

Virginia

UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/31/2019 2:38:59 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 2020

End Year 2021

State SAPT DUNS Number

Number 627383102

Expiration Date

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

Agency Name Virginia Department of Behavioral Health and Developmental Services

Organizational Unit Office of Adult Community Behavioral Health

Mailing Address P. O. Box 1797

City Richmond

Zip Code 23219-1797

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

First Name Gail

Last Name Taylor

Agency Name Virginia Department of Behavioral Health and Developmental Services

Mailing Address P. O. Box 1797

City Richmond

Zip Code 23219-1797

Telephone (804) 786-1411

Fax

Email Address gail.taylor@dbhds.virginia.gov

State CMHS DUNS Number

Number 627383102

Expiration Date

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

Agency Name Virginia Department of Behavioral Health and Developmental Services

Organizational Unit Office of Adult Community Behavioral Health

Mailing Address P.O. Box 1797

City Richmond

Zip Code 23218-1797

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

First Name Margaret

Last Name Steele

Agency Name Virginia Department of Behavioral Health and Developmental Services

Mailing Address PO Box 1797

City Richmond

Zip Code 23218

Telephone (804) 655-4432

Fax

Email Address margaret.steele@dbhds.virginia.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ☐ Yes ☐ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Nathanael

Last Name Rudney

Telephone 804-663-7270

Fax 804-371-0091

Email Address nathanael.rudney@dbhds.virginia.gov

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

Footnotes:

State Information

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

Fiscal Year 2020

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 nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Daniel Carey

Signature of CEO or Designee¹: _____

Title: Secretary of Health and Human Resources

Date Signed: _____

mm/dd/yyyy

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

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

Footnotes:



COMMONWEALTH of VIRGINIA

Office of the Governor

Ralph S. Northam
Governor

August 2, 2018

Odessa Crocker, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E20
Rockville, MD 20857

Dear Ms. Crocker:

I am delegating responsibility for the administration of Virginia's Community Mental Health Services (CMHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant to Dr. Hughes Melton, Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, VA 23218
Telephone: (804)786-3921

I am also authorizing Dr. Daniel Carey, Secretary of Health and Human Resources for the Commonwealth, to sign the required certifications and assurances required for application to the Substance Abuse and Mental Health Services Administration for the CMHS and SAPT Block Grants for this and subsequent years of my administration.

Sincerely,

A handwritten signature in black ink, appearing to read "Ralph S. Northam".

Ralph Northam

cc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources
Hughes Melton, M.D., Virginia Department of Behavioral Health and Developmental Services

Patrick Henry Building • 1111 East Broad Street • Richmond, Virginia 23219
(804) 786-2211 • TTY (800) 828-1120
www.governor.virginia.gov

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: See HHA _____

Date Signed: 06/12/2019
mm/dd/yyyy

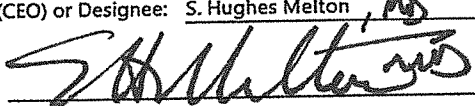
¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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State: _____

Name of Chief Executive Officer (CEO) or Designee: S. Hughes Melton, MD

Signature of CEO or Designee¹: 

Title: Commissioner

Date Signed: _____

6/17/19

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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and
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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As the duly authorized representative of the applicant I certify that the applicant:

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

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

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Daniel Carey

Signature of CEO or Designee¹: _____

Title: Secretary of Health and Human Resources

Date Signed: _____

mm/dd/yyyy

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

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

Footnotes:



COMMONWEALTH of VIRGINIA

Office of the Governor

Ralph S. Northam
Governor

August 2, 2018

Odessa Crocker, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E20
Rockville, MD 20857

Dear Ms. Crocker:

I am delegating responsibility for the administration of Virginia's Community Mental Health Services (CMHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant to Dr. Hughes Melton, Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, VA 23218
Telephone: (804)786-3921

I am also authorizing Dr. Daniel Carey, Secretary of Health and Human Resources for the Commonwealth, to sign the required certifications and assurances required for application to the Substance Abuse and Mental Health Services Administration for the CMHS and SAPT Block Grants for this and subsequent years of my administration.

Sincerely,

A handwritten signature in black ink, appearing to read "Ralph S. Northam".

Ralph Northam

cc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources
Hughes Melton, M.D., Virginia Department of Behavioral Health and Developmental Services

Patrick Henry Building • 1111 East Broad Street • Richmond, Virginia 23219
(804) 786-2211 • TTY (800) 828-1120
www.governor.virginia.gov

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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 which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: See HHA _____

Date Signed: 06/12/2019
mm/dd/yyyy

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

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: S. Hughes Melton, MD

Signature of CEO or Designee¹: _____



Title: Commissioner

Date Signed: _____

6/17/19

mm/dd/yyyy

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

Footnotes:

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	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature:

Date:

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

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, 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. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

Footnotes:

NOT FINAL

Step 1: Assess Strengths and Needs

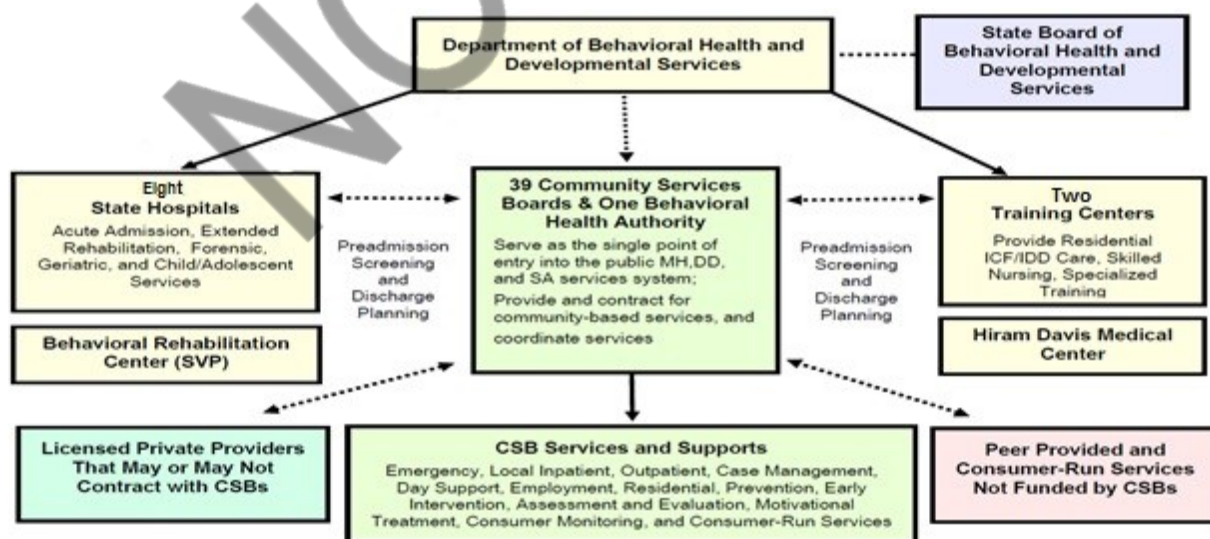
Description of Virginia's Public Behavioral Health System

The Department of Behavioral Health and Developmental Services (DBHDS) is tasked with providing public behavioral health (mental health and substance use disorders) as well as developmental (intellectual disability) services in Virginia. Title 37.2 of the Code of Virginia establishes DBHDS as the state authority for Virginia's public behavioral health and developmental services system, thus designating the agency as the Single State Alcohol and Drug Agency (SSA) and State Mental Health Authority (SMHA).

Virginia operates 13 facilities: eight behavioral health facilities for adults, two training centers, a psychiatric facility for children and adolescents, a medical center, and a center for behavioral rehabilitation. State facilities provide highly structured, intensive services for individuals with mental illness, intellectual disability or are in need of substance use disorder services. The Commonwealth Center for Children and Adolescents (CCCA) in Staunton remains the only state hospital for children with serious emotional disturbance. Community Services at the local level are provided by 39 community services boards and 1 behavioral health authority (referred to as CSBs). Local governments that provide services directly to consumers or through contracts with private providers across the Commonwealth have established these CSBs. Maps of CSB service areas and the locations of state facilities are included in this section of the application.

A state policy board, appointment by Virginia's Governor, advises BDBHDS.

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



DBHDS' central office provides leadership and service to support and improve Virginia's system of quality treatment, prevention services, as well as supports for individuals and families whose lives are affected by mental health or substance use disorders or developmental disabilities. The DBHDS Central Office seeks to promote a culture of recovery, self-determination, and wellness in all aspects of life for these individuals.

Responsibilities of DBHDS include:

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

The Community Services Board System

The 133 local governments in Virginia, pursuant to Chapters 5 and 6 of Title 37.2 of the Code of Virginia established CSBs. CSBs may serve single or multiple jurisdictions. CSBs provide services directly to consumers within their catchment area, as well as through contracts with private providers. Private providers are identified as partners who play an important role in delivering behavioral health and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services. It is important to note discharge planning for individuals leaving state facilities is also performed at the CSB level. They function as advocates for individuals who are receiving services and those in need of services. In addition, CSB staff act as community educators, organizers, and planners through community outreach. In some cases they educate and advise their local governments about behavioral health and developmental services and needs.

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

CSB Mental Health Services

CSBs provide a wide array of mental health services to children and adults. In State Fiscal Year (SFY) 2018, an unduplicated 123,101 individuals received CSB mental health services. Services include: Outpatient Services, Case Management, Assertive Community Treatment, Day Treatment/Partial

Hospitalization, Ambulatory Crisis Stabilization, Rehabilitation, Sheltered Employment, Individual and Group Supported Employment, Residential Crisis Stabilization Services, Highly Intensive and Intensive Residential Services, and Supervised and Supportive Residential Services. A significant number of these individuals have severe disabilities; of the individuals receiving mental health services in SFY 2018, 62,414 adults had a serious mental illness (71% of adults served) and 24,154 children had or were at risk of having a serious emotional disturbance (68% of children served). Between SFY 2008 and SFY 2018, the number of individuals receiving CSB mental health services increased from 101,796 to 123,101, an increase of about 19%.

CSB Substance Abuse Services

In FY 2018, an unduplicated 31,475 individuals received substance abuse services from CSBs. Services include: Inpatient Services, Community-Based SA Medical Detox Inpatient Services, Outpatient Services, Intensive Outpatient Services, Case Management Services, Medication Assisted Treatment, Day Treatment/Partial Hospitalization, Rehabilitation, Individual Supported Employment, Highly Intensive Residential Services, Residential Crisis Stabilization Services, Intensive Residential Services, Supervised Residential Services, Supportive Residential Services and Prevention Services. Alcohol was reported as the primary drug of abuse for 8,747 of these individuals (27.8%), opiates for 9,061 (28.9%), marijuana/hashish for 5,701 (18.1%) and cocaine/crack for 2,791 (8.9%). About half of the 40 CSBs provide medication assisted treatment (methadone or buprenorphine), either directly or through a contract with a local private provider, serving 3,175 individuals in 2018. Women made up 52.6% (1,170) of this treatment population. All CSBs provide some specialized services to pregnant women and women with dependent children. There are four regional programs that provide residential services to pregnant and postpartum women and women with dependent children and nine programs that provide intensive wrap-around case management services to pregnant and postpartum women in close collaboration with local social services and health departments (Project Link).

CSB Prevention

Virginia's focus on behavioral health is changing the prevention context by supporting the creation of thriving communities that promote healthy outcomes. This is happening through state and community level-change, structural and systems change as well as integrating more seamlessly mental health and substance use approaches to address shared root causes. Virginia's Block Grant activities have been selected through an intentional, data-driven process at the state local provider level based on the Strategic Prevention Framework (SPF) developed by SAMHSA. The SPF consists of a set of steps and principles that are designed to ensure effective substance use prevention services and outcomes. The Virginia State Epidemiological Outcomes Workgroup (SEOW) provided data through the Virginia Social Indicator Study Data Dashboard which was accessible to the 40 Community Services Boards and their partner coalitions. DBHDS' OBHW Needs Assessment and Evaluation contractor provided SPF capacity building at the state and local levels resulting in 40 local needs assessments and 40 local Logic Models linked to their needs assessments. The state completed a state level needs assessment which has led to the identification of prioritized risk and protective factors. Best practices in prevention science

State Hospital System

DBHDS operates eight state mental health hospitals for adults across Virginia. The hospitals are Catawba Hospital in Salem, Central State Hospital in Petersburg, Eastern State Hospital in Williamsburg, Piedmont Geriatric Hospital in Burkeville, Northern Virginia Mental Health Institute in Falls Church, Southern Virginia Mental Health Institute in Danville, Southwestern Virginia Mental Health Institute in Marion, and Western State Hospital in Staunton. The Commonwealth Center for Children and Adolescents, the only state hospital for children with serious emotional disturbance, is located in Staunton. State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided to older adults, children and adolescents, and individuals with a forensic status.

DBHDS continues its reformation efforts, re-engineering a system that will truly provide for Virginians with behavioral health and substance use needs. Through legislative, administrative and collaborative efforts with the community, Virginia has made significant improvements in quality and service delivery. No individual has been turned away from a state psychiatric hospital bed when needed. Working with our community service boards and other stakeholders, DBHDS has addressed the qualification and training needs of the emergency custody and preadmission screeners. Other improvements include updated communications infrastructures between the courts and behavioral health care providers and reduced jail wait lists for state hospital admissions. DBHDS has established contracts with private providers and agreements with CSBs to provide residential supports that fill a service gap. These contracted residential supports target individuals who are in state hospitals and are clinically ready to be discharged but need a particular level of supervision and support in the community. DBHDS is in the process of developing teams that can assist individuals with their transition from hospital to community, see that they have the proper services, and provide consultation regarding the care needs of individuals with mental illness to their residential providers.

System Transformation

DBHDS has initiated several system reform efforts, layering one on top of the next, to develop a model that will move Virginia forward in a cohesive, strategic manner, specifically:

System Transformation Excellence and Performance (STEP-VA) – DBHDS continues to pursue innovation with the goal of addressing the significant challenges in Virginia’s mental health and substance-use disorder services across the lifespan: a pathway to excellence in behavioral healthcare and to a healthy Virginia, or System Transformation Excellence & Performance (STEP-VA). STEP-VA features a uniform set of required services, consistent quality measures, and improved oversight in all Virginia communities.

STEP-VA: Virginia’s Path Forward

STEP-VA is orchestrated in a stepwise fashion, incorporating services over multiple years, each providing the infrastructure and expertise needed to build on the next. Specific details include:

- A stakeholder and policy-informed model, built on the two-year transformation team effort and lessons learned during the CCBHC planning grant.
- Nine core required services, plus care coordination as the linchpin, evidence-based best practices and key quality measures to assess performance and outcomes
- Same day access, medication assisted treatment, in-home children's services and linkages to critical social services, like housing, employment and education.

The result is a Virginia-specific CCBHC model tailored to meet current and future needs of Virginians with behavioral health disorders. STEP-VA's services were identified by the transformation teams as part of the CCBHC process to meet the needs of Virginians and fill gaps in the system.

Services include:

- Same Day Access
(Phase 1 of Planning and Initiation completed July 1, 2019)
- Outpatient Services
(Phase 1 initiated July 1, 2019)
- Primary Care Integration
(Phase 1 initiated July 1, 2019)
- Care Coordination-
- Peer and Family Support
(Phase 1 initiated)
- Psychosocial Rehabilitation/Skill Building
- Targeted Case Management
- Veterans Services
(Phase 1 initiated)
- Mobile Crisis Services
(Moving into Phase 2 starting July 7/1 2020)

As part of implementing STEP-VA across the Commonwealth, DBHDS continues to expand certain existing services as well as to implement new services to maximize impact, increase access in all locales, strengthen quality of services provided, and build consistency among training and expectations. Notably, STEP-VA services intent to foster a focus on wellness among individuals with behavioral health disorders and prevent crises before they arise. As part of the changes the projected result would be fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system. The first two STEP-VA services implemented were same day access and primary care screening.

Same day access allows individuals to be connected to the services they need without the significant wait time associated with scheduling. Primary Care Screening allows individuals to have a brief medical screening as part of their assessment process that identifies any needs they may have for medical follow up by a physician. It was noted, after the appointment with same day access, there could still be a waiting period, perhaps six weeks or more, for additional needed psychiatric services. As such, expanding outpatient services would help ensure individuals who normally would be waiting long

periods for subsequent appointments would be seen sooner and before crises could develop. Additional details about these two programs follow:

- **Same Day Access-**

Same day access is when a person calls or appears at the CSB and is assessed the same day. Based on assessment, the person is scheduled for appropriate initial treatment within ten days. Same day access is a best practice with the goal of eliminating “no show” appointments, increasing adherence to follow-up appointments, reducing the “wait time” for initial appointments, and makes more cost-effective use of staff resources. Implementation requires a change in CSBs’ business practices, such as scheduling, documentation, caseload management, and utilization of shorter term, more focused and practical therapies. It is the best lever to begin shifting care away from crisis response when individuals are more at risk to themselves and to others.

- **Primary Care Screening-**

Individuals with serious mental illness (SMI), a population primarily served by the CSBs, are known to be at higher risk for poor physical health outcomes largely due to unidentified chronic conditions. Therefore it is important for behavioral health staff to provide primary care screening to identify and provide related care coordination to ensure access to needed physical health care. The long-term goal of this step is to provide a primary care screening on a yearly basis for all children with SED/adults with SMI who have established care with the CSB and are receiving behavioral health services on an ongoing basis.

Medicaid Behavioral Health Redesign

Medicaid is the largest payer of behavioral health services in the Commonwealth, and nearly a third of all Medicaid members have a behavioral health diagnosis. Medicaid has disproportionately high spending on fewer individuals despite strong evidence that demonstrates investment in universal health promotion and prevention improves health outcomes and resiliency, slows progression of mental illness, and is far less costly for the benefit of broader populations. The vision for Medicaid redesign is to keep Virginians well and thriving in their communities, shift our system’s need to focus on crisis by investing in prevention and early intervention with mental illness, and support and sustain STEP VA. Transitioning of funding toward a more robust array of outpatient services, integrated behavioral health services in primary care and schools, and intensive community-based and clinic-based supports will yield improved outcomes and reduce downstream costs of emergency department visits and hospitalizations to the Medicaid program and the State General Fund.

The Behavioral Health Needs Assessment

The purpose of the Virginia Behavioral Health System Assessment is to assess the need of Virginians for publicly funded behavioral health services, to assess current capacity of the State of Virginia’s behavioral health (BH) system to meet the behavioral health needs of Virginians across the continuum of

Prevention, Treatment and Recovery; community based, crisis and facility care. The information from the assessment will be used as a base to guide system improvements as well as to proactively prepare for future system change. It is intended that this assessment will also include an analysis of existing DBHDS funding sources and how funds are allocated; DBHDS behavioral health data sets and DBHDS' Performance management infrastructure to include the Community Services Board Performance contracts. This assessment will be funded and guided by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). For this assessment, the publicly funded behavioral health system is defined as services to Virginians predominantly funded by state, local, federal grants, Medicaid and Medicare. The preliminary assessment draft will be available in November 2019 and the final report in the spring of 2020.

Services System Partnerships

DBHDS partnerships with other state agencies and organizations that are involved in the provision of services and supports to or interact with individuals who have mental health or substance use disorders, intellectual or other developmental disabilities, or co-occurring disorders allows for additional supports to help raise awareness of the needs and challenges of individuals receiving behavioral health and developmental services face. They also provide opportunities for coordinating state-level policy direction provisions of guidance to local services systems, and support statewide and community-based initiatives that promote access to and continuity of needed services and supports.

Many state agencies contribute to the development of and provide ongoing guidance for DBHDS' strategic plan, along with state-level advocacy organizations and persons with lived experience:

Medicaid: Administered by the Department of Medical Assistance Services (DMAS), Medicaid is the largest single source of funds for community mental health services across Virginia. DBHDS works closely with DMAS in policy development, provider expansion, provider education and training, development of quality assurance measures, and provider oversight.

Social Services: DBHDS and the Department of Social Services (DSS) collaborate through a variety of programs and services to help individuals cope with and recover from the effects of poverty, abuse, or neglect and achieve self-sufficiency. This includes services to families who are TANF recipients, to families confronting child custody issues, and to substance-exposed infants and their families. Currently, Virginia is using a Three Branch approach for Families First Prevention and Services Act implementation. The Virginia Department of Social Services (VDSS), which is leading the effort, is working closely with the Virginia Department of Behavioral Health (DBHDS), Virginia Department of Medical Assistance Services (DMAS), the Virginia Department of Health (VDH), the Virginia Supreme Court, the Virginia House of Delegates and the Virginia Senate to develop and implement integrated approaches to prevention throughout the state. DBHDS is an active participant on the Evidenced Based Practices, Finance, and Prevention workgroups.

Housing: Virginia's legislative reform commission, the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the Twenty-first Century, identified housing for individuals with serious mental illness as a priority area in 2015. Since that time, Virginia has invested more than \$12 million in state general mental health funds in permanent supportive housing (PSH). DBHDS oversees 16

PSH providers who housed nearly 700 individuals with SMI in 2018. DBHDS supports implementation of evidence-based practice standards for PSH with its providers who prioritize individuals with histories of institutional use and homelessness. Additionally, DBHDS partners with other state agencies to implement a Housing Action Plan for individuals with SMI. This plan, approved by the leadership of both state housing and disability services agencies in 2019, identifies strategies to develop state infrastructure to fund housing development and operations as well as the supportive services needed to assist individuals with securing and maintaining housing. At the direction of the General Assembly, the Virginia Department of Housing and Community Development produces an annual report on the progress toward the action items in the plan.

Primary Health Care: There are a number of published studies showing that individuals with serious mental health disorders have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. Physical health care is considered a core component of basic services for individuals with behavioral health disorders although this care is often fragmented for these individuals. DBHDS maintains partnerships with appropriate agencies and entities, including the Virginia Department of Health (VDH), Department of Health Professions (DHP), the Virginia Community Healthcare Association, Virginia Rural Health Resource Center, Virginia Hospital and Healthcare Association, Virginia College of Emergency Physicians, and Virginia Association of Free Clinics. In addition, a variety of primary medical and behavioral health partnerships exist across the state between CSBs and community health centers in their catchment areas.

Addressing issues of substance use disorders and addiction presents many opportunities to work closely with public health agencies, including referring individuals for HIV, hepatitis and TB testing and treatment, assisting women with infants and young children in accessing primary health care, including childhood immunization and primary healthcare, and working closely with the Office of the Chief Medical Examiner to utilize mortality data as a tool for identifying emerging substance use issues. DBHDS staff also works closely with VDH to coordinate policy and services for at-risk families identified through the Home Visiting Network.

DBHDS also works closely with the DHP in a number of areas. Those focused on public health include serving on the Advisory Committee of the Prescription Monitoring Program and working to improve knowledge of addiction among healthcare providers to improve identification and referral efforts, as well as to improve access to medication assisted treatment and knowledge about the impact of addiction on physical health. DBHDS has worked very closely with DHP and VDH in implementing a pilot project to train friends and family members of individuals at risk for opioid overdose to utilize naloxone. The pilot required the individual to obtain a prescription for naloxone from a physician. This project was recently expanded to statewide and, thanks to the close collaboration between agencies, statutory changes now allow pharmacists working under a specific protocol to prescribe naloxone, thus making it more accessible.

Employment Services and Supports: Individuals with mental health or substance use disorders, or co-occurring disorders face challenging obstacles to obtaining and maintaining competitive employment. Mental health and substance use disorder employment initiatives between DBHDS and the Department of Aging and Rehabilitative Services (DARS) provide specialized vocational assistance services in CSBs. A

multi-agency initiative involving DBHDS, DARS, DMAS, and the academic community has further developed Virginia-specific WorkWORLD™ decision support software to support people with disabilities who are making decisions about gainful work activity and the use of work incentives. DBHDS supports use of this software to expand training on Social Security work incentives and other benefits counseling. DBHDS also funds 22 positions that are placed in 19 CSBs for the sole purpose of providing vocational counseling to individuals recovering from substance use disorders.

Criminal Justice and Juvenile Justice Services: DBHDS works diligently with the Department of Corrections (DOC), Department of Juvenile Justice (DJJ), and Department of Criminal Justice Services (DCJS) with the goal of improving access to screening, appropriate treatment and supports within the criminal justice setting. This partnership provides enhancements related to interagency planning and coordination in the hopes of better meet the needs of individuals involved with the criminal justice system. As part of this process better support for jail diversion programs such as Crisis Intervention Teams (CIT) and CSB provisions related to short-term behavioral health services within the jails as well as juvenile detention centers. DOC works with DBHDS for increased access to community treatment and inpatient needs for those recently released from incarceration as well as providing screening for inmates who may qualify for civil commitment related to being identified as sexually violent predators. DCJS and DBHDS jointly provide training in behavioral health evaluation and treatment methods for law enforcement personnel who may include jail security staff.

Education: DBHDS partners with the Department of Education (DOE) to support collaborative activities between schools and the behavioral health and developmental services system. For children birth to three, DBHDS is the lead agency for the services under Part C of the Individuals with Disabilities Education Act. DOE is involved with all state initiatives focused on Part C services, including the state Virginia Interagency Coordinating Council for Part C. For the school age population, DBHDS and DOE work closely on a variety of interagency initiatives to improve in-school support for school-age children with behavioral health problems and improve outcomes for Virginia's children. This includes intensive efforts to keep children in their homes and community schools. In addition, DOE holds a designated seat on the Virginia Behavioral Health Advisory Council.

Advocacy: DBHDS central office and state facilities work cooperatively with the disAbility Law Center of Virginia (dLCV) to protect and advocate for the human and legal rights of individuals receiving behavioral health or developmental services. Section 51.5-37.1 of the Code of Virginia requires DBHDS to report all deaths and critical incidents to the dLCV within 48 hours of occurrence or discovery and provide follow-up reports.

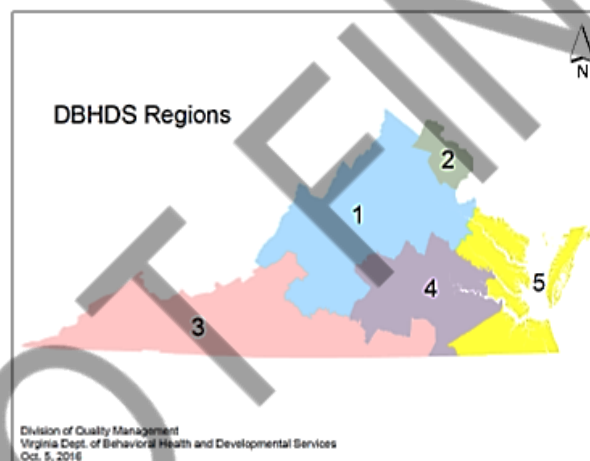
Local Interagency and Regional Planning Partnerships

Local governments continue to collaborate with DBHDS in most cases through the CSBs in order to develop plans and create a sustainable system of care not just within their own locality but within their identified region of the Commonwealth as well.

At the local level, CSBs maintain critical interagency partnerships with local agencies, including school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies include Medicaid rehabilitation services, waiver services, auxiliary grants for

assisted living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Some local agencies also participate on Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Five regional partnerships including one region with two sub-regional partnerships (Region 3) have been established to facilitate regional planning for services system transformation and promote regional utilization management. These partnerships provide forums to address regional challenges and service needs and collaboratively plan and implement regional initiatives. Partnership participants include CSBs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family members, advocates, and other stakeholders. Each regional partnership has established a regional utilization review team or committee to manage the region's use of inpatient beds and funds allocated to purchase local inpatient psychiatric crisis care and residential substance abuse treatment, including state general funds as well as federal Community Mental Health Services (CMHS), and Substance Abuse Prevention and Treatment (SAPT) block grant monies. The following map depicts the five regional partnership areas.



Licensed Providers of Behavioral Health or Developmental Services

One of the statutory duties of DBHDS is licensing behavioral health and developmental services in the state. In FY 2018, DBHDS licensed 1,071 providers of behavioral health (mental health and substance abuse) and developmental services. This included 639 licenses issued to new providers. Licensed providers must meet and adhere to regulatory standards of health, safety, service provision, and individual rights.

Partnerships with Private Providers

The private sector remains an important partner with CSBs in serving people with mental health, substance use disorders, or co-occurring disorders. In addition to serving many individuals through varied contracts with CSBs, private providers can also serve other individuals directly. Private providers are an especially important source of substance abuse treatment for persons with opiate addiction as many consumers receiving CSB treatment for it including injection drug users (IDUs), are referred to

private providers for methadone or other medication-assisted treatment as contractual relationships with these providers exist.

Peer/Recovery Support Services

Peer services are provided by independent consumer-run programs and CSBs, and through collaboration between CSBs and consumer-run programs. Services include (but are not limited to) outreach, crisis intervention, individual and group peer support, individual and group family support, education on recovery and wellness, assistance with meeting basic needs, job skill development, employment readiness activities, community integration, housing supports, and social/recreational opportunities.

The Office of Recovery Services, established by DBHDS in January 2015, has coordinated the efforts of multiple and diverse stakeholders involved in creating a peer recovery specialist certification and registration process. Effective July 1, 2017, the certification process allows providers to bill Medicaid for reimbursement for Peer Services. The certification recognizes the training, knowledge and abilities of peers to provide recovery support services to individuals with mental illnesses and/or substance use disorders. It is also the basic training required for Family Peer Partners. Peer Recovery Specialists (PRS) are seen as an integral part of the Virginia's response to the opioid epidemic at all ASAM levels of care. This is evidenced by the growing numbers of peers in Office-Based Opioid Treatment (OBOT) clinics and in demonstration projects utilizing peers in emergency overdose response.

As of June 2019, 1468 PRS have completed the DBHDS approved PRS Training (since 01/01/2017). In June 2019, there were 507 Certified Peer Recovery Specialists in Virginia. Virginia also offers Peer Recovery Specialist Supervisor Training. Supervision by someone who has completed this training is required for any PRS whose services will be billed to Medicaid. There are currently 401 trained supervisors.

The staff of the Office of Recovery Services, supported with federal block grant funds, has had a role in implementing the SAMHSA Opioid State Opioid Response Grant (SOR), expanding the penetration of peer-provided, recovery- oriented services throughout Virginia's behavioral health care delivery system. In addition, CMHS and SAPT funds are used to support the work of statewide consumer and family advocacy organizations, such as the Virginia Chapter of the National Alliance on Mental Illness (NAMI Virginia), the Virginia Organization of Consumers Asserting Leadership (VOCAL), Mental Health America of Virginia, and the Substance Abuse and Addiction Recovery Alliance (SAARA). These organizations advocate for the needs of individuals with behavioral health disorders and their families and offer a variety of information, referral and support services across the state.

Services for Populations of Interest

Cultural, Racial/Ethnic and Language Minorities

Consumers in Virginia's public behavioral health system are highly diverse. According to the 2012-2017 U.S. Census 5 Year American Community Survey estimates, 68% of Virginia's general population is white; however, nearly 40% of individuals receiving CSB mental health and substance use services are of some other race, including those who self-identify as biracial or multi-racial. In addition, more than 7% of

MH/SA consumers self-identify as Hispanic/Latino, which is one of the largest and fastest-growing ethnic groups in the state.

DBHDS recognizes the striking disparities in mental health and substance abuse services and supports for cultural, racial and ethnic minorities, both in our state and nationwide. The U.S. Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity (2001) found that behavioral health disparities are inextricably linked to race, culture, and ethnicity where people of color, as well as members of other underserved cultural groups, have less access to, and availability of, behavioral health care services. Even when services are available, members of these groups tend to receive a poorer quality of care that does not meet their unique needs. The findings in this comprehensive study continue to be valid as more recent analyses have examined disparities in the behavioral health system and developed similar conclusions.

The Behavioral Health Equity Coordinator with the Office of Behavioral Health Wellness focuses on promoting wellness and achieving behavioral health equity for all Virginians. DBHDS previously had a more linguistic focus whereas currently there is a broader focus on equity throughout the behavioral health system. The Behavioral Health Equity Coordinator's current primary focuses have been:

- Developing the Behavioral Health Equity Summit and 12 behavioral health equity mini-grants that went out following participation in the summit. The summit provided education on the frameworks for understanding behavioral health equity, the rising rates of deaths of despair and social bias in behavioral healthcare. The grants will be completed in October. Awarded grants covered a diverse spectrum programming to address behavioral health inequities including: making more inclusive environments for LGBTQ+ clients, increasing substance misuse services for the deaf/blind/hard of hearing populations and expanding services to the immigrant, refugee and LEP community.
 - The Behavioral Health Equity Summit showed through evaluations, an increase in knowledge about health equity, social determinants in health, healthcare biases, CLAS standards, and engagement to promote health equity for summit participants.
- Participating in the process to develop the Behavioral Health Equity Index with Virginia Commonwealth University Institute for Society and Health which is focused on creating a new funding formula that balances needs and resources of populations to determine how CSBs should be funded
- Involvement in the development and implementation of the Behavioral Health Interpretation Curriculum (BHIC) which was developed by a cohort of members from DBHDS, interpreters, healthcare professionals and organizations in service of immigrant and refugee populations with the goal of training interpreters from other fields using a standardized curriculum
- Coordination and mediation for Partnership for Equity Advisory Committee (previously the Cultural Linguistic Committee) which is comprised of individuals who work at DBHDS, CSBs, training centers, and state hospitals and seek to promote behavioral health equity through advocacy, education, and policy change

Military Personnel and Their Families

Virginia has the 8th largest veteran population (approx. 725,000 in 2017) and the 4th largest Active Duty population in the Nation (approx. 90,000). In addition, the Virginia National Guard has 8,700 Service Members with Army and Air components. In FY18, DBHDS, partnered with VHA, SAMHSA, Virginia Department of Veterans Services (DVS), and various state and local agencies to host the Richmond City Mayor's Challenge to Prevent Suicide Among SMVF (started in March 2018) and the Statewide Governor's Challenge to Prevent Suicide Among SMVF (started in December 2018). Both Challenges are ongoing and provide a strategic and comprehensive approach to suicide prevention emphasizing access to culturally competent behavioral health services, lethal means safety, and systemic partnerships between mainstream/civilian (CSBs, State and Private Hospitals etc.) and SMVF resources (VHA, Military Treatment Facilities, National Guard programs etc.).

DBHDS and CSBs partner with DVS to refer SMVF to the Virginia Veteran and Family Support (VVFS) Program. VVFS provides care coordination services, peer and family support statewide. VVFS also provides military culture training to CSB staff and other community stakeholders. DBHDS and DVS also operate a joint advisory body on community-based behavioral health services for SMVF, the Virginia Military and Veterans Coordinating Committee (VMVCC). Since 2016, the VMVCC has worked closely with the SAMHSA Service Member, Veteran, and Family (SMVF) TA Center to expand military culture training for community providers, peer services and suicide prevention for SMVF.

SMVF are a priority population for the System Transformation Excellence and Performance initiative in Virginia (or STEP VA). Modeled after the SAMHSA Certified Community Behavioral Health Clinic model, STEP VA emphasizes access to community-based behavioral health services for SMVF. DBHDS is working collaboratively with CSBs to consistently identify SMVF seeking services, train staff in military culture and clinical best practices for treatment of trauma related to combat and/or military service and collaborate with Federal, State, and local resources for SMVF.

Homeless Individuals

Individuals with serious mental illness (SMI) and those with co-occurring substance use disorders (SUD) are at disproportionately high risk of homelessness. As of January 2018, Virginia had an estimated 5,975 individuals experiencing homelessness on any given day, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD). According to this annual Point in Time Count, 985 individuals with SMI and 656 individuals with SUD were homeless. Since 2010, Virginia has decreased overall homelessness by 34%; however, only a 20% decrease has been realized for the population of homeless individuals with SMI.

The continued support of the MHBG will assist in targeting needed resources to persons with SMI. In the fourteen (14) areas of the state with the highest prevalence rates, DBHDS allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) Program to CSBs to provide outreach, engagement and case management services to homeless persons with SMI/SUD. Through collaborative relationships with the continuum of homeless service providers in local catchment areas, Virginia's PATH programs assist consumers in accessing housing, mental health and substance abuse treatment services, entitlement benefits and other services needed to support them in the process of

recovery. Those who are literally homeless – meaning either living on the streets, in encampments, or other locations that are unfit for human habitation -- are the priority population served by Virginia's PATH providers. Providers expect to contact an estimated 2,969 individuals and enroll 1,426 individuals during Federal Fiscal Year 2019; approximately 88% of these individuals are anticipated to be literally homeless.

The majority of Virginia's 14 PATH programs operates in urban areas and spends significant time conducting street and shelter outreach to identify individuals with SMI who meet the PATH definition of homeless. Those programs operating in suburban and rural areas conduct outreach to homeless individuals in woods, encampments, under bridges and in other places where unsheltered persons congregate. The end goal of PATH is always to assist the individual to obtain housing, engage in behavioral health services, and access disability and other benefits. The SSI/SSDI Outreach, Access and Recovery (SOAR) model of engagement is an additional service provided to PATH-enrolled consumers by five of Virginia's PATH programs. Access to Social Security benefits also provides access to medical insurance, making it more likely that PATH consumers, many of whom are medically vulnerable, can access medical treatment as well as behavioral healthcare. As the state SOAR lead, DBHDS continues to actively facilitate strong community-level collaboration with the Social Security Administration and Virginia's Disability Determination Services. This unique SOAR model provides homeless persons with SMI a greater chance of approval for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits. As a result of these local relations, Virginia's disability approval rate increased in State Fiscal Year (SFY) 19 to 74% from 67% in SFY18. Additional increases are anticipated with regional SOAR certified trainings being offered to enable streamlined pre-release forensic and state hospital discharge planning processes.

Virginia also continues to work to further former Governor McDonnell's Executive Order 10, signed in 2010, that called for a Housing Policy Framework focused on addressing the needs of homeless Virginians, and housing and services for those with very low incomes. The Governor's Coordinating Council on Homelessness was created soon thereafter and is responsible for carrying out activities requested by the Governor which may include but not be limited to: implement state plan to effectively address homelessness; address policy issues; oversee coordination among and between secretariats and state agencies; and enhance coordination and collaboration between state agencies and local organizations.

Virginia became the first state in 2015 to effectively end veteran homelessness meaning "functional zero" had been reached through the development of local systems established to make homelessness rare, non-recurring and brief for veterans whose homelessness could not be prevented. In November 2018, Governor Northam signed Executive Order 25 which affirmed cross-secretariat efforts aimed at: addressing the shortage of quality affordable housing; reducing the rate of evictions throughout the state; and increasing the supply of permanent supportive housing units (PSH). Many of the PSH units are targeted for chronically homeless persons with SMI and SUD. Virginia recognizes the importance of promoting best practices in serving homeless individuals with SMI and SUD and will continue to support and strengthen local systems established to prevent and end homelessness for these populations.

Individuals with Criminal Justice Involvement

It is well known that individuals identified as living with a serious mental illness (or co-occurring disorder) are at notably higher risk for being incarcerated, and in many cases may remain incarcerated for longer periods of time than the general population. Ongoing concerns related to potential negative impact of longer-term incarceration on their behavioral health needs and overall wellbeing as well as their risk of reoffending continue to drive efforts related to earlier intervention on their behalf as early as possible within their interactions with the criminal justice system. It is the hope that linking them to appropriate behavioral health treatment services can change the trajectory of an individual's future mental health recovery.

In Virginia, an annual survey of mental illness in jails is administered by the State's Compensation Board. Per the 2018 Mental Illness in Jails Survey, Virginia's jails held on average 28,279 at any given time. At the time of the survey, 34.8% of the female and 16.74% of the male inmates were known or suspected of having mental illness. 10.42% of the inmates were known or suspected to suffer from a serious mental illness. At the time of the survey there were 7,852 inmates known or suspected to have a mental illness. This is 400 inmates higher than were identified the year before. Since 2012 the percentage of inmates known or suspected of having a mental illness has grown from 11% to 19.84%.

The Commonwealth of Virginia is keenly aware of the multiple challenges it faces and actions needed to improve response to and outcomes for individuals with mental health issues at risk for arrest or involved in the criminal justice system. Three statewide efforts: Virginia's Cross Systems Mapping initiative (2008-2013), the Governor's Task Force for Improving Mental Health Services and Crisis Response (2013-2014), and DBHDS's Transformation Team initiative (2014-2016) each provided critical insights into the totality of the problem, specific areas of concern, and recommendations for improvement.

Some of those recommendations for improvement included:

Crisis Intervention Teams: Crisis Intervention Team (CIT) programs are nationally recognized, police-based, mental health crisis response initiatives that are interdisciplinary, collaborative, and community based. CIT programs enhance law enforcements capability to respond to situations involving individuals with symptomatic behavioral health issues. In FY2017, over 7,700 first responders were CIT trained and throughout the history of CIT in Virginia, 11,000 staff from law enforcement, mental health, the court system, hospitals, and peer support specialists have participated in a CIT training. In concert with local CIT programs, DBHDS provides funding for the operation of 37 CIT Assessment sites also known as "Drop Off Centers" or in some locales as "Receiving Center" operating out of 36 CSB's. These Assessment Sites exist across the Commonwealth to provide a non-criminal justice setting where persons with mental illness can be taken by law enforcement officers in lieu of arrest or incarceration for behavioral health assessment and linkage to services. In FY2017, Virginia's CIT Assessment Sites provided 12,548 assessments to individuals experiencing a behavioral health related crisis who might have otherwise gone to jail.

Jail Diversion Programs: DBHDS supports a number of Jail Diversion Initiatives, all of which reside within the Office of Forensic Services. Jail Diversion Initiatives come in several forms of forms, but all essentially strive to identify individuals diagnosed with mental illness in jails.

In total, 20 CSB's across the Commonwealth have received Jail Diversion funding between 2007 and 2019. Some of the funds have been for one time expenditures, while others are ongoing initiatives. A more complete review of Virginia's various Jail Diversion programs can be found in the FY18 Jail Diversion Annual Report. In FY18, 2981 individuals were screened for eligibility, and 514 were enrolled in a Jail Diversion Program. Overall, 1081 individuals were served in some capacity through a Jail Diversion Initiative in FY18.

Mental Health Screening in Jails: During the 2017 General Assembly session, budget language was approved requiring all local and Regional jails to screen inmates upon admittance for mental health issues using a scientifically validated tool designated by the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS)⁵. DBHDS recommended two tools: the Brief Jail Mental Health Screen (BJMHS) and the Correctional Mental Health Screen for women or for men (CMHS-W or CMHS-M).

To support the jails as they move towards implementation, DBHDS developed a 1 ½ hour training on basic mental health awareness and identification, basic interviewing skills and an overview of how to administer the Brief Jail Mental Health Screen (BJMHS) and the Correctional Mental Health Screen (CMHS) for jail staff and others serving this population.

Multiple web based trainings were also made available for viewing after the live trainings concluded. By the end of the August live trainings, nearly 700 individuals representing jail intake/booking staff, mental health staff and qualified mental health practitioners (QMHP), correctional officers, and others were estimated to have attended the training. Jails in the Commonwealth have been offered the opportunity to request additional training as needed.

Behavioral Healthcare Standards for Jails: During the 2019 General Assembly Session, bills were passed to require the Board of Corrections, in consultation to DBHDS to establish minimum standards for behavioral healthcare in jails. DBHDS has taken the lead on this initiative and the standards will soon be released for public comment. It is expected that the standards will improve both access and quality of behavioral healthcare provided in jails.

Forensic Discharge Planning: During the 2018 General Assembly Session, funds were allocated to DBHDS to distribute to provide forensic discharge planning services for individuals with SMI in local and regional jails. A solicitation for proposals was released and two large regional jail systems were selected to receive the funding. The CSBs are actually providing the services within the jails (which will enhance continuity of care). It is hoped the General Assembly will continue to fund these services in other jails.

Problem Solving Dockets: The Chief Justice of the Supreme Court of Virginia issued a Rule of Court in 2017 allowing jurisdictions to establish problem solving dockets for individuals with behavioral health challenges who become involved in the criminal justice system. This Rule coincided with DBHDS' release of best practice standards for mental health dockets. DBHDS funds three MH dockets and is in the process of collecting data on the effectiveness of these programs. One of the requirements for a community to establish a docket is for all partners to participate in standardized training on best

practices for dockets. DBHDS actively participates with the Office of the Executive Secretary of the Supreme Court in providing this training.

Sexual Minority Groups

Many individuals who are Lesbian, Gay, Bisexual, Transgendered, or Questioning (LGBTQ) have behavioral health needs. The 2015 National Survey on Drug Use and Mental Health found that LGBTQ+ individuals experience mental health issues such as depression, anxiety, and suicide ideation much more frequently than their heterosexual counterparts. Additionally, sexual minorities are more likely have substance use issues and need substance use treatment. DBHDS is participating in efforts to have Virginia's CSBs and state hospitals serve LGBTQ individuals and communities equally, and address issues of sexual orientation in the context of individual and group therapy, supportive services, and other behavioral health care.

DBHDS has partnered with Side by Side, a Virginia organization dedicated to creating supportive communities for LGBTQ+ youth to develop the Safer Space Training and Action Planning Workshops. These will occur July-August of 2019 in multiple parts of the state with the goals of education on inclusivity, risk factors, and protective factors as well as participation in community planning around policy and agency change.

Rural Populations

The Commonwealth of Virginia covers a wide range of geographic regions. Depending on its location, one CSB might serve a combined population of urban, suburban and ex-urban or rural areas. According to the most recent decennial census, the Census Bureau indicated that 75.5% of the population in Virginia resided in urban areas and 24.5% in rural areas. Twenty-six of the 40 CSBs contain one or more counties in their jurisdiction that are majority rural. During SFY 2018, these twenty-six CSBs served 68% of all mental health consumers and 61% of individuals receiving substance abuse treatment.

CSBs vary according to budget size and population density, and many in rural areas do not have the infrastructure to support the services needed within the community. In addition to this concern an individual in a rural area may have experienced different levels of access to transportation, availability of psychiatric and medical care, difficulty with linkages to supports, capacity to handle life tasks such as having access to a grocery store. CSBs use different approaches, such as sharing services regionally with other CSBs and collaborating with local and regional contract agencies to meet the service needs of their consumers. Telepsychiatry and telecommunication, for example, are in use in some rural areas to facilitate specialty psychiatric services for adult consumers, children and their families, and veterans.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and 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.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). 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 should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁶ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

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Footnotes:

Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Data Sources

The data sources used to inform DBHDS's behavioral health needs assessment and ongoing planning and development process encompass the full spectrum of available data sources on mental health and substance use disorders. They range from a wide scope sources including the National Survey on Drug Use and Health and the Treatment Episode Data Set, to the Community Consumer Submission, Virginia's unique data system, to individual surveys conducted of various stakeholders throughout the Commonwealth. DBHDS utilizes data to identify the needs and gaps in the Commonwealth's behavioral health service continuum in addition to a way of defining and tracking progress related to system transformation. These data sources have been described below in more detail.

Core DBHDS Databases

Community Consumer Submission 3 (CCS3) – CCS is Virginia's unique, consumer-level data collection system that is used in partnership with CSBs statewide. CCS is a compilation of demographic, clinical, and service utilization data for all individuals receiving services from CSBs.

AVATAR – This is the client-level DBHDS inpatient facility database, including demographic, clinical and service information about individuals receiving inpatient services in DBHDS hospitals.

CSB Automated Reporting System (CARS) – This is the financial reporting system for CSBs, showing revenues by source and expenditures and costs by service category.

Databases External to DBHDS

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

DMAS – DBHDS obtains reports from DMAS about utilization of behavioral health services reimbursed through Medicaid.

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

Other Global Data Sources

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

National Outcome Measures (NOMs) – NOMs were developed jointly by SAMHSA, the states, and the District of Columbia to track and measure real-life outcomes for people in recovery from mental health and substance abuse disorders. The identifiers selected as NOMs, including metrics such as housing,

employment, retention, and social connectedness embody meaningful outcomes for people who are striving to attain and sustain recover, build resilience, and work, learn, live and participate in their communities.

National Survey on Drug Use and Health (NSDUH) – The NSDUH provides national and state level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. Virginia uses Nationwide as well as state-level estimate from the NSDUH to inform other state agency collaborators as well as the General Assembly on substance use and mental health disorders in Virginia. NSDUH data also aids needs assessment processes throughout the Commonwealth and state-level estimate data is used in future program-planning processes.

Ad Hoc Data Sources

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

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

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

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

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

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

Partnerships with other State Agencies

DBHDS participates with a number of other agencies in data sharing efforts including the Department of Education, Department of Criminal Justice Services, Department of Motor Vehicles, Department of Alcoholic Beverage Control, Department of Health (including the Office of the Chief Medical Examiner), Department of Social Services, and the Virginia Employment Commission.

Transforming the Behavioral Healthcare System

DBHDS initiated a transformation process in need 2014 that included a comprehensive review of the state behavioral health and developmental services system. The effort continues to focus on access,

quality, stewardship of resources, and accountability. Virginia's behavioral health system faces many challenges. These include:

- insufficient service capacity coupled with high demand;
- inconsistent access to best practices;
- inadequate integration of care for individuals with MI and SUD, consumers with complex, co-morbid health and behavioral health care needs, and/or behavioral health and criminal justice involvement;
- lack of peer and family involvement and support;
- Criminalization of individuals with MI and SUD; and fragmentation of services due to lack of care coordination.

These challenges continue to be compounded by broader, external factors including an aging workforce, inadequate resources, regulatory stressors, complexities with system-wide implementation of electronic health record technology, and lack of access to critical support services such as transportation, employment, and affordable housing.

Identifying the Need

During the federal CCBHC grant awarded in 2015, DBHDS engaged national consultants, the Public Consulting Group (PCG), to conduct a community needs assessment with eight CSBs' to determine readiness to provide the services required by the grant. PCG's efforts focused primarily on accessibility, cultural competency and the provision of the required CCBHC service array. In order to develop the three main components of the community needs assessment, PCG reviewed publicly available data sets, collected primary source data through CSB site visits, and conducted consumer and stakeholder surveys. It is important to note, in most cases, findings and assessment results were based on information self-reported by the CSB rather than independently verified information. In addition, quality of services provided was not measured in any statistically significant manner. Collected documentation was reviewed subsequent to the site visits and additional follow-up with the CSBs was conducted as needed.

The results of the analysis concluded that none of the eight CSBs at the time could deliver the array of required services at the level needed to become a certified CCBHC. In fact, of the 11 services measures, none of the eight CSBs was ready to implement more than four of the services at the time of the analysis. Importantly, the CSBs' current ability to provide these required services was largely based on the need for additional funding. The analysis performed by PCG provided a foundational level of understanding of how close the eight CSBs in the grant project were to being ready to provide the robust array of required CCBHC services.

Example Funding Timeline for STEP-VA (as of 2017)

The following chart provides the budget and funding timeline for STEP-VA services pending Virginia General Assembly approving funding for specific components. The services may be implemented incrementally, and the chart below an implementation plans by year to 2022 and beyond.

	FY 2018		FY 2019		FY 2020		FY 2021		FY 2022+	
	GF	NGF	GF	NGF	GF	NGF	GF	NGF	GF	NGF
Same Day Access	\$ 8.21	\$ 1.33	\$ 14.71	\$ 2.60	\$ 14.71	\$ 2.60	\$ 14.71	\$ 2.60	\$ 14.71	\$ 2.60
Outpatient Services							\$ 20.83	\$ 3.68	\$ 41.65	\$ 7.35
Primary Care Integration			\$ 17.60		\$ 17.60		\$ 17.60		\$ 17.60	
Detoxification							\$ 2.03	\$ 2.03	\$ 4.05	\$ 4.05
Peer Services							\$ 3.69	\$ 0.65	\$ 7.38	\$ 1.30
Psychological Rehab/Skills							\$ 2.61	\$ 0.46	\$ 5.21	\$ 0.92
Care Coordination Services							\$ 9.20		\$ 18.40	
Targeted Case Management							\$ 3.44	\$ 0.61	\$ 6.87	\$ 1.21
Veterans Services							\$ 2.37	\$ 0.42	\$ 4.73	\$ 0.84
Mobile Crisis Services							\$ 14.84	\$ 2.62	\$ 29.68	\$ 5.23
New Services Total	\$ 8.21	\$ 1.33	\$ 32.31	\$ 2.60	\$ 32.31	\$ 2.60	\$ 91.30	\$ 13.05	\$ 150.28	\$ 23.50
Additional Infrastructure Needs	\$ 4.50		\$ 30.22		\$ 21.50		\$ 15.40		\$ 0.99	
Total Cost	\$ 12.71	\$ 1.33	\$ 62.53	\$ 2.60	\$ 53.81	\$ 2.60	\$ 106.70	\$ 13.05	\$ 151.27	\$ 23.50

(Costs shown are amounts in million dollar increments)

(GF refers to state general funds, NGF refers to state non-general funds)

Service Gaps

The DBHDS Comprehensive State Plan 2014-2020 (December, 2013) documented the following waiting list and service need data displayed in Tables 1 and 2 based on a point-in-time survey of CSBs. These data demonstrate that 45% of the individuals needing mental health services and 37% of those needing SUD services wait more than four months to receive them. The survey reported that some people received some services but others received none while on waiting lists.

Average Wait Times in Weeks for CSB Services

As part of the waiting list survey, CSBs were asked to estimate the number of weeks individuals waited prior to their receipt of specific services. Average wait times for specific services follow.

Table
1

Service	MH Services		DEV Services		SUD Services	
	Adults	C & A	Adults	C & A	Adults	Adolescents
Outpatient Services						
Medication Services	6	5.75	4.82	5.94	6.48	5.74
Psychiatric Services	5.9	6.07	5.4	6.16	6.12	5.95
Counseling & Psychotherapy	6.38	4.28			4.48	3.83
Behavior Management			45.36	4.5		
Intensive SA Outpatient					1.63	2
Intensive In-Home		3.33				
Medication Assisted Treatment					9.25	1
Assertive Community Treatment	11.24					
Case Management Services						
Case Management Services	5.87	2.73	2.89	2.95	5.46	5.07

Table
2

Service	MH Services		DEV Services		SUD Services	
	Adults	C & A	Adults	C & A	Adults	Adolescents
Day Support Services						
Day Treatment/Partial Hospitalization	2	2.6			3	
Ambulatory Crisis Stabilization Services	2	N/R*				
Rehabilitation or Habilitation	6.39	2	56.73	63.8	2	N/R*
Employment Services						
Sheltered Employment	12.83		68.00	150.00	22.00	N/R*
Group Supported Employment	11.50		86.00	285	20.50	N/R*
Individual Supported Employment	10.22	2	36	N/R*	15	N/R*
Residential Services						
Highly Intensive Residential Services	13.00	2	80.9	55.50	3.33	7.00
Residential Crisis Stabilization Services	1	1	25.33	2	N/R*	N/R*
Intensive Residential Services	21.40	2	79.69	81	4.38	4.50
Supervised Residential Services	53.73	1.5	66.10	112.00	1.5	N/R*
Supportive Residential Services	21.83	3	62.18	70.63	13.5	2.00
ID Waiver Services						
Nursing Services			80.86	49.67		
Environmental Modifications			42.93	26.93		
Assistive Technology			66.35	40.5		
Personal Response System (PERS)			144.26	64		
Therapeutic Consultation			60.5	24.21		
Limited Services					Average Wait Time	
Motivational Treatment Services					2.50	
Consumer Monitoring Services					15.00	
Assessment and Evaluation Services					3.67	
Early Intervention Services					2.83	
Consumer Run Services					2.00	

* N/R indicates that CSBs did not provide any information regarding wait times for this service.

Services for Pregnant and Parenting Women

DBHDS requires that programs provide substance use treatment to pregnant and parenting women and offer priority admission to pregnant women. Programs are informed through the DBHDS performance contract that they must publicize the following information: that they provide substance use treatment services to pregnant woman; that pregnant women receive priority admission for substance abuse services and that these women will be seen within 48 hours of their request for services.

DBHDS posts the SAPT regulations for pregnant and parenting women on its website and distributes a memo to programs each year with these expectations. The document includes the expectation that programs provide interim services to pregnant women whenever they are unable to provide services within the 48 hour required time frame and mandates that they contact the Women's Services Coordinator at DBHDS to request assistance to develop an alternate service plan.

As part of the DBHDS review process, DBHDS verifies that each program has policies and procedures directing staff to accord treatment priority to pregnant women. This information is also reflected on the program's website and included in the brochures and posters that are disseminated in the community. DBHDS women's services coordinator, behavioral health consultants and audit office address this expectation as part of their routine monitoring and oversight efforts.

In addition to the services outlined in the SAPT regulations, DBHDS requires that programs assess withdrawal risk and provide the woman with appropriate guidance as part of their interim services.

All CSBs serve pregnant and parenting women, however, lack of funding makes it more difficult for parenting women to access MAT due to pregnant women having priority. CSBs usually absorb the cost of MAT for pregnant women and consequently they have fewer funds available to spend on these services for postpartum and/or parenting women and other individuals. DBHDS oversees 40 CSBs which provide substance use services. All are required to provide outpatient services to pregnant and parenting women or contract out these services with a formal MOU. Four CSBs provide residential services for pregnant and parenting women and are able to admit women from other CSBs.

Services for Individuals who Inject Drugs

DBHDS continued to define IVDUs in need of treatment as persons who typically use injected drugs, such as heroin, and those abusing or dependent on opioid prescription drugs, such as OxyContin or Oxycodone. The Centers for Disease Control's National Notifiable Diseases Surveillance System reported that Virginia was above the Healthy People 2020 goal of 0.25 Acute Hepatitis C cases/100,000 people.¹ Many Hepatitis C cases are linked to injection-drug use.. Opioid IVDUs were treated in OTPs, in office-based settings using buprenorphine, naloxone, and in drug-free settings. Non-opioid IVDUs were treated in other modalities (e.g., outpatient, intensive outpatient, day treatment, case management, and residential). During SFY 2018, 24,866 individuals receiving substance abuse services from CSBs reported some degree of opioid use

All 40 CSBs offer outpatient medication assisted services to opioid dependent individuals who enroll in treatment services; however the ability to access these services varies by community. Virginia has four public and 34 private opioid treatment programs. Alexandria, Norfolk, Portsmouth and Hampton Newport News CSBs are each licensed to dispense methadone within their respective catchment areas for individuals who participate in treatment services at the CSB. Alexandria CSB contracts to provide methadone to individuals enrolled in substance abuse treatment at four other northern Virginia CSBs. The remaining programs in the Commonwealth refer participants to private methadone programs in their community or nearby. Nine CSBs employ medical staff able to prescribe buprenorphine. The other CSBs must seek physicians in the community who are willing to prescribe buprenorphine.

Hampton Newport News (HNN) CSB, Richmond Behavioral Health Authority (RBHA) and Region Ten CSB offer residential treatment for pregnant women and ensure that opioid dependent women enrolled in their residential program are able to access methadone services. Opioid dependent pregnant women enrolled at HNN CSB's Southeastern Family Project receive methadone services through HNN CSB's OTP. RBHA refers women to a contracted provider and an appointment is scheduled for induction. If other MAT is preferred, the individual is scheduled to see the OBOT physician. The Women's Center at Moore's Creek at Region Ten receive methadone services through a contracted provider, but may access the OBOT if other MAT is desired.

¹ <https://www.cdc.gov/hepatitis/statistics/2016surveillance/index.htm>

Accessing MAT is difficult in Virginia due to the scarcity of programs and lack of funding. Virginia's four public opioid treatment programs accept Medicaid reimbursement. Initiation of the DMAS substance use disorder waiver is expanding access to this service. There are pockets throughout the Commonwealth where access to MAT varies from poor to non-existent. Although DBHDS licensed 18 additional OTPs between 2011 and 2016, opioid-dependent individuals who live in the catchment areas for Alleghany Highlands, Eastern Shore, There is an OTP in Prince George now so access for D19 has improved., Piedmont, Rappahannock Rapidan, or Planning District One CSBs must travel one to four hours each way to receive medically assisted treatment.

Services for Persons at Risk for Tuberculosis

DBHDS does not track the number of persons receiving SA services who also receive TB services. The MOE calculation is based on the number of positive TB cases during the year. The MOE base and annual compliance figure is calculated by totaling state general fund expenditures for TB Prevention and Control, TB Drugs, TB Outreach and TB Drugs-Resistance. For 2017, the percent of drug-related TB cases was (9.0%. In 2017 the Virginia Department of Health determined that there were a total of 204 positive TB cases statewide.³ Due to the increase of positive cases over the last several years, finding and treating at-risk-for-latent TB testing has become a high priority.

DBHDS continued to adhere to a "targeted testing" methodology. This strategy has reduced the numbers of false positives and maximized scarce resources by skin testing only persons with symptoms of TB and certain risk factors. DBHDS continued to work with the Department of Health (VDH) and the CSBs to ensure that services to consumers continue to focus on identifying who may have tuberculosis infection. DBHDS continued to make available tuberculosis screening protocols and continued to require sub recipients to utilize them to screen persons entering publicly-funded substance abuse treatment programs. DBHDS continued to work closely with the Virginia Department of Health (VDH) to review existing protocols for efficacy. DBHDS staff was involved in several ongoing work groups with VDH on infectious disease control (CPG HIV/AIDS, Hepatitis, and Disaster/Pandemic Planning). VDH provided technical assistance to programs upon request. DBHDS continued to require CSBs to refer, track and monitor persons referred for treatment for tuberculosis.

All programs in the Commonwealth are licensed by DBHDS, which conducts unannounced inspections at least annually (12VAC 35-105-70). The licensing regulations require that all persons entering treatment be screened for communicable diseases. The Office of Licensure requires the provider to submit a corrective action plan in the event a non-compliance issue arises. The State Opioid Treatment Authority (SOTA) is working with the Office of Licensure to strengthen communication between the offices regarding non-compliance with this requirement, and discussing clinical protocols to be implemented when screening indicates the need for additional diagnostic attention.

All OTPs are required to have and maintain accreditation with an entity approved under federal regulations. Accreditation requires a TB baseline skin test for anyone seeking treatment upon admission and then annually thereafter. If a person has ever had a positive skin test then a chest x-ray is required

³ <http://www.vdh.virginia.gov/data/communicable-diseases/>

to insure the person is free of M. tuberculosis infection. OTPs are visited by DBHDS staff multiple times a year to insure compliance with regulations.

Services for Individuals in Need of Primary Substance Abuse Prevention

DBHDS Office of Behavioral Health and Wellness (OBHW) convened a Virginia State Epidemiological Workgroup (SEOW) to conduct a Social Indicator Study (SIS) that developed state and county/city epidemiological profiles based on risk indicators for substance abuse and mental illness. Risk factors linked to Adverse Childhood Experiences (ACE) are also included. This data is essential in creating state and local planning, target determination and outcome achievement. This data allows the examination of relationships between risk and protective factors with subsequent behavioral health outcomes, and are identifying areas of focus and opportunity for prevention efforts. These data have also provided the foundation for the Virginia SUD Prevention Needs Assessment and prioritized risk and protective factors for the strategic plan which is under development. Local providers, known as Community Services boards (CSBs), have used this data as the foundation for local needs assessment. They have coupled this with focus groups, additional local data and a resource assessment to development a strategic plan and logic model for local planning and a strategy implementation effort.

Support Services for Children

The Virginia Office of Children's Services conducted its Service Gap Analysis from FY2016, surveying local community policy and management teams. The survey analysis demonstrated the lack of a complete array of children's services in all areas of the State. It identified the following top six statewide gaps by services: family support services, community based behavioral health services, foster care services, educational services, residential services, and crisis services. Within the top three broad categories the following services were identified:

Category	Services
Family Support Services	<ul style="list-style-type: none">• Transportation to Access Services• Respite• Parent Coaching
Community Based Behavioral Health Services	<ul style="list-style-type: none">• Trauma Focused/Informed Services• Applied Behavioral Analysis• Medication Management
Foster Care	<ul style="list-style-type: none">• Family Foster Care Homes• Therapeutic Foster Care Homes• Independent Living Services

Services for Military Service Members, Veterans, and their Families (SMVF)

Veterans Health Administration (VHA) facilities provide medical and behavioral health services for veterans, however, ineligibility for services, geographic distance from a VHA facility, and/or stigma may prevent many veterans from seeking care. Stigma associated with behavioral health services and concerns about job security and the ability to deploy for military duty may also decrease access to care for Active Duty, Reserve Component, and National Guard Service Members in the Military Treatment system. In addition many National Guard Service Members are not considered 'Veterans' eligible for

federal programs and services (due to insufficient Active Duty time) or geographically dispersed from military installations so they rely on community-based services.

VHA estimates that 20 veterans die by suicide every day; of the 20, only 6 were connected with the VHA for healthcare prior to their deaths⁴. Suicide rates vary across the Nation, and the veteran rates mirror trends of the general population. However, veterans and service members are at a greater risk for suicide than civilians. According to the Virginia Violent Death Reporting System (VVDRS), over 13,100 Virginians died by suicide from 2003 to 2016 including 3,019 veterans or service members⁵. The use of a firearm is the leading means in suicide deaths among veterans (65-80% of suicide deaths compared to 50% among civilians). In 2016, veteran suicides were the highest since VVDRS started monitoring in 2003 (248 suicide deaths). Veterans need greater access to community-based behavioral health services to end this public health crisis.

DBHDS worked with Virginia Department of Veterans Services (DVS) and CSBs to improve services delivery to SMVF and data quality within the CSBs through a voluntary Ask the Question Campaign which started in May 2017 and continues today. The campaign encourages CSBs to ask consistently about military/veteran status or connection (family members) and highlights military/veteran specific data elements to be completed within the existing CSB data system. The Campaign also emphasizes the need for CSB service providers to be trained in military cultural competency and to work with military/veteran specific resources such as VHA, DVS, and Military Treatment Facilities etc. A total of 4,947 veterans (includes military service members) were served by CSBs in SFY18 which is an increase from 4,805 in SFY17. Dependent family members (spouses and children) served by CSBs also increased from 890 in SFY17 to 1,207 in SFY18. SMVF accessed primarily emergency, outpatient mental health, case management and outpatient substance abuse services in CSBs. The Ask the Question Campaign continues to improve data quality in CSBs. For instance, SMVF status was missing in 28,762 treatment records in SFY18 (or 13% of total treatment records) which is a decrease from 34,093 in SFY17 (or 15% of total treatment records). STEP VA will build upon the voluntary Ask the Question Campaign components and codify service enhancements for SMVF in the CSB system.

⁴ "VA Releases Veteran Suicide Statistics by State". 15 September 2017. U.S. Department of Veterans Affairs. Office of Public and Intergovernmental Affairs.
<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2951>.

⁵ Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health. A National Violent Death Reporting System project.
<http://www.vdh.virginia.gov/medExam/NVDRS.htm>.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?
Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Quality and Data Collection Readiness

From the guidance:

Describe your State's approach to quality and data collection and how it can be improved and result in better client level data and outcomes.

DBHDS recognizes the critical importance of data and evaluation for monitoring progress and determining success, maintaining transparency and accountability, and advancing systems with continuous quality improvement. It has long-established data collection processes with its provider and agency partners, including Community Services Boards (CSBs) via the Community Consumer Submission (CCS 3) application and state facility data, via AVATAR. CCS 3 is Virginia's unique, consumer-level data collection system that is used in partnership with CSBs statewide. CCS3 is a compilation of demographic, clinical, and service utilization data for all individuals receiving services from CSBs. AVATAR is the client-level DBHDS inpatient facility database, including demographic, clinical and service information about individuals receiving inpatient services in DBHDS hospitals.

This data is reported at the individual, program, and provider levels. DBHDS and its data providers are committed to continuously improving the quality of the data collected and the use of information for planning, program evaluation, and measuring outcomes. As has been evidenced in a prior Block Grant reporting, DBHDS is able to utilize these two data sources to provide both aggregate level data and client-level data with or without identifying information.

The Office of Behavioral Health Wellness (OBHW) in the Division of Behavioral Health Services has recently converted to a new data system - Collaborate Planning Group (CPG) Performance Based Prevention System (PBPS) - a Performance Management Data System. This data system allows DBHDS OBHW to collect individual, program, community, and population level data and link it to specific goals and objectives that will allow OBHW to measure provider performance through measurable outcomes.

The state's current data collection and reporting system includes individuals receiving substance use disorder and mental health services and is not part of a larger data system. The OBHW prevention data system is specific to substance abuse prevention and mental health promotion services. Social Solutions ETO is a centralized data system so that all providers use the same system, and it is not part of a larger data system.

Virginia also reports client-level data for the current data elements required for the Treatment Episode Data Set (TEDS) and the MHBG Uniform Reporting System (URS) tables, and we report the MH data elements using the MH-CLD protocols.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Retention in Community Substance Use Disorder (SUD) Treatment Services

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Provide adequate support to individuals receiving community SUD treatment services early in the treatment process to help ensure they complete their treatment program.

Objective:

Increase the number of individuals receiving community SUD treatment services through the completion of their treatment program.

Strategies to attain the objective:

1. Encourage and provide support to providers to use engagement strategies such as Motivational Enhancement Therapy and Motivational Interview by providing training on these evidence-based practices.
2. Encourage providers to utilize Contingency Management as an evidence-based practice where appropriate, and provide training to providers in this practice.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In last 12 months, percent of individuals admitted to SUD program area who received either a valid SUD or MH service every month after admission for at least the following 2 months.
Note: Denominator is all individuals admitted to SUD the previous 12 months receiving either a valid SUD or MH service the month following admission.

Baseline Measurement: 61%

First-year target/outcome measurement: 62%

Second-year target/outcome measurement: 63%

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse

Description of Data:

Data will track individuals who have been admitted to the SUD services program area and who have also received subsequent behavioral health services for two consecutive months the month after admission.

Data issues/caveats that affect outcome measures::

None at this time

Indicator #: 2

Indicator: In last 12 months, percent of individuals admitted to SUD program area who received either a valid SUD or MH service every month after admission for at least 5 consecutive months after being admitted to SUD service area. Note: Denominator is all individuals admitted to SUD the previous 12 months receiving either a valid SUD or MH service the month following admission.

Baseline Measurement: 32%

First-year target/outcome measurement: 33%

Second-year target/outcome measurement: 34%

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System and DBHDS Data Warehouse.

Description of Data:

Data will track individuals who have been admitted to the SUD services program area and who have also received subsequent behavioral health services for 5 consecutive months the month after admission.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 2

Priority Area: Increase Peer Support Services

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID

Goal of the priority area:

Increase peer services and supports in the public behavioral health system.

Objective:

Expand the number of peer support specialists in direct service roles and recovery support services.

Strategies to attain the objective:

Increase the number of peer support specialists in Virginia's public behavioral health system through inclusion of peer support as a Medicaid reimbursable service.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of peer staff offering recovery support services in substance use disorder service settings.

Baseline Measurement: 40 FTE

First-year target/outcome measurement: 45 FTE

Second-year target/outcome measurement: 50 FTE

Data Source:

Data to be collected by DBHDS from CSBs.

Description of Data:

Data is the number of FTE peer support specialists providing recovery support services in CSBs SUD treatment programs.

Data issues/caveats that affect outcome measures::

None at this time.

Indicator #: 2

Indicator: Number of peer staff offering mental health peer support services in mental health treatment settings.

Baseline Measurement: 110 FTE

First-year target/outcome measurement: 120 FTE

Second-year target/outcome measurement: 130 FTE

Data Source:

Data will be collected by DBHDS from CSBs and state hospitals.

Description of Data:

The number of FTE mental health peer support specialists reported by CSBs and state hospitals.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 3

Priority Area: Intensity of engagement in SUD outpatient services

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Increase the intensity of individuals' engagement in community SUD treatment services.

Objective:

Increase the frequency of treatment sessions for individuals receiving community SUD treatment services.

Strategies to attain the objective:

1. Work with providers to establish guidance concerning case load sizes that supports adequate frequency of treatment services.
2. Work with providers to ensure that current resources are used efficiently.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Of those adults admitted to SUD program area in previous 12 months, the % who had additional 90 minutes or more Outpatient Services within 30 days of admission. Note: individuals must have received 45 minutes of Outpatient Services upon admission (denominator).

Baseline Measurement: 69%

First-year target/outcome measurement: 70%

Second-year target/outcome measurement: 71%

Data Source:

Virginia Community Consumer Submission (CCS-3) System; DBHDS Data Warehouse

Description of Data:

Data will track individuals who have received services within 30 days of being admitted into the SUD services program area.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 4

Priority Area: Intensity of engagement in child mental health case management services

Priority Type: MHS

Population(s): SED, PWWDC, ESMI

Goal of the priority area:

Increase the intensity of child and family engagement in mental health outpatient services.

Objective:

Increase the frequency of treatment sessions for children receiving mental health case management outpatient services.

Strategies to attain the objective:

1. Continue to expand access to a uniform array of children's behavioral health services using the System Transformation Excellence and Performance (STEP-VA) model.
2. As the outpatient services step of STEP-VA continues to be implemented, focus on strategic initiatives to fill gaps in the STEP-VA array of services for children.
3. Continue to expand the Children's Behavioral Health Academy. There is an extreme shortage of licensed professionals in CSBs to meet the challenging needs of children with behavioral health problems. The academy provides continuing education for the children's behavioral health workforce. This training is provided free of charge to assist clinicians in getting licensed or maintaining current licenses. (This strategy is currently implemented with federal funding.)
4. Improve DBHDS quality management and quality assurance and oversight capacity for child and adolescent behavioral health services. Additional resources are needed for this initiative. (This strategy is contingent on state funding.)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of children admitted to the mental health services program area during the previous 12 months who received one hour of outpatient services within 30 days of admission (denominator) who received at least two additional hours of outpatient services within 60 days of admission (numerator).

Baseline Measurement: 64%

First-year target/outcome measurement: 65%

Second-year target/outcome measurement: 66%

Data Source:

Virginia Community Consumer Submission (CCS-3) System; DBHDS Data Warehouse.

Description of Data:

Data will track children who received services within 30 days of admission into the mental health services program area.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 5

Priority Area: Address the housing needs of individuals with mental health and/or substance use disorders.

Priority Type: SAT, MHS

Population(s): SMI, PWWDC, ESMI, PWID

Goal of the priority area:

Address the housing needs of individuals with behavioral health disorders to support a secure and stable recovery.

Objective:

Increase the number of individuals with mental health and/or substance use disorders that have ongoing stable housing.

Strategies to attain the objective:

1. Continue participation in cross-secretarial and interagency activities to leverage housing resources and create affordable housing options for individuals receiving public behavioral health services.

2. Continue providing training and consultation to service providers to increase affordable housing and appropriate supports by leveraging housing resources and implementing supportive housing models.
3. Continue including housing stability of individuals receiving CSB behavioral health services as a Performance Contract goal and responsibility, and track outcomes on a regular basis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Oxford Houses in Virginia.

Baseline Measurement: 140

First-year target/outcome measurement: 144

Second-year target/outcome measurement: 148

Data Source:

Oxford House, Inc.

Description of Data:

Count of the number of Oxford Houses available to consumers in Virginia.

Data issues/caveats that affect outcome measures::

None at this time

Indicator #: 2

Indicator: Percent of individuals receiving Assertive Community Treatment (ACT) services who, in the previous 12 months, a) lived in stable housing, b) had no arrests, and c) had no more than one psychiatric hospital admission.

Baseline Measurement: 76%

First-year target/outcome measurement: 77%

Second-year target/outcome measurement: 78%

Data Source:

DBHDS Programs of Assertive Community Treatment Database

Description of Data:

Data for this measure will be obtained from the 30 CSBs who currently provide ACT and Intensive Community Treatment, which provides for smaller-scale ACT services.

Data issues/caveats that affect outcome measures::

None at this time.

Indicator #: 3

Indicator: Number of individuals housed in Permanent Supportive Housing programs through DBHDS.

Baseline Measurement: 644

First-year target/outcome measurement: 820

Second-year target/outcome measurement: 1260

Data Source:

DBHDS Permanent Supportive Housing Database

Description of Data:

Data are the total number of individuals housed since the inception of the DBHDS Permanent Supportive Housing Initiative.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 6

Priority Area: Intensity of engagement in adult mental health outpatient services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the intensity of engagement of adults with SMI in mental health outpatient services

Objective:

Increase the frequency of treatment sessions for adults with SMI receiving mental health outpatient services

Strategies to attain the objective:

1. Continue to expand access to a uniform array of adult behavioral health services using the System Transformation Excellence and Performance (STEP-VA) model.
2. As the outpatient services step of STEP-VA continues to be implemented, focus on strategic initiatives to fill gaps in the STEP-VA array of services for adults.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of adults admitted to the mental health services program area during the previous 12 months with serious mental illness who received one hour of outpatient services within 30 days of admission (denominator) who received at least three additional hours of outpatient services within 90 days of admission (numerator).

Baseline Measurement: 47%

First-year target/outcome measurement: 48%

Second-year target/outcome measurement: 49%

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse.,

Description of Data:

Individuals who have received services within 30 days of admission into a mental health services program area.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 7

Priority Area: Suicide Prevention

Priority Type: SAP, SAT, MHS

Population(s): Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Creation and maintenance of a suicide prevention infrastructure at the state and community levels.

Objective:

Increase the number of "Lock and Talk" activities annually, i.e. Gun Shop Project, Media Campaign Materials (Med Box/ Lock Box Distribution)

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Total number of firearm retailer partners established
Baseline Measurement: 110
First-year target/outcome measurement: 132
Second-year target/outcome measurement: 152

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of wellness activities supporting Suicide Prevention in the State.

Data issues/caveats that affect outcome measures::

None at this time

Indicator #: 2
Indicator: Total number of "Lock and Talk" outreach via total Med Box and Gun Locks distributed.
Baseline Measurement: 0
First-year target/outcome measurement: 6032
Second-year target/outcome measurement: 7000

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of wellness activities supporting Suicide Prevention in the State.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 8

Priority Area: Youth retail access to all tobacco products, including smokeless, cigarillos, e-cigarettes, and other vapor products

Priority Type: SAP

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

Goal of the priority area:

Decrease the number of minors being sold tobacco and nicotine products

Objective:

Decrease the Synar Retail Violation Rate (RVR) in Virginia.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of all retail outlets in Virginia that have violated sale of tobacco and nicotine products to minors (Retail Violation Rate).

Baseline Measurement: 10.1

First-year target/outcome measurement: 9.9

Second-year target/outcome measurement: 9.7

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall impact of the reduction of retail outlets selling tobacco and nicotine products to underage youth in the State.

Data issues/caveats that affect outcome measures::

None at this time.

Priority #: 9

Priority Area: Increase the public's knowledge about mental illness and decrease the associated stigma

Priority Type:

Population(s): Other (All people in the Commonwealth)

Goal of the priority area:

Decrease the stigma associated with mental illness through increased public knowledge and understanding of mental illness and its effects on individuals, families and communities.

Objective:

Increase the number of Mental Health First Aid trainers and Virginians trained in Mental Health First Aid.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of Mental Health First Aid Trainers from inception of program.

Baseline Measurement: 531

First-year target/outcome measurement: 550

Second-year target/outcome measurement: 575

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of trainers available to increase public's knowledge about mental illness and reduce stigma.

Data issues/caveats that affect outcome measures::

None at this time

Indicator #: 2

Indicator: The total number of individuals trained in Mental Health First Aid by certified Trainers in Virginia since the inception of the program.

Baseline Measurement: 51976

First-year target/outcome measurement: 58000

Second-year target/outcome measurement: 64000

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall impact of MH First Aid outreach to increase public's knowledge about mental illness and reduce stigma.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 10

Priority Area: Addressing Adverse Childhood Experiences (ACEs) as a community to reduce the impact of childhood trauma leading to problem behaviors, i.e. substance use disorder, suicide, and anxiety.

Priority Type:

Population(s): Other (All)

Goal of the priority area:

To better service individuals with Adverse Childhood Experiences so that the likelihood that trauma leads to problem behaviors is significantly reduced.

Objective:

Increase the number of Adverse Childhood Experience (ACEs) Prepared CSB Catchment Areas

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The total number of Virginia Community Service Boards (CSBs) that are trained to serve individuals with ACES

Baseline Measurement: 8

First-year target/outcome measurement: 18

Second-year target/outcome measurement: 30

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Measure of State's ability to serve individuals with ACE by number of CSBs trained to serve as catchment areas.

Data issues/caveats that affect outcome measures::

None at this time

Priority #: 11
Priority Area: Community mobilization organized to prevent substance use disorders
Priority Type: SAP

Population(s):

Goal of the priority area:

Greater connections between a variety of community coalitions across the state will have an impact on reducing the number of Virginians who become diagnosed with a substance use disorder.

Objective:

Increase the number of community coalitions linked to CADCA and/or CCOVA

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The total number of community coalitions in Virginia that have established a network with CADCA and/or CCOVA
Baseline Measurement: 42
First-year target/outcome measurement: 50
Second-year target/outcome measurement: 60

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Measure of networking touchpoints between community coalitions and CADCA and/or CCOVA.

Data issues/caveats that affect outcome measures::

None at this time.

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$31,489,761		\$0	\$5,967,688	\$59,103,294	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$4,715,501		\$0	\$677,935	\$1,379,866	\$0	\$0
b. All Other	\$26,774,260		\$0	\$5,289,753	\$57,723,428	\$0	\$0
2. Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$8,397,270		\$0	\$3,390,292	\$0	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$1,190,132	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$2,099,317		\$769,782	\$593,463	\$12,496,477	\$0	\$40,515
10. Total	\$41,986,348	\$0	\$769,782	\$9,951,443	\$72,789,903	\$0	\$40,515

* Prevention other than primary prevention

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

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$1,712,718	\$0	\$0	\$4,000,000	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$49,996,495	\$4,460,079	\$318,176,858	\$0	\$4,411,455
7. Other 24 Hour Care		\$0	\$0	\$0	\$14,920,738	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$14,558,081	\$206,575,147	\$3,769,674	\$236,759,945	\$0	\$0
9. Administration (Excluding Program and Provider Level)***		\$856,357	\$3,731,400	\$365,344	\$52,310,897	\$0	\$196,389
10. Total	\$0	\$17,127,156	\$260,303,042	\$8,595,097	\$626,168,438	\$0	\$4,607,844

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

NOT FINAL

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4873	469
2. Women with Dependent Children	102075	3966
3. Individuals with a co-occurring M/SUD	228123	40215
4. Persons who inject drugs	83660	12334
5. Persons experiencing homelessness	3824	1423

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

#2- 2010 US Census (Households with dependent- two parents, or single female parent) #3- ACS 2017 5 Year Estimates- 16 years or older #4- ACS 2017 5 Year Estimates #5- ACS 2017 5 Year Estimates US Interagency Council on Homelessness (2018)

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	\$31,489,761
2 . Primary Substance Abuse Prevention	\$8,397,270
3 . Early Intervention Services for HIV**	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	\$2,099,317
6. Total	\$41,986,348

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

NOT FINAL

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

	A	B
Strategy	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	\$578,394
	Selective	\$6,317
	Indicated	\$3,053
	Unspecified	\$93,866
	Total	\$681,630
2. Education	Universal	\$1,471,274
	Selective	\$183,831
	Indicated	\$7,939
	Unspecified	\$376,650
	Total	\$2,039,694
3. Alternatives	Universal	\$580,461
	Selective	\$459,366
	Indicated	\$890
	Unspecified	\$251,379
	Total	\$1,292,096
4. Problem Identification and Referral	Universal	\$36,238
	Selective	\$143,639
	Indicated	\$99,367
	Unspecified	\$129,797
	Total	\$409,041
	Universal	\$1,302,642

5. Community-Based Process	Selective	\$31,956
	Indicated	\$2,703
	Unspecified	\$1,841,555
	Total	\$3,178,856
6. Environmental	Universal	\$504,579
	Selective	\$8,596
	Indicated	\$488
	Unspecified	\$172,882
	Total	\$686,545
7. Section 1926 Tobacco	Universal	\$109,407
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$109,407
8. Other	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$0
Total Prevention Expenditures		\$8,397,269
Total SABG Award*		\$41,986,348
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	\$3,923,593
Universal Indirect	\$3,034,222
Selective	\$1,265,716
Indicated	\$173,739
Column Total	\$8,397,270
Total SABG Award*	\$41,986,348
Planned Primary Prevention Percentage	20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

Footnotes:

NOT FINAL

Planning Tables

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

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	\$43,247	\$104,880	\$148,127
2. Infrastructure Support			
3. Partnerships, community outreach, and needs assessment	\$194,003	\$125,184	\$319,187
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement	\$170,101	\$91,789	\$261,890
6. Research and Evaluation	\$160,250	\$20,733	\$180,983
7. Training and Education	\$87,841	\$42,369	\$130,210
8. Total	\$655,442	\$384,955	\$1,040,397

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

The allocation for this table will likely change by 10/1/2020 as DBHDS explores implementing logic model for funding determinations and more closely matching the amount of funding from block grants to the actual MH/SA duties of the positions

NOT FINAL

Planning Tables

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

MHBG Planning Period Start Date: 10/01/2019

MHBG Planning Period End Date: 09/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	\$125,000
2. Infrastructure Support	\$294,478
3. Partnerships, community outreach, and needs assessment	\$621,901
4. Planning Council Activities (MHBG required, SABG optional)	\$17,558
5. Quality Assurance and Improvement	\$0
6. Research and Evaluation	\$101,042
7. Training and Education	\$156,830
8. Total	\$1,316,809

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

The allocation for this table will likely change by 10/1/2020 as DBHDS explores implementing logic model for funding determinations and more closely matching the amount of funding from block grants to the actual MH/SA duties of the positions

Environmental Factors and Plan

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

Narrative Question

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

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

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

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³⁰ Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁶ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

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

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

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

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

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

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

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

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

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

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

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

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

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

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

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

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

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

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

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

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.
Please see attached 1. The Health Care System, Parity and Integration
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.
Please see attached 1. The Health Care System, Parity and Integration
3.
 - a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☐ Yes ☒ No
 - b) and Medicaid? ☐ Yes ☒ No
4. Who is responsible for monitoring access to M/SUD services by the QHP?
The Commonwealth of Virginia has not designated an agency to monitor this
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☒ Yes ☐ No
6. Do the M/SUD providers screen and refer for:
 - a) Prevention and wellness education ☒ Yes ☐ No
 - b) Health risks such as
 - ii) heart disease ☒ Yes ☐ No
 - iii) hypertension ☒ Yes ☐ No
 - iv) high cholesterol ☒ Yes ☐ No
 - v) diabetes ☒ Yes ☐ No
 - c) Recovery supports ☒ Yes ☐ No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ☐ Yes ☒ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ☐ Yes ☒ No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
Lack of personnel and financial resources
10. Does the state have any activities related to this section that you would like to highlight?
See attached 1. The Health Care System, Parity and Integration
Please indicate areas of technical assistance needed related to this section
None at this time

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

Footnotes:

NOT FINAL

Environmental Factors and Plan

1. The Health Care System, Parity and Integration

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

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

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

The Commonwealth of Virginia continues to work toward implementation of the model developed during applied for and was awarded the. Although Virginia did not go onto apply for the CCBHC Implementation grant, the model developed during the planning year DBHDS and community partners received in relation to the 2015 award of the SAMHSA Certified Community Behavioral Health Clinic planning grant. This model is called System Transformation Excellence and Performance in Virginia, or STEP VA.

STEP VA focuses on the development and sustainment of needed services, which includes same day access for assessment; primary care screening, referral, and follow up; behavioral health crisis services; outpatient behavioral health; psychiatric rehabilitation; peer support and family support services; veterans behavioral health services; care coordination; and targeted case management. This model has continues to have support from stakeholders including the Virginia General Assembly, and in March 2017, members introduced HB1549 and SB1005, "Community Services Boards and Behavioral Health Authorities; services to be provided," were passed and are now part of the Code of Virginia. The amended Code language states that by July 1, 2019, all public behavioral health agencies will provide same-day access, and primary care screening. It also states that by July 1, 2021, the other seven services indicated above will be provided. It is important to note, the General Assembly has continued to allocate funds toward STEP VA, however, several of the steps remain unfunded or lack complete funding at the time of this application.

The STEP VA model comes from a person-centered, trauma-informed, and recovery-oriented approach, seeking to be inclusive of the needs of all Virginians. The services listed above are or will be available across the life span for individuals with mental health, substance use, and co-occurring disorders. Same Day Access and Primary Care Screening are completed steps with all CSBs following the guidelines and agreements set up as part of these two models. Currently, DBHDS is working with agency partners to complete outpatient services and crisis transformation, with peer and veteran services in the early stages of development.

Funding streams in the Commonwealth vary related to their level of support for an integrated system of care. The block grants for mental health and substance abuse remain separate and must be reported as

such although providers work to integrate services in order to work with the whole person in the context of his or her environment rather than seeing the individual in compartments. State general funds are most often used for specific populations or program support. As an example, the General Assembly has provided funding for over 20 Programs for Assertive Community Treatment (PACT). PACT is a wholly inclusive service assessing and addressing the individual's life needs in total as part of their treatment process. DBHDS continues to seek more collaboration with behavioral health, substance use, co-occurring disorders, and intellectual and developmental disabilities. This is highlighted by the development of a housing division merged to meet the needs of behavioral health consumers as well as those who have developmental and intellectual disabilities. This division is has a central director and has combined the staff traditionally separated by funding streams into one functional unit with a specific skill set. It is the hope that changes such as these at the central office level will encourage community changes across the state to become less separate.

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

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

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

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

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁴⁷. 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 populations⁴⁸. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

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

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

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

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

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?

The Behavioral Health Equity Coordinator with the Office of Behavioral Health Wellness focuses on promoting wellness and achieving behavioral health equity for all Virginians. DBHDS previously had a more linguistic focus whereas currently there is a broader focus on equity throughout the behavioral health system. The Behavioral Health Equity Coordinator's current primary focuses have been:

Developing the Behavioral Health Equity Summit and 12 behavioral health equity mini-grants that went out following participation in the summit. The summit provided education on the frameworks for understanding behavioral health equity, the rising rates of deaths of despair and social bias in behavioral healthcare. The grants will be completed in October. Awarded grants covered a diverse spectrum programming to address behavioral health inequities including: making more inclusive environments for LGBTQ+ clients, increasing substance misuse services for the deaf/blind/hard of hearing populations and expanding services to the immigrant, refugee and LEP community.

The Behavioral Health Equity Summit showed through evaluations, an increase in knowledge about health equity, social determinants in health, healthcare biases, CLAS standards, and engagement to promote health equity for summit participants.

Participating in the process to develop the Behavioral Health Equity Index with Virginia Commonwealth University Institute for Society and Health which is focused on creating a new funding formula that balances needs and resources of populations to determine how CSBs should be funded

Involvement in the development and implementation of the Behavioral Health Interpretation Curriculum (BHIC) which was developed by a cohort of members from DBHDS, interpreters, healthcare professionals and organizations in service of immigrant and refugee populations with the goal of training interpreters from other fields using a standardized curriculum

Coordination and mediation for Partnership for Equity Advisory Committee (previously the Cultural Linguistic Committee) which is comprised of individuals who work at DBHDS, CSBs, training centers, and state hospitals and seek to promote behavioral health equity through advocacy, education, and policy change

Please indicate areas of technical assistance needed related to this section

None at this time

Footnotes:

NOT FINAL

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ÷ Cost, ($V = Q \div C$)

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

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

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

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

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

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

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

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

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

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

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

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

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <http://store.samhsa.gov/shin/content/SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No
2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) ☐ Leadership support, including investment of human and financial resources.
 - b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) ☐ Use of financial and non-financial incentives for providers or consumers.
 - d) ☐ Provider involvement in planning value-based purchasing.
 - e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
 - f) ☐ Quality measures focus 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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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. Does the state have policies for addressing early serious mental illness (ESMI)? ☐ Yes ☒ No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ☒ Yes ☐ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.
See attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside
3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
See attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ☒ Yes ☐ No
5. Does the state collect data specifically related to ESMI? ☒ Yes ☐ No
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☐ Yes ☒ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.
See attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside
8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?
See attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside
9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.
See attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside
10. Please list the diagnostic categories identified for your state's ESMI programs.
See attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside
Please indicate areas of technical assistance needed related to this section.
None at this time.

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NOT FINAL

Environmental Factors and Plan

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

Please respond to the following items:

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI?

Since 2015, eight (8) Virginia community services boards (CSBs) have been operating Coordinated Specialty Care (CSC) programs for the treatment of youth and young adults experiencing their first episode of psychosis (FEP). These providers continue to be allocated the MHBG 10% set-aside for Early Serious Mental Illness (ESMI), plus an additional \$4 million per year State General Funds allocated by the Virginia General Assembly annually to address emerging serious mental illness in young people. Virginia has also applied for SAMHSA's FY2019 Transforming Lives through Supported Employment grant and if so awarded will target some of the funding towards enhancing Support Employment/Individual Placement and Support Services (SE/IPS) services across its CSC programs.

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

Coordinated Specialty Care Programs Coordinator meets quarterly with team leaders to discuss and review practice, routinely alerts providers to available resources/ training opportunities, and encourages provider participation in listservs such as the Psychosis Risk and Early Psychosis Program Network (peppnet) <http://med.stanford.edu/peppnet.html>.

In addition, the CSC Coordinator reached out to the Center for Social Innovation to advocate for Virginia's inclusion in the NIMH-sponsored "CSC OnDemand" study. Seven of our eight teams have been selected for participation.

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

Seven of Virginia's eight Coordinated Specialty Care teams were trained in the "OnTrack" model by the Center for Practice Innovation. The remaining CSC team is modeled after the "NAVIGATE" program.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

- All eight CSC teams will be participating in “CSC OnDemand” study.
- Specialized training and technical assistance in SE/IPS for CSC teams if awarded SAMHSA Supported Employment grant.
- Partnering with DBHDS Office of Child & Family Services to hold a statewide “Youth Services Summit”.

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

Current Data Collection Process

Data reporting by CSC teams began in March 2016 with two mechanisms. First, CSBs are using two (2) survey tools to collect data relating to the recovery measure (one individual self-report and the other a clinician report), and are using the Modified Colorado Symptom Index to measure the impact of symptoms. Providers send that data to DBHDS via secure email monthly. Second, individual demographic and service data on CSC participants is sent to DBHDS by the CSBs via a secure data extract from their electronic health records on a monthly basis; this monthly extract is the mechanism through which DBHDS collects CSB consumer and service data to report on the National Outcome Measures, TEDS, and the URS tables for the MHBG.

State Reporting

Due to key positions being either cut or vacated within DBHDS since reporting began in 2016, the data collected was not analyzed in any meaningful way until early 2019 when DBHDS filled a Behavioral Health Evaluation & Research Specialist position within its Office of Adult Community Behavioral Health. Coordinated Specialty Care Coordinator began working with this individual almost immediately, and in April 2019, DBHDS Evaluation Specialist produced a report titled “*Early Impacts of the Coordinated Specialty Care (CSC) Program*”. That initial report is available here:

<http://dbhds.virginia.gov/assets/doc/BH/mhs/csc-report-final.pdf>

With key positions now filled, DBHDS intends to begin reporting on its CSC programs with more regularity. CSC Coordinator and Behavioral Health Evaluation & Research Specialist have taken the lead internally to identify ways to include data on key functional outcome indicators such as educational/employment gains, decreased use of crisis services/hospitalizations, and housing stability, for example, in future reports.

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

Basic fidelity standard for CSC admission includes diagnoses along the Schizophrenia Spectrum. Programs are allowed variances for Affective Psychosis if all other basic standards continue to be met, and a clinically valid justification for the variance is provided.

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

Please see the answers to the questions above.

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

None at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

1. Does your state have policies related to person centered planning? ☒ Yes ☐ No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
Please see attached 5. Person Centered Planning (PCP)
4. Describe the person-centered planning process in your state.
Please see attached 5. Person Centered Planning (PCP)
Please see attached 5. Person Centered Planning (PCP)
Please indicate areas of technical assistance needed related to this section.
None at this time

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5. Person Centered Planning (PCP) - Required MHBG

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

As part of Commonwealth's ongoing dedication to *System Transformation, Excellence and Performance in Virginia* (STEP VA), described elsewhere in this application, the continued expectation remains that all services must integrate not only person-centered planning but also trauma-informed and recovery-oriented approaches as a standard part of care and service development. Virginia continues to maintain its dedication to recovery-oriented approaches, and these approaches complement person-centered planning. Developed in 2015, the peer-led Office of Recovery Services, continues to support, maintain, and encourage the recovery centered focus used as part of the STEP VA process and has ongoing relationships with local community services boards as well as Virginia Medicaid. Virginia Medicaid continues to reimburse for services delivered by peer recovery coaches in both mental health and substance use engagement. While there is always more work to be done DBHDS remains committed to the process of individuals making their own decisions related to their service options as an equal partner.

Person-Centered Planning for Psychiatric Crisis

One area in which the Commonwealth has expanded its person-centered approach is in the area of pre-planning for mental health crisis. In 2009, the Virginia Health Care Decisions Act, a state law which allows for the use of advance directives to plan for end-of-life care and other health care decisions, was amended to include the ability to pre-plan for psychiatric crisis. Some states offer this option through the use of a stand-alone psychiatric advance directive, but in Virginia, policymakers opted to integrate mental health crisis planning into the larger health care advance directive. Through the use of MHBG funds, DBHDS partners with the University of Virginia Institute of Law, Psychiatry and Public Policy (ILPPP) to educate consumers with SMI, family members, advocates and providers about this option. DBHDS and the ILPPP provide training across our system on advance directives as an important mechanism for pre-planning for psychiatric care, and in collaboration with other system partners, including Mental Health America of Virginia, the Virginia Organization of Consumers Asserting Leadership, and the disAbility Law Center of Virginia, have developed a Certified Advance Directive Facilitator training program which trains peer support specialists to assist individuals with SMI to develop their own advance directives. Research demonstrates that individuals with SMI who create their own advance directives with the assistance of a trained facilitator are more likely to be engaged in treatment, have better relationships with service providers, and are less likely to need more expensive and restrictive levels of care such as hospitalization. With the advent of Medicaid reimbursement of peer support in Virginia, the facilitator training, in which trainees participate in two full days of didactic training plus an observed facilitation, is becoming more popular. In addition, as part of this effort, DBHDS and the ILPPP have developed a resource website, VirginiaAdvanceDirectives.org, which is maintained by Mental Health America of Virginia.

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

Currently, Virginia does not have a specific person-centered planning policy. DBHDS continues to maintain the outlook that person-centered planning remains a best practice to ensure individuals in our system receive recovery-oriented, trauma-informed services meeting their expectations of services

focused on their individual needs. DBHDS continues to support Virginia providers in making this practice a priority for consumer care.

NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒ Yes ☐ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☒ Yes ☐ No
3. Does the state have any activities related to this section that you would like to highlight?
See attached 6. Program Integrity
Please indicate areas of technical assistance needed related to this section
None at this time

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6. Program Integrity - Required

6. Program Integrity

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

Federal program requirements are conveyed to sub-recipients via performance contract documents and ongoing technical assistance provided by DBHDS staff responsible for federal grants management. In Virginia, the primary sub-recipients of SAPT and MH Block Grant funds are CSBs and privately operated not-for-profit organizations. The mechanism for assuring federal program requirements are conveyed to each type of sub-recipient is described below.

Requirements of CSB Sub-recipients

The Community Service Performance Contract is required by §§ 37.2-508 and 37.2-608 of the Code of Virginia and State Board Policy 4018 to be the primary accountability and funding mechanism between DBHDS and each individual CSB. Each year, DBHDS and each CSB enter into a performance contract to fund services provided directly or contractually by the CSB “in a manner that ensures accountability to the Department and quality of care for individuals receiving services and implements the mission of supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life” (FY FY 2018 Community Service Performance Contract). Section 9 of the Performance Contract, Terms and Conditions, states that “The CSB shall maintain documentation and reports for all expenditures related to the federal Mental Health Block Grant and federal Substance Abuse Prevention and Treatment Block Grant funds contained in Exhibit A sufficient to substantiate compliance with the restrictions, conditions, and prohibitions related to those funds.” Performance Contract requirements also include requirements for CSB audits and other financial accountability. Exhibit A enumerates the statutory requirements of each block grant that are relevant to the provision of services.

Requirements of Not-for-Profit Organizations

The award of block grant funds to private, not-for-profit organizations is governed by (a) the restrictions, conditions and prohibitions of Block Grant funds, and (b) the requirements of the Virginia Public Procurement Act. Non-CSB sub-recipients are identified by either a public request for proposals process, or by justification of a “sole source contract” which is approved by the Division of Purchases and Supply at the Virginia Department of General Services. Contract terms and conditions include federal block grant requirements, and contract managers in the DBHDS offices of Behavioral Health Wellness, Child and Family Services, Mental Health Services, and Substance Abuse Services, which oversee program aspects of SAPT and MH Block Grant funds, provide continual technical assistance, monitoring and oversight to ensure contractors adhere to all federal requirements. Non-profit organization receiving block grant funds under contract with DBHDS are also subject to state audit requirements as indicated.

Program monitoring and oversight of federal block grant funds allocated to both CSB and not-for-profit organizations is detailed below in item 2.

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Compliance standards are included in the performance contract between DBHDS and the CSBs, and in contract documents for with other sub grantees that receive block grant funds.

All CSBs are subject to annual audit requirements. DBHDS Office of Internal Audit leads site visits at five CSBs each year. Activities conducted during these site visits include reviewing financial policies and procedures, reviewing block grant budgets and expenditures, and reviewing staffing patterns. DBHDS Office of Adult Community Behavioral Health Services (OACBHS) leads block grant compliance site visits at 20 CSBs each year, visiting half of the 40 CSBs in even years and the other half in odd years. Activities include reviewing program administration policy and procedures manuals, interviewing staff, reviewing program materials, staffing patterns, budgets, and reviewing clinical treatment services to individuals who use drugs intravenously, and gender-specific services. OACBHS provides ongoing technical assistance to CSBs throughout the year to ensure programs and services are compliant the MHBG and SAPTBG requirements.

For the SAPTBG, the Office of Behavioral Health Wellness (OBHW) conduct reviews of the prevention services required by the SAPTBG. For the Prevention Set-Aside, OBHW reviews specific federal policy and directives that are outlined in the performance contract. When a CSB is not operating within identified standards, OBHW staff provides technical assistance to ensure compliance. For the MHBG, the offices of Adult Community Behavioral Health Services (OACBHS) and Child and Family Services (OCFS) similarly participate in the review process to ensure services supported by MHBG funds are provided to adults with serious mental illness and children and youth with serious emotional disturbance in accordance with MHBG regulations. For treatment services provided by both the SAPTBG and MHBG, DBHDS staff review clinical records to determine that services are provided in accordance with accepted standards for clinical practice.

For non-CSB sub-recipients, audits are conducted on a scheduled basis, and staff of OCFS, OABHS and OBHW provide ongoing technical assistance to not-for-profit contractors to ensure compliance with all federal regulations

NOT FOR PUBLICATION

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](https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf)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?
2. What specific concerns were raised during the consultation session(s) noted above?
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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8. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ☒ Yes ☐ No
 - a) ☒ Data on consequences of substance-using behaviors
 - b) ☒ Substance-using behaviors
 - c) ☒ Intervening variables (including risk and protective factors)
 - d) ☒ Other (please list)
Demographic data, Economic data, Suicide data that can help to better understand behavioral health disparities and adverse childhood experiences
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - ☒ Children (under age 12)
 - ☒ Youth (ages 12-17)
 - ☒ Young adults/college age (ages 18-26)
 - ☒ Adults (ages 27-54)
 - ☒ Older adults (age 55 and above)
 - ☒ Cultural/ethnic minorities
 - ☐ Sexual/gender minorities
 - ☒ Rural communities
 - ☐ Others (please list)

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

- ☒ Archival indicators (Please list)
- ☒ National survey on Drug Use and Health (NSDUH)
- ☒ Behavioral Risk Factor Surveillance System (BRFSS)
- ☒ Youth Risk Behavioral Surveillance System (YRBS)
- ☒ Monitoring the Future
- ☐ Communities that Care
- ☒ State - developed survey instrument
- ☒ Others (please list)

- Virginia Department of Behavioral Health and Developmental Services (DBHDS)- Treatment Admissions (2008-2015)
- Virginia Department of Behavioral Health and Developmental Services (DBHDS)- Mental Health Services Provided (2016)
- Virginia Department of Juvenile Justice- Intake Cases, Probation Cases, and Direct Care Cases (2005-2015)
- Virginia Department of Forensic Science- Drug Seizures (2001-2015)
- Virginia Office of the Chief Medical Examiner- Accidental and Undetermined Fatal Drug Overdoses (2007-2014)
- Virginia Office of the Chief Medical Examiner- Suicides (2003-2012)
- Virginia Department of Social Services- Poverty Estimates (2000-2014)
- Virginia Department of Social Services- Unemployment Estimates
- Virginia Department of Criminal Justice Services- Uniform Crime Reports: Drug-Related Arrests (2006-2015)
- Virginia Department of Health- Virginia Youth Survey: Middle & High School (2013-2015)
- U.S. Census Bureau- Population Estimates (2000-2014)

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

If yes, (please explain)

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

This is a goal of the state for FFY19. Currently the state allocates resources based on a historical formula based on population. Virginia is currently in the process of creating a funding formula that will be based on need and population to be implemented in FY19. We are currently taking it into consideration in supplemental funding or special projects such as our Family Wellness Initiative.

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ☒ Yes ☐ No
If yes, please describe
The Virginia Certification Board (VCB) is a member of IC&RC, the credentialing of prevention, addiction treatment, and recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in 24 countries, 47 states and territories, five Native American regions, and all branches of the U.S. military.
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ☒ Yes ☐ No
If yes, please describe mechanism used
Virginia has 5 trainers that have completed SAMHSA Substance Abuse Prevention Skills Training (SAPST) and provide trainings to prevention professionals across the state . We also have a full-time position dedicated to workforce development.
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No
If yes, please describe mechanism used
During the needs assessment process, a community readiness and coalition readiness assessment was implemented as a part of the needs assessment.

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

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ☐ Yes ☒ No
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ☐ Yes ☒ No ☐ N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) ☐ Timelines
 - c) ☐ Roles and responsibilities
 - d) ☐ Process indicators
 - e) ☐ Outcome indicators
 - f) ☐ Cultural competence component
 - g) ☐ Sustainability component
 - h) ☐ Other (please list):
 - i) ☒ Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ☒ Yes ☐ No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ☒ Yes ☐ No

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

Inclusion on NREPP or another federal listing of evidence based approaches. Additionally, the EBWG has a tool for providers to use when an approach is not identified on a list for review and approval.

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Implementation

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

The state requires local city/county government entities to partner with local community coalitions to implement work.
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
 - Alcohol Screenings
 - Anti-Tobacco Billboards
 - ASAC Information Dissemination Campaign
 - ATOD Presentation
 - ATOD Prevention Parent Education
 - ATOD Prevention Youth Education
 - Awareness Events and Health Fairs
 - Children's Mental Health Week
 - Coalition Other Projects
 - Coalition Speaking Engagement
 - Coalition Websites
 - Community Event
 - Community Health Fair/Events
 - ScreeningsAnti-Tobacco BillboardsASAC Information Dissemination CampaignATOD PresentationATOD Prevention Parent EducationATOD Prevention Youth EducationAwareness Events and Health FairsChildren's Mental Health WeekCoalition

Other ProjectsCoalition Speaking EngagementCoalition WebsitesCommunity EventCommunity Health Fair/Events
 Community Health Fairs
 Community Presentations
 Community wellness resource guide
 Community Workshops/Events
 CPES Presentations
 D19 suicide prevention community events
 Depression Screenings
 Designated Driver
 Eating Disorder Screenings
 General Media
 General Prevention Speaking Engagements
 General School or Community Events
 Great American Smokeout
 Handouts, pamphlets, brochures, etc.
 Health Fairs/Community Events
 Information Dissemination
 Informational Workshops and Booths
 Kevin Hines Event
 Kick Butts Day
 lethal means reduction
 Lethal Means Restriction Resources
 Man Cave
 Mass Media Campaign
 Media Promotion
 Media PSA
 Mental Health and Substance Use Talks
 Mental Health Awareness Campaign Mental Health Media Campaign Mental Health Promotion MH Awareness
 and Suicide Prevention Activities National Mental Health Awareness Month National Night Out National Prevention Month
 National Prevention Week Operation Medicine Cabinet Cleanout Other Health Promotion -- SAP Out of Darkness-Walk
 Pamphlet Distribution Parent Awareness Campaigns Parent Outreach Parent Presentations & Workshops Parent
 Workshops Parents Who Host Lost the Most Positive Parenting Website Prevention Awareness Activities Prevention
 Presentations Prevention social media & marketing Prevention Speaking Engagements Prevention Website Project LINK
 Events Project Link/PSA PSAs Public Forums and School Prevention Education Public Service Announcements RASAP
 Speakers Bureau Red Flag Campaign Red Ribbon Week Regional Prevention Resource Directory Regional Suicide
 Prevention Conference Resources to medical providers RRCS Media Campaign Info Dissemination Secure Medication
 Storage Box and Information Distribution Smoking Stinks Tobacco Prevention Fair social media campaign Speakers Bureau
 Speaking Engagement StopSubstanceAbuse.com Resource Center Suicide Logo Dissemination Campaign Suicide
 Awareness Week Suicide Prevention Suicide Prevention Awareness Suicide Prevention Information Dissemination Suicide
 Prevention Month Suicide Prevention Talks Suicide Prevention Week Tabling Events -- CACHY Take Back The Night Teens
 CARE Too Education and Awareness Efforts Underage Use Materials/Parent Guides Virginia Aquarium Drug Education
 Virginia Healthy Youth Day We Don't Support Underage Use Campaign Wellness promotion Wellness/Suicide Prevention
 Resource Guide
 FairsCommunity PresentationsCommunity wellness resource guideCommunity Workshops/EventsCPES PresentationsD19
 suicide prevention community eventsDepression ScreeningsDesignated DriverEating Disorder ScreeningsGeneral
 MediaGeneral Prevention Speaking EngagementsGeneral School or Community EventsGreat American SmokeoutHandouts,
 pamphlets, brochures, etc.Health Fairs/Community EventsInformation DisseminationInformational Workshops and
 BoothsKevin Hines EventKick Butts Daylethal means reductionLethal Means Restriction ResourcesMan CaveMass Media
 CampaignMedia PromotionMedia PSAMental Health and Substance Use TalksMental Health Awareness Awareness
 Campaign Mental Health Media Campaign Mental Health Promotion MH Awareness and Suicide Prevention Activities
 National Mental Health Awareness Month National Night Out National Prevention Month National Prevention Week
 Operation Medicine Cabinet Cleanout Other Health Promotion -- SAP Out of Darkness-Walk Pamphlet Distribution Parent
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 Most Positive Parenting Website Prevention Awareness Activities Prevention Presentations Prevention social media &
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 Week Regional Prevention Resource Directory Regional Suicide Prevention Conference Resources to medical providers
 RRCS Media Campaign Info Dissemination Secure Medication Storage Box and Information Distribution Smoking Stinks
 Tobacco Prevention Fair social media campaign Speakers Bureau Speaking Engagement StopSubstanceAbuse.com
 Resource Center Suicide Logo Dissemination Campaign Suicide Awareness Week Suicide Prevention Suicide Prevention
 Awareness Suicide Prevention Information Dissemination Suicide Prevention Month Suicide Prevention Talks Suicide
 Prevention Week Tabling Events -- CACHY Take Back The Night Teens CARE Too Education and Awareness Efforts Underage
 Use Materials/Parent Guides Virginia Aquarium Drug Education Virginia Healthy Youth Day We Don't Support Underage
 Use Campaign Wellness promotion Wellness/Suicide Prevention Resource Guide

b) Education:
 24/7 Project Dads
 2nd Grade Substance Abuse Seminar
 ACT: Raising Safe Kids
 Active Parenting Now
 Active Parenting of Teens: Families in Action ADHD Parenting Class Aggressors, Bystanders and Victims All Stars Program
 AI's Pals BE FAIR/HERO Botvin Lifeskills Program Boys Council Business of Co-Parenting Celebrating Families Children First
 Classes Children In Between Children in the Middle Children of Divorce Children-In-Between Choose Respect Chronic
 Disease Self Management Program Club REAL Coalition Sponsored Community Trainings Co-parenting Classes Coping
 With Your Child's Behavior Curriculum Based Support Groups - Universal Direct (Aggregate) DARE To Be You Dimensions
 Tobacco Free Program Do You
 Drugs: True Stories
 Families In Action - Parent Class - Indicated Families In Action - Teen Class - Indicated Families Overcoming Drug Addiction
 Family Wellness Initiative FAST FAST Works- Appomattox FAST Works- DESI Friend Factor Getting To Know Your Young
 Child Girl Power Girls Circle GRAV Guiding Good Choices HALO Head Start Parent Education Healthy Alternatives for Little
 Ones (HALO) Healthy Families I'm Special (unique YOU) Incredible Years Independant Parenting Inside Out Dad Intervening
 with Teen Tobacco Users (TEG) Keep A Clear Mind Program
 LEADS: For Youth (Linking Education and Awareness of Depression and Suicide) Life Skills Training (High School) Life Skills
 Training (Middle) Life Skills Training Elementary Lunch Bunch Media Detectives Media Ready Mental Health First Aid
 Training New Directions Program New Life Parent Education Not on Tobacco Nurturing Parent Program Parent
 Consultation / Coaching Parent Education and Support Workshops Parent Power Parent Workshops Parenting Wisely
 Partners In Parenting Positive Action Positive Action PreK Power UP!
 Dads2nd Grade Substance Abuse SeminarACT: Raising Safe KidsActive Parenting NowActive Parenting of Teens: Families in
 Action ADHD Parenting Class Aggressors, Bystanders and Victims All Stars Program AI's Pals BE FAIR/HERO Botvin Lifeskills
 Program Boys Council Business of Co-Parenting Celebrating Families Children First Classes Children In Between Children
 in the Middle Children of Divorce Children-In-Between Choose Respect Chronic Disease Self Management Program Club
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 Based Support Groups - Universal Direct (Aggregate) DARE To Be You Dimensions Tobacco Free Program Do YouDrugs:
 True StoriesFamilies In Action - Parent Class - Indicated Families In Action - Teen Class - Indicated Families Overcoming
 Drug Addiction Family Wellness Initiative FAST FAST Works- Appomattox FAST Works- DESI Friend Factor Getting To Know
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 Elementary Lunch Bunch Media Detectives Media Ready Mental Health First Aid Training New Directions Program New Life
 Parent Education Not on Tobacco Nurturing Parent Program Parent Consultation / Coaching Parent Education and
 Support Workshops Parent Power Parent Workshops Parenting Wisely Partners In Parenting Positive Action Positive Action
 PreK Power UP!
 Project ALERT
 Project LINK Nurturing Parenting Program Project LINK Outreach Education Project Link Support Group Project Link's
 Women Support Group Project Success Project TNT: Towards No Tobacco Use (TNT) Project Towards No Drug Abuse
 Protecting You Protecting Me Quit Tobacco Program Reality Store Relate Response Suicide Ripple Effects - all ages Safe
 Dates Second Chance Second Step Signs of Suicide Skill Building Workshops for Youth SODA Students Organized for
 Developing Attitudes SOS Signs of Suicide Staying Connected with your Teen STEP Strengthening Families Program, 10 -
 14 Strengthening Families Program, 6 - 11 Substance Abuse Intervention Program (SAIP) Systematic Training for Effective
 Parenting Teen Ambassadors Teen Outreach Program Thinking for a Change Time Mentoring Too Good for Drugs Too
 Good for Drugs (Middle) Too Good for Drugs and Violence (High School) Too Good for Violence 6-8 Too Good for
 Violence K-5 Virginia Rules
 ALERTProject LINK Nurturing Parenting Program Project LINK Outreach Education Project Link Support Group Project Link's
 Women Support Group Project Success Project TNT: Towards No Tobacco Use (TNT) Project Towards No Drug Abuse
 Protecting You Protecting Me Quit Tobacco Program Reality Store Relate Response Suicide Ripple Effects - all ages Safe
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 Good for Drugs (Middle) Too Good for Drugs and Violence (High School) Too Good for Violence 6-8 Too Good for
 Violence K-5 Virginia Rules

c) Alternatives:
 Adult Summit
 After Prom
 After School Program
 ATOD House of Horrors
 Camp
 Coalition Sponsored Alternative Activities Culpeper Law Explorer's Program Culpeper Youth Library Programs Girl Power

Girls on the Run Positive Peer Group Pro-Social Drug-Free Alternative Activities SPARC of Hope Walk Youth Summer Programs Summer Youth Employment Program (SYEP) Survivors of Suicide Support Group Teens CARE Too Coalition Youth Leadership Activities Youth Summit
SummitAfter PromAfter School ProgramATOD House of HorrorsCampCoalition Sponsored Alternative Activities Culpeper Law Explorer's Program Culpeper Youth Library Programs Girl Power Girls on the Run Positive Peer Group Pro-Social Drug-Free Alternative Activities SPARC of Hope Walk Youth Summer Programs Summer Youth Employment Program (SYEP) Survivors of Suicide Support Group Teens CARE Too Coalition Youth Leadership Activities Youth Summit

d) Problem Identification and Referral:

Parent coaching & referrals (indiv supportive counseling for parents) Project SUCCESS Reconnection Referrals Self-Sufficiency Project Student Assistance Program (SAP) Student coaching & referrals

e) Community-Based Processes:

CoalitionAbove the Influence ClubAdult Mental Health First AidAdvisory BoardAI's Pals Technical AssistanceApplied Suicide Intervention Skills Training (ASIST) At Risk for Elementary School Educators At Risk for High School Educators At Risk for Middle School Educators Bristol and Washington County Program Managers Capacity Building Child Protection Partnership Task ForceCollaboration-- SAPCommunity Builder's NetworkCommunity Coalitions of Virginia (CCOVA) Community consultation Community Health Assessment Team (CHAT) Community Health Forum Community Prevention Conference Community TA Community Trainings Planning Committee Colloborative Groups Informal Collaboration Just Checking ProgramKognito: At-Risk for High School EducatorsKognito: At-Risk for Middle School EducatorsKognito: Step In, Speak Up!Lead and SeedLethal Means Restriction TrainingsLocal Law Enforcement TrainingsMental Health First Aid - AdultsMental Health First Aid - YouthMore Than SadPrescription Drug Abuse Training for Providers Project LINK Advisory Board QPR Gatekeeper Training for Suicide Prevention Question, Persuade and Refer (QPR) REVIVE SADD Club Safe Talk Step in Speak up Suicide prevention work Youth ACT: Signs of Suicide Youth and Community Action Team (YCAT) Youth Development / YPQI Training and Assessment Youth Engagement

f) Environmental:

f) Environmental:

Merchant Education (Tobacco)
Alternative Red Ribbon Week
Be The REAL You
Coalition Sponsored Campaigns
Community Restoration Task Force
DMV Social Marketing Campaign
Alternative Red Ribbon WeekBe The REAL YouCoalition Sponsored CampaignsCommunity Restoration Task ForceDMV Social Marketing Campaign
Drinking & Driving Prevention Social Marketing Campaign Drug Take Back Events EBP's in Schools Employee Wellness Program Fatherhood Educational Community Fair Hanover Cares Parent Campaign Legislative Roundtable Media Campaign Merchant Education Merchant Education (Alcohol) Merchant Education (Tobacco) Prescription Drug Receptor Prescription Drug Take Back Events Project LINK Project Sticker Shock - Merchant Education (SPAN) Rx Abuse Prevention Initiative RX Permanent Drop Off School Policy Revision Secure Meds Campaign Social Host Ordinance Social Norms CampaignTalk They Hear You Campaign Tobacco and Alcohol Compliance Checks. SABG funds are not used for these checks. Tobacco Free School Policies Tobacco Social Norms Campaign TTYL Media Campaign Underage Use Campaign We Don't Support Underage Use
Program Fatherhood Educational Community Fair Hanover Cares Parent Campaign Legislative Roundtable Media Campaign Merchant Education Merchant Education (Alcohol) Merchant Education (Tobacco) Prescription Drug Receptor Prescription Drug Take Back Events Project LINK Project Sticker Shock - Merchant Education (SPAN) Rx Abuse Prevention Initiative RX Permanent Drop Off School Policy Revision Secure Meds Campaign Social Host Ordinance Social Norms CampaignTalk They Hear You Campaign Tobacco and Alcohol Compliance Checks. SABG funds are not used for these checks. Tobacco Free School Policies Tobacco Social Norms Campaign TTYL Media Campaign Underage Use Campaign We Don't Support Underage Use

All of non-SA specific activities are supported by state general funds for Mental health promotion, Mental Health First Aid and suicide prevention. The SAP workforce are members of coalitions that address these issues because of the intersections of SA, MH and Suicide.

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

If yes, please describe

Onsite monitoring visits in addition to strategic plan approval by the state's Behavioral Health Wellness Consultants.

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Evaluation

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

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

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

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

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

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

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

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

- d)** ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)** ☐ Other (please describe):

NOT FINAL

Footnotes:

NOT FINAL

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-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.
The Virginia Community Services Boards (CSBs) offer most of the services in #2 below, with some variations depending on location and resources.

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-occurring M/SUDs ☒ Yes ☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

All of Virginia's 40 Community Services Boards offer the majority of the services on the list above with varying levels of accessibility. The possible exceptions are in the areas of housing and educational services.

Physical Health: Many of Virginia's 40 CSBs maintain partnerships with local community health clinics or providers to offer primary care services to consumers. Primary care services may be provided in a variety of ways; some primary care is provided on-site at CSB locations by CSB-employed or -contracted healthcare providers. In other areas, the CSB partners with the local federally-qualified health center (FQHC) to offer co-located services in which either the CSB provides behavioral health services on site at the FQHC's location, or the FQHC offers primary care services on site at CSB service programs. In addition, some CSB case managers work with family members, MHSS providers, or care coordinators to ensure their consumers are transported to their PCP for ongoing follow up care.

Rehabilitation Services: All 40 Virginia CSBs offer psychiatric rehabilitation services to individuals with SMI. These programs may include vocational rehabilitation and employment-related services, including the evidence-based practice of Supported Employment. This service is also provided outside of the CSB system by private community-based mental health providers, as Psychosocial Rehabilitation is a Medicaid-reimbursable service under our state Medicaid plan. Psychosocial rehabilitation, as mentioned previously in this application, is an identified step in the STEPVA system transformation process.

Housing Services: In recent years, DBHDS and the CSBs have been expanding support for Housing First programs and

Permanent Supportive Housing (PSH). In 2015 for the first time, the Virginia General Assembly allocated state funds to DBHDS for Permanent Supportive Housing. With these funds and continued investments from subsequent General Assembly sessions, DBHDS has implemented sixteen PSH programs across the state, expected to house more than 1200 individuals with SMI.

3. Describe your state's case management services

Targeted case management is a Medicaid-billable service in Virginia for adults with SMI and children with SED which is also licensed by DBHDS under Title 12, Chapter 105 of the Virginia Administrative Code, "Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services." These regulations require that providers of case management services provide the following services:

1. Enhance community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
2. Make collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment;
3. Assess needs and planning services to include developing a case management individualized services plan;
4. Link the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as developed in the Individualized Services Plan (ISP);
5. Assist the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
6. Assure the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments;
7. Monitor service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual;
8. Provide follow up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;
9. Advocate for individuals in response to their changing needs, based on changes in the individualized services plan;
10. Plan for transitions in the individual's life;
11. Know and monitor the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed; and
12. Understand the capabilities of services to meet the individual's identified needs and preferences and serve the individual without placing the individual, other participants, or staff at risk of serious harm.

4. Describe activities intended to reduce hospitalizations and hospital stays.

A wide variety of clinical and recovery support services are provided in the community and in our state psychiatric facilities to reduce hospitalizations and hospital stays. Most of the services in item 1 above continue to be offered in the community having been initially designed to prevent or reduce psychiatric crisis. For adults with SMI in particular, important services include psychiatric and medication management services, psychosocial rehabilitation, peer supports, and permanent supportive housing. As the need for appropriate response to psychiatric crisis continues to grow STEP VA as system transformation process is examining a significant number of these services to improve access to services as well as to better support maintaining consumers in the community.

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	47,032; 5.4% of Adult Population	83,237; 1.3% of Adult Population
2.Children with SED	94,618, 10% of Child Population	26,736; 2.8% of Child Population

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.

The prevalence data and rates for adults with SMI and children with SED are directly from the most current state-level prevalence data provided by NRI, 2016. The incidence data and rates for adults with SMI and children with SED are the figures we submitted in URS Table 15A to NRI for FY2018.

NOT FINAL

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 | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) | Educational services, including services provided under IDE | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) | Juvenile justice services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) | Substance misuse preventiion and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) | Health and mental health services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) | Establishes defined geographic area for the provision of services of such system | <input checked="" type="radio"/> Yes <input type="radio"/> No |

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

- a. Describe your state's targeted services to rural population.

RURAL COMMUNITIES:

The Commonwealth of Virginia covers a wide range of geographic regions. Depending on its location, one CSB might serve a combined population of urban, suburban and ex-urban or rural areas. According to the most recent decennial census, the Census Bureau indicated that 75.5% of the population in Virginia resided in urban areas and 24.5% in rural areas. Twenty-six of the 40 CSBs contain one or more counties in their jurisdiction that are majority rural. During SFY 2018, these twenty-six CSBs served 68% of all mental health consumers and 61% of individuals receiving substance abuse treatment.

Individuals in need of behavioral health services in rural areas face special challenges. Many in rural areas do not have the infrastructure to support the services that are needed in the community. Access to transportation, especially for those individuals found to be ineligible for Medicaid, is frequently an issue. In some cases access to simple daily tasks remains impossible for those with minimal support as in some areas in Virginia there may be up to a 25 minute drive to the closest grocery store with no public transit option. CSBs in these rural areas vary widely in their funding and staff capacity. They use different approaches, such as sharing services regionally with other CSBs and collaborating with local and regional contract agencies to meet the service needs of their consumers. Telepsychiatry and telecommunication, for example, are in use in some rural areas to facilitate specialty psychiatric services for adult consumers, children and their families, and veterans.

- b. Describe your state's targeted services to the homeless population.

HOMELESS POPULATIONS: Individuals with serious mental illness (SMI) and those with co-occurring substance use disorders (SUD) are at disproportionately high risk of homelessness. According to Virginia's 2017 annual Point in Time Count of individuals experiencing homelessness, nearly 1,000 individuals with SMI are homeless on any given night. In the 14 areas of the state with the highest prevalence rates, DBHDS allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) Program to CSBs provide outreach, engagement and case management services to homeless persons with SMI/SUD.

Through collaborative relationships with the continuum of homeless service providers in their catchment areas, Virginia's PATH programs assist consumers to access housing, mental health and substance abuse treatment services, entitlement benefits and other needed services to assist them in the process of recovery. Those who are literally homeless -- meaning either living on the streets, in encampments, or other locations that are unfit for human habitation -- are the priority population served by Virginia's PATH providers. Of the 1,792 individuals served by Virginia PATH during SFY 2016, approximately 76% were literally homeless and 50% were chronically homeless. The majority of Virginia's 14 PATH programs operates in urban areas and spends significant time conducting street and shelter outreach to identify individuals with SMI who meet the PATH definition of homeless. Those programs operating in suburban and rural areas conduct outreach to homeless individuals in woods, encampments, under bridges and in other places where unsheltered persons congregate. The end goal of PATH is always to assist the individual to obtain housing, engage in behavioral health services, and access disability and other benefits. The SSI/SSDI Outreach, Access and Recovery (SOAR) model of engagement is an additional service provided to PATH-enrolled consumers by six of Virginia's PATH programs. Through a unique process of community-level collaboration with the Social Security Administration and Virginia's Disability Determination Services, the SOAR model provides homeless persons with SMI a greater chance of approval for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits. Access to Social Security benefits also provides access to medical insurance, making it more likely that PATH consumers, many of whom are medically vulnerable, can access medical treatment as well as behavioral healthcare.

- c. Describe your state's targeted services to the older adult population.

OLDER ADULTS: DBHDS allocates \$1 million in MHBG funds each year to support two regional geropsychiatric services initiatives, one in Northern Virginia operated by Arlington CSB and one in Hampton Roads operated by Hampton-Newport News CSB. These partnerships provide mental health services to older adults, including care coordination, case management, psychiatric services, screening for assisted living, and other behavioral health services to prevent institutionalization and assist the older adult to remain in their home to the extent possible.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Describe your state's management systems.

The management of our system was substantially described in Planning Step 1, "Overview of the Service System." The following provides additional information about financial resources, staffing, training, and expenditures of MHBG funds,

FINANCIAL RESOURCES: During State Fiscal Year 2016, system funding allocated to DBHDS (state facilities and Central Office) and the Community Services Boards totaled \$1,822,120,846. Sources of funding included the following:

State General Funds: 39.49% of the total Fees, including Medicaid: 38.5% Local Funds: 14.6% Federal Grants: 4.4% Other: 3.17%

Of the total \$1,822,120,846 in funding, \$650,139,308, or 35.6%, was expended by CSBs for community-based mental health services. Virginia CSBs served 55,657 adults with SMI, or 67.08% of all adults served, and 25,989 children with SED or who were SED at-risk, or 79.5% of all children served.

STAFFING: A total of 6,786.04 FTE in direct-care staff provide mental health services in the CSBs (66.1% of the total) and state psychiatric hospitals (13.6%). In addition, a total of 89.01 FTE provide peer support services to individuals with mental illness, the majority (88.8%) in the CSBs.

STAFF TRAINING: Training of CSB clinical staff is substantially provided at the local level, but DBHDS does collaborate with the CSBs in providing training, and variety of training initiatives have been undertaken in recent years. DBHDS provides financial support for, and in some cases coordination of, training on a number of evidence-based practices that treat both children and adults. For children, the DBHDS Children's Workforce Development Initiative, which is funded with both MHBG and SAPTBG funds, provides training to child-serving direct-care staff on trauma-informed care, EBPs such as Functional Family Therapy and others. Training for direct-care staff serving adults with SMI is also varied, and in recent years has included financial support for training in Assertive Community Treatment, Permanent Supportive Housing, trauma-informed care, recovery-oriented systems, clinical supervision of Certified Peer Support Specialists, and others. To date, DBHDS has not provided training of emergency health services staff about SMI or SED.

MHBG BUDGET FOR FFY 2018: In recent years, Virginia's MHBG award has been allocated as follows:

CSB MH Services for Adults with SMI: 31% of award CSB MH Services for Children with SED: 17% of award, based on Children's Set-Aside First Episode Psychosis Services: 10% (includes ESMI 0% Set-Aside) Peer and Family Workforce Support and Education: 8% of award Contracted Peer Support Services: 7% of award DBHDS Administrative Set-Aside: 5.0% of award Program Evaluation and Data Reporting: 1%

Whether these ratios will continue for FFY 2019 depends upon Virginia's final MHBG allocation for the fiscal year.

Footnotes:

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- | | |
|---------------------------------|---|
| i) Screening | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ii) Education | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iii) Brief Intervention | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iv) Assessment | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| v) Detox (inpatient/social) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vi) Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vii) Intensive Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| viii) Inpatient/Residential | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ix) Aftercare; Recovery support | <input checked="" type="radio"/> Yes <input type="radio"/> No |

b) Services for special populations:

- | | |
|--------------------------------------|---|
| Targeted services for veterans? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Adolescents? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Other Adults? | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Medication-Assisted Treatment (MAT)? | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Criterion 2

NOT FINAL

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☐ No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ Yes ☐ No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☐ No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling ☒ Yes ☐ No
 - b) Establishment of an electronic system to identify available treatment slots ☐ Yes ☒ No
 - c) Expanded community network for supportive services and healthcare ☒ Yes ☐ No
 - d) Inclusion of recovery support services ☒ Yes ☐ No
 - e) Health navigators to assist clients with community linkages ☐ Yes ☒ No
 - f) Expanded capability for family services, relationship restoration, and custody issues? ☒ Yes ☐ No
 - g) Providing employment assistance ☒ Yes ☐ No
 - h) Providing transportation to and from services ☒ Yes ☐ No
 - i) Educational assistance ☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DBHDS uses the following guidelines to monitor compliance and to guide corrective actions to address identified problems:

1. SAPTBG's WOMEN'S "SET-ASIDE"

The SAPT BG requires that sub-recipients provide specific services for pregnant and parenting women and their children and that they do so in certain ways¹

Programs must treat the family as a unit and admit both women and their children into treatment services if appropriate. Community service boards are required to use their set aside – at minimum – to provide the following services to pregnant and parenting women as well as those women who are seeking to regain custody of a child. Boards may provide these services themselves or arrange and refer the woman elsewhere to receive these services:

- Gender specific treatment services - Refers to individual and/or group services that have been adapted to address issues specific to women i.e., the role of relationships, parenting, child care, sexual and/or physical abuse, trauma etc.

- Therapeutic services for the children of these women - Includes developmental assessment

and treatment services; services that address the child's experiences of abuse, neglect or trauma; therapeutic child care etc.

- Primary medical care for women and their children - Boards should determine whether:

? Women are receiving necessary medical care (including prenatal care, STDs and family planning). If not, the CSB should refer her to a medical provider, help her obtain necessary medical coverage and work with her to be sure she is able to access medical care.

? Children of these women have medical coverage. If not, the CSB should help the woman obtain coverage and refer her and her children to an appropriate medical provider. Staff should also monitor whether her children are receiving necessary immunizations, routine and emergent care and arrange for care as needed.

- Transportation and Childcare. CSBs' must provide or arrange for necessary transportation and childcare so that women are able to access substance use services. CSBs can offer these support services themselves i.e., van transportation, bus tokens, cab vouchers, on-site child

care or provide case management services targeted at resolving transportation and childcare problems.

2. SAPT BG REQUIREMENTS FOR PREGNANT WOMEN

3. Accord Treatment Priority for Pregnant Women

- Pregnant women who are referred/ seek treatment and are in need of substance use treatment must receive treatment priority. CSBs must prioritize clients as follows:

- 1) pregnant injecting drug users or opiates by any means;
- 2) other pregnant substance users;
- 3) injecting drug users; opiates by any means and
- 4) all others."

- Boards must publicize that they provide substance use treatment services to pregnant women and that pregnant women in need of substance use services receive treatment priority. Boards may publicize substance use services for pregnant and parenting women through

? Street outreach programs

? Frequent notification to their network of community based organizations, health care providers and social services agencies

? Ongoing public service announcements

? Posters placed in targeted areas

? Regular advertisements in local/regional print material

? Health fairs

Provide Services for Pregnant women within 48 hours of their request

- To reduce health risks to the woman and her unborn child, pregnant women must be admitted into treatment within 48 hours of their request

- If unable to provide services within 48 hours, CSB staff must:

? Contact the State to inform them of this difficulty and obtain assistance to resolve the problem. CSBs should call and provide email documentation to:

Amanda Stehura, Women's Services Coordinator Office of Adult Community Behavioral Health Services
Department of Behavioral Health and Developmental Services Email:
amanda.stehura@dbhds.virginia.gov Phone: (804) 225-4649

? Provide "interim services" until they are able to place the woman in treatment. The following "interim services" should be provided:

- Counseling and education regarding HIV and TB, the risks of needle sharing, risks of transmission of HIV to partners and infants, steps that can be taken to reduce the risk of HIV transmission as well as referral for HIV and TB treatment if needed.

- Women not currently receiving prenatal care should be referred to a medical facility, treatment provider or – if appropriate – an emergency room where they can obtain prenatal care.

- Women should be advised regarding the impact that continued alcohol and drug use may have on her unborn child as well as any risks that she and/or her baby might experience if she were to stop her use abruptly.

- In addition, staff should attempt to:

- 1) Identify her trimester of pregnancy.

- 2) Determine what substances she is using and her last episode of use in order to assess her risk of withdrawal.

- 3) If staff suspect the woman may be physically dependent on opiates, alcohol and/or benzodiazepines, she should be

immediately referred to a medical provider so she can be assessed regarding the "risk of withdrawal", evaluated for medically assisted treatment and, if indicated, placed on appropriate medication.

NOT FINAL

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 ☐ 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, older adults)? ☐ Yes ☒ No
3. States are required to monitor program compliance related to activities 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.

3. States are required to monitor program compliance related to activities 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 Regional Behavioral Health Consultants assigned to each of the five areas of the state communicate frequently with the CSBs in their respective regions to monitor compliance with SAPT BG requirements.

The Performance Contract that all CSBs have executed with DBHDS includes the following requirements related to services for PWID:

 1. Preference in admission;
 2. Admission within 14 days of the person requesting services
 - a. If unable to admit within 48 hours, provide interim services
 - i. Counseling and education about HIV and TB;
 - ii. Risks of needle sharing, risk of transmission of HIV to sexual partners
 - iii. Steps to prevent transmission of HIV and TB; referral for HIV/TB treatment, if necessary.
 3. Must notify DBHDS within seven days if the program reaches 90 percent capacity
 4. Admit PWID within 14 days of the person requesting services, or within 120 days if the program lacks capacity and make interim services available
 5. Maintain an active waiting list that includes a unique identifier for each PWID
 6. Have an active means of maintaining contact with individuals awaiting admission and admit the individual to treatment at the earliest possible time. Individuals may only be removed from the waiting list if the person cannot be located or if the person refuses treatment.
 7. Must encourage PWID to engage in treatment using outreach methods that:
 - a. Are utilized by trained outreach workers using scientifically sound methods including contacting, communicating, and following up with PWID and their support systems with the constraints of 42 CFR Part 2;
 - b. Promote awareness among PWID about the relationship between injecting drugs and communicable disease, such as HIV;

c. Recommending steps that can be taken to ensure that HIV transmission does not occur; and

d. Encouraging entry into treatment.

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.

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 Performance Contract that all CSBs have executed with DBHDS includes the following requirement related to TB services.

1. Counseling individuals with respect to TB;

2. Testing to determine if the individual has been infected with mycobacteria tuberculosis to identify the appropriate form of treatment;

3. Providing for or referring the individual who is infected for appropriate medical evaluation and treatment;

4. Follow protocols established by VDH for screening, detecting and providing access to treatment for TB

5. Report individuals with active TB to VDH/Division of TB Control, in compliance with 42 CFR Part 2.

6. Ensure that all individuals receive these services and refer individuals who are unable to access SUD treatment services to other providers of TB services

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 the 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 SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C. 300x-31(a)(1)F)? ☒ Yes ☐ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ☐ Yes ☒ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ☐ Yes ☒ No

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

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 members, veterans, tribal entities, older adults, sexual and gender minorities) ☒ Yes ☐ No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations ☐ Yes ☒ No
 - f) Explore expansion of services for:
 - i) MAT ☒ Yes ☐ No
 - ii) Tele-Health ☒ Yes ☐ No
 - iii) Social Media Outreach ☒ Yes ☐ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ☐ Yes ☒ No
 - b) Establish a program to provide trauma-informed care ☒ Yes ☐ No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education ☒ Yes ☐ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? ☒ Yes ☐ No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries ☐ Yes ☒ No
 - b) An organized referral system to identify alternative providers? ☐ Yes ☒ No
 - c) A system to maintain a list of referrals made by religious organizations? ☐ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments ☒ Yes ☐ No
 - b) Review of current levels of care to determine changes or additions ☒ Yes ☐ No
 - c) Identify workforce needs to expand service capabilities ☒ Yes ☐ No

- 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 include the exceptions for disclosure ☒ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
- Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
- A minimum of two Community Services Boards participate in SAPTBG peer review activities each year.
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

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

The following are relevant links:

1. Title 37.2 of the Code of Virginia, which is the state law establishing our public behavioral health and developmental services system and establishing DBHDS as the responsible state agency: <http://law.lis.virginia.gov/vacode/title37.2/>

2. Virginia Administrative Code Chapter 105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services: <http://www.dbhds.virginia.gov/library/licensing/ol%20%20chapter%20105%20rules%20and%20regulations%20for%20licensing%20providers%20by%20the%20department%20of%20behavioral%20health%20and%20developmental%20services%203.pdf>

3. State Fiscal Year 2019 and 2020 Community Services Board Administrative Regulations:
<http://www.dbhds.virginia.gov/assets/doc/BH/oss/19-pc-csb-administrative-rqmts-june-8-2018.pdf>

4. State Fiscal Year 2017 and 2018 Community Services Performance Contract:
<http://www.dbhds.virginia.gov/assets/doc/BH/oss/19-pc-contract-june-8-2018.pdf>

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ☒ Yes ☐ No

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

Please see attached 11. Quality Improvement Plan

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NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan

DBHDS conducts a variety of oversight activities to improve the quality and accountability of behavioral health services including:

- Licensing all behavioral health services pursuant to § 37.2-403 et seq. of the Code of Virginia and the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105), available at <http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/>, to ensure that providers adhere to regulatory standards of health, safety, service provision, and individual rights;
- Protecting individual human rights through a statewide program established pursuant to § 37.2-400 et seq. of the Code of Virginia and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115), available at <http://law.lis.virginia.gov/admincode/title12/agency35/chapter115/>, to protect the human rights of individuals receiving services from programs operated, licensed, or funded by DBHDS;
- Complying with federal and state laws, regulations, and practices that assure appropriate stewardship over the Commonwealth's assets;
- Conducting annual consultative site reviews of state-operated psychiatric hospitals;
- Negotiating and monitoring compliance with the Community Services Performance Contract serves as the primary accountability and funding mechanism between DBHDS and each of the 40 CSBs;
- Requiring and reviewing the results of annual CPA audits of CSBs;
- Performing operational reviews of selected CSBs conducted by the Office of Internal Audit, chosen using a risk assessment methodology, to examine the financial condition of the CSB and fulfill DBHDS subrecipient monitoring responsibilities; and
- Performing operational reviews of CSBs conducted by the Office of Community Behavioral Health Services to improve service quality and monitor SAMHSA SAPT and MHBG block grant compliance.

The Community Service Performance Contract, available on the DBHDS web site at <http://www.dbhds.virginia.gov/assets/doc/BH/oss/19-pc-contract-june-8-2018.pdf> requires CSBs to monitor the percentage of individuals for whom the CSB is the identified case management CSB who keep a face-to-face (non-emergency) outpatient service visit within seven calendar days after having been discharged from a private psychiatric hospital or psychiatric unit in a public or private hospital following involvement in the civil involuntary admission process. This includes all individuals referred to the CSB upon discharge from a private psychiatric hospital or psychiatric unit in a public or private hospital who were under a temporary detention or an involuntary commitment order or who were admitted voluntarily from a commitment hearing. The Department will monitor this measure using AVATAR (state hospital) and CCS 3 (CSB) data.

The FY 2019-20 Performance Contract also contains several new performance measures that DBHDS will monitor in 2018;

- adults who are receiving mental health or substance use disorder outpatient or case management services or mental health medical services and have a new or recurrent diagnosis of major depressive disorder who received suicide risk assessments,
- children ages seven through 17 who are receiving mental health or substance use disorder outpatient or case management services or mental health medical services and have a new or recurrent diagnosis of major depressive disorder who received suicide risk assessments,
- adults with SMI who are receiving mental health case management services who received a complete physical examination in the last 12 months,
- adults who are receiving mental health medical services, had a Body Mass Index (BMI) calculated, and had a BMI outside of the normal range who had follow-up plans documented,
- adults who are receiving mental health outpatient, medical, or case management services and have a major depression or dysthymia who demonstrate remission at 12 months, and
- initiation, engagement, and retention in substance use disorder services for adults and children who are 13 years old or older with a new episode of substance use disorder services

DBHDS is refining its quality improvement system to ensure that individuals who are receiving behavioral health services in Virginia obtain services and supports that are available and accessible, are of good quality, and meet the needs of individuals. This system is designed to identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs; collect and evaluate data to document individual outcomes; and identify and respond to trends to ensure continuous quality improvement.

DBHDS has enhanced its computerized Human Rights Information System (CHRIS) to align with new reporting requirements that expand the type of serious incidents that licensed providers must report, which includes any suspected or alleged incident of abuse or neglect, serious incidents, serious injury, or deaths. Reports are reviewed, monitored, and investigated by the Offices of Human Rights and Licensing.

DBHDS works collaboratively with the Virginia Association of Community Services Boards (VACSB) through subcommittees of the Technical Administration Committee to ensure oversight and continuous improvement of services and data quality. DBHDS collaborates with the VACSB through multiple quality improvement committees to include the:

- Quality and Outcomes Committee – created by the VACSB, this committee is co-chaired by DBHDS and the VACSB to partner together to review, discuss, and provide input on the development of measured CSB outcomes, focusing on development of the dashboard measures and trends reported by CSB, by Region and by the State.
- Data Management Subcommittee works collaboratively with DBHDS to provide input on CCS3 reporting requirements, review CCS3 data quality reports, provide

input and feedback to DBHDS related to data and quality issues identified, and to share best practices among CSBs to mitigate issues identified.

Quality Leadership Subcommittee shares internal and external survey review results with the intent of improving the provision of services and shares best practices related to quality assurance and quality improvement. DBHDS produces a monthly data dash board that includes the following measures to track positive or negative movement toward the accomplishment of agency strategic goals.

Measure
<i>Community Services Boards</i>
Adult Suicide Risk Assessment
Child Suicide Risk Assessment
Annual Physical Examination
Calculated BMI
BMI Outside the Normal Range
BMI Follow-Up Plan
Initiation of SUD Services
Engagement of SUD Services
Retention of SUD Services

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁵⁸ paper.

57 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

58 Ibid

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ☒ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ☒ Yes ☐ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ☒ Yes ☐ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☒ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight.
See attached 12. Trauma
Please indicate areas of technical assistance needed related to this section.
None at this time

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Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

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

Adults

DBHDS Office of Behavioral Health Wellness has begun to build an Adverse Childhood Experiences (ACEs) Infrastructure to include heightening community awareness and building local ACEs community. To date, 38 of the 40 CSBs have been trained in ACEs, resulting in over 100 ACEs Master trainers. The next step will be building the coalitions.

DBHDS also oversees Project LINK, a program that offers intensive case management, care coordination and home visiting services to pregnant, parenting and any risk women with substance use and their families. Many of the women who enter treatment have been exposed to trauma. Project LINK has 9 sites throughout Virginia and each utilize one or more of the following evidence based practices to women to address trauma in their respective population: Seeking Safety, Beyond Trauma, and TREM (Trauma Recovery Empowerment Model). Each Project LINK site utilizes Nurturing Parenting program curriculum to further educated parents on healthy relationships with their children in efforts to decrease or eliminate future abuse or neglect.

Children

The Office of Child and Family Services (OCFS) offers opportunities for providers to increase their capacity to deliver trauma-specific interventions. As a part of the SOC Expansion Planning grant, DBHDS has created a workforce development plan. One topic that has been included in the plan addresses the impact of trauma on children and their families and intervention strategies that assist systems in identifying trauma and addressing the issue in the early stages of the treatment process.

In the summer of 2019, DBHDS plans to train 108 clinicians in Trauma Focused Cognitive Behavior Therapy (TF-CBT). Those clinicians that participate in the 2 day training will continue with consultation calls during 2019-2020. It is anticipated that all clinicians that participate in the 2-day training and follow up consultation calls will be certified in TF-CBT within the next two years. DBHDS recognizes the lasting effects of trauma and believes that all child serving systems should be aware of and incorporate trauma related principles in their work.

Training	Date	Location
Trauma Focused-Cognitive Behavior Therapy	July 2019	Blacksburg
Trauma Focused-Cognitive Behavior Therapy	August 2019	Arlington
Trauma Focused-Cognitive Behavior Therapy	September 2019	Newport News

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁵⁹

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶⁰

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁵⁹ Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ☒ Yes ☐ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ☒ Yes ☐ No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ☒ Yes ☐ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ☒ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?
See attached 13. Criminal and Juvenile Justice
Please indicate areas of technical assistance needed related to this section.
None at this time

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

5. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?

Adult System

Virginia supports a number of initiatives which work diligently to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification), and develop strategies to divert these identified individuals away from the criminal justice system (or penetrating, if identified after arrest/incarceration). As part of this process the goal is to connect them with meaningful services and treatment (as early as possible, but often during initial court appearance, during incarceration, or upon release from jail). In some cases, CSBs provide jail-based mental health and re-entry planning services. Other localities have established specialty courts or mental health dockets as a means of better identifying and diverting individuals to appropriate community services.

Drug Treatment Courts

There are 7 juvenile drug treatment courts, 2 regional DUI drug treatment courts, 4 family drug treatment courts, and 37 adult treatment courts currently operating in Virginia. These courts operate in communities as diverse as the City of Richmond, a setting significantly urban in nature, and the juvenile court district that serves the counties of Lee, Scott and Wise, located in the coalfields of Appalachia. The CSBs that serve the communities in which these courts operate are integrally involved in supporting and providing treatment services to individuals and families adjudicated through these courts.

In addition to the juvenile and adult drug treatment courts, there are four family drug treatment courts that are also administered by local juvenile and domestic relations courts. These courts focus on abuse and neglect cases in which parental substance abuse is a primary factor and operate with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent. Family drug treatment courts aid parents in regaining control of their lives and promote long term stabilized recovery to enhance the possibility of family reunification.

Mental Health Docket

In 2018, the Office of the Executive Secretary and the Supreme Court of Virginia performed a review of the Mental Health Dockets in Virginia. As part of this review, they assessed 8 existing MH dockets from all areas across the Commonwealth. They reviewed each docket for compliance to set standards, data collection, and funding and resources. Their recommendations included further promotion being needed as part of the docket process, greater development of local resources, interagency sharing and collaboration, and expansion of the mental health dockets based on their results.

Re-entry Support

Regarding the re-entry process for juveniles, the *Code* of Virginia (§ 16.1-293.1), requires DJJ, in consultation with DBHDS to promulgate regulations for the planning and provision of post-release services for persons committed to the DJJ if the youth has been identified as having “a recognized mental health, substance abuse, or other therapeutic treatment need.” § 16.1-293.1 also specifies certain elements that must be included in the services transition process and plan. The goal is to ensure implementation and continuity of necessary treatment and services in order to improve short and long-term outcomes for juvenile offenders with significant needs in these areas. The plan addresses the juvenile’s need for, and ability to access, medication, medical insurance, disability benefits, mental health services, and funding necessary to meet the juvenile’s treatment needs.

The Virginia Department of Corrections (VDOC) is focusing on identifying service needs, including behavioral health services, prior to an individual’s release. VDOC re-entry or transition specialists work with individuals to identify service needs, including behavioral health services, prior to release. As such the transition specialists contact the local CSB for the area in which the inmate will be released. VDOC has utilized grant funds in some communities to support a visit from CSB staff while the identified consumer remains incarcerated to begin to establish relationships. Local CSBs participate in Regional Re-Entry Community Collaboration Councils that may be headed by VDOC and VDSS. The member agencies on the local councils help coordinate services for individuals returning to the community. Several CSBs utilize the same cognitive based therapy (Thinking for a Change) that VDOC employs with inmates in the last months of custody to provide continuity, and DBHDS is continues to develop collaboration with these partners to ensure access to EBPs for individuals who are involved with the criminal justice system.

During the 2017 General Assembly Session, DBHDS was tasked with developing a plan to provide forensic discharge planning services for individuals with Serious Mental Illness who are incarcerated in local and regional jails. DBHDS developed the plan and drafted best practice standards for forensic discharge planning from jail. DBHDS shared the plan with the General Assembly along with the associated costs of implementing this practice. During the 2018 General Assembly Session, DBHDS was awarded funds to implement forensic discharge planning in two jails who have historically had a very high proportion of individuals with SMI. A competitive request for proposals was published and DBHDS awarded funding to several CSBs who provide forensic discharge planning in two regional jails systems. That funding became effective July 1, 2018. DBHDS is gathering data on the outcomes from this program and hope that the General Assembly will fund the remainder of the jails.

The Joint Commission on Health Care (a joint legislative body) did complete a study on the quality of healthcare services (to include behavioral healthcare services) in jails. As a result of that study, DBHDS, the Virginia Department of Corrections, and the State Compensation Board were asked to create a statewide, uniform, release of information authorization to be used in all state psychiatric hospitals, CSBs, jails, and other healthcare providers. The JCHC study identified the lack of a uniformly accepted release of information authorization form as a major impediment to continuity of care. That form is under development. A separate bill required DBHDS to work with the CSBs and jails to develop a process to identify any inmate who has previously received behavioral healthcare services from a CSB and to

develop a process to share treatment information between the CSB and the jail healthcare provider. DBHDS has convened a work group, has gained access to jail data, and is working with data warehouse staff on the feasibility of creating a daily matching query to identify individuals in jail who have previously received services.

During the 2019 General Assembly Session, the GA ordered that the Board of Corrections in collaboration with DBHDS work to develop minimum standard for behavioral healthcare in jails. The GA seemed to follow the advice of DBHDS (and others) that more progress could be achieved by creating minimum standards than by forcing CSBs to become the default provider of jail based behavioral healthcare services. The minimum standards are under development and will be published later this summer.

Juvenile Justice System

Twenty-three community services boards (CSBs) provide mental health and substance abuse services in juvenile detention centers. CSBs dedicate staff at the local juvenile detention center to offer mental health screening/assessment and other mental health and substance abuse services as indicated through the initial intake assessment process.

The Code of Virginia includes a provision for mental health assessments for youth that are detained. If it is determined that a youth needs an assessment, that assessment shall take place within twenty-four hours. It is the responsibility of the CSB to conduct the assessment.

The Massachusetts Youth Screening Instrument (MAYSI-II) is used in each detention center as an initial screening instrument. CSB clinicians conduct follow up assessments as needed.

DBHDS provides restoration to competency services for any child that is involved in the juvenile justice system and ordered by the court to receive restoration services. Over 200 children are served per year. Since July 1, 1999 the Code of Virginia, §16.1-357, has provided that the Commissioner of the DBHDS shall arrange for the provision of restoration services. Only the DBHDS Commissioner has the statutory authority to arrange for Juvenile Competency Restoration Services in Virginia.

The statutory requirements for the Commissioner of DBHDS are as follows:

- Upon receipt of a court order, arrange for the provision of restoration services in a manner consistent with the order.
- Submit reports to the court.
- Approve the training and qualifications for juvenile forensic evaluators.
- Approve the training and qualifications for individuals authorized to provide juvenile restoration services.
- Provide all juvenile courts with a list of guidelines for the court to use in the determination of qualifying individuals as experts in matters relating to juvenile competency and restoration.

Juvenile Competency Restoration Services are court ordered education, training, and intensive case management services provided to juveniles who have been found incompetent to stand trial by a Juvenile & Domestic Relations District Court. These individualized education and training services are provided on a one-to-one basis in the least restrictive environment in which the Court permits the juvenile to reside.

Behavioral Health Services for youth that are in correctional facilities are provided by the Department of Juvenile Justice (DJJ). DJJ is transforming its system to be more community based and trauma-informed. With a reduction in the size and number of juvenile correctional facilities, DJJ is serving more children in the community.

The Office of Child and Family Services participates on a workgroup that is related to Juvenile Justice. The workgroup is described below:

Workgroup Name	Convening Agency	Workgroup Purpose
Advisory Council for Juvenile Justice and Prevention	Department of Criminal Justice Services (DCJS)	Advises the Board, the Executive Branch, and localities on matters related to the prevention/treatment of juvenile delinquency and the administration of the juvenile justice system; reviews grant applications for Juvenile Justice & Delinquency Prevention (JJDP) Act and Juvenile Accountability Block Grant funds (when federally funded), as well as other juvenile justice-related grant applications, and makes recommendations on them to the Board.

Training and resources

The Office of Child and Family Services (OCFS) offers numerous training opportunities throughout the year. Topics range from Cultural and Linguistic Competency to Trauma Informed Care. All training opportunities are available to anyone in the field regardless of discipline.

In the fall of 2018, the OCFS sponsored training specifically for mental health staff and juvenile detention staff. Topics covered ACES and trauma, a round table discussion and an overview of the DJJ transformation efforts and their impact on detention. Participants included: mental health clinicians and case managers, detention line staff and detention home superintendents.

The Virginia Department of Criminal Justice Services (DCJS) is charged with planning and carrying out programs and initiatives to improve the functioning and effectiveness of the criminal justice system as a whole ([§9.1-102 of the Code of Virginia](#)).

The Virginia Department of Criminal Justice Services:

- conducts research and evaluation on criminal justice issues;
- develops short and long-term criminal justice plans;
- distributes federal and state funding to localities, state agencies and nonprofit organizations in the areas of law enforcement, prosecution, crime and delinquency prevention, juvenile justice, victim services, corrections and information systems;
- provides training, technical assistance and program development services to all segments of the criminal justice system;

- establishes and enforces minimum training standards for law enforcement, criminal justice and private security personnel; and
- licenses and regulates the private security industry in Virginia.

The agency's primary constituents are local and state criminal justice agencies and practitioners, private agencies, private security practitioners and businesses, and the public-at-large. Other constituents include local governments and state agencies, the federal government and advocacy groups/associations.

DCJS is unique in state government because of its system-wide perspective on criminal justice. While it directs programs and services to each component of the system, it has an overarching responsibility to view the system as a whole, to understand how changes in one part of criminal justice will affect other parts, and to work to assure that plans and programs are comprehensive. DBHDS participates on the Advisory Council for Juvenile Justice and Prevention which is convened by DCJS.

Department of Juvenile Justice Transformation

Based on the assessments, national research, and considerable staff and stakeholder input, DJJ is transforming the work of the agency to reflect what they have learned. Many of the changes they are making are based on evidence and research on what best promotes success and reduces recidivism rates among court-involved youth. DJJ also recognize that to be successful they must focus not only on the positive development of the young people in their system, but also the positive development and sustainability of the staff who serve them. Accordingly, DJJ must strive in all of the work they do to meet the needs of their youth and staff in the following four areas:

- **SAFETY**
Youth and staff need to feel safe in their environment and need a sense of physical and emotional well-being.
- **CONNECTION**
Youth and staff need to feel connected to supportive and caring adults, whether they are family, staff, or coworkers.
- **PURPOSE**
Youth and staff need to have goals to strive toward, skills to hone, and a sense that they have a valuable role to play in the lives of people and the community around them.
- **FAIRNESS**
Youth need to perceive their environment and interactions as fair and transparent. They need to be held accountable in a manner proportionate to their offense and offense history and similar to other youth in their situation. Staff needs to feel that they are treated fairly, compensated adequately, and supported in their efforts to meet the expectations of the department.

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

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

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ☒ Yes ☐ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ☒ Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds? ☒ Yes ☐ No
 - a) ☒ Methadone
 - b) ☒ Buprenorphine, Buprenorphine/naloxone
 - c) ☐ Disulfiram
 - d) ☐ Acamprosate
 - e) ☒ Naltrexone (oral, IM)
 - f) ☒ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ☐ Yes ☒ No
5. Does the state have any activities related to this section that you would like to highlight?

Please see attached 14. Medication Assisted Treatment

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment -Requested

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

Medication Assisted Treatment (MAT)

In Virginia, 38 Opiate Treatment Programs, (OTPs) are licensed by DBHDS. (The McGuire Veterans Affairs Medical Center in Richmond also operates an OTP but since it is federally operated, it is not licensed by DBHDS.) Four of these OTPs are directly operated by CSBs; the other 34 are privately owned. In addition to at least one annual announced visit from the Office of Licensing, OTPs may receive unannounced visits as well. Furthermore, all OTPs receive at least one announced visit from DBHDS as the State Opioid Treatment Authority (SOTA). The SOTA also provides technical assistance with OTPs at their request, works as a liaison between the OTPs and the CSBs, as well as provide ongoing reports to SAMHSA as needed. The SOTA meets with representatives from all of the OTPs at a centrally located quarterly meeting. DBHDS also sponsors scholarships to the annual training conference sponsored by the OTP association, the Virginia Association of Medication Assisted Recovery Programs (VAMARP), as well as to the American Association for the Treatment of Opioid Dependence (AATOD) national conference held every 18 months.

Evidence-based practices are discussed at both of these meetings and DBHDS often sponsors a speaker to address EBPs. As the Virginia Department of Medical Assistance Services developed the Addiction Recovery Treatment Services initiative (ARTS, a Center for Medicare and Medicaid Services Substance Use Disorder Waiver Waiver) to support MAT, DBHDS was an active collaborator and provided extensive technical assistance to DMAS related to OTPs, as well as the use of buprenorphine in office-based settings.

The Virginia Board of Medicine developed Standards of Care and then promulgated emergency regulations [18VAC85-21-10 et seq.] for the use of buprenorphine products in the treatment of addiction. DBHDS was represented on the workgroup that developed these standards and provided technical assistance in the development of the regulations. About half of the 40 CSBs are currently utilizing MAT, including buprenorphine.

DBHDS is providing technical assistance to the Supreme Court of Virginia Drug Treatment Court Administrator in the use of MAT (extended release naltrexone) as several drug treatment courts received limited funding to pilot the use of this medication.

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- a) ☒ Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) ☒ Psychiatric Advance Directives
- c) ☒ Family Engagement
- d) ☒ Safety Planning
- e) ☒ Peer-Operated Warm Lines
- f) ☐ Peer-Run Crisis Respite Programs
- g) ☒ Suicide Prevention

2. Crisis Intervention/Stabilization

- a) ☒ Assessment/Triage (Living Room Model)
- b) ☐ Open Dialogue
- c) ☒ Crisis Residential/Respite
- d) ☒ Crisis Intervention Team/Law Enforcement
- e) ☒ Mobile Crisis Outreach
- f) ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) ☒ Peer Support/Peer Bridgers
- b) ☒ Follow-up Outreach and Support
- c) ☒ Family-to-Family Engagement
- d) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
- e) ☒ Follow-up crisis engagement with families and involved community members

- f) ☒ Recovery community coaches/peer recovery coaches
- g) ☒ Recovery community organization

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

Virginia does not offer "Psychiatric Advance Directives" per se. Under the Code of Virginia, individuals have the right to pre-plan for psychiatric/mental health crisis through the use of an Advance Directive which covers both physical and mental health care. Individuals can complete an Advance Directive that is solely for psychiatric crisis, but the Code of Virginia does not provide for a standalone Psychiatric Advance Directive. This item is discussed in further detail in the Person-Centered Planning and Recovery sections of the Environmental Factors and Plan.

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

None at this time

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Footnotes:

NOT FINAL

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ☒ Yes ☐ No
- b) Required peer accreditation or certification? ☒ Yes ☐ No
- c) Block grant funding of recovery support services. ☒ Yes ☐ No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ☒ Yes ☐ No
2. Does the state measure the impact of your consumer and recovery community outreach activity? ☐ Yes ☒ No
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
See attached 16. Recovery
4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
See attached 16. Recovery
5. Does the state have any activities that it would like to highlight?
See attached 16. Recovery
Please indicate areas of technical assistance needed related to this section.
None at this time

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Environmental Factors and Plan

16. Recovery - Required

1. Does the state support (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. As a result of DBHDS strategic planning efforts to expand the participation of peers, family members and service recipients in implementing the agency's vision and mission, in January 2015, DBHDS established the Office of Recovery Services (ORS). The ORS Director is a person with lived experience. The position is funded with a combination of SAPT and MH block grant dollars. ORS has three full-time staff members with lived experience. ORS staff facilitates the continuing development of strategies that use person-centered, participant-led care in the public and private sectors of our system, including peer-run organizations and agencies that use peer supporters within their continuum of care.

Individuals and families with lived experience participate on a variety of state-level councils, committees and work groups. Similarly, the same happens at the local level. One important mechanism for to ensure this happens is outlined in [Title 37.2 of the Code of Virginia](#) providing that at least one-third of the members of the State Board of Behavioral Health and Developmental Services be consumers or family members of consumers, with at least one member being a direct consumer of services. The State Board has the statutory authority for the establishment of policy for DBHDS, our state facilities, and the Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs). Members of the State Board are appointed by the Governor and confirmed by the General Assembly. The Code has the same requirement of the CSBs' oversight boards (also called Community Services Boards). In this way, the DBHDS and our primary partners in the public behavioral health system have substantive input by peers/consumers and family members.

DBHDS and the CSBs collaborate with a wide variety of stakeholder groups in the development of public policy, programs and services. The following are some examples; additional groups exist at the local level which may not be reflected here:

Organization	Constituency
Center for Excellence in Aging and Lifelong Health	Older adult consumers and family members
Cultural Linguistic Competency Steering Committee	Consumers, providers, advocates

McShin Foundation	Consumers and advocates
Mental Health America of Virginia	Consumers and family members
NAMI Virginia	Consumers and family members
Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA)	Consumers and family members
Virginia Association of Community Services Boards	Providers
Virginia Behavioral Health Advisory Committee (formerly the Mental Health Planning Council)	Consumers, family members, providers, advocates
Virginia Coalition for Language Access	Minority and multicultural communities
Virginia Family Network	Parents of children with behavioral health challenges
Virginia Intercommunity Transition Council	Families, providers, advocates
Virginia Military and Veterans Coordinating Committee	Veterans, Veteran service organizations, family members, Virginia National Guard, active-duty military representatives
Virginia Organization of Consumers Asserting Leadership (VOCAL)	Consumers
Virginia's Refugee Wellness Partnerships	Minority and Multicultural Communities
Voices for Virginia Children	Parents and family members
YouthMOVE	Young adults with behavioral health challenges

Virginia Recovery Initiative

The Virginia Recovery Initiative is an extension of the SAMSHA 2012 initiative where DBHDS was selected by SAMHSA to participate in the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Policy Academy to develop a framework for recovery oriented care and expand peer services within CSBs, facilities, and peer run advocacy and service groups. This initiative focuses on building and expanding a recovery oriented system of care for persons with behavioral health challenges, as well as for their families and those who care about them.

This is being accomplished through continued education about the value peer services, the role of the peer supporter, developing the peer workforce, and

providing technical assistance on how to integrate peer support into the continuum.

The initiative focused on moving away from supporting individuals only through episodes of acute care to a model of supporting and maintaining a path to recovery and resilience. It also includes providing trauma informed and person-centered services.

The Virginia Recovery Initiative (VRI), has developed an official statement of recovery and recovery values that captures the vision of recovery, resiliency and self-determination for all populations served by the Virginia public behavioral health and developmental services system. The official definition meets Virginia's unique characteristics while aligning with SAMHSA's definition. The work of the state-level team is supplemented by regional VRI teams across the state which are collaborating locally and regionally to implement the DBHDS vision of a recovery-oriented system of care.

The mission of the Virginia Recovery Initiative is the same as SAMHSA's mission and purpose statement of *"Moving people, health authorities, policy makers, researchers, treatment providers, and other health and human service organizations toward a Recovery Orientation regarding mental wellness, and freedom from addiction."* VRI sustains the focus on people in recovery from behavioral health conditions through project development and community based strategies designed to highlight strengths and gaps in recovery capital such as housing, transportation, and access to recovery supports.

The regional VRI groups are the network hubs for dissemination of best or emerging practices and share successful, innovative, recovery-oriented service delivery strategies. DBHDS provides leadership, technical assistance and structural support to these regional groups. The regional VRI groups have evolved and thrived since their original inception; they now provide impetus to local behavioral health entities to hire Peer Recovery Specialists, host workshops about trauma-informed services, and promote widespread use of recovery language in written and oral communications. Regional VRI groups are also exploring collaboration among public agencies to provide housing, transportation and employment to people who are overcoming mental health and addiction challenges.

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Adults with SMI

Our state system includes a wide variety of recovery support services. CSBs, state hospitals and private providers offer access to recovery support groups, peer support services, recovery-oriented clinical and rehabilitative services, etc. January 2017, Virginia recognized the Certified Peer Recovery Specialist in State code and Medicaid reimbursement for peer support in behavioral health services became effective. This policy change came about as a result of Center for Medicare and Medicaid Services' approval of an SUD Waiver which led to the

development of Virginia Medicaid's Addiction Recovery Treatment Services (ARTS), which is discussed in further detail below.

Certification standards have been essential to developing peer support services as a reimbursable mainstream service option in our system. DBHDS has included Family Support Services by Family Support Partners (FSPs) under the Peer Recovery Support program. DBHDS adopted the International Certification and Reciprocity Consortium (IC&RC) co-occurring Certified Peer Recovery Specialist (CPRS) certification for this initiative. In accordance with IC&RC standards, performance competencies, professional ethics and training standards are fundamental elements of the certification. The performance contract between DBHDS and the CSBs includes the use of CPRSs and FSPs in a multitude of settings, including crisis intervention, assertive community treatment, jail diversion, and recovery education.

DBHDS also provides significant financial support for peer-run organizations through both the MH and SAPT block grants as well as state general funds. With MHBG funds, DBHDS contracts with ten providers, seven of whom are independent recovery community organizations, for the delivery of behavioral health peer support services. In addition, MHBG funds support statewide organizations such as NAMI Virginia, which provides programming such as the Family to Family, In Our Own Voice and Connection programs; Mental Health America of Virginia, which offers, among other services, the Consumer Empowerment Leadership Training curriculum; the Virginia Organization of Consumers Asserting Leadership (VOCAL), Virginia's SAMHSA-designated state consumer network, which offers technical assistance to peer-run programs, trains WRAP facilitators, and supports a statewide peer network and an annual conference for individuals receiving services; and the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), the only statewide addiction recovery advocacy organization, which provides technical assistance and an advocacy platform for individuals and families that are affected by substance use/addiction.

Virginia's Advance Directives Initiative began in 2010 after amendments to the Virginia Health Care Decisions Act in 2009 provided the ability for individuals to pre-plan for mental health crisis through the use of an Advance Directive (AD). (Unlike in most other states, the Commonwealth incorporated mental health care planning into its AD format instead of developing a separate Psychiatric AD.) Beginning in 2010, through a partnership with the Institute of Law, Psychiatry and Public Policy (ILPPP) at the University of Virginia School of Law, DBHDS, the ILPPP and a variety of stakeholders that included peer supporters, service providers and advocacy organizations, began implementation of this initiative to educate consumers, family members and service providers about the importance of pre-planning for mental health crisis care. More detail is available on this effort in Section 5.

The DBHDS Office of Child and Family Services (OCFS) supports the Statewide Family Network, known as the Virginia Family Network (VFN). VFN is a

grassroots network of families committed to providing opportunities that support, educate, and empower other families with children and youth with mental health needs while also promoting family driven and youth guided policy throughout the child serving systems. The initiative is designed to “meet the family where they are” through activities such as providing support groups, training, resources, and mentorship from other families with children and youth with mental health needs. The VFN has grown over the past two years as a result of Systems of Care efforts statewide through the development of groups, trainings, and other resources for families. The VFN currently has 37 Family Support Groups in four of the five regions across the state with three of those being specifically for parents/caregivers of youth. Parents/caregivers are also welcome to attend family support groups

The parent groups facilitate the following activities:

- Identifying and referring families to trainings and other community groups.
- Expanding and utilizing List-servs to provide families with information, education, training, and support opportunities.
- Mentoring and training youth and families through information and resources shared at monthly support group meetings.
- Community networking with local agencies.
- Providing information and resources on how to utilize natural supports.
- Providing training, mentoring, and support on how parents/families can work effectively with their services providers.
- Mentoring, supporting and preparing parents/families to participate on workgroups, boards, and commissions.
- Serving as parent representatives for their local Family Assessment and Planning Teams, which assist children and youth with emotional disturbances and other issues to obtain needed community services, and various CSB committees and councils.

In addition, the Office of Child and Family Services has sponsored several trainings specifically for families, including Family Support Activities, workshops on co-occurring disorders, and support for families and professionals to attend conferences to learn about best practices around children and family services.

Young Adults with Lived Experience

Virginia supports Youth MOVE Virginia. Youth MOVE (Motivating Others through Voices of Experience) is a national youth-led organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare.

While working in partnership with youth and young adult leaders, NAMI affiliates, and other community organizations, the goal is to have at least one youth group in every region with an array of trainings being offered throughout

the year, all of which are available and within reach of our affiliates. The vision is to be a resource to youth, young adults, affiliates and other organizations, as they grow their efforts to reach youth and young adults.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

As stated above, for some years now, DBHDS has allocated both MH and SAPT block grant funds to support peer-run programs and family and consumer advocacy organizations. In addition, DBHDS has been appropriated additional State General Funds to contract for recovery support services for individuals with SUD. Organizations supported with state and federal funds include peer-run recovery centers, resource centers, drop-in centers and advocacy organizations operated by and for people with mental health, substance use disorder and co-occurring disorder challenges that foster the development of skills related to self-directed care and informed choice. These organizations offer a wide variety of peer recovery support services, including individual and group peer support, Wellness Recovery Action Planning (WRAP), Whole Health Action Management (WHAM), recovery coaching, peer-led help groups, mutual aid groups and telephone warm lines.

DBHDS currently either contracts with or has provided financial support to a variety of organizations that provide peer and family supports, all of which are designed to enhance individuals' skill and ability to engage in informed self-directed care and intervention. DBHDS has also fostered the development of peer recovery support services into more mainstream settings such as the CSBs and private providers. Housing, employment and responsive access to services are becoming foundational throughout the state. SAPT Block Grant and state general funds for SUD recovery services currently support nine recovery support programs.

Addiction Recovery Treatment Services Medicaid Waiver

Through the ARTS initiative, Virginia Medicaid will reimburse organizations eligible for ARTS reimbursement for peer and family support services. In order to qualify for ARTS funding, organizations must be licensed by DBHDS and meet service level criteria established by the American Society of Addiction Medicine Criteria, or a hospital emergency department licensed by VDH. Peer services can be integrated into any ASAM level of care.

In addition, peer support services will be reimbursed in the following settings where people may be entering care because of mental health challenges and may also have addiction challenges:

- Acute Care General Hospitals licensed by the Virginia Department of Health
- Freestanding psychiatric hospital and inpatient psychiatric units licensed by DBHDS
- Outpatient mental health clinic services licensed by DBHDS
- Outpatient psychiatric services provider (where the practitioner is licensed by DHP)
- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)

- Day Treatment/ Partial Hospitalization licensed by DBHDS
- Psychosocial Rehabilitation licensed by DBHDS
- Crisis Intervention licensed by DBHDS
- Intensive Community Treatment licensed by DBHDS
- Crisis Stabilization licensed by DBHDS
- Mental Health Skill-building Services licensed by DBHDS;
- Mental Health Case Management licensed by DBHDS; or
- Case Management through the Governor's Assistance Program (GAP), a Medicaid waiver program for individuals with serious and persistent mental illness with are not eligible for "full" Medicaid.

NOT FINAL

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :
 - Housing services provided. ☒ Yes ☐ No
 - Home and community based services. ☒ Yes ☐ No
 - Peer support services. ☒ Yes ☐ No
 - Employment services. ☒ Yes ☐ No
2. Does the state have a plan to transition individuals from hospital to community settings? ☒ Yes ☐ No
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?

Please refer to Virginia's Olmstead Strategic Plan

<https://www.olmsteadva.com/downloads/2017FINALOlmsteadStrategicPlan.pdf>

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

None at this time

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶³ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁶⁴ For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.⁶⁵

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁶⁶ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ 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).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, 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.

⁶⁵Centers 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.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸ http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? ☒ Yes ☐ No
 - The recovery and resilience of children and youth with SUD? ☒ Yes ☐ No
- 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:
 - Child welfare? ☒ Yes ☐ No
 - Juvenile justice? ☒ Yes ☐ No
 - Education? ☒ Yes ☐ No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? ☒ Yes ☐ No
 - Costs? ☒ Yes ☐ No
 - Outcomes for children and youth services? ☒ Yes ☐ No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
 - Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? ☒ Yes ☐ No
 - for youth in foster care? ☒ Yes ☐ No
- 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.)
Please see attached 18. Children and Adolescents Behavioral Health Services
- Does the state have any activities related to this section that you would like to highlight?
Please see attached 18. Children and Adolescents Behavioral Health Services
Please indicate areas of technical assistance needed related to this section.
None at this time

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

Footnotes:

18. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

6. Describe how the state provides integrated services through the system of care.

For almost thirty years Virginia has had the opportunity to participate in several initiatives to expand and implement Systems of Care (SOC) statewide. Some of the most successful of past initiatives are summarized below:

Comprehensive Services Act (CSA)

- Landmark legislation, to create a collaborative system of services and funding that is child-centered, family-focused, community-based and cost-effective when addressing the strengths and needs of troubled and at risk youths and their families in the Commonwealth (*Code of Virginia § 2.2-5200*).
- A primary purpose of the law is to preserve and strengthen families through providing appropriate services in the least restrictive environment, enabling children to remain in their homes and communities when possible, while protecting the welfare of children and maintaining public safety.
- Funding streams placed in the CSA funds pool came from the Departments of Education (DOE), Department of Social Services (DSS), Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Juvenile Justice (DJJ).
- The State Executive Council (SEC) is the Supervisory council that provides leadership for CSA (*Code of Virginia §2.2-2648*). It oversees the development and implementation of state interagency program and fiscal policies. The SEC is chaired by the Secretary of Health and Human Resources or a designated deputy.
- The State and Local Advisory Team (SLAT) is required by statute to advise the SEC by managing cooperative efforts at the state level and to provide support to community efforts. It is comprised of a parent, private provider association representative, representatives from six state agencies, juvenile and domestic relations judge, local CSA Coordinator and local CPMT representatives from community service boards, local departments of social services, court service units, health departments, and schools.
- Community Policy and Management Teams (CPMTs) have the statutory authority and accountability for developing interagency policies that govern CSA in the community. They manage local CSA fund allocations and coordinate community wide planning to develop needed resources and services. They are comprised of a parent, local government official, agency heads from local child serving agencies (community services boards, courts service units, health, social services, and public schools) and private provider. Community agency representatives are authorized to make policy and funding decisions for their agencies. Localities must have a utilization management process and report minimum data on child demographics, services and funding.
- Family Assessment and Planning Teams (FAPTs) are established by CPMTs to provide for family participation, assess the strengths and needs of children and their families, and develop individual family services plans. They make recommendations to the CPMTs.

They are comprised of a parent, representatives from local child serving agencies (community services boards, courts service units, social services, and public schools). They may include a local health department and private provider representatives.

- CSA Coordinators are hired by many communities to manage local implementation, including program, fiscal, and administrative responsibilities.

System of Care Grant

Virginia received a SOC Expansion and Sustainability Grant which focuses on these key strategies:

- 1) Establishment of regional SOC Expansion Centers in each of the five DBHDS regions in the state to expand the SOC approach in additional local government jurisdictions through HFW.
- 2) Demonstration project with previous SOC grant communities to pilot Family Support Partner services outside of HFW.
- 3) Wraparound Center of Excellence continues to offer training and coaching support.
- 4) The Virginia Family Network and Youth MOVE Virginia will continue to engage and support families and youth through strategic planning, training, and support.
- 5) Establishment of a statewide SOC data driven strategic planning process.

The project name is “Bringing Systems of Care to Scale.” The population of focus for the project is children through age 21 that have a serious emotional disturbance that is diagnosable under the Diagnostic and Statistical Manual of Mental Disorders. Additionally, the youth served are unable to function in the family, school, or community or a combination of these settings and the disability must have been present for at least one year or expected to last more than one year.

A System of Care Expansion Team was developed to advise the System of Care Expansion Planning Grant and the System of Care Implementation Grant. This planning and governance team will continue beyond grant funding. Members of the System of Care Expansion Team include the following children’s services stakeholders: family membership, youth membership, statewide family network, DBHDS, DSS, OCS, DMAS, DJJ, and DOE

In addition to the System of Care Expansion Team, DBHDS serves on multiple interagency workgroups which develop and promote Virginia’s priorities. Some of the most successful past initiatives and partnerships are listed below:

- Comprehensive Services Act
- State Executive Council (SEC)
- State and Local Advisory Team (SLAT)
- Community Policy and Management Teams (CPMTs)
- Family Assessment and Planning Teams (FAPTs)

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

Working with other State Agencies

The Office of Child and Family Services (OCFS) at DBHDS actively participates and collaborates with many state agencies. The following chart provides a sample of some of the partnerships:

Name of Entity	Meeting Frequency	Lead Agency	Purpose of DBHDS Participation
FAMIS Advisory Committee	Quarterly	DMAS	The purpose of the committee is to assess the policies, operations and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus (children's Medicaid) and to evaluate enrollment, utilization of services, and health outcomes of children eligible for such programs. DBHDS is mandated by the Code of Virginia to have a member serve on CHIPAC.
Behavioral Health Redesign Project Team	Time Limited Weekly	DBHDS/ DMAS	Subject matter expert.
Interagency Partnership to End Youth Homelessness	Monthly	DHCD	Provide recommendations on addressing the behavioral health needs of homeless youth.
Child Welfare Advisory Committee	Quarterly	DSS	The Advisory Committee will be the primary organization to advise the Director of the Division of Family Services on child welfare issues including policy and CFSR Plans of Improvement. The Advisory Committee should ensure that all child welfare activities are child centered, family focused, and community based. Child welfare programs include Adoption, Child Protective Services, Family Preservation, Foster Care, and Interstate Compact on the Placement of Children (ICPC).
Commission on Youth	Quarterly	Legislative Branch	Issues impacting children. Serve on COY study committees when needed.
Project Aware State Management Team	Monthly and as needed	DOE	Provide recommendations on improving comprehensive mental health approaches in schools and communities.
VA Perinatal Collaborative	Semi-Annual	VDH	Represent EI and provide information and coordination of activities.

Outcomes for Children and Youth in Services

DBHDS adopted measurement-based care, using the standardized, Daily Living Activities- 20 (DLA-20), instrument to monitor treatment progress. The DLA-20 beginning in January 1, 2019 will be completed for each child age 6 and up and adult receiving a behavioral health service in a CSB. This includes mental health, substance use disorders, and co-occurring issues. On March 1, 2019, Community Services Boards fully implemented the DLA-20.

The DBHDS Office of Management Services (OMS), formerly known as the Office of Support Services negotiates and administers performance contracts and monitors the accomplishment of contract objectives, performance and outcome measures, and compliance with contract

assurances directly and in conjunction with other DBHDS offices. In addition, OMS facilitates the receipt of CSB data, consults on CSB administrative and management issues, interprets policies and procedures, fosters mutual understanding and cooperation between CSBs and DBHDS, and works with advocacy organizations and stakeholders.

Evidence Based Practice Training

In the summer of 2019, DBHDS began training 108 clinicians in Trauma Focused-Cognitive Behavior Therapy (TF-CBT) and 18 clinicians in Parent Child Interaction Therapy (PCIT). Those clinicians that participate in the in person TF-CBT and PCIT training will continue with consultation calls during 2019-2020. It is anticipated that all clinicians that participated in the in person training and follow up consultation calls will be certified in TF-CBT and PCIT within the next two years.

Training	Date	Location
Parent Child Interaction Therapy	June 2019 September 2019	Richmond
Trauma Focused Cognitive Behavior Therapy	July 2019	Blacksburg
Trauma Focused Cognitive Behavior Therapy	August 2019	Arlington
Parent Child Interaction Therapy	August 2019 January 2020	Durham, NC
Trauma Focused Cognitive Behavior Therapy	September 2019	Newport News

Young Adult Substance Abuse Treatment (YSAT) for Transition Age Youth

In Virginia, youth and young adults ages 16-25, often referred to as “transition-age,” are underserved in the Commonwealth’s behavioral health system. Those who are diagnosed with substance use disorders and/or co-occurring substance use and mental health disorders are often trapped between an adolescent system that is inconsistent in the array of services provided and an adult system that does not always address the need for developmentally appropriate, evidence- based treatment and recovery supports. Furthermore, the lack of integrated services perpetuates the “silo” effect for both treatment providers and the youth and families who seek help. DBHDS is addressing these needs by bringing together stakeholders across the systems servicing the population of focus to strengthen our existing network and enhance and expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices and implement financial reforms to improve the integration and efficiency of SUD treatment and the recovery support system

DBHDS is leveraging the work, knowledge and information conducted and gathered by the department’s planning effort specifically related to the SAMHSA-funded State Youth

Treatment-Planning grant. By collaborating with other public and private providers and agencies that serve transition-age youth and their families, the Commonwealth of Virginia has an opportunity to make systemic changes to our service system in the treatment of substance abuse and/or co-occurring disorders among this underserved age group. Implementation of this initiative enables the Commonwealth to build upon the efforts of Coordinated Specialty Care, a new evidence-based practice for the treatment of emerging serious mental illness for transition-age youth and young adults currently being rolled out in Virginia while assuring youth and young adults have access to evidence-based assessments, treatment models and recovery services supported by strengthening the existing infrastructure system. CSC is described in more detail in Section 4 Evidenced Based Practices for Early Intervention to Address ESMI. DBHDS is implementing this project in four geographically diverse regions of Virginia. Providers were selected from among the 40 Community Services Boards located throughout the Commonwealth and DBHDS is working with them to implement services and activities for the population of focus that are evidence-based and client-focused.

Department of Social Services, Services for Older Youth

Youth services (also known as the Independent Living Program) assist foster care youths ages 14-21 in developing the skills necessary to make the transition from foster care to independent living. Independent Living services include activities that are based on a written assessment of life skills. Areas of focus include personal development skills such as self-esteem, communication skills, decision-making, conflict resolution and anger management. Examples of independent living skills are career exploration, job skills, money, management, housing, transportation, and legal issues.

- **Community College Tuition Grant**

This program will provide tuition and fees at any Virginia community college specifically for high school graduates or those who have received their GED if, at the time of graduation or completion of the GED, they were in foster care, in the custody of a social services agency or in a special needs adoption

- **Education and Training Voucher**

The Education and Training Voucher (ETV) Program assists eligible foster care and adopted teens or young adults with post-secondary education and training expenses. It is designed to help teens or young adults aging out of foster care with the education, training and services needed for employment.

Program funds can be applied toward, but not limited to, colleges, universities, community colleges, vocational programs, and one-year training institutions.

- **Great Expectations**

Great Expectations is a nationally recognized program that helps Virginia's foster youth earn the postsecondary credentials they need to achieve an independent and successful life. Great Expectations is currently available at 21 of Virginia's Community Colleges.

Great Expectations was created in 2008 as a partnership between Virginia's Community Colleges and philanthropists supporting the Virginia Foundation for Community College Education. The program launched at five Virginia Community Colleges, each of which received a grant to pilot components of the program. Since then, the program has expanded to 18 community colleges across the Commonwealth.

Great Expectations helps Virginia's foster youth complete high school, gain access to a community college education and transition successfully from the foster care system to living independently.

Key components include:

- Individualized tutoring
- Help applying for college admission and financial aid
- Career exploration and coaching
- Help applying for and keeping a job
- Life skills training, including managing finances
- Personalized counseling
- Student mentors

Families First Prevention and Services Act

Currently, Virginia is using a Three Branch approach for Families First Prevention and Services Act implementation. The Virginia Department of Social Services (VDSS), which is leading the effort, is working closely with the Virginia Department of Behavioral Health (DBHDS), Virginia Department of Medical Assistance Services (DMAS), the Virginia Department of Health (VDH), the Virginia Supreme Court, the Virginia House of Delegates and the Virginia Senate to develop and implement integrated approaches to prevention throughout the state. DBHDS is an active participant on the Evidenced Based Practices, Finance, and Prevention workgroups.

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☒ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

Goal 1: Foster leadership, collaboration and partnerships among public, private, non-profit and community entities, including the integration and coordination of suicide prevention efforts across multiple sectors and settings. Collaboration between all stakeholders is critical to the success of Virginia's suicide prevention effort. Through this collaboration, gaps in services can be identified and addressed. Additionally, greater coordination of efforts among different stakeholders and settings can increase the reach and effect of suicide prevention activities.

Recommendations:

1.1 DBHDS and VDH should maintain leadership and provide support for the Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia, including planning, implementation, monitoring and evaluation.

1.2 Continue to pursue federal, state and private funding to support the Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia.

The Commonwealth of Virginia will:

? Sustain and expand state funding to support comprehensive suicide prevention efforts in the Commonwealth.

? Provide funding to support a full-time suicide prevention manager within DBHDS.

? Identify communities and coalitions that are working together on suicide prevention and assist coalitions to sustain and grow community partnerships.

? Provide financial support to localities for suicide prevention.

? Maintain and expand resource directories to include faith-based associations like Partners in Care (VANG).

? Identify grant opportunities to support suicide prevention and intervention efforts.

? Provide resources to support grants management and performance reporting.

? Utilize the Suicide Prevention Interagency Advisory Group to ensure concerns of older adults are represented.

? Support and sustain the Suicide Prevention Interagency Advisory Group and ensure that the group is representative of the lifespan.

? Form a committee to address mental illness-related suicide.

Early Learning Centers, Schools, Colleges and Universities can:

? Create a comprehensive, best-practice-based suicide intervention and postvention plan for these campuses and school districts.

Community, Non-profit and Faith-based Organizations can:

? Expand and sustain community coalitions to address suicide prevention.

? Work with stakeholders to develop and submit consolidated grant proposals.

? Promote wellness education.

? Teach and promote help seeking skills.

? Train helpers in culturally appropriate suicide prevention models.

? Examine how suicide impacts their constituents and how to partner to address those needs.

? Create a comprehensive, best-practice-based suicide intervention and postvention plan for these campuses and school districts.

Community, Non-profit and Faith-based Organizations can:

? Expand and sustain community coalitions to address suicide prevention.

? Work with stakeholders to develop and submit consolidated grant proposals.

? Promote wellness education.

? Teach and promote help seeking skills.

? Train helpers in culturally appropriate suicide prevention models.

? Examine how suicide impacts their constituents and how to partner to address those needs.

Goal 2: Promote research-informed communication designed to increase acceptance, understanding and recovery for mental, emotional and behavioral well-being.

It is widely believed that stigma and misinformation create barriers to help-seeking for mental health problems. Community messages regularly reinforce isolation and a lack of acceptance for the person in an emotional crisis. The Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia attempts to address these roadblocks in its many different settings, including the promotion of responsible media reporting of suicide. Resiliency has been proven to increase mental wellness and quality of life.

Recommendations:

2.1 Improve mental health literacy of Virginia's citizens and professionals through intentional educational efforts that promote appropriate messaging about suicide.

2.2 Increase collaboration among public service agencies and organizations and increase the number of communities that are working together on suicide prevention to enhance individual, family and community resilience.

2.3 Reduce the stigma associated with mental or emotional distress and facilitate support necessary to maintain positive mental well-being.

The Commonwealth of Virginia will:

? Sustain best-practices training (RRSR, ASIST, QPR and other best-practice programs).

? Partner with organizations currently working to increase mental health literacy where possible, including the military, federal and state agencies and advocacy groups.

? Ensure that programs and literature are culturally competent, by ensuring that both programs and literature are translated and/or that interpreter services are available where possible.

? Develop and maintain the capacity to provide on-line dialogue with stakeholders to increase awareness of prevention information.

? Increase collaboration between lead agencies and other community-based stakeholders including first responders, the Department of Social Services, the Department of Veteran Services, primary care physicians, psychiatrists, emergency rooms, and services providers for housing/homeless.

? Increase stakeholder utilization of Recommendations for Safe Reporting on Suicide (www.reportingonsuicide.org).

? Promote social media opportunities to develop and expand healthy communities, by responding to individual community needs and culture.

? Promote programs and literature that support person-first language.

? Ensure that community events, forums and materials promote safety and help-seeking.

? Continue process of certification for peer services.

Early Learning Centers, Schools, Colleges and Universities can:

? Promote programs and literature that support person-first language.

? Promote educational opportunities to include the national suicide prevention awareness and mental health awareness week.

? Increase stakeholder utilization of Recommendations for Reporting on Suicide. (www.reportingonsuicide.org).

? Promote programs and literature that support person-first language.

? Promote educational opportunities to include the national suicide prevention awareness and mental health awareness week.

? Increase stakeholder utilization of Recommendations for Reporting on Suicide. (www.reportingonsuicide.org).

Community, Non-profit and Faith-based Organizations can:

? Promote educational opportunities to include national suicide prevention awareness and mental health awareness week.

? Increase stakeholder utilization of Recommendations for Reporting on Suicide. (www.reportingonsuicide.org).

? Promote social media opportunities to develop and expand healthy communities that promote help-seeking behavior.

? Promote mental wellness through faith-based communities.

? Facilitate the support necessary to maintain positive mental well-being.

? Offer education targeted for families to support healthy communities collaboratively with existing peer run organizations.

? Offer education targeted for individuals to support resilience, help-seeking behavior and mental well-being.

? Explore the process of reimbursement through Medicaid for peer services.

? Reach out to diverse communities and increase collaboration with those non-traditional entities and key community informants.

Goal 3: Provide training and education to enable communities to recognize and respond to suicide risk and educate the support systems of those at risk for suicide.

Over the past 10 years, considerable effort has provided evidence-based training for many key gatekeepers in the community.

These training efforts distinguish the Commonwealth as a leader in creating communities that are safer from suicide and aim to increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Continued training to the community and clinical service providers and the expansion of education requirements are essential to maintaining this leadership. Training should be expanded to include health professionals, law enforcement and Crisis Intervention Team (CIT) officers, and behavioral health service workers.

Recommendations:

3.1 Expand and sustain evidence-based, best-practice suicide prevention, risk assessment and intervention training. Encourage evaluation of innovative practices to expand best-practice knowledge.

3.2 Support public and community education about suicide and suicide prevention.

3.3 Sustain a coordinated central point of access where suicide prevention resources and training are accessible to the community.

- 3.4 Collaborate with programs licensed by DBHDS to promote a culture that reflects that suicide is preventable.
- 3.5 Collaborate with practitioner licensing and certifying organizations to ensure that healthcare and other professionals receive formalized training in suicide prevention and/or intervention as part of the credentialing process.

The Commonwealth of Virginia will:

- ? Devote state and federal funds to support evidence-based suicide prevention and risk assessment training.
- ? Increase and sustain a network of trainers and collaboration between resources.
- ? Utilize local capacity to promote community forums for suicide prevention.
- ? Support innovation in awareness, prevention and intervention.
- ? Use targeted data provided by the VVDRS to inform public outreach materials and events.
- ? Determine, with the Department of Health Professions, whether legislation and regulations are needed to implement suicide prevention and intervention training as a part of licensing for healthcare and other professions as appropriate.
- ? Encourage all certifying entities working within the Commonwealth to include formal suicide prevention and/or intervention training.
- ? Partner with the Department of Criminal Justice Services (DCJS) to increase the use of training in suicide prevention for their personnel.
- ? Encourage the inclusion of evidence-based, best-practice programs for CIT curricula.

Early Learning Centers, Schools, Colleges and Universities can:

- ? Require health and behavioral health academic institutions to include best-practices suicide prevention training in their curriculum across disciplines as appropriate.
- ? Require that on-going support and education is available to professionals who have an opportunity to intervene with persons at risk for suicide.
- ? Recommend educational curricula to incorporate best-practice information to help educators recognize and respond to suicide risks.
- ? Incorporate follow-up procedures for at-risk students who present in counseling offices, to aid them in treatment access and recovery.

Community, Non-profit and Faith-based Organizations can:

- ? Promote wellness trainings.
- ? Provide peer-support programs.
- ? Fund, participate and disseminate information in a variety of settings on wellness, helpseeking behavior and suicide prevention.
- ? Host best-practice prevention trainings for their members.

Goal 4: Ensure a continuum of care for those at risk for suicide and their support networks.

There are gaps in services which persons at risk must navigate during a time in crisis. When these gaps can be identified and addressed through a seamless continuum of care of services and providers, safety is increased and lives are saved. Coordinated efforts involving all care providers, family and social supports are essential to this effort. Also essential is the development, implementation, and monitoring of effective programs that promote wellness and prevent suicide and related behaviors. Healthy interpersonal relationships and connectedness are essential elements within this continuum.

Recommendations:

- 4.1 Promote early identification of mental health needs and access to quality services.
- 4.2 Develop, ensure and promote evidence-based and best-practice protocol for all points of service between clinical and professional behavioral health services.
- 4.3 Foster collaboration and partnerships among public, private, non-profit and community entities. Ensure that supports and resources are available for individuals at risk (specifically including suicide attempt survivors) and their families, friends, loved-ones and caregivers.
- 4.4 Develop or expand relationships between Community Service Boards and Behavioral Health Authorities (CSBs and BHAs) and local health and related service providers such as clinics and health centers, hospitals and emergency departments, nursing facilities, rehabilitation centers, the Departments of Social Services, schools, veteran services agencies, local agencies on aging, faith-based organizations, military resources and others.
- 4.5 Collaborate with the licensing entities to ensure that healthcare and other professionals receive formalized training in suicide prevention and/or intervention as part of the credentialing process.

The Commonwealth will:

- ? Cultivate a culture based on the belief that suicide is preventable.
- ? Support community collaboration with existing and new peer-run organizations and services in the community.
- ? Develop a best-practice protocol for all points of service that provides seamless comprehensive linkages for persons at risk of suicide across all levels of care.
- ? Research and disseminate existing protocols and information related to the prevention of suicide to care providers at facilities.

? Require the inclusion of person-centered suicide prevention and intervention protocols in health and behavioral healthcare standard operating procedures and licensing regulations.

? Encourage family and social supports to participate in discharge planning for persons at risk.

? Explore the feasibility of establishing anonymous points of access to provide safe resources and access to crisis intervention.

Early Learning Centers, Schools, Colleges and Universities can:

? Create partnerships between community mental health and academic settings to provide linked services.

? Maximize efficiency and effectiveness of on-campus services.

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? Support best-practice protocols for all points of services that provide seamless comprehensive linkages for persons at risk of suicide across all levels of care.

Community, Non-profit and Faith-based Organizations can:

? Enhance peer supported and facilitated suicide attempt survivor groups throughout the Commonwealth.

? Continue to support and expand existing suicide prevention hotlines and warmlines through collaboration with other agencies.

? Continue to support and expand programs that teach personal coping, resilience and relational health.

? Incorporate follow-up services with persons at-risk of suicide in order to support their independent recovery.

? Disseminate literature designed to help individuals and families recover from a suicide attempt or death.

? Increase partnerships between hotlines and emergency departments to include follow-up with those referred and discharged from emergency departments.

Goal 5: Reduce barriers and increase access to mental/behavioral health services and supports.

Geographical, social, economic, language and other barriers are deterrents to help-seeking behavior. In order to promote an environment where mental health services are open and available to all in need, careful planning is needed to identify and address barriers. When barriers to care are removed and suicide prevention is a core component of mental and healthcare services, persons in crisis and their families are more likely to seek assistance.

Recommendations:

5.1 Fund additional local behavioral health services to sufficient capacity.

5.2 Promote tele-health and other technology applications for expanding access to behavioral health services and supports to those who are geographically distant from mental health centers.

5.3 Address the need for cultural and linguistic competence, both individual and organizational, in all community services to military, refugees and other cultural and social groups.

5.4 Develop, sustain and expand peer-support services that can assist systems to aid a person in crisis as they navigate the many layers of services available to them.

The Commonwealth will:

? Provide funding to increase broad-band accessibility for those who must use tele-health in order to be connected to behavioral health services, particularly in rural areas.

? Designate locations and funding for adequate equipment to increase accessibility to behavioral health services and supports.

? Identify corporate sponsorships and resources to increase tele-health accessibility.

? Support and collaborate with community-based peer-run organizations, programs and services.

? Address the need for cultural awareness and sensitivity in all community services by supporting organizational strategic planning that builds capacity for working effectively with diverse communities.

? Ensure hotlines and emergency services have the capability to provide support in the dominant languages present in the community where possible.

Early Learning Centers, Schools, Colleges and Universities can:

? Promote availability of anonymous initial contacts for persons at risk.

? Utilize satellite mental health check-in stations in academic settings.

? Create a system of triage and accommodating walk-in services to address persons at risk.

? Promote a culture of mental health literacy by utilizing organizations focused on changing the dialogue to acceptance and wellness.

Community, Non-profit and Faith-based Organizations can:

? Utilize peer-service within traditional service agencies; including employing peer-recovery specialists as well as collaborating with existing peer- and consumer-run organizations and volunteers.

? Provide advocacy for those at risk to help them navigate mental health services during times of acute crisis.

? Provide support to individuals and family members to obtain services.

? Ensure treatment services are culturally appropriate.

Goal 6: Cultivate resources and leadership among attempt survivors and survivors of suicide loss and provide support and care for these individuals, while also implementing postvention strategies within communities.

People with lived experience (survivors of suicide attempts and suicide loss) are an invaluable and underused resource to the prevention community. These individuals provide insight into helping both persons at risk and their support networks. People with lived experience are strong sources of advocacy and many have a unique opportunity to advance suicide prevention efforts in the Commonwealth. This resource should be cultivated to continue prevention efforts.

Recommendations:

6.1 Identify community outlets that might be positioned to support families in the immediate aftermath of a suicide loss. Identify,

assess and fund suicide loss support models at the local community level.

The Commonwealth will:

- ? Use the statewide suicide prevention resource directory to identify and support community leadership.
- ? Support the implementation of best-practice programs that support safe messaging and leadership within the survivor of the suicide loss community.
- ? Support community and campus awareness events, such as Out of the Darkness Community Walk, that raise awareness around suicide prevention and survivor supports with materials.
- ? Provide funding to train community volunteers to provide support services to families and individuals dealing with the aftermath of suicide using models such as Local Outreach to Suicide Survivors (LOSS) Teams or National Organization for Victim Assistance (NOVA).

Early Learning Centers, Schools, Colleges and Universities can:

- ? Promote best-practices protocols regarding postvention planning and preparation in school and university settings.
- ? Adapt postvention protocols to reflect the needs of their school settings.
- ? Encourage tabletop exercises to effectively disseminate postvention protocols.
- ? Participate in awareness events that utilize safe messaging.
- ? Encourage campus news sources and journalism students to incorporate Recommendations for Reporting on Suicide.

Community, Non-profit and Faith-based Organizations can:

- ? Develop, expand and publicize local survivor leadership groups for community peer supports.
- ? Develop and provide culturally and linguistically sensitive survivor resources.
- ? Bring the Survivor Voices training to your community.
- ? Provide meeting space for survivors of suicide loss and survivors of suicide attempt support and recovery groups.
- ? Utilize resources of volunteer organizations active in responding to disasters to promote the coordination of services for crisis intervention and survivors of suicide loss.

Goal 7: Refine and expand data collection and evaluation of suicide prevention initiatives.

Surveillance data and evaluation are fundamental elements of suicide prevention, and essential to meeting the needs of the individuals, families and communities. Evaluators and epidemiologists enable Virginia to remain competitive for grant funding. Data allows stakeholders to develop a comprehensive, informed approach to suicide prevention.

Recommendations:

- 7.1 Promote the open use of fatal suicide and non-fatal suicide attempt data for health promotion, suicide prevention, policy making, training and resource allocation.
- 7.2 Ensure continued support for data collection through VDH's Office of the Chief Medical Examiner and the VVDRS in order to sustain a comprehensive suicide surveillance database.
- 7.3 Consolidate data reporting at the state level of state and local suicide prevention activities.
- 7.4 Support the development of tools for tracking information from suicide intervention to better understand how systems can improve services.
- 7.5 Support qualitative and quantitative evaluation of training programs.

The Commonwealth will:

- ? Continue to provide funding support for the VVDRS.
- ? Continue to support funding for the collection and use of fatal and non-fatal suicide attempt data.
- ? Establish and fund a public health-focused statewide Suicide Fatality Review Team through the Office of the Chief Medical Examiner.
- ? Encourage the use of both qualitative and quantitative information to continue to improve safety for those at risk.

Early Learning Centers, Schools, Colleges and Universities can:

- ? Target education programs that have incorporated data to support learning.
- ? Cooperate with agencies to provide data on suicide, suicidal behavior and intervention with high risk individuals.
- ? Encourage the development of innovative methodologies that provide qualitative and quantitative data to examine suicidal behavior, fatalities and intervention.

Community, Non-profit and Faith-based Organizations can:

- ? Use data to support program and services.
- ? Use data to understand and target groups of at-risk individuals.
- ? Conduct program evaluation to add to knowledge base.
- ? Evaluate training programs to be sure the guidelines and outcomes are consistent with the agenda.

3. Have you incorporated any strategies supportive of Zero Suicide? ☒ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☒ Yes ☐ No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ☒ Yes ☐ No

If so, please describe the population targeted.

The state has a full time Suicide Prevention Coordinator that coordinates all state efforts in addressing suicide prevention to

include: state plan development; partnership development, statewide capacity building, funding and project monitoring.

Please also see the link for DBHDS Annual Report on Activities Related Suicide Prevention

<https://rga.lis.virginia.gov/Published/2018/RD556/PDF>

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

None at this time

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

Footnotes:

NOT FINAL

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☒ Yes ☐ No
2. Has your state identified the need to develop new partnerships that you did not have in place? ☒ Yes ☐ No
If yes, with whom?
Please see attached 20. Support of State Partners
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.
Please see attached 20. Support of State Partners
Please indicate areas of technical assistance needed related to this section.
None at this time

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners -Required for MHBG

2. Has your state identified the need to develop new partnerships that you did not have in placed? If yes, with whom?

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.

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

TREATMENT PARTNERSHIPS

- **Department of Medical Assistance Services (DMAS)** –DBHDS continues to partner with the Department of Medical Assistance Services (DMAS) to prepare in relation to the Addiction, Recovery and Treatment Services (“ARTS”) initiative that began implementation April 1, 2017 (with CPRS coverage initiating July 1, 2017). This initiative remains an impactful collaboration with positive results throughout the system of care.
- **Department of Aging and Rehabilitative Services (DARS)** – DBHDS contracts with DARS for delivery of vocational services to local CSB service recipients. In addition, DBHDS collaborates with the Division for the Aging within DARS on behavioral health policy and services for older adults.
- **Virginia Department of Health (VDH)** – DBHDS collaborates with VDH in suicide prevention, surveillance of drug-related death, suicide, and early childhood home visiting services, and DBHDS’ opioid overdose prevention program, REVIVE!.. DBHDS remains a collaborator with VDH in relationship to initiatives related to the ongoing opioid epidemic. We are also collaborating on training Emergency Medical Technicians and volunteer rescue squads about the use of naloxone to reverse opioid overdose. DBHDS has been a key player with VDH in providing leadership to the Governor’s Executive Leadership Team on Addiction. The General Assembly has granted VDH permission to establish syringe exchange programs in areas of the state at high-risk for communicable disease transmission (such as hepatitis C and HIV) due to needle sharing, and DBHDS is actively collaborating on implementation plans. VDH continues to make naloxone available through all local health departments, and DBHDS will be providing funding (from SOR Opioid funds) to support this project.
- **Department of Health Professions (DHP)** – DBHDS is represented on the Advisory Council of the Prescription Monitoring Program and collaborates with the Board of Pharmacy in providing oversight and technical assistance to OTPs and programs utilizing buprenorphine

products. DBHDS worked closely with the Board of Counseling in the development of a certification registry for individuals who are Certified Peer Support Specialists.

- **Department of Veterans Services (DVS)** – DBHDS is a partner with DVS on delivering services and supports to service members, veterans and their families through the Virginia Veteran and Family Support. Areas of collaboration include delivery of behavioral health services across the 40 CSBs via a regional structure, state- and program-level input into services and supports for service members, veterans and their families, and suicide prevention.
- **Department of Social Services (DSS)** – DBHDS collaborates with DSS to coordinate services for substance exposed and/or substance affected children and their caregivers. This now includes collaborating on the families’ first initiative.
- **Department of Criminal Justice Services (DCJS)** – DBHDS and DCJS have worked closely to develop curriculum to train local law enforcement officers to administer naloxone to overdose victims. DCJS and DBHDS continue to partner in relationship to the CARA grant funds related to (1) improving treatment services for justice involved individuals and (2) naloxone and overdose reversal and prevention among local law enforcement.
- **Department of Corrections (DOC)** – DBHDS frequently provides training to DOC Probation and Parole Officers about working with individuals with SUD.
- **Virginia Commission on Alcohol Safety Action Programs (VASAP)** - a legislative agency, VASAP has oversight over 24 local alcohol safety action programs that provide an alternative to conviction for individuals who are arrested while driving under the influence. By Code of Virginia, the SSA is a member of the Commission and provides input on policy related to clinical treatment for offenders who elect to participate in ASAP.

Planning Partners

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

- **Child and Adolescent Services** – Agency stakeholders such as DMAS, OCS, DJJ, DOE, and DSS provided stakeholder input into the priorities for system development. See the section “Child and Adolescent Services Partnerships” below for more detailed information.
- **Substance Abuse Treatment Services** – DOC, DJJ, DCJS, VDH, DHP, DSS, DMAS, DARS and the State Supreme Court have been involved in developing Plan goals for this area. In addition, providers, both public and private, as well as consumer advocacy organizations participated in the development of Plan goals.
- **Housing** – DBHDS is a member of several interagency planning bodies including the Governor’s Coordinating Council on Homelessness, the Housing and Supportive Services Interagency Leadership Team, the Permanent Supportive Housing Steering Committee and the SMI Housing Strategy Stakeholder group. Together, these entities work to implement

strategies to improve access to housing and services for vulnerable populations.

- **Employment** – The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to set the targets for the number of individuals in the target population who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members are appointed for two-year terms. The E1AG has twenty-six members. It includes self-advocates, family members, advocacy organization representatives, CSB staff, educators, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE. This Advisory Group has several sub-committees: membership, training and education, policy, data, and interagency collaboration. DBHDS and members report that the membership of the group will be expanded in January 2019 to include individuals who represent the needs of individuals served by DBHDS who have mental health challenges and other disabilities to ensure all disability groups are included in the mission of the Advisory Group.
- **Criminal Justice** – DBHDS collaborates with DCJS DJJ, and DOC planning relating to the needs of individuals with behavioral health problems who are re-entering their communities post-incarceration. As a result of past close collaboration with DCJS, DBHDS continues to support implementation of, Crisis Intervention Teams (CIT), Cross-Systems Mapping and other strategies used to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification). This approach, diverts individuals from the criminal justice system (or penetrating more deeply, if identified after arrest/incarceration), and connects individuals to meaningful services and treatment (as early as possible, but often during initial court appearance, during incarceration, or upon release from jail). Similarly, DBHDS works closely with DJJ to address the needs of court-involved youth with behavioral health problems. DBHDS is a sitting member of the State Drug Treatment Court Advisory Committee, part of the State Supreme Court, which reviews and approves the operation of new and existing drug treatment courts.

Existing Cross-Agency Partnerships

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

- **The State Executive Council (SEC)** – This is the policy-making authority for services to children and youth provided under the Comprehensive Services Act. The SEC includes members from the Departments of Education, Social Services, Behavioral Health and Developmental Services, Health,

Juvenile Justice, the Supreme Court of Virginia, the Governor's Office, and the General Assembly.

- **Children's Cabinet**- Children's Cabinet develops and implements a policy agenda that will help better serve Virginia's children and will also foster collaboration between state and local agencies.
- **Governor's Housing Policy Advisory Committee** – This is a cross-agency gubernatorial effort to expand affordable and accessible housing for all Virginians, including persons with disabilities (see above). The Transformation effort is led by the DBHDS CJ/MH Transformation Director.
- **Substance Abuse Services Council** – This 29-member council is established in the *Code of Virginia* (§2.2-2696) to provide policy advice to the Governor, the General Assembly and the State Board of DBHDS. It includes representatives from state agencies including DBHDS, Health, Corrections, Juvenile Justice, Criminal Justice Services, Motor Vehicles, Alcohol Safety Action Program, Medical Assistance Services, Social Services, Alcoholic Beverage Control, and the VA Foundation for Healthy Youth. Also included are representatives from the Virginia Association of Community Services Boards (VACSB), drug court association, the sheriffs' association, substance abuse provider organizations, consumer advocacy organizations, and the Virginia General Assembly (four members from the House of Delegates, two from the Senate.)
- **Virginia Drug Treatment Court Advisory Committee** – The Virginia General Assembly established special docket drug treatment courts under the Drug Treatment Court Act (§18.2-254.1). The goals of drug treatment courts in Virginia include: reducing drug addiction and drug dependency among offenders, reduce the incidence of drug use, drug addiction, family separation due to parental substance abuse, and drug related crimes. As cited by the Drug Treatment Court Act, the state drug court advisory committee is established to evaluate and recommend standards for the planning and implementation of drug treatment courts; assist in the evaluation of their effectiveness and efficiency; and encourage and enhance cooperation among agencies that participate in their planning and implementation. The committee membership includes executive branch agencies (DBHDS, DCJS, DJJ, DOC, & DSS), and local community-based probation and pretrial services agencies, legal and law enforcement entities, and representatives from the Virginia Drug Court Association.
- **Behavioral Health System Reform** -- In addition, DBHDS is collaborating with ILPPP, the court system, and other community stakeholders to review its Mandatory Outpatient Treatment law (known as Assisted Outpatient Treatment in other states). The goal is to strengthen the various partnerships required to run successful programs, develop recommendations to modernize the program to better meet the needs of Virginians and their communities as they have been impacted by the mental health crisis, and the addiction epidemic. Recommendations are anticipated to align with other states and SAMHSA, standardize and strengthen the program and processes across the Commonwealth, in order to prevent/reduce unnecessary and costly hospitalization, and to serve individuals in the community whenever possible.

CHILDREN'S SERVICES PARTNERSHIPS

Virginia relies heavily on strategic partnerships with other child serving agencies. A System of Care Expansion Team was developed to advise the System of Care Planning Grant, and this planning team will continue with the System of Care Expansion Grant. This advisory body includes all members of the Expert Input Panels for the Commonwealth's Plan for Community-Based Children's Behavioral Health Services in Virginia, released by DBHDS in 2011, along with others deemed appropriate to advise and support the project. This team will be the advisory body for the grant, meeting throughout the life of the grant. Members of the System of Care Expansion Team include the following children's services stakeholders: family membership, youth membership, statewide family network, Office of the Secretary of Health and Human Resources, DBHDS, the Department of Social Services (DSS), the Office of Comprehensive Services (OCS), the Department of Medical Assistance Services (DMAS), the Department of Juvenile Justice (DJJ), the Department of Education (DOE), DBHDS state facility for children, non-profit agencies for children's mental health services, community services boards, local Comprehensive Services Agency representatives, private provider associations, hospital association, private provider representatives, health professional lobbyists, state early childhood coordinator, and a child psychiatrist.

In addition to the System of Care Expansion Team, DBHDS partners with a number of other interagency workgroups which help to support Virginia's priorities. Over the past twenty six years Virginia has had the opportunity to participate in several initiatives to expand and implement Systems of Care (SOC) statewide.

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

- **The State Executive Council (SEC)** – This is the policy-making authority for services to children and youth provided under the Comprehensive Services Act. The SEC includes members from the Departments of Education, Social Services, Behavioral Health and Developmental Services, Health, Juvenile Justice, the Supreme Court of Virginia, the Governor's Office, and the General Assembly.
- **The Governor's Children's Cabinet**- The Children's Cabinet develops and implements a policy agenda that will help better serve Virginia's children and will also foster collaboration between state and local agencies. Currently the Children's Cabinet is focused on three challenged school districts in Virginia.
- **State Child Fatality Review Team** - A multi-disciplinary team which is defined in statute and includes physicians and representatives from state and local agencies who provide services to families and children or who may be involved in the investigation of child deaths. Through the death

review process, the Team identifies gaps in laws, policies, and a program designed to keep children safe and healthy; and develops recommendations to address these gaps, to prevent similar deaths in the future, and to improve child death investigations in the state.

- **Child Welfare Advisory Committee** - An Advisory Committee that serves as the primary organization to advise the Director of the Division of Family Services on child welfare issues. This Committee ensures that all child welfare activities are child centered, family focused, and community based. Child welfare programs include Adoption, Child Protective Services, Family Preservation, Foster Care, and Interstate Compact on the Placement of Children (ICPC).

DBHDS is the lead agency for Virginia's Part C of IDEA- Early Intervention program. DBHDS has been the lead agency since Virginia began participating in Early Intervention. The DBHDS contracts with forty (40) local lead agencies to provide services to infants, toddlers, and their families. In Virginia, children from birth to age three are eligible for Part C Early Intervention services if:

- They are functioning 25% or more below their chronological age or adjusted age in one or more areas of development (i.e., having a 25% or greater delay in cognitive, physical, communication, social, emotional or adaptive development); and/or
- They show atypical development (e.g., behavioral disorders, affective disorders, abnormal sensory-motor responses); and/or
- They have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

Virginia has adopted evidenced-based practices for the provision of services. These include providing services in natural environments and using coaching techniques to fully engage the family. Over 20, 800 infants and toddlers were served in the Part C – Early Intervention program in State Fiscal Year 2019. The Virginia Department of Education oversees all programs under Individuals with Disabilities Education Act (IDEA) Part B.

PREVENTION PARTNERSHIPS

DBHDS prevention services are housed in the Office of Behavioral Health Wellness (OBHW), which provides direction and guidance for substance abuse prevention, suicide prevention and mental health promotion. DBHDS OBHW has garnered many partnerships in the planning and implementation of many initiatives to include:

- **Virginia Office on Substance Abuse Prevention (VOSAP) Collaborative** which is comprised of 12 other state systems and numerous professional organizations to ensure prevention services address issues related to education, health, child development, law enforcement, juvenile justice, substance abuse including alcohol, tobacco and other drugs, veterans, fire safety, and others. The VOSAP Collaborative also serves as the Virginia Partnership for Success State Incentive Grant (PFS SPG) Advisory Council.

- **Prevention Promotion and Advisory Council is now the Evidenced Based Outcomes Workgroup (EBWG)** for the SABG and the PFS SPF. It has representation from university population health research staff, community coalitions, providers and state staff.
- **Virginia Suicide Prevention and Mental Health Promotion Steering Committee**- state level suicide prevention planning to include Mental Health First Aid
- **Virginia Association of Community Services Boards (VACSB) Prevention Council**- SABG provider network
- **Virginia Foundation for Healthy Youth** -merchant education and workforce development training
- **Virginia Alcoholic Beverage Control Board**- Synar Inspection and Compliance
- **Virginia State Epidemiological Workgroup (SEOW)** to conduct a Social Indicator Study (SIS) that will result in state and county/city epidemiological profiles based on risk indicators for substance abuse and mental illness is comprised of epidemiologic staff from any state agency that collects behavioral health related data.

NOT FINAL

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health](#)

[Planning Councils: The Road to Planning Council Integration.](#)⁶⁹

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

- a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The state uses a wide variety of mechanisms for planning services, including data-driven decision making; obtaining input from stakeholders, including service providers, consumers, family members and others; state-level executive policy making and leadership, including from the Governor, the Virginia General Assembly, the Secretary of Health and Human Resources, and the DBHDS Commissioner and executive leadership team.

In response to SAMHSA's expectations that states integrate their Mental Health Planning Councils to include substance abuse and addiction recovery perspectives, DBHDS began discussing the integration of Virginia's Mental Health Planning Council in the summer of 2011. The Council embraced the idea, and December 2011, voted to change its name from the Virginia Mental Health Planning Council to the Virginia Behavioral Health Advisory Council (BHAC). The Council subsequently voted to modify its bylaws to add seats specifically for individuals who have lived experience with substance use disorders or with co-occurring mental health and substance use disorders, their family members, substance abuse/addiction recovery advocates, and providers of substance abuse treatment services. Seats also were added for state agencies that had particular relevance for addiction services that were not represented on the Council, including the Virginia Department of Health and the Department of Criminal Justice Services.

Per its bylaws, the Council serves as an advisory and information-sharing body which meets six times each year. In that role, the Council is responsible for reviewing and providing input to Virginia's annual behavioral health plan. As the combined Single State Agency and State Mental Health Authority, DBHDS retains responsibility for planning, allocating and managing the Mental Health and Substance Abuse Prevention and Treatment block grants. As an advisory and information-sharing body, the Council's stated role in regards to the block grants is to review expenditures and budgets in the state system for mental health and substance abuse services.

The Council's membership is diverse and although active membership has continued to evolve, it has over the last two years included racial/ethnic minority group members, LGBT members, and representation from urban and rural areas of the state. BHAC continues to work towards its mission but continues to face ongoing challenges both internally as well as externally.

In regards to internal challenges, due to membership transitions BHAC continues to work on recruiting new members and developing an onboarding protocol to help welcome and inform new members to help them feel ready to participate and contribute. Additionally, BHAC continues to explore ways to engage members who have difficulty travelling or attending meetings due to issues with travel logistics, work conflicts, etc. However, due to FOIA regulations for councils that are

required to make their proceedings available to the public, there are restrictions regarding tele-conferencing that have inhibited BHAC's ability to accommodate all of its membership.

In regards to external issues, DBHDS continues to undergo continued re-organization which has included staff turnover as well. In 2018, there were periods of time in which BHAC had difficulty accessing the necessary budget and program information required to provide ongoing advisory duties regarding the block grants. However, since the current State Planner has taken the role in September of 2018, work has taken place to bring in members of DBHDS from various departments to help update and inform BHAC and provide documentation that helps BHAC stay informed throughout the block grants administration process. This also will contribute to BHAC's ability to oversee the State Plan and explore opportunities for advocacy. This work is ongoing as DBHDS and BHAC continue to work on planning and identifying core activities to focus on for the coming years to fulfill its capacity as an important advisory body.

With respect to providing input into the 2020-2021 Block Grant application and plan, this section will be completed prior to submission of the final application on September 3, after the Council has had the opportunity to review and comment on the plan.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ☒ Yes ☐ No

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

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

BHAC continues to recruit new members that help broaden its diverse composition and its wide-ranging perspectives. Its current membership includes individuals with various racial, ethnic, and other backgrounds including a large contingent of individuals who work in community peer-led and peer support services.

One example of BHAC's efforts to gather input from its members was in regards to drafting letters to the Commissioner to help address needs that the council identified as critical to its mission to advocate for individuals with SMI or SED. In April 2019, BHAC met and discussed ongoing needs and decided as a group to draft letters requesting ongoing support from DBHDS to fill critical positions that help keep BHAC informed and engaged as well as to increase funding for a key area that addresses SMI and SED. BHAC advocated in the letter that due to the increase in MHBG state allocation from 2018-2019, more funds should be allocated to peer support services primarily with community organizations but also at the CSB level. Following these letters, peer services contracts with peer-led community organizations received an increase of about \$215,000 dollars for SFY19 and discussions are ongoing about increasing allocation to peer services for SFY20. Additionally, DBHDS has continued to be fully staffed in the key positions that BHAC identified and this will continue to be necessary as BHAC seeks to broaden its membership and activities to achieve its stated mission.

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

None at this time

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Total Membership	41	
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)	1	
Parents of children with SED/SUD *	0	
Vacancies (individual & family members)	10	
Others (Advocates who are not State employees or providers)	4	
Total Individuals in Recovery, Family Members and Others	23	56%
State Employees	12	
Providers	4	
Vacancies	2	
TOTAL State Employees & Providers	18	44%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations	N/A	
Providers from Diverse Racial, Ethnic, and LGBT Populations	N/A	
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations	N/A	
Persons in recovery from or providing treatment for or advocating for SUD services	8	
Federally Recognized Tribal Representatives	0	
Youth/adolescent representative (or member from an organization serving young people).	0	

*States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

Behavioral Health Advisory Council Members

Last Name	First Name	Agency/Type of Membership
Confer	Sherry	State (DMAS)
Harrison	Catharine	State (DARS)
Hunter	Katharine	State (DBHDS)
Belfast-Hurd	Tara	State (DBHDS)
Jansen	Livia	State (DJJ)
Wooten	Lisa	State (Dep of Hlth)
Parham	Patricia	State (DOC MH Clinic)
Taylor	Gail	State (DBHDS BH&W)
O'Dell	Sandra	State (Subst. Abuse Svs)
Gregory	Michael	State (DoE)
Hoyt	Jean	State (VDH)
Rudney	Nathanael	State (DBHDS)
Levenston	Kathleen	Service Provider (Adult MH)
Pritchard	Ron	Service Provider (VSIAS/VAAP)
Floyd-White	Shatada	Service Provider (Private Provider)
Clevert-Smith	Karlyn	Service Provider (Child MH)
Cruser	Bruce	Advocates (MHAV)
Piland	Hilary	Advocates (VACSB)
Reynolds	Caitlin	Advocates (NAMI VA)
Poore	Malaina	Advocates (VOCAL)
Everette	Ashley	Advocates (Voices for VA's Children)
Larry	Almarode	Consumer/Peer/Person in Recovery
Hart	William	Consumer/Peer/Person in Recovery
Seaman	Heather	Consumer/Peer/Person in Recovery
Jones	Calendria	Consumer/Peer/Person in Recovery
Kallay	Karen	Consumer/Peer/Person in Recovery
Hairfield-Cook	Robin	Consumer/Peer/Person in Recovery
Lalla	Betsy	Consumer/Peer/Person in Recovery
Yates	Marjorie	Consumer/Peer/Person in Recovery
Girard	Rita	Family Member

Footnotes:

NOT FINAL

Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Total Membership	41	
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)	1	
Parents of children with SED/SUD *	0	
Vacancies (individual & family members)	10	
Others (Advocates who are not State employees or providers)	4	
Total Individuals in Recovery, Family Members and Others	23	56%
State Employees	12	
Providers	4	
Vacancies	2	
TOTAL State Employees & Providers	18	44%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations	N/A	
Providers from Diverse Racial, Ethnic, and LGBT Populations	N/A	
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations	N/A	
Persons in recovery from or providing treatment for or advocating for SUD services	8	
Federally Recognized Tribal Representatives	0	
Youth/adolescent representative (or member from an organization serving young people).	0	

*States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

Behavioral Health Advisory Council Members

Last Name	First Name	Agency/Type of Membership
Confer	Sherry	State (DMAS)
Harrison	Catharine	State (DARS)
Hunter	Katharine	State (DBHDS)
Belfast-Hurd	Tara	State (DBHDS)
Jansen	Livia	State (DJJ)
Wooten	Lisa	State (Dep of Hlth)
Parham	Patricia	State (DOC MH Clinic)
Taylor	Gail	State (DBHDS BH&W)
O'Dell	Sandra	State (Subst. Abuse Svs)
Gregory	Michael	State (DoE)
Hoyt	Jean	State (VDH)
Rudney	Nathanael	State (DBHDS)
Levenston	Kathleen	Service Provider (Adult MH)
Pritchard	Ron	Service Provider (VSIAS/VAAP)
Floyd-White	Shatada	Service Provider (Private Provider)
Clevert-Smith	Karlyn	Service Provider (Child MH)
Cruser	Bruce	Advocates (MHAV)
Piland	Hilary	Advocates (VACSB)
Reynolds	Caitlin	Advocates (NAMI VA)
Poore	Malaina	Advocates (VOCAL)
Everette	Ashley	Advocates (Voices for VA's Children)
Larry	Almarode	Consumer/Peer/Person in Recovery
Hart	William	Consumer/Peer/Person in Recovery
Seaman	Heather	Consumer/Peer/Person in Recovery
Jones	Calendria	Consumer/Peer/Person in Recovery
Kallay	Karen	Consumer/Peer/Person in Recovery
Hairfield-Cook	Robin	Consumer/Peer/Person in Recovery
Lalla	Betsy	Consumer/Peer/Person in Recovery
Yates	Marjorie	Consumer/Peer/Person in Recovery
Girard	Rita	Family Member

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Larry Almarode	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Tara Belfast-Hurd	State Employees	DBHDS		
Karlyn Clevert-Smith	Providers			
Sherry Confer	State Employees	Virginia DMAS		
Bruce Cruser	Others (Advocates who are not State employees or providers)	Mental Health America of Virginia		
Ashley Everette	Others (Advocates who are not State employees or providers)			
Shatada Floyd-White	Providers			
Rita Girard	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Michael Gregory	State Employees	Virginia Department of Education		
Robin Hairfield-Cook	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Catharine Harrison	State Employees	Virginia DARS		
William Hart	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jean Hoyt	State Employees	Virginia Department of Health		
Katharine Hunter	State Employees	DBHDS		
Livia Jansen	State Employees	Virginia DJJ		
Calendria Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

Karen Kallay	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Betsy Lalla	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathleen Levenston	Providers			
Sandra O'Dell	State Employees	Planning District One Behavioral Health Services		
Patricia Parham	State Employees	Virginia Department of Corrections		
Hilary Piland	Others (Advocates who are not State employees or providers)	VACSB		
Malaina Poore	Others (Advocates who are not State employees or providers)	VOCAL		
Ron Pritchard	Providers			
Caitlin Reynolds	Others (Advocates who are not State employees or providers)	NAMI		
Nathanael Rudney	State Employees	DBHDS		
Heather Seaman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Gail Taylor	State Employees	DBHDS		
Lisa Wooten	State Employees	Virginia Department of Health		
Marjorie Yates	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

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

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	12	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	10	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	10	83.33%
State Employees	0	
Providers	0	
Vacancies	2	
Total State Employees & Providers	2	16.67%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

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:
- c) Other (e.g. public service announcements, print media) ☒ Yes ☐ No

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

Footnotes: