episode Psychosis (FEP)/ESMI "Quiet Minds" (https://quietmindswv.com/) coordinated specialty care services at six regional centers collectively providing statewide coverage
6. Work with providers and community partners to adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children and families receiving WV Wraparound and Children with Serious Emotional Disorder (CSED) services

Baseline Measurement: approximately 500 unique children receiving WV Wraparound or CSED services in 2022

First-year target/outcome measurement: 5% increase or about 525 unique children receiving WV Wraparound or CSED services in 2023

Second-year target/outcome measurement: 10% increase or about 550 unique children receiving WV Wraparound or CSED services in 2022

Data Source:

Kids Thrive/DOJ Partnership semi-annual reports at https://kidsthrive.wv.gov/DOJ/Pages/default.aspx

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of calls to the Children's Crisis and Referral Line (844-HELP4WV)

Baseline Measurement: approximately 1,100 calls in 2022

First-year target/outcome measurement: 5% increase or about 1,155 calls in 2023

Second-year target/outcome measurement: 10% increase or about 1,210 calls in 2024

Data Source:

First Choice Services (vendor) data and reporting

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Number of Children's Mobile Crisis Response Teams serving up to age 21 and available 24/7

Baseline Measurement: 7 active regional teams in 2022-2023

First-year target/outcome measurement: Approval of Medicaid state plan amendment (SPA) to reimburse mobile response services

Second-year target/outcome measurement: Number of additional mobile crisis teams serving up to age 21 through Medicaid reimbursement

Data Source:

WV Bureau for Medical Services state plan and claims data

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 4

Indicator: Number of regional Family Coordinators

Baseline Measurement: 12 regional Family Coordinators

First-year target/outcome measurement: 12 regional Family Coordinators maintained

Second-year target/outcome measurement: Add six regional Family Coordinators for a total of 18

Data Source:

Regional Youth Service Center grant agreements and reporting; State Opioid Response grant agreements and reporting; read more about Family Coordinators at https://dhhr.wv.gov/BBH/DocumentSearch/Children%2C%20Youth%20and%20Family%20Services/Regional%20Family%20Coordinators%20Brochure.pdf

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 5

Indicator: Number of youth and families receiving services (including outpatient treatment, FEP services, peer support, youth suicide intervention)

Baseline Measurement: 2022 data

First-year target/outcome measurement: 5% overall increase in first year

Second-year target/outcome measurement: 10% overall increase in second year

Data Source:

Regional Youth Service Center reporting data; FEP reporting data; Youth Suicide Intervention Specialist reporting data; Regional Transition Navigator reporting data. Read more about Regional Youth Service Centers at https://dhhr.wv.gov/BBH/DocumentSearch/Children,%20Youth%20and%20Family%20Services/Regional%20Youth%20Service%20Centers%20Flyer.pdf; read more about FEP services at https://quietmindswv.com/; read more about Regional Transition Navigators at https://rtn.cedwvu.org/

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 6

Indicator: Number of schools receiving funding for Expanded School Mental Health (ESMH) from BBH or WV Department of Education

Baseline Measurement: 93 total schools with BBH grants or WV Department of Education Project AWARE grants in 2022

First-year target/outcome measurement: maintain 93 schools

Second-year target/outcome measurement: at least 100 schools

Data Source:

ESMH grants from BBH or WV Department of Education; grantee reporting; information posted at https://wvesmh.org/

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 5

Priority Area: Crisis Continuum of Care

Priority Type: BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Continue to build the crisis continuum of care someone to talk to, someone to respond, and a safe place to be or go

Strategies to attain the goal:

1. Ensure the state's single 988 Crisis & Referral Line center has adequate resources.
2. Develop workflow protocols between the 988 Center, behavioral health providers, and 911 centers/Public Safety Answering Points (PSAPs), law enforcement, and other first responders. This includes increasing the number of Crisis Intervention Teams (CIT) across the state and NAMI chapters.
3. Work with state, regional, and local partners to develop or enhance behavioral health disasters plans.
4. Increase the number of mobile crisis response teams for both adults and children with financial assistance from planned Medicaid state plan amendment for mobile crisis response services.
5. Develop protocols between overlapping mobile crisis response teams and First Choice Services, which operates both the WV 988 Center and state-specific helpline, 844-HELP4WV.
6. Work with the Bureau for Medical Services (BMS) and providers to expand intensive outpatient, respite, and other services that may prevent hospitalization or higher levels of care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In-state answer rate for 988 Suicide & Crisis Lifeline calls, chats, and texts

Baseline Measurement: 90% of 988 calls and 84% of 988 chats and texts initiated in WV answered by the WV 988 call center

First-year target/outcome measurement: at least 90% of 988 calls, chats, and texts initiated in WV answered by the WV 988 call center

Second-year target/outcome measurement: at least 90% of 988 calls, chats, and texts initiated in WV answered by the WV 988 call center

Data Source:

Vibrant 988 Broad Metrics monthly reports for West Virginia

Description of Data:

Monthly data report from Vibrant Emotional Health that includes answer rates, number of abandoned calls, answer speed

Data issues/caveats that affect outcome measures:

WV 988 center internal answer-rate data varies at times from Vibrant data because of calls to the 988 termination line that are not routed nationally. The center will be piloting the Uniform Platform for chat and text this fiscal year, which may affect chat and text data.

Indicator #: 2

Indicator: Number of 911 Centers/Public Safety Answering Points (PSAPs) with workflow protocols with WV 988 Center

Baseline Measurement: Fewer than 10 of 51 PSAPs (19.6%) with 988-911 workflow protocols in place

First-year target/outcome measurement: At least 20 of 51 PSAPs (39.2%) with 988-911 workflow protocols in place

Second-year target/outcome measurement: At least 30 of 51 PSAPs (58.8%) with 988-911 workflow protocols in place

Data Source:

Workflow protocols or memoranda of understanding between the WV 988 Center and PSAPs

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Number of Crisis Intervention Teams (CIT)

Baseline Measurement: At least four active CIT

First-year target/outcome measurement: At least six active CIT

Second-year target/outcome measurement: At least 10 active CIT

Data Source:

Completion of CIT training by law enforcement, first responders and follow-up with detachments and community partners

Description of Data:

Training data, survey of training participants and community partners

Data issues/caveats that affect outcome measures:

Indicator #: 4

Indicator: Development of NAMI state agency and affiliate chapters

Baseline Measurement: one local NAMI chapter (NAMI of Greater Wheeling)

First-year target/outcome measurement: Work with national NAMI and NAMI of Greater Wheeling to develop a state NAMI agency

Second-year target/outcome measurement: Implement state NAMI agency and at least two affiliate chapters

Data Source:

National NAMI agreements with state or local affiliate NAMI chapters

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 5

Indicator: Development of a State Behavioral Health Disaster Plan

Baseline Measurement: no state behavioral health disaster plan

First-year target/outcome measurement: Convene stakeholders and develop plan

Second-year target/outcome measurement: Formalized state behavioral health disaster plan

Data Source:

State behavioral health disaster plan document; meetings or trainings related to the developed plan

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 6

Priority Area: Persons Who Inject Drugs

Priority Type: SUP, SUT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

1. Increase the number of harm reduction programs in WV.
2. Increase the number of Naloxone kits distributed throughout the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SOR funded harm reduction programs.

Baseline Measurement: 9

First-year target/outcome measurement: Increase by 1

Second-year target/outcome measurement: Increase by 2

Data Source:

SOR data

Description of Data:

SOR program and financial reports.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of Naloxone kits distributed

Baseline Measurement: 94,000

First-year target/outcome measurement: Increase by 10%

Second-year target/outcome measurement: Increase by 10%

Data Source:

BBH, University of Charleston

Description of Data:

Narcan Direct data system, University of Charleston distribution reports

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: Recovery Services

Priority Type: SUR

Population(s): PWWDC, PP, PWID, Other

Goal of the priority area:

Support recovery services so that individuals with SUD can improve their health and wellness, live self directed lives, and strive to reach their full potential.

Strategies to attain the goal:

1. Increase the number of WV Alliance of Recovery Residences (WVARR) certified recovery residences.
2. Increase the number of certified PRSS.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of WVARR certified recovery residences.

Baseline Measurement: 110

First-year target/outcome measurement: Increase by 10%

Second-year target/outcome measurement: Increase by 10%

Data Source:

WVARR, BBH

Description of Data:

WVARR certification reports

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Increase the number of certified PRSS.

Baseline Measurement: 650

First-year target/outcome measurement: Increase by 10%

Second-year target/outcome measurement: Increase by 10%

Data Source:

BMS, BBH

Description of Data:

BMS reports

Data issues/caveats that affect outcome measures:

None

Priority #: 8

Priority Area: Persons with or at risk for tuberculosis (TB) who are receiving SUD treatment services.

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Improve health outcomes for persons with or at risk of TB who are receiving SUD treatment services.

Strategies to attain the goal:

1. Include specific requirements for TB screening, referrals, and active monitoring are included in all BBH SUD service provider grant agreements.

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 SOWs outline specific requirements in each SUD grant agreement mandating TB compliance. BBH requires providers to use a TB risk assessment for individuals using SUD services.

Data issues/caveats that affect outcome measures:

None

Priority #: 9

Priority Area: Primary Substance Use Prevention for All Ages

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Reduce substance misuse or use disorder statewide for individuals of all ages, including higher risk populations, through a trained prevention state, regional, and community network that uses the strategic prevention framework (SPF) to select effective strategies and evidence-based practices/programs to meet the needs of certain geographic areas and populations of focus

Strategies to attain the goal:

1. Maintain regional Prevention Lead Organizations (PLOs), which will provide support, training, and technical assistance to local level county coalitions. Read more about the prevention network at https://helpandhopewv.org/prevention-works.html
2. Ensure the implementation of effective and evidence-based prevention strategies, programs, and practices through prevention training, including Prevention Ethics, Strategic Prevention Framework (SPF), and SPF Application for Prevention Success
Training or SAPST, as well as selection of evidence-based programs using the SPF.
3. Involve youth and older adults in prevention coalitions and planning to help plan and inform prevention activities focused on youth and older populations.
4. Obtain available data, including through the State Epidemiological Outcomes Workgroup (SEOW) to inform the needs and overall SPF process to focus prevention efforts for all populations.
5. Support youth-led peer support and leadership initiatives, such as Youth MOVE or SADD, to promote protective factors and positive alternatives to substance use.
6. Collaborate with schools, juvenile residential facilities, and other initiatives (e.g., Expanded School Mental Health, Collegiate Initiative to Address Substance Use, and the WV Department of Education's Project AWARE) to implement effective
prevention strategies/programs with schools, higher education institutions, and community partners.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of prevention professional trained in Prevention Ethics and SAPST
Baseline Measurement:	50

First-year target/outcome measurement: 100

Second-year target/outcome measurement: 200

Data Source:

BBH Prevention Lead Organizations

Description of Data:

All BBH grantees must report on programmatic activities and client level information on individuals served on a monthly 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: 50,000 direct prevention materials and reach 50 organizations

First-year target/outcome measurement: 55,000 direct prevention materials and reach out to 55 community organziations

Second-year target/outcome measurement: Distribute 105,000 direct prevention materials and reach out to 105 community organizations

Data Source:

BBH Grantee Reporting

Description of Data:

All BBH grantees must repot on programmatic activities and groups served

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of meetings focuses on SPF process and prevention efforts for older adults

Baseline Measurement: 5 meetings with a focus on adults

First-year target/outcome measurement: A minimum of 6 meetings with a focus on older adults

Second-year target/outcome measurement: A minimum of 16 meetings with a focus on older adults

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 page views and/or social media campaigns

First-year target/outcome measurement: Baseline Increase page views and social media campaigns by 10%

Second-year target/outcome measurement: Increase page views and social media campaigns by an additional 10%

Data Source:

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

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	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 (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$12,952,347.00		$1,500,000.00	$17,682,726.00	$22,202,357.00	$0.00	$0.00		$140,400.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$610,000.00			$1,950,000.00	$2,400,000.00					
b. Recovery Support Services	$960,000.00		$0.00	$10,000,000.00	$11,000,000.00					
c. All Other	$11,382,347.00		$1,500,000.00	$5,732,726.00	$8,802,357.00				$140,400.00	
2. Primary Prevention[d]	$3,453,959.00		$0.00	$80,520,000.00	$4,400,000.00	$0.00	$0.00		$1,204,912.00	$0.00
a. Substance Use Primary Prevention	$3,453,959.00			$80,520,000.00	$4,400,000.00				$1,204,912.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$863,490.00				$608,000.00					
12. Total	**$17,269,796.00**	**$0.00**	**$1,500,000.00**	**$98,202,726.00**	**$27,210,357.00**	**$0.00**	**$0.00**	**$0.00**	**$1,345,312.00**	**$968,304.00**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

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

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Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	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 (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$1,017,899.00						$105,598.00		$777,876.00	$65,681.00
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$8,143,191.00	$32,124,168.00	$15,667,016.00	$141,310,276.00			$486,023.00		$175,000.00	
10. Crisis Services (5 percent set-aside)[f]		$508,949.00			$6,234,704.00			$71,428.00		$5,660,000.00	$375,000.00
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$508,949.00			$612,385.00						
12. Total	**$0.00**	**$10,178,988.00**	**$32,124,168.00**	**$15,667,016.00**	**$148,157,365.00**	**$0.00**	**$0.00**	**$663,049.00**	**$0.00**	**$6,612,876.00**	**$440,681.00**

[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" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[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" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

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To date the state has spent $3,772,029 of the COVID-19 relief funds. Of that total, $394,402 was spent for first episode psychosis and $1,010,06 was spent for children's crisis services.

To date the state has spent $792,833.44 of the ARP funding.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	105	9
2. Women with Dependent Children	3,091	612
3. Individuals with a co-occurring M/SUD	5,674	1,542
4. Persons who inject drugs	2,168	410
5. Persons experiencing homelessness	629	163

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

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Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$5,996,173.00	$140,400.00	
2 . Substance Use Primary Prevention	$1,726,980.00	$1,204,912.00	$968,304.00
3 . Early Intervention Services for HIV[4]	$0.00		
4 . Tuberculosis Services	$0.00		
5 . Recovery Support Services[5]	$480,000.00		
6 . Administration (SSA Level Only)	$431,745.00		
7. Total	**$8,634,898.00**	**$1,345,312.00**	**$968,304.00**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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 FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data 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 SUPTRS BG 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$167,698		
	Selected			
	Indicated			
	Unspecified			
	Total	**$167,698**	**$0**	**$0**
2. Education	Universal	$251,547		
	Selected	$83,849		
	Indicated	$83,849		
	Unspecified			
	Total	**$419,245**	**$0**	**$0**
3. Alternatives	Universal	$125,773		
	Selected	$125,773		
	Indicated			
	Unspecified			
	Total	**$251,546**	**$0**	**$0**
4. Problem Identification and Referral	Universal	$83,849		
	Selected			
	Indicated			
	Unspecified			
	Total	**$83,849**	**$0**	**$0**
	Universal	$335,396		

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$335,396**	**$0**	**$0**
6. Environmental	Universal	$419,246		
	Selected			
	Indicated			
	Unspecified			
	Total	**$419,246**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$50,000		
	Selected			
	Indicated			
	Unspecified			
	Total	**$50,000**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,726,980**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$8,634,898**	**$1,345,312**	**$968,304**
Planned Primary Prevention Percentage		**20.00%**	**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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$1,433,509		
Universal Indirect			
Selected	$209,622		
Indicated	$83,849		
Column Total	**$1,726,980**	**$0**	**$0**
Total SUPTRS BG Award[3]	**$8,634,898**	**$1,345,312**	**$968,304**
Planned Primary Prevention Percentage	**20.00%**	**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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☐	☐
Heroin	☑	☐	☐
Inhalants	☑	☐	☐
Methamphetamine	☑	☐	☐
Fentanyl	☑	☐	☐
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☑	☑
Rural	☑	☑	☑

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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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Footnotes:

Planning Tables

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

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation					
7. Training and Education	$163,008.00			$140,400.00	
8. Total	**$163,008.00**	**$0.00**	**$0.00**	**$140,400.00**	**$0.00**

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

[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 expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: 07/01/2023 MHBG Planning Period End Date: 06/30/2025

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems								
2. Infrastructure Support	$190,000.00		$900,000.00	$275,000.00	$142,500.00			$275,000.00
3. Partnerships, community outreach, and needs assessment	$730,657.00			$65,681.00	$547,993.00			$65,681.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$55,500.00				$41,625.00			
5. Quality Assurance and Improvement								
6. Research and Evaluation								
7. Training and Education				$100,000.00				$100,000.00
8. Total	**$976,157.00**	**$0.00**	**$900,000.00**	**$440,681.00**	**$732,118.00**	**$0.00**	**$0.00**	**$440,681.00**

[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" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[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 captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

West Virginia is making significant progress in integration of mental health into community health with its system of comprehensive behavioral health centers. SAMHSA-grant funded start-ups of Certified Community Behavioral Health Clinics in West Virginia include Prestera, Westbrook, Seneca, FMRS, and Southern Highlands.

The main focus of West Virginia's integration of mental health into community health is via the CCBHC movement. 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 also was successful in its application for a SAMHSA CCBHC Planning Grant in early 2023.
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.

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.

While CCBHCs will increase access to services for all of the sub-populations listed, a few examples are as follows. a) Adults with serious mental illness will be a focus via the Assertive Community Treatment team requirement. Five of West Virginia's six regions have active ACT teams currently; building capacity for the sixth region's ACT team has been a long-time focus. Staff have engaged in capacity-building efforts with several organizations in the state's eastern panhandle and have begun focusing on one organization in particular that is working on CCBHC certification. b) Pregnant women with SUD are a focus of the MOM model program in West Virginia, with outreach and engagement shared between the MOM model and Drug Free Mom and Babies for individuals with SUD that does not include opioid use disorder. The MOM Model focuses on providing perinatal care as well as SUD care for the parent-baby dyad. f) Among its efforts, WV participates in the SAMHSA Region III Learning Collaborative. In the State's correctional system, WV in 2022 utilizes the same medical and behavioral health vendor, which supports integrated health for persons with SUD in the justice system.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

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.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

At least 1 in 4 West Virginians receives primary care from a Federally Qualified Health Center or Look Alike Center. These centers integrate medical, behavioral, dental, pharmacy, and other health services within one site. There are 193 behavioral health service locations throughout the FQHC system in West Virginia, of which 24 sites offer Medication for Addiction Treatment. In 2022, the Health Resources and Services Administration (HRSA) provided more than $16M in behavioral health awards focused on integration of behavioral health into primary care in the state. Examples of programs include the Behavioral Health Workforce Education and Training Program (BHWET) and Pediatric Mental Health Care Access. In 2021, 28 WV Health Centers upported more than 225 full-time mental health providers and 49 SUD providers, serving 35,814 patients who received mental health services and 3,384 patients who received SUD services. In addition, in 2022 West Virginia received the SAMHSA Integration of Primary and Behavioral Health Care (PIPBHC) notice of award from SAMHSA; implementation is underway in partnership with three of the state's community behavioral health centers.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Adults with Serious Mental Illness (SMI) benefit from the care coordination that is part of West Virginia's 1115 SUD Medicaid Waiver, currently under review for renewal through 2027. Targeted Case Management is a service for individuals with SUD and/or SMI that is included under the State's current Medicaid State Plan Benefits. West Virginia's managed care programs are Mountain Health Trust and Mountain Health Promise. Mountain Health Promise covers mandatory enrollment for children with serious emotional disorders waiver members under the 1115 SUD Waiver. WV Health Homes include the Behavioral Health Health Home, available to individuals who have bipolar disorder and have or are at risk of having hepatitis B or C.

Targeted Case Management (TCM) is the coordination of services to ensure that eligible Medicaid members have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying a member's problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist members and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid member are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs. Targeted Case Management is not a direct service. TCM is composed of a number of federally designated components: Needs assessment and Reassessment; Development and Revision of TCM Service Plan; Referral and Related Activities; and Monitoring and Follow-up.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Mental health screenings, and subsequent referrals to the Assessment Pathway for further evaluation and connection to services, conducted as part of early intervention via multiple avenues including Youth Services (YS), Child Protective Services (CPS), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthCheck wellness visits, Division of Corrections and Rehabilitation-Bureau of Juvenile Services (BJS), and Probation Services, have increased since 2019. Screening via EPSDT/HealthCheck wellness visits continues to be an area of focus with establishment of an EPSDT/HealthCheck wellness visit Performance Improvement Project (PIP) team to review and address low screening rates.
The implementation of the Children's Crisis and Referral Line (CCRL) in October 2020 created a resource for children and families in crisis to access needed support and created an avenue for anyone seeking information on available services and supports. The CCRL is available 24 hours per day, 7 days per week. Calls to the CCRL are answered within 14 seconds, on average. In October 2021, DHHR implemented the Assessment Pathway, creating a "no wrong door" approach to streamline and facilitate access to assessment and connection to home and community-based services (HCBS) for children and families. As part of this process, children and families are assessed for and given the option of applying for the Children with Serious Emotional Disorder (CSED) Waiver, which offers treatment and supportive services in the home and community-based setting and includes Wraparound Facilitation services for children with SED. In early 2023, the five-year CSED Waiver renewal was approved, extending the waiver through January 2028. These significant enhancements to the children's mental health system remain in the implementation phase and continue to be monitored by DHHR through continuous quality improvement (CQI) efforts.

In order to improve Screening, Brief Intervention and Referral to Treatment (SBIRT) in the adult population, the WV Bureau for Behavioral Health released an Announcement of Funding Availability with the intent to add eight new SBIRT sites across the state in the following settings: school based mental health, primary care practices, Federally Qualified Health Centers (FQHC), hospitals, criminal justice settings, veteran services centers, and colleges/universities, that had not previously offered BBH-funded SBIRT services.

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

NA

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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[5]. 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[6]. 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, LGBTQI+ 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

[6] **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?

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?

For 3 years, 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 also supported BBH in establishing a Statewide Training Advisory Council, which is composed of a variety of stakeholders and provides 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.

West Virginia was fortunate to receive 2 Transformation Transfer Initiative (TTI) awards from the National Association of State Mental Health Program Directors (NASMHPD) to expand and improve 988 and mobile crisis service teams for adults with serious mental illness (SMI) in our state. This builds on a previous TTI WV received that focused on children's crisis services and connects a continuum of crisis care that is responsive to needs of all ages.

The Workforce TTI initiative focuses on entry-level workforce recruitment, retention, and training for 988 crisis counselors and other staff around the state who work with adults with SMI.
The Building Crisis Services that Serve Under-Resourced Minority Communities initiative is in the process of engaging BIPOC and LGBTQ+ focused organizations within WV, existing state government champions in relevant roles, and national SMEs to pool these 3 groups subject matter expertise to engage with WV's 988 vendor, BBH's pilot Behavioral Health Workforce Training Center, and WV's mobile crisis providers. It is anticipated that these groups will review outreach and engagement plans and materials, such as call scripts, marketing materials, and protocols for recommendations on how to make outreach and engagement of WV's crisis system and 988 more culturally appropriate.

BBH has worked with its regional Central East Addiction, Mental Health, and Prevention Training Center (ATTC/MTTC/PTTC), the Danya Institute, to coordinate Culturally and Linguistically Appropriate Services (CLAS) training; BBH anticipates the training to begin in fall 2023 or early spring 2024.

While the State requires all providers to follow CLAS Standards, has funded and piloted the WV Behavioral Health Workforce and Health Equity Training Center, and is coordinating with the Danya Institute on CLAS training, the State does not currently have a written workforce plan; however, preparing a concrete workforce plan is a goal for 2024.

Please indicate areas of technical assistance needed related to this section

NA

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Footnotes:

Revision request note: Question 4 was inadvertently checked no. This has been changed to yes which is the State's correct intended response.

Revision request note 2: Clearing this revision per an email with Angie Walker on 11.7.2023. Question 11 referenced in this revision is intended for another form and has been addressed therein.

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. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] 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)**[8] 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. Each 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.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

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, ACO, 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:

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.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care	7

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
730000	730000

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

We currently are using the coordinated specialty care model and all services under this model except supportive employment and supportive education are billable under Medicaid. The provider agency will direct bill Medicaid at the time of service completion.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Currently we have 7 programs Our model emulates the Coordinated Specialty Care Model. 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.

5. Does the state monitor fidelity of the chosen EBP(s)?

○ Yes ◉ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

◉ Yes ○ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

These programs facilitate early identification and treatment of psychosis in a collaborative, recovery-oriented approach involving individuals experiencing FEP, and therefore reduce the disruption to the young person's functioning and psychosocial development.

In October 2020 we launched the Children's Crisis Referral Line(CCRL) which is a system point of entry for all children's services. CCRL received referrals and requests for crisis services via phone, texts or chat. This line is designed for families to call and be able to get referrals to system services including FEP. The individuals are provided the information and the respective agency is also notified that a referral has been made, to what program and the name and contact info of the referral.

We have also added screening and assessment for Clinical High Risk individuals and all agencies will receive training in SIPS in August of 2023.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

Clinical High Risk for Psychosis assessments and screenings which will seek to provide community awareness and education and the early symptoms of psychosis and will also help to identify, prevent, intervene, and/or lessen the impact of psychotic disorders in youth and young adults.
First Episode Psychosis services which will include the diagnosis and treatment of early onset psychosis using the CSC model.

We added screening and assessments for CHR-P so that we can connect to appropriate interventions when necessary to prevent the onset of psychosis

In 9/21 our teams began using the The First Episode Psychosis Services Fidelity Scale (FEPS-FS) as a self reporting tool. From 9/21-10/22 all teams self reported information and began a second year in 10/22 which will end on 09/23. In January of 2023, the teams took the data that had been collected and identified 5 common areas across the state to target for improvement. At the end of 9/23 they will have 5 months of data from these 5 areas. During FY 2024 & 25 they will continue to collect this data and using a continuous quality improvement process will make changes as needed to improve statewide services with the goal of reducing the areas from 5 common areas to 2 or 3 common areas at the end of 10/25.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Eligibility criteria includes:
14-30 years of age and their families who are experiencing FEP

Residents of WV
DSM-5 diagnostic criteria: 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

Rules out:
substance/medication-induced psychotic disorder
psychotic disorder due to another medical condition
bipolar disorder with psychosis
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

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

Using the national standard of .03% our incidence is about 533 individuals.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

In August 2023, BBH funded training on the Structured Interview for Psychosis-Risk Syndromes (SIPS) for the seven Quiet Minds WV (FEP/ESMI) providers and other providers to aid in early screening and diagnosis of FEP. Additional outreach efforts include BBH staff speaking engagements and Quiet Minds WV outreach materials, including a video series (https://quietmindswv.com/category/blog-resources/videos/), brochure (https://quietmindswv.com/wp-content/uploads/2019/09/brochure.jpg), and other resources. Using its MHBG BSCA supplement, the state is also starting workgroup to promote coordination among FEP providers, Medicaid, and Public Health on awareness and screenings-- including Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-- to identify, prevent, intervene, or lessen the impact of psychotic disorders or serious emotional disturbances (SEDs) in youth and young adults.

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

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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.

N/A

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 and require 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.

See for example: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CFCM/Pages/Resources.aspx The WV Bureau of Senior Services provides in person and on line training for Aged and Disabled Waiver funded providers on PCP:

http://www.wvseniorservices.gov/HelpatHome/MedicaidAgedandDisabledWaiver/TrainingPresentationsforADWManualEff12115/tabid/181/Default.aspx

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). Over the past 15 years the 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.

For example, PBS provides person-centered planning to individuals receiving services as well as agencies working with individuals with disabilities. The WVU Center of Excellence describes person-centered planning as "a fun interactive eight-step process that focuses on the individual's dream and what they want for their future. It helps participants develop goals and create an action plan for achieving their goals and increase their quality of life. PBS staff use tools such as Making Action Plans (MAPs) and Planning Alternative Tomorrows with Hope (PATHs) to graphically facilitate person-centered planning with the participant and their team. Person-centered planning generally occurs in the person's home or location of the focus person's choosing with a support team of their choosing. The MAPs process takes about 1.5 - 2 hours to complete and the PATHs generally takes 2-3 hours to complete. These can be modified for individual needs."

In addition, as noted elsewhere in the application BBH and BMS are working together to help Certified Community Behavioral Health Clinics get off the ground in West Virginia and the national standards for these programs require that CCBHCs to offer their services "in a person-centered and family-centered manner."

As SAMHSA notes on its website https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/care-coordination/person-family-centered the CCBHC criteria also include the following requirements related to person- and family-

centered care and peer-and family-support services:

Program Requirement 1: Staffing
• 1.b.2 The CCBHC staffing plan must include peer staff and the state should consider, along with other disciplines, requiring peer specialists/recovery coaches and staff trained to provide family support.
• 1.c.1 Staff training must address person-centered and family-centered care. At orientation and annually thereafter, the CCBHC provides training about, among other things, the roles of families and peers.

• 2.b.1 New consumers must receive a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days of the first request for services.
Program Requirement 3: Care Coordination

• 3.d.1 All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of Section 2402(a) of the Affordable Care Act.
Program Requirement 4: Scope of Services

• 4.b.2. Person-centered and family-centered care includes care which recognizes the particular cultural and other needs of the individual.
• 4.e.1. The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning.
• 4.j.1 The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. States should specify the scope of peer and family services they will require based upon the needs of the population served. Peer services that might be considered include peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services. Potential family/caregiver support services that might be considered include family/caregiver psycho-education, parent training, and family-to-family/caregiver support services.

Finally, BBH models the person-centered approach in all of its grant documents, guidance, reporting and grant training that puts people first, emphasizing the person first rather than their disability, which puts the focus on getting to know the person, not just their illness.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

The use of Psychiatric Advance Directives is promoted through our Bureau funded Peer Centers and Peer Coaches in addition to being promoted through advocacy programs such as the West Virginia Leadership Academy.

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

N/A

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:

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?

BBH's program integrity efforts are applied to all federal grant and contract awards. This includes administrative oversight of programmatic evaluation, financial review, and compliance tests of allowable activities through reporting and audits of grantee records. BBH conveys the appropriate use of block grant funds by providing specific citations, requirements and guidance throughout the grant agreement, along with ongoing technical assistance and training through the process of administering and monitoring grant activities, which includes standardized reviews of budget and expenditure reports, programmatic service activities, client-level performance data, and audits. Fiscal and programmatic reviews, along with compliance tests, are all part of a systematic monitoring approach. Block grant awards include monitoring efforts to test and ensure compliance with federal block grant requirements and eligibility standards.

Please indicate areas of technical assistance needed related to this section

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DHHR Policy 3801 - Award and Monitoring of Subrecipient Grants is available on request.

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?

   N/A

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

   N/A

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Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

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)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ 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)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☑ Rural communities
- **i)** ☐ Others (please list)

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

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☑ Monitoring the Future
- **f)** ☑ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

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

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

  The Bureau for Behavioral Health Clearinghouse utilizes a thorough review process to ensure each program/practice submitted to the Clearinghouse receives a rating commensurate with standards established by the Clearinghouse. After receiving specialized training, Subject Matter Experts (SMEs) and Graduate Assistants (GAs) work together to review existing research and determine ratings for those programs and practices reviewed. GAs utilize academic electronic libraries, program websites and other clearinghouses to obtain pertinent research related to the program/practice. GAs prioritize research conducted in the last 5-10 years. In cases where it seems necessary or appropriate, GAs receive approval from SMEs to utilize older research. Randomized Controlled Trials (RCTs) and meta-analyses are prioritized over other research, but quasi-experimental, pre-test/post-test, retrospective chart review and case studies can be reviewed if RCTs and meta-analyses are unavailable. GAs complete and send summaries of each research article reviewed to the SMEs, and then together they assign a rating for the program/practice. The ratings provide guidance but not definitive judgments as to whether a program should be implemented in a specific community or circumstance. The ratings are based on the available evidence at the time the program was reviewed. The Bureau for Behavioral Health Clearinghouse is located here https://clearinghouse.helpandhopewv.org/.
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  WV requires the implementation of SAMHSA's Strategic Prevention Framework (SPF) for all primary prevention. The first step of the SPF is Assessment which identifies populations vulnerable to behavioral health disparities, the specific disparities experienced by these populations and where they are located. this process includes the assessing existing behavioral health disparities and gaps at the individual and social level
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  During the assessment process of the SPF, preventionist begin making decisions based on a clear understanding of the local level prevention needs. it is at this initial step of the SPF, relationship building begins with those who collect /maintain data and stakeholders who have important roles of supporting and sustaining local level prevention efforts.
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

WV Certification Board of Addiction & Prevention Professionals (WVCBAPP) currently is the sole credentialing body for professionals working in the substance use prevention field. WVCBAPP currently credentials Level 1 and 2 Prevention Specialists. One of the states regional prevention lead organization has a prevention 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. Read more at https://www.wvcbapp.org/.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

All grantees have the same requirements within their statements of work that outlines to them as the mandatory trainings they must meet annually for their prevention workforce. BBH created Help and Hope WV as a resource for prevention professionals; see https://helpandhopewv.org/, including the prevention section https://helpandhopewv.org/prevention-works.html. Regular training and TA is offered through various state partners and the Region 3 PTTC. Examples of state training are available at https://www.marshall.edu/coefr/education-and-training/.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) 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

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The SPF Capacity step includes the development of new partnerships to expand resources and improve readiness to address behavioral health disparities that are identified through the assessment process. Preventionist utilize the CLAS standards to increase access to culturally competent prevention services. This step also works to engage populations

experiencing behavioral health disparities in community prevention planning efforts.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The SPF contributes to sustainability through intentional capacity building at all levels to ensure that successful programs are sustained within a larger community context and therefore not vulnerable to local budgetary fluctuations. Building capacity also involves promoting public awareness and support for evidence-based prevention and engaging partners and cultivating champions who are vital to the success and sustainability of local level prevention efforts. WV and regional prevention lead organizations work with local level coalitions to help identify and cultivate prevention champions to help sustain prevention efforts at the local and regional levels.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

Planning

1. Does your state have a strategic plan that addresses substance use primary 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 use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) 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 SUPTRS BG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component (i.e., National CLAS Standards)
- **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 SUPTRS BG 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 SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) 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 stakeolders.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

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

The Bureau for Behavioral Health Clearinghouse utilizes a thorough review process to ensure each program/practice submitted to the Clearinghouse receives a rating commensurate with standards established by the Clearinghouse. After receiving specialized training, Subject Matter Experts (SMEs) and Graduate Assistants (GAs) work together to review existing research and determine ratings for those programs and practices reviewed. GAs utilize academic electronic libraries, program websites and other clearinghouses to obtain pertinent research related to the program/practice. GAs prioritize research conducted in the last 5-10 years. In cases where it seems necessary or appropriate, GAs receive approval from SMEs to utilize older research. Randomized Controlled Trials (RCTs) and meta-analyses are prioritized over other research, but quasi-experimental, pre-test/post-test, retrospective chart review and case studies can be reviewed if RCTs and meta-analyses are unavailable. GAs complete and send summaries of each research article reviewed to the SMEs, and then together they assign a rating for the program/practice. The ratings provide guidance but not definitive judgments as to whether a program should be implemented in a specific community or circumstance. The ratings are based on the available evidence at the time the program was reviewed. The Bureau for Behavioral Health Clearinghouse is located here https://clearinghouse.helpandhopewv.org/.

8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

National CLAS Standards into the Planning step by engaging populations experiencing behavioral health disparities in community prevention efforts, culturally adapting/tailoring evidence-based programs to meet the needs addressed, and providing training and technical assistance to prevention providers on strategies to address behavioral health disparities. WV has currently been holding meeting with stakeholders serving LGBTQ+ and BIPOC populations for input and prevention service and outreach to meet the needs of these populations throughout WV.

b) If no, please explain in the box below.

n/a

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

In order to ensure sustainability in the planning step of the SPF, providers consider the level to which prevention interventions fit with the local needs, capacity, and culture of the population. This helps to ensure more success and sustainability of the population served. Community Readiness Assessments encompass this and are completed prior to the implementation of prevention interventions.

b) If no, please explain in the box below.

n/a

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one 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:

Students Against Destructive Decisions (SADD), Loved Ones, Youth Coalitions, Kidding Around Yoga, Mindfulness, Drug Free All Stars, Afterschool Programs, 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, 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 SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) 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.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

WV ensures that National CLAS Standards are integrated into the implementation step of the SPF by culturally adapting/tailoring evidence-based programs as needed for disparate populations, tracking and adaptions made to evidence-based programs to enhance cultural relevance, and involving populations experiencing behavioral health disparities throughout the implementation process

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

WV and the regional prevention lead organizations work closely with community partners to deliver evidence-based programs and practices as intended, closely monitoring and improving service delivery, and celebrating any successes along the way. Preventionists continue during the SPF implementation step to weave prevention into the fabric of the community to build sustainability

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

Evaluation

1. Does your state have an evaluation plan for substance use primary 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 SUPTRS BG 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 SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use

c) ☑ Binge use

d) ☑ Perception of harm

e) ☑ Disapproval of use

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

g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The evaluation step of the SPF integrates National CLAS Standards in WV by tracking adaptions made to evidence-based programs to enhance cultural relevance and by allocating additional evaluation resources for these adaptions.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

WV utilizes process and outcome evaluation so that communities can make important mid-course corrections to prevention efforts as needed, identify practices that are worth expanding and/or sustaining, and examining ongoing plans toward the sustainability of the programs/practices that work. Through sharing of evaluation findings, support to expand and sustain prevention efforts are supported.

b) If no, please explain in the box below.

Footnotes:

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.

BBH funds a variety of community based mental health programs to serve individuals with mental illness in the community. As part of the Hartley decree, BBH funds the follow programs statewide:

Community Engagement (20 programs)
Day Programs - Day Support (11 programs)
Group Homes (18 locations)
Forensic Group Homes (7 locations with 2 in development)
Permanent Supportive Housing (6 locations)
Co-Occurring Aftercare programs (2 locations)

Furthermore, all 13 CBHC's receive continuum enhancement funds and indigent care funds to provide essential behavioral health services statewide. Telehealth is funded through West Virginia University's Telepsychiatry program.

As referenced throughout this application, West Virginia is in the process for implementing the CCBHC model statewide.

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. The mechanism of coordination varies by each provider's capacity with some providing services directly while others coordinating services through referral and resource coordination.

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 also with 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 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 funds Adult Mobile Crisis and Stabilization Teams as part of our broader Adult Crisis Response Program which includes support for West Virginia's 988 initiative.

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

N/A

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	76,882	11,532
2.Children with SED	24,770	37,716

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. BBH uses this data to complete annual reporting as required by SAMHSA. This data is then used for planning purposes in the following ways:

1) Bureau internal strategic planning.
2) Annual program and outcome evaluation and planning.
3) When reviewing funding decisions based upon the annual grant cycle.

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

N/A

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

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 IDEA	◉ 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 systems	◉ Yes	○ No

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

N/A

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Narratve Question

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. **See SAMHSA's Rural Behavioral Health page for program resources**

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. CBHC's maintain offices in each of WV's 55 counties. Mobile services are provided to reach particularly isolated mountain areas. There is an active transportation workgroup that meets to coordinate transportation resources for consumers. Rural outreach and targeted services is also a focus area for BBH's emerging CCBHC Initiative.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

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. The Statewide PATH Contact (SPC) is actively involved with MHBG Program planning.

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. **See SAMHSA's Resources for Older Adults webpage for resources.**

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 through the 13 Comprehensive Behavioral Health Centers. BBH also promotes best practices for services to older adults by dedicating staff time and resources to offering trainings and presentations.

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

N/A

Narratve Question

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.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. 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 coordinates with 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 full time 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.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

BBH funds the West Virginia University (WVU) Telepsychiatry Initiative to provide telehealth services to CBHC locations across the states. Services include psychiatric diagnostic examinations, pharmacologic management examinations, and associated services. Adult and Child Psychiatric Services are also provided. Additionally, each provider has varying in house capacities to provide telehealth services, an initiative that began in earnest during COVID-19 and continues to expand.

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

N/A

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

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/residential)	◉ 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:

i)	Prioritized services for veterans?	◉ Yes ○ No
ii)	Adolescents?	◉ Yes ○ No
iii)	Older Adults?	◉ Yes ○ No

Criterion 2

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.

he Bureau for Behavioral Health provides funding, via grants, to a variety of organizations for the implementation and delivery of services to PWWDC. Each grantee agrees to a Statement of Work (SOW), and the SOW requires the grantee to deliver specific services while meeting certain requirements to achieve benchmarks in order to receive the funds. The grantee is required to provide progress reporting on the specific services provided to PWWDC. BBH program staff review and monitor progress reports to track overall programmatic progress. BBH has a Compliance Division, and along with the Director, Women's Health Services/PPW Program Manager, they share responsibility for ensuring that grantee reporting is being submitted and reviewed. Staff may perform desk reviews and/or site visits to address grant compliance. If the grantee does not meet reporting and progress requirements or there are indications that services are not being provided as agreed, the compliance issues will be addressed with the grantee, and a corrective action plan will be developed to remedy the issues. Technical assistance may also be offered to help the PWWDC organization reach an appropriate level of service to meet the needs of its clients. If compliance issues are not resolved, funding may be delayed or discontinued.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	● Yes	○ No
b)	14-120 day performance requirement with provision of interim services	● Yes	○ No
c)	Outreach activities	● Yes	○ No
d)	Syringe services programs, if applicable	○ Yes	● No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	● Yes	○ No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	○ Yes	● No
b)	Automatic reminder system associated with 14-120 day performance requirement	○ Yes	● No
c)	Use of peer recovery supports to maintain contact and support	● Yes	○ No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	● Yes	○ No

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.

The Bureau for Behavioral Health provides funding, via grants, to a variety of organizations for the implementation and delivery of services. Each grantee agrees to a Statement of Work (SOW), and the SOW requires the grantee to deliver specific services while meeting certain requirements to achieve benchmarks in order to receive the funds. The grantee is required to provide progress reporting on the specific services provided to the identified population. BBH program staff review and monitor progress reports to track overall programmatic progress. BBH has a Compliance Division, and along with the assigned Program Manager, they share responsibility for ensuring that grantee reporting is being submitted and reviewed. Staff may perform desk reviews and/or site visits to address grant compliance. If the grantee does not meet reporting and progress requirements or there are indications that services are not being provided as agreed, the compliance issues will be addressed with the grantee, and a corrective action plan will be developed to remedy the issues. Technical assistance may also be offered to help the organization reach an appropriate level of service to meet the needs of its clients. If compliance issues are not resolved, funding may be delayed or discontinued.

Tuberculosis (TB)

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? ● Yes ○ No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	● Yes	○ No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	● Yes	○ No
c)	Established co-located SUD professionals within FQHCs	● Yes	○ No

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.

The Bureau for Behavioral Health provides funding, via grants, to a variety of organizations for the implementation and delivery of services. Each grantee agrees to a Statement of Work (SOW), and the SOW requires the grantee to deliver specific services while meeting certain requirements to achieve benchmarks in order to receive the funds. The grantee is required to provide progress reporting on the specific services provided to the identified population. BBH program staff review and monitor progress reports to track overall programmatic progress. BBH has a Compliance Division, and along with the assigned Program Manager, they share

responsibility for ensuring that grantee reporting is being submitted and reviewed. Staff may perform desk reviews and/or site visits to address grant compliance. If the grantee does not meet reporting and progress requirements or there are indications that services are not being provided as agreed, the compliance issues will be addressed with the grantee, and a corrective action plan will be developed to remedy the issues. Technical assistance may also be offered to help the organization reach an appropriate level of service to meet the needs of its clients. If compliance issues are not resolved, funding may be delayed or discontinued.

Early Intervention Services for HIV (for "Designated States" Only)

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 such service delivery? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

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 SUPTRS BG 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 SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

All BBH grantees are notified that SUPTRS BG funds are not to be used to provide individuals with hypodermic needs or syringes.

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)** MOUD — (●) 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

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.

a) 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)

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

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

If the answer is No to any of the above, please explain the reason.

BBH does not feel that a waiver for any of the aforementioned items is needed at this time.

Footnotes:

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 2022-FFY 2023? ○ Yes ◉ No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *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 guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers?	◉ Yes	○ No
4.	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
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	◉ Yes	○ No
6.	Does the state use an evidence-based intervention to treat trauma?	◉ Yes	○ No

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

N/A

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

N/A

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☐ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☐ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☐ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☐ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☐ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☐ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☐ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☐ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☐ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☐ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☐ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☐ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☐ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☐ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☐ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. 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

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

N/A

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

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

BBH, along with several other government and community partners, have been planning Save A Life Day on September 14, 2023. Save A Life Day involves educating individuals on SUD, resources, naloxone, instruction on how to use naloxone, and provides naloxone to those who request it. While this day was previously celebrated statewide throughout WV, 2023 will see an expansion beyond state borders. This year Save A Life Day will involve approximately 130 counties throughout the entire Appalachian region.

Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

With leadership from the West Virginia (WV) Bureau for Behavioral Health (BBH), the state's mental health authority (SMHA), WV's crisis system continues to evolve and expand. BBH uses the five-percent set-aside of the SAMHSA Community Mental Health Services Block Grant (MHBG) is an essential investment in the behavioral health crisis continuum of care. In addition to the MHBG set-aside, BBH supports its crisis system with state, supplemental MHBG, and discretionary SAMHSA funding. The following is a description of the current system and planning for crisis system enhancement.

Current West Virginia Crisis System Core Services/Elements

A. Access to Local Crisis Call Centers (Someone to talk to)

BBH funds the state's single 988 Suicide & Crisis Lifeline center through First Choice Services, which has been operating the state's Lifeline since 2017, with the five-percent MHBG set-aside, supplemental MHBG funding, and a SAMHSA 988 Capacity grant. The WV 988 center answers in-state

calls, chats, and texts. First Choice Services is also a national 988 backup center and operates the following complementary state lines:
• 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 through the Children's Crisis and Referral Line;
• 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.

In addition to the First Choice Services center, West Virginia has the following local crisis numbers available:
• Thirteen regional Comprehensive Community Behavioral Health Centers (CBHCs) with 24/7 crisis lines for all ages.
• Regional Children's Mobile Crisis Response and Stabilization Teams take calls directly 24/7, in addition to calls they receive by warm transfer from the 24/7 Help4WV Children's Crisis and Referral Line.

B. Availability of Mobile Crisis Behavioral Health First Responder Services (Someone to respond)

For children and young adults up to age 21 and their families, seven regional Children's Mobile Crisis Response and Stabilization teams respond in all 55 counties. These teams are currently funded by state funding or Medicaid reimbursement through the WV Bureau for Medical Services (BMS) Children with Serious Emotional Disorder (CSED) waiver.
Six Adult Mobile Crisis Response teams are fully staffed and covering nearly half of WV's 55 counties through MHBG supplemental funding or direct SAMHSA funding to behavioral health agencies.

More children's and adult mobile crisis response services will emerge when BMS receives approval for a requested Medicaid state plan amendment (SPA) to reimburse mobile response services. The state is also developing criteria for Certified Community Behavioral Health Clinics, which will require these services for all ages.

West Virginia recently received funding from SAMHSA for the West Virginia Bureau for Behavioral Health Cooperative Agreement for Innovative Community Response Partnerships Program, which will create mobile crisis response teams to serve adults, children, and youth experiencing behavioral health crises in Kanawha County.

Crisis Intervention Teams (CIT) have been growing across the state with the first 988 and CIT Summit taking place in June 2023 for an audience largely of law enforcement leaders and behavioral health providers. The BBH 988/Crisis/Disaster Coordinator, WV 988 Planning Coalition, and WV 988 center continue to provide outreach to first responders and other partners 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.

In addition to mobile crisis response teams and CIT, quick response teams (QRTs) of behavioral health and other professionals contact adult individuals within 24-72 hours of an overdose to connect them with treatment and other services. Approximately half of the state's 55 counties are covered by a QRT.

Prevent Suicide WV, the American Foundation for Suicide Prevention WV chapter, and a dozen BBH and SAMHSA-funded regional youth and adult suicide intervention specialists 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. The WV Behavioral Health Workforce and Health Equity Training Center also provides several suicide prevention trainings, include Question, Persuade, Refer (QPR).

More than 100 community engagement specialists (CES) 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.

C. Availability and Utilization of Short-Term Crisis Receiving and Stabilization Centers (Place to go)

For children and young adults up to age 21 and their families, Children's Mobile Crisis Response and Stabilization teams offer short-term Crisis Respite Services. These services are currently funded by a SAMHSA Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (System of Care or SOC) grant.

Psychiatric Residential Treatment Facilities (PRTFs) with more than 100 beds for children and youths up to age 17 are also available through private insurance and Medicaid funding.

The state has more than 100 adult crisis stabilization unit (CSU) beds.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*

*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☑	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to: WV's 988 Suicide & Crisis Lifeline Center is established and answering the majority of in-state calls, chat, and texts. 844-HELP4WV provides a state-specific, 24/7 call, chat, and text option. The state continues to raise awareness of these helplines.
Someone to respond: Children's Mobile Crisis Response teams are statewide, and Adult Mobile Crisis Response teams cover about half of the state. Mobile Crisis services for individuals of all ages will continue to expand with a new Medicaid state plan amendment (SPA) for mobile response services and a planned SPA for Certified Behavioral Health Clinics (CCBHCs).
Safe place to go or to be: BBH has developed more outpatient options for children and adults and will have quicker access with the establishment of CCBHCs. BBH is working with the WV Bureau for Medical Services and Bureau for Social Services to open more intensive outpatient programs (IOPs), as well as a children's crisis center and additional children's crisis beds. The BBH Office of Adult Services released two funding opportunities for psychiatric urgent care centers. Due to no response to these funding opportunities, BBH is currently evaluating next steps while continuing to collaborate with WV Medicaid to encourage sustainable funding streams.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

West Virginia continues to develop its crisis system, starting with a strong "someone to talk to" component with WV 988 and 844-HELP4WV. This dovetails with the "someone to respond" piece of the crisis system, in which the state is developing workflow and follow-up protocols among 988, behavioral health providers, and law enforcement/911/public safety answering points/first responders. The "someone to respond" piece will continue to expand with Medicaid state plan amendments that will increase availability of mobile crisis response teams for children and adults. In accord with the National Guidelines, the state is also enhancing the availability of peer support, including additional youth peers at the Regional Youth Service Centers. The final frontier is a "safe place to be or go," which will be enhanced with CCBHCs and the planned children's crisis center.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Each year, BBH uses the 5% MHBG crisis set-aside for a $190,000 grant to First Choice Services, operator of the WV 988 Suicide & Crisis Lifeline center, which is a key part of the "someone to talk to" part of the crisis system. This funding helps the WV 988 center sustain its workforce, including supervisors and crisis counselors. The state also uses two SAMHSA 988 Capacity grants and supplemental MHBG funding to fund the WV 988 center at the approximate $1.8 million level recommended by a Vibrant cost projection.

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

None at this time. West Virginia has received extensive technical assistance (TA) from the University of Connecticut Innovations Center, including through the Mobile Response and Stabilization Services (MRSS) quality learning collaborative and System of Care TA. SAMHSA discretionary grants, including 988 Capacity and CCBHC planning, also provide TA. The state will also explore the resources of the new SAMHSA Crisis Systems Response Training and Technical Assistance Center (CSR-TTAC).

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining 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- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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, 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:

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) Use 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.

Recovery and recovery support services in WV for children with SED includes the availability of peer support in the community. This service is supported by the WV Bureau for Behavioral Health (BBH) and is and accessed through the Youth Peer Center in Huntington, WV and through the six Regional Youth Service Center (RYSC) locations throughout the state. The RYSCs provide recovery supports via Youth Service Coordinators and Family Service Coordinators. The Youth Service Coordinators directly support youth, and the Family Service Coordinators work directly with the parents and youth as a family unit. The resources and recovery support services provided support youth and families living successfully in the community.
Adults with SMI can access peer support through BBH funded Peer Centers. There are nine Peer Centers throughout WV, one of which is a National Association for Mental Illness (NAMI) affiliate. These Centers are one-stop, drop-in locations for individuals and families impacted by an SMI. Individuals may access peer support, education, resources, and assistance with obtaining resources for basic needs such as food and clothing. The Centers also provide access to resources for obtaining employment, housing, and other needs.
Telephonic (including text/chat) peer support is available 24/7 via First Choice Services, which is the organization that oversee the 988 call center, treatment resource line, and other resources.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Youth diagnosed with an SUD receive recovery supports including peer support through the Youth Drop-in Center (Huntington, WV), the RYSCs, and the Prevention Lead Organizations (PLOs). Youth and families impacted by an SUD may access recovery and resiliency supports at any of these locations including peer support, resources, and education. Assistance with locating inpatient or outpatient treatment resources can also be provided if needed.
Adults 18 and older who are diagnosed with an SUD can access support in a variety of ways. This includes one-on-one or group peer support through WV Alliance for Recovery Residences (WVARR) certified recovery residences, Recovery Community Organizations (RCOs), community Quick Response Teams, emergency rooms, and at a Licensed Behavioral Health Centers.
Telephonic (including text/chat) peer support is available 24/7 via First Choice Services, which is the organization that oversee the 988 call center, treatment resource line, and other resources.

5. Does the state have any activities that it would like to highlight?

WV recently invested in RCOs, bringing the statewide total to six. These RCOs have increased SUD recovery support services in their communities and are working to reduce stigma. WV also contracted with Faces & Voices of Recovery (FAVoR), which provided technical assistance to the RCOs to help launch their recovery support services and obtain accreditation from the Association of Recovery Community Organizations (ARCO).
The West Virginia Peer Recovery Training Hub was established with Marshall University. Known as the HUB, it supports and expands the peer workforce in WV by providing participants with access to high-quality training and resources at low or no cost. Peer recovery support services, including Peer Recovery Support Specialists (PRSS), play a critical role in helping individuals diagnosed with SUD achieve and maintain recovery. The HUB is supported through a partnership between the BBH, Marshall University's Center of Excellence for Recovery, the WV Collegiate Recovery Network, and WV Office of Drug Control Policy. Individuals who are PRSS, certified or those interested in becoming a PRSS, can utilize the HUB's resources and training. Training is provided on a variety of topics, including peer support basics, PRSS core training, peer support delivery service ethics, and evidence-based practices.
Children's Mental Health recently changed reporting tools which is anticipated to provide the ability to better answer this question next year. A new strategic plan was completed last year and it will be reviewed annually to determine program implementation progress. As part of the yearly review, the plan will be revised as needed. Monthly grantee meetings regarding program implementation are conducted. The providers, including the PRSS-Y attend, and give updates including what is working and challenges they are experiencing to service implementation. At a minimum of once a year, the PRSS-Y and BBH Children's Mental Health staff review previous programmatic reporting as a group to determine successes and plan for the coming year.
The Office of Adult SUD has been working to better collect and assess data received from subgrantees. The data is being used to determine the impact that has been made in the community and if there are areas for improvement. The push for this type of assessment has occurred over the past several months. While staff is limited, they are actively trying to determine how impactful these initiatives are. This will help provide for the continuation of successful programs, help promising initiatives become more successful, and identify which initiatives may need to be discontinued.

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

Technical Assistance and information on what other states are doing to address attrition, compassion fatigue, burnout, self-care, and other peer workforce concerns would be helpful. Strategies regarding ethical recruitment and retention of a knowledgeable peer workforce would also be beneficial.

Footnotes:

Response to the Recovery Revision Request is addressed at the end of #5.

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:

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

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Olmstead planning is directed by the West Virginia Olmstead Office. The Olmstead Office was established on August 13, 2003, and has the following responsibilities: develop, implement and monitor West Virginia's Olmstead activities in compliance with Title II of the ADA; provide support to the Olmstead Council in carrying out their duties; manage grant funding to carry out Olmstead-related projects; facilitate the implementation of the Transition Navigator Program; and provide information, referral and assistance to West Virginia citizens about Olmstead-related issues and needs. The Olmstead Office provides West Virginia citizens with information, referral, and assistance services concerning Olmstead-related issues. For example: West Virginia activities, national initiatives, available community-based supports and providers, and available advocacy services.

BBH provides funding to the Olmstead Office for the West Virginia Olmstead Transition & Diversion Program. The Olmstead Transition & Diversion Program assists people who live in facilities such as nursing homes, intermediate care facilities, state psychiatric facilities, rehabilitation facilities, etc. to transition into the community and to help people who are at risk of placement into a facility stay in their own home.

This program provides:
- Security deposits required to obtain a lease on an apartment or house
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
- Moving expenses
- Assistive devices or technology
- Home accessibility adaptations or modifications

- Essential and basic household furnishings required to occupy an apartment or house, including furniture, window coverings, food preparation items, and bed/bath linens

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

N/A

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]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.

[3]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.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]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**

[6] **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 of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The 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) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) 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

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ○ Yes ◉ No

d) Does the state have an established FEP program? ◉ Yes ○ No

Does the state have an established CHRP program? ◉ Yes ○ No

e) Is the state providing trauma informed 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.)

Concerns about access to and availability of community-based mental health services for children and youth with serious emotional disorder (SED) or serious mental illness (SMI) led to WV entering an agreement with the U.S. Department of Justice (DOJ) in 2019 to improve its mental health system to ensure that children can receive appropriate mental health and social services in their homes, schools, and communities. The same year, BBH received a SAMHSA System of Care (SOC) grant, which enhanced the state's SOC, including implementing a statewide, 24/7 Children's Crisis and Referral Line (844-HELP4WV) in 2020 that connects callers, chatters, and texters with several statewide children's services, including SOC staples: mobile crisis response, intensive in-home services (WV Wraparound), a Children with Serious Emotional Disorder Medicaid Waiver (CSEDW), and increased parental support with a state lead and regional family coordinators. In 2022, about 1,000 individuals contacted the the Children's Crisis and Referral Line, and more than 500 youth received WV Wraparound or CSEDW services.

In addition to DOJ agreement-related programs, BBH uses SAMHSA block grant funding for Regional Youth Service Centers, which include outpatient mental health and substance use treatment and peer support services for youth and young adults; statewide early serious mental illness (ESMI) or first-episode psychosis (FEP) services called Quiet Minds WV; and newer Regional Transition Navigators to provide support, training, and linkages to youth and young adults aged 14-25 who are experiencing, have experienced, or are at risk of experiencing SED, mental illness, or substance use disorders, with an emphasis on individuals who are experiencing homelessness, are aging out of foster care or juvenile detention, or are at risk for human trafficking. A March 2023 SAMHSA Certified Community Behavioral Health Clinic (CCBHC) planning grant award has promise to expand state mobile crisis response, intensive outpatient, and other community-based behavioral health services.

To ensure behavioral health services are delivered with fidelity, BBH developed a training system for providers at no cost to them through the WV Behavioral Health Workforce and Health Equity Training Center. For Wraparound and mobile crisis response provider training, WV receives technical assistance from the now-University of Connecticut Innovations Center.
Prevention and early invention services have also flourished in WV. More than 90 schools receive grants to implement multi-tiered Expanded School Mental Health (ESMH), including 18 sites funded through two SAMHSA Project AWARE grants to the WV Department of Education. BBH expanded its substance use prevention workforce with SAMHSA block grant, Partnerships for Success, and State Opioid Response funding. BBH also funds Prevent Suicide WV and regional youth suicide intervention specialists through a SAMHSA Garrett Lee Smith (GLS) State Youth Suicide Prevention and Early Intervention grant. The state's prevention infrastructure includes six regional prevention lead organizations, county coalitions, and an overarching WV Prevention Strategic Plan addressing risk and protective factors that transcend types of prevention, including child abuse and neglect, sexual violence, and suicide.

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

System of Care approach: The state has created a network of services to support children and youth with SED and SMI and their families, including WV Wraparound and mobile crisis response services. These services can be accessed through the Children's Crisis and Referral Line (844-HELP4WV). The Regional Youth Service Centers provide outpatient SUD, SED/SMI, FEP, and co-occurring treatment for youth and young adults.
Collaboration with child- and youth-serving organizations. BBH and the state agencies serving children and youth continue to enhance the state system of care with the Kids Thrive Collaborative, , https://kidsthrive.wv.gov/Pages/default.aspx. BBH works with child welfare and juvenile justice agencies on diversion, drug court, and juvenile competency remediation initiatives.
Monitoring progress and service utilization: BBH receives and reviews grantee reporting to ensure grant goals and objectives are met. BBH also holds regular meetings with grantees and convenes collaborative groups that provide feedback, including the Family Advisory Board. DHHR also established a data quality office that regularly reviews data on certain programs; those data reports may be found at https://kidsthrive.wv.gov/DOJ/Pages/default.aspx.
Evidence-Based Training: BBH established the WV Behavioral Health Workforce and Health Equity Center (https://wvbhtraining.org/) in 2021, which includes training on Wraparound and mobile crisis services. In 2023, the BBH Children's office also established the BBH Clearinghouse (https://clearinghouse.helpandhopewv.org/) to help guide practitioners, funders, and families on selecting effective programs.
Plans for Transitioning Youth: Several BBH programs focus on transitioning youth, including the Regional Youth Service Centers, Quiet Minds WV (FEP), and the new Regional Transitional Navigators (https://rtn.cedwvu.org/), who provide information, training, and resources/services to youth and young adults 14-25 years of age who are at risk of or experiencing SED/SMI, SUD, co-occurring disorders, and housing insecurity.

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

N/A. West Virginia receives TA as needed through its SAMHSA System of Care grant, the National Association of State Mental Health Program Directors (NASMHPD), National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC), and other national resources.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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:

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.

With a combination of SAMHSA Garrett Lee Smith Youth Suicide Intervention and State Opioid Response grant funding, BBH funds Prevent Suicide WV and regional youth and adult suicide intervention specialists. These professionals work with community partners, schools, emergency departments, and other departments to train on suicide prevention practices, connect individuals with services, and provide postvention services for families, schools, and communities affected by suicide. BBH also leads the Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF). The WV Behavioral Health Workforce and Health Equity Training Center also offers several suicide prevention trainings. Read more at https://preventsuicidewv.com/, https://wvbhtraining.org/, and https://veterans.wv.gov/GCP/Pages/default.aspx.

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

If yes, please describe how barriers are eliminated.

The regional Youth Suicide Intervention Specialists have been working on continuity of care with emergency departments and other residential placements to help families understand restriction of lethal means and connect youth with follow-up services. They have also been receiving training with the Mobile Crisis Response teams on collaboration and cross-referrals.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

BBH hired a 988/Crisis/Disaster Coordinator to help with implement of the WV 988 Suicide & Crisis Lifeline, crisis continuum of care, and behavioral health disaster planning and readiness. The state is working on enhancing collaboration for the crisis continuum to include more Crisis Intervention Teams, 988/911 workflow protocols, and exploration of expansion of NAMI within the state.

The Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF) continues to work on supports for SMVF, including enhancement of suicide fatality data.

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

N/A

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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 SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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?

Leaders within BIPOC communities. Examples of outreach conducted with organizations providing leadership within the BIPOC communities in WV thus far include: Partnership of African American Churches, Health Equity Action Team (HEAT), WV Minority Health Initiative, Appalachian American Indians of West Virginia, Jobs & Hope, Keep Your Faith Corp., and Herbert Henderson Office of Minority Affairs, The Greater Kanawha Valley Foundation, The Healing House Inc, and WV COVID19 African American Task Force for Racial Disparities.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

As described in the sections above, BBH collaborates with other bureaus and partners to provide a full continuum of behavioral

health care to help West Virginians thrive in their homes, schools, and communities. Whenever possible, funding is braided (e.g., Medicaid coverage and reimbursement paired with state or federal grant funding for individuals or services that are not covered). BBH and its partners share information, training, and strategic planning on evidence-based practices (EBPs) to stretch resources. Examples include the WV Prevention Strategic Plan (https://helpandhopewv.org/prevention-works.html) that includes multiple types of prevention and the new BBH Clearinghouse (https://clearinghouse.helpandhopewv.org/) with effective EBPs researched by in-state experts. BBH is part of the Kids Thrive collaborative to bolster in-home and community-based services (https://kidsthrive.wv.gov/Pages/default.aspx). To help children and youth thrive in their homes, schools, and communities, BBH funds a wide array of services, including behavioral support services through the West Virginia University Center for Excellence in Disabilities Positive Behavior Support (PBS) Program (https://pbs.cedwvu.org/) and Legal Aid of West Virginia Family Advocacy, Support, and Training for educational advocacy (https://legalaidwv.org/our-programs/legal-services/special-education-fast/), including support with individual education plans (IEPs).

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

NA

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder 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 SUPTRS BG, 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.**[1]

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.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Director of the Bureau's Office of Planning presented to the West Virginia Behavioral Health Planning Council (WVBHPC) on July 19, 2023 on the current year Block Grant planning process. The draft application was sent to the WVBHPC in August 2023 for review and input. The WVBHPC's comments are included with the application.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The WVBHPC's Systems and Monitoring Committee meets monthly to plan and implement block grant services. BBH is represented on this committee. The WVBHPC also meets quarterly as a whole to make system and service recommendations.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. 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.

The State has current technical assistance related to this section. State staff representing MHA / SSA is meeting with JBS and AHP (Advocates for Human Potential, www.ahpnet.com) to assist with technical assistance about the challenges of outreach, engagement, and orientation with current and future WV Behavioral Health Planning Council members. This is in follow-up to the

State's participation in the NASMHPD Planning Council Learning Collaborative and discussions of membership recruitment and training and retention.

Footnotes:

West Virginia Behavioral Health Planning Council
PO Box 8885
Charleston, WV 25303

28 August 2023
Dawn Cottingham-Frohna, Commissioner
Bureau for Behavioral Health
350 Capitol Street, Room 350
Charleston, WV 25301

Dear Commissioner Cottingham-Frohna,

The primary duty of behavioral health planning councils as listed in the authorizing statute 42 USC 300x-3 Public Law 102-321-July 10, 1992 – Section 1914 is to review the state's plan using SAMHSA's Mental Health Block Grant funds for any modification and submit a letter from the planning council detailing the planning council's activities, including their review of the plan.

The West Virginia Behavioral Health Planning Council has four primary goals:

- Implement an integrated approach for the collection, analysis, interpretation, and use of data to inform the planning, allocation, and monitoring of the West Virginia behavioral health service delivery system.
- Build the capacity and competency of West Virginia's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.
- Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention /promotion, early identification, treatment, and recovery services that are high quality and person-centered.
- Manage resources effectively by promoting good stewardship and further development of the West Virginia behavioral health service delivery system.

The WV Behavioral Health Planning Council composition is as follows:

- Parents of Children with Serious Emotional Disorder
- Youth (Ages 18-25)
- Individuals in Recovery (Mental Health)
- Substance Use Seats (Individuals in Recovery)
- Substance Use Seats (Providers)
- Family members of Individuals in Recovery
- Providers
- State Mandated Seats: Medicaid, BHHF, Dept of Education, Dept. of Corrections, Division of Vocational Rehab, and HUD/Housing

Some of the overview recommendations for the block grant:

- The Council would like to be more involved in writing the block grant as we only see the document released a few days prior for public comment. Members are encouraged to submit recommendations for our letter as well as individual comments.
- Council members have also attended various town hall forums, and conferences and participated in several reviews this past year to give their comments about services to the state.

The Council would like to recognize the state's work in applying for and receiving various grants throughout the year. We are very excited about the planning grants that the State and several comprehensives have received regarding the Certified Community Behavioral Health Clinics (CCBHC) in our state. We feel that this will help enhance what we currently have in our state now, such as Help4WV, 988, Mobile Crisis, etc. It will also help with care coordination and the continuum of care where the current systems seem to be fragmented and poorly coordinated.

West Virginia needs to assess its unique needs and collaborate with experts, stakeholders, and neighboring states to identify and implement strategies that will most effectively address the neglected areas of behavioral health and improve outcomes for its residents.

The Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG) programs, which provide critical funding for prevention, treatment, recovery support, and other services, are vital to the residents of our state.

We are asking and recommending that the Bureau for Behavioral Health

- Conduct a thorough assessment of the current state of services for the mentioned populations to identify gaps and areas of improvement. This can be done in a variety of ways including but not limited to Peer Reviews, Consumer and family surveys,
- Communicate regularly the progress and outcomes to the WVBHPC Council and the public to maintain transparency and accountability in the use of all funding.
- Establish clear performance metrics and outcome measures to ensure that the allocated funds are effectively addressing the needs of these populations and improving their outcomes. ● Collect performance and outcome data to assess the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services, and plan the implementation of new services statewide.

During the Council's review of the draft plan, members identified several concerns in the proposed grant submission.

Funding

- We encourage the state to seek any additional funding from federal and private sources, such as grants and Medicaid expansion, to bolster behavioral health services.
- A shortage of behavioral health professionals, such as psychiatrists, psychologists, and social workers, is a common issue across the U.S. This shortage limits the capacity to provide timely and quality care.
- Establishment of an educational program for mental health advance directives is needed. ● Fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals, individuals without insurance, or those whose coverage is terminated for a short time with a focus on those services demonstrating success in improving

outcomes and supporting recovery.

- Fund primary prevention activities and services, including universal, selective, and indicated prevention, for individuals not identified as needing treatment.
- Assist with creating a solid infrastructure to ensure the sustainability of Recovery Community Organizations
- Strengthen community-based services, including outpatient and day programs, to provide ongoing support to individuals in their communities.

Crisis Services:

- Crisis services, including crisis hotlines and mobile crisis teams, are vital for immediate help during mental health emergencies. Neglecting these services can result in unnecessary hospitalizations or even tragic outcomes. We are encouraging the expansion of services to serve the entire state.
- Establishing crisis stabilization centers can divert individuals in crisis away from emergency rooms or jails and into appropriate care settings.
- First Responders need training and additional training in Crisis Intervention Teams as well for their own needs.
- Additional Assertive Community Treatment teams are needed for those with severe and persistent mental illness.

Health

- Harm Reduction Programs are needed, and government officials educated on the benefits of the various harm reduction programs.
- Increasing the use of telehealth can help address access issues, particularly in rural areas. This allows people to receive care from a distance, reducing barriers to treatment.
- The development of distinct care coordination models for different demographic groups is needed and should include holistic care.
- Mental Health Services for first responders are lacking.
- Expand the services offered for Collegiate Recovery. MATCH Data shows that the state's 18-34 year old age group is in high need of services.
- Integrating behavioral health into primary care settings can improve early identification and intervention for mental health issues.
- The opioid epidemic has hit West Virginia particularly hard. Our state needs a robust and accessible substance use disorder treatment program, including medication-assisted treatment (MAT) and harm reduction initiatives.

Children and Families

- Children and adolescents often face long waiting times for mental health services. Neglecting this population can lead to long-term consequences, including academic struggles and an increased risk of mental health disorders in adulthood.
- Expansion of the Healthy Grandfamilies program to include other types of kinship family situations.
- Explore education and training for health care providers for Medications for Opioid Use Disorder.
- Allocate a significant portion of the SABG and MHBG funds to initiatives that directly benefit. children in foster care, individuals with substance use disorder, foster children, and WV waiver recipients.
- Preventing behavioral health issues and intervening early to address them is critical. Neglecting prevention programs and early intervention can result in more severe and costly issues later. ● The augmentation of recovery beds and other programs for mothers is needed in each county.

Peer Services

- Continue the Peer Recovery Support Specialist Training program in conjunction with the Division of Rehabilitation. These services pay for the hours needed for PRSS certification.
- Utilizing peer support specialists who have personal experience with mental health or substance use challenges can be effective in providing support and reducing stigma.
- Quick Response Teams need to be enhanced and expanded.
- Enhance and Expand Peer Recovery and Recovery Community Organizations

Prevention

- Preventing behavioral health issues and intervening early to address them is critical. Neglecting prevention programs and early intervention can result in more severe and costly issues later.

Veterans

- Additional addiction and overdose services are needed for this population.

Criminal Justice

- Additional beds and services are needed for violent offenders and sexual offenders. ● Review and expand treatment and recovery beds, community-based services need to be available for both diversion and reentry

Transportation

- Review and improve transportation services provided by Modivcare.
- There are not sufficient transportation services, particularly in rural areas.

Thank you for the opportunity to provide comments on the State Mental Health and Substance Abuse Block Grant plan. Again, the Council would like to be more involved in the writing of the block grant, rather than only seeing the document that is released for public comment.

Sincerely,

Chair, West Virginia Behavioral Health Planning Council

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.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Shawn Allen	Parents of children with SED			
Dr. Ayne Amjad	State Employees			
Vickie Ashcraft	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Chassidy Bays	Youth/adolescent representative (or member from an organization serving young people)			
Elliot Birckhead	State Employees			
Elizabeth Brooks	Parents of children with SED			
Reed Mason Byers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Carolyn Canini	Providers			
Ardella Cottrill	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Holly Crookshanks	Providers			
Nancy Deming	Persons in recovery from or providing treatment for or advocating for SUD services			
Joyce Floyd	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Heather Hoelscher Garcia	Providers			
Jennifer Keener	Parents of children with SED			
Tammy Ketchem	Providers			
Brenda Lamkin	Providers			

Carmen Maniak	State Employees			
Richard Martin Jr.	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
John McAtee	Parents of children with SED			
Kelly Modecki	State Employees			
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			
Cynthia Parsons	State Employees			
Linda Pauley	Persons in recovery from or providing treatment for or advocating for SUD services			
Cathy Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Phil Reed Sr.	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Ava Reinstein	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
James Ruckle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
David Sanders	State Employees			
Nate Siggers	Persons in recovery from or providing treatment for or advocating for SUD services			
Misty Stambler	Parents of children with SED			
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			
Richard Ward	State Employees			
Julie Williams	Providers			
Wesley Wood	Persons in recovery from or providing treatment for or advocating for SUD services			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

The State employee 'State Social Services Agency' seat is currently vacant due to a staff transition within that agency. This seat will be filled at the next WVBHPC meeting.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	4	
Parents of children with SED	6	
Vacancies (individual & family members)	1	
Others (Advocates who are not State employees or providers)	0	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**19**	**54.29%**
State Employees	7	
Providers	7	
Vacancies	2	
Total State Employees & Providers	**16**	**45.71%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	4	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	1	
Total Membership (Should count all members of the council)	**40**	

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Footnotes:

The State employee 'State Social Services Agency' seat is currently vacant due to a staff transition within that agency. This seat will be filled at the next WVBHPC meeting.

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

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dhhr.wv.gov/BBH/getconnected/Pages/SAMHSA-Block-Grants.aspx

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

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

N/A

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

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.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.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.

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;

- 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:

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes: