



Virginia Department of
Behavioral Health &
Developmental Services

D R A F T

**Community Mental Health Services Block Grant and
Substance Abuse Prevention and Treatment Block Grant Application
Federal Fiscal Years 2018-2019/State Fiscal Years 2019-2020**



State Information

State Information

Plan Year

Start Year 2018

End Year 2019

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 Rhonda

Last Name Thissen

Agency Name Virginia Department of Behavioral Health and Developmental Services

Mailing Address P. O. Box 1797

City Richmond

Zip Code 23219-1797

Telephone 804-786-2316

Fax

Email Address rhonda.thissen@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 Jack

Last Name Barber

Agency Name Virginia Department of Behavioral Health and Developmental Services

Mailing Address PO Box 1797

City Richmond

Zip Code 23218

Telephone (804)786-3921

Fax (804)371-6638

Email Address jack.barber@dbhds.virginia.gov

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

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Rhonda

Last Name Thissen

Telephone 804-786-2316

Fax

Email Address rhonda.thissen@dbhds.virginia.gov

Footnotes:



COMMONWEALTH of VIRGINIA

Office of the Governor

Terence R. McAuliffe
Governor

March 31, 2014

Ms. Bonnie Myhre
SAMHSA/CSAT/PPGB
1 Choke Cherry Road
5th Floor, Room 1074
Rockville, Maryland 20857

Dear Ms. Myhre:

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 the Acting Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Acting Commissioner's office at:

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

I am also authorizing the 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 "Terence R. McAuliffe", written over a large, stylized circular flourish.

Terence R. McAuliffe

cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources
John Pezzoli, Acting Commissioner
Virginia Department of Behavioral Health and Developmental Services

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and
Certifications (Form 03)
Fiscal Year 2018/19

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

Title XIX, Part B, Subpart I 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
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

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: Virginia

Name of Chief Executive Officer (CEO) or Designee: William A. Hazel, Jr., MD

Signature of CEO or Designee¹: _____

Title: Secretary, Health and Human Resources

Date Signed: _____
mm/dd/yyyy

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: 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 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.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction
Programs and Certifications (Form 3)
Fiscal Year 2018/19

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 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
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Section 1947	Nondiscrimination	42 USC § 300x-57
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State: Virginia

Name of Chief Executive Officer (CEO) or Designee: William A. Hazel, Jr., MD

Signature of CEO or Designee¹: _____

Title: Secretary, Health and Human Resources

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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.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
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1. CERTIFICATION REGARDING LOBBYING

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The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

Planning Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health 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 gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

NOT FINAL

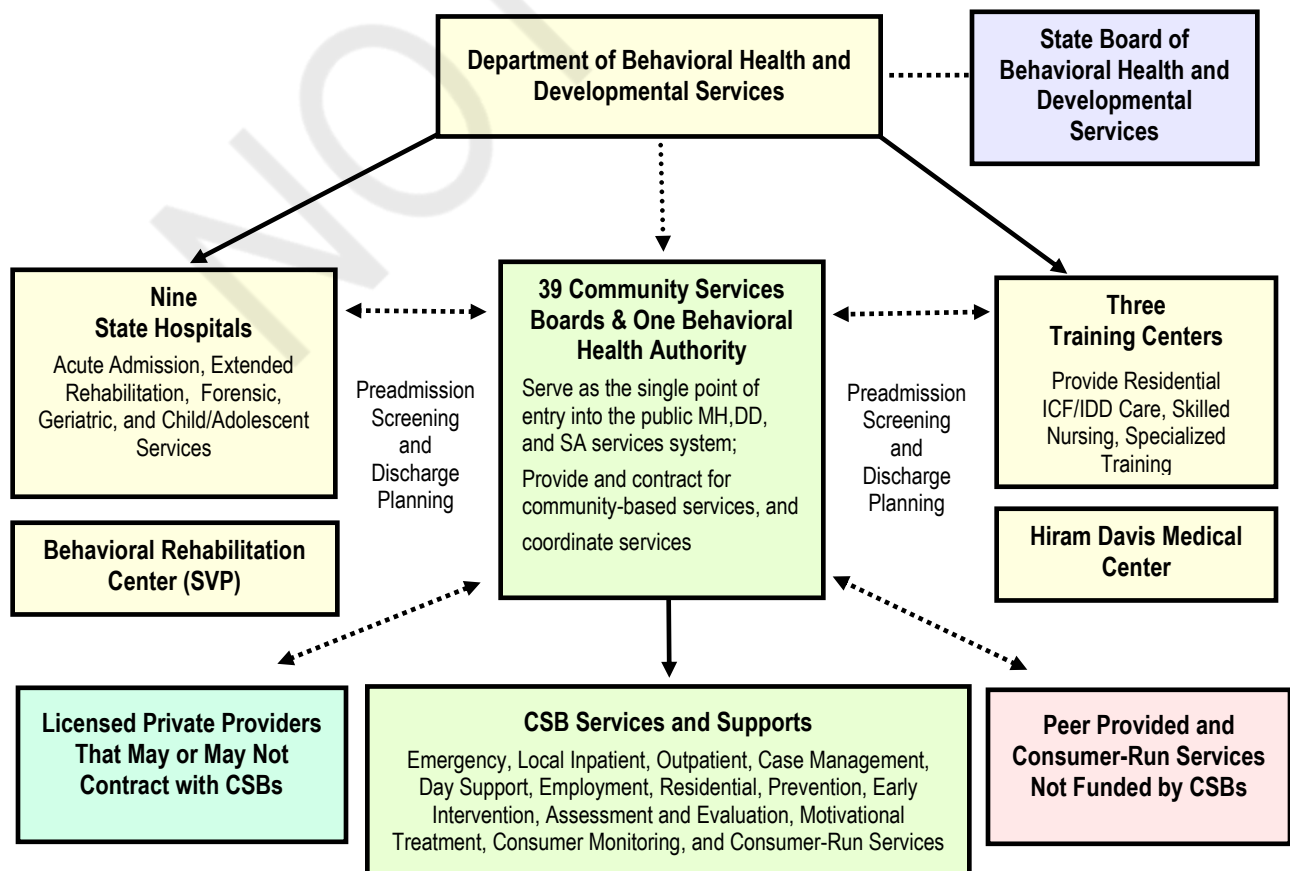
Step 1: Assess Strengths and Needs

Description of Virginia's Public Behavioral Health System

The Department of Behavioral Health and Developmental Services (DBHDS) is responsible for providing public behavioral health (mental health and substance use disorders) and 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, thereby designating the agency as the Single State Alcohol and Drug Agency (SSA) and State Mental Health Authority (SMHA).

Local community services are provided by 39 community services boards and one behavioral health authority (referred to as CSBs), established by local governments, that provide services directly or through contracts with private providers. DBHDS directly operates eight state hospitals, three training centers, a medical center, and a behavioral rehabilitation center for sexually violent predators (SVP). The Commonwealth Center for Children and Adolescents (CCCA) in Staunton is the only state hospital for children with serious emotional disturbance. DBHDS is advised by a state policy board appointed by the Governor. Maps of CSB service areas and the locations of state facilities are included in this section of the application.

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).



The mission of DBHDS' central office is to provide leadership and service to improve Virginia's system of quality treatment and prevention services and supports for individuals and families whose lives are affected by mental health or substance use disorders or developmental disabilities. The central office seeks to promote 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

CSBs are established by the 133 local governments in Virginia pursuant to Chapters 5 and 6 of Title 37.2 of the Code of Virginia and may serve single or multiple jurisdictions. CSBs provide services directly and through contracts with private providers, which are vital partners 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, and discharge planning for individuals leaving state facilities. CSBs advocate for individuals who are receiving services or who are in need of services, act as community educators, organizers, and planners, 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. DBHDS' relationships with all CSBs are based on 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) 2016, an unduplicated 115,679 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 2016, 55,657 adults had a serious mental illness (67% of adults served) and 25,989 children had or were at risk of having a serious emotional disturbance (79% of children served). Between SFY 2008 and SFY 2016, the number of individuals receiving CSB mental health services increased from 101,796 to 115,679, an increase of over 13%.

CSB Substance Abuse Services

In FY 2016, an unduplicated 30,180 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 9,404 of these individuals (3.2%), opiates for 8,370 (27.7%), marijuana/hashish for 5,976 (19.8%) and cocaine/crack for 2,515 (8.3%) .

About half of the 40 CSBs provide medication assisted treatment (methadone or buprenorphine), either directly or through a contract with a local private provider. Women made up 40.2% (12,132) of this treatment population. All CSBs provide some specialized services to pregnant women and women with dependent children. There are three regional programs that provide residential services to pregnant and postpartum women and women with dependent children and seven programs that provide intensive wrap-around case management services to pregnant and post-partum women in close collaboration with local social services and health departments (Project Link).

CSB Prevention Services

DBHDS defines prevention as activities that involve people, families, communities and systems working together to promote their strengths and potentials. Prevention goals and activities are primarily focused on substantially reducing the incidence of mental illness, developmental disabilities, and alcohol and other drug dependency and abuse. The emphasis is on the enhancement of protective factors and the reduction of risk factors. Through the performance contract, CSBs are required to develop and execute prevention plans for the communities they serve, and they are required to engage community partners in developing necessary coalitions in the development and execution of these plans. In FY 2014, a total of 37,266 individuals were served in the Universal Direct category of Prevention Services. Selective and Indicated programs were provided to 1,569 individuals and 652,396 individuals were involved in Universal Indirect programs.

State Hospital System

DBHDS operates eight state mental health hospitals for adults across Virginia, which are identified on the map included in this section. 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 is working to reform Virginia's system from a system that has been patched together by responses to crises into one that truly meets the needs of Virginians with behavioral health disorders. Over the past two years, Virginia has made significant improvements in the quality and accountability of community services through legislative and administrative efforts. These accomplishments have ensured that no person has been turned away from a psychiatric hospital bed when needed, increased qualifications of emergency custody and preadmission screening evaluators, updated communications infrastructure between the courts and behavioral health care providers, reduced the jail waiting list for state hospital admissions, improved key outcome and performance measures, and strengthened community services board (CSB) performance contracts by increasing administrative requirements and outcome and performance measures. In addition, the administration has initiated efforts to address Virginia's opioid crisis and substance-use disorder (SUD) challenges and supported DMAS, along with DBHDS, in the application for a federal SUD Waiver. These efforts represent meaningful progress in strengthening the behavioral health system and Virginia's safety net.

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:

1. DBHDS Transformation Initiative – A two year system-wide transformation effort that included broad representation of diverse stakeholders from across the Commonwealth. Four Transformation Teams met monthly to address critical issues facing Virginia's public mental health, substance-use disorder and developmental disability system. The effort culminated in comprehensive, expert recommendations to help Virginia solve its ongoing challenges related to access, quality, consistency and accountability.

2. CCBHC Planning Grant – Virginia engaged with the CSBs and other community and state stakeholders in a year-long federal grant regarding Certified Community Behavioral Health Clinics (CCBHCs). Eight CSBs located across Virginia were part of the grant to plan for potentially becoming certified as CCBHCs. The requirements for ten specific, evidence-based services for mental health and substance-use disorders that would be provided by the CCBHCs and the desired outcomes of the clinics were closely aligned with many of the transformation team recommendations. Although continuing with the next phase of the grant proved not to be fiscally responsible, DBHDS and the CSBs learned a great deal during the planning grant, including best practices for required services that will fill gaps and push Virginia's system towards needed reform

3. System Transformation Excellence and Performance (STEP-VA) – DBHDS has identified an innovative initiative to meet 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 is derived from the transformation recommendations and informed by critical lessons learned during the CCBHC grant. 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 and part of the CCBHC process to meet the needs of Virginians and fill gaps in the system. Services include:
 - Same Day Access
 - Outpatient Services (including MAT and improved in-home services for children)
 - Primary Care Integration
 - Detoxification
 - Care Coordination
 - Peer and Family Support
 - Psychosocial Rehabilitation/Skill Building
 - Targeted Case Management
 - Veterans Services
 - Person-Centered Treatment
 - Mobile Crisis Services

To implement these changes across the Commonwealth, STEP-VA will expand certain existing services and implement new services to maximize impact, increase access, strengthen quality, build consistency and bolster accountability. DBHDS is also currently drawing from transformation team recommendations to build jail behavioral health services and diversion efforts into STEP-VA. Notably, STEP-VA services are intended to foster wellness among

individuals with behavioral health disorders and prevent crises before they arise. The 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 to be implemented would be same day access and outpatient services. Same day access gets individuals in the door and connected to the system. After the first follow up appointment with same day access, there could still be a waiting period, perhaps six weeks or more, for additional needed psychiatric services. Expanding outpatient services during the same day access implementation would help ensure individuals who normally would be waiting long periods for subsequent appointments would be seen sooner and before crises 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 that virtually eliminates “no show” appointments, increases adherence to follow-up appointments, reduces 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.
- **Outpatient Services.** The public mental health system is severely limited in its capacity to provide the most fundamental outpatient behavioral health services, such as timely evaluation and treatment for conditions such as depression, anxiety and substance use, in a counselor-client setting, as early as possible to the onset of the problem. These services include medication management, individual, group and family counseling, medication assisted treatment (MAT), children’s in-home and other services. In the public sector and for uninsured individuals, access to outpatient services is virtually non-existent because resources have had to be allocated to the most pressing, highest risk needs such as crisis services and support of persons with long-term disabling mental health conditions.

Services System Partnerships

DBHDS has partnerships with many state agencies and other 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. These partnerships help to raise awareness of the needs and challenges of individuals receiving behavioral health and developmental services, provide opportunities for coordinating state-level policy direction and 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 contributed to the development of 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.

Housing: DBHDS has collaborative partnerships with the Virginia Housing Development Authority (VHDA) and Department of Housing and Community Development (DHCD) to promote, enhance, and develop housing opportunities for individuals receiving behavioral health services. DBHDS also collaborates with the Virginia Coalition to End Homelessness, and allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) program to 15 CSBs who provide outreach and engagement services to homeless or at-risk persons with serious mental illness and/or co-occurring disorders. In addition, DBHDS supports recovery-focused housing alternatives, such as Oxford Houses, for individuals with substance use disorders.

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 abuse 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 work 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: In too many cases, the criminal justice system has become the primary source for behavioral health care. DBHDS works with the Department of Corrections (DOC), Department of Juvenile Justice (DJJ), and Department of Criminal Justice Services (DCJS) in ongoing efforts to improve screening, ensure appropriate treatment and supports, and enhance interagency planning and coordination to better meet the needs of individuals involved with the criminal justice system. This includes support for jail diversion programs such as Crisis Intervention Teams (CIT) and CSB provision of short-term behavioral health services in jails and juvenile detention centers. DBHDS and DOC work closely to improve access to hospital and community treatment resources for inmates who have been released from DOC facilities and screen inmates who are potentially eligible for civil commitment to DBHDS as sexually violent predators. DCJS and DBHDS have jointly provided cross training in behavioral health evaluation and treatment methods for law enforcement personnel, including jail security staff, and jointly surveyed local and regional jails to determine what types of services for people with substance use disorders were available. DBHDS and DJJ have also co-sponsored training for clinical supervisors working their respective systems.

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.

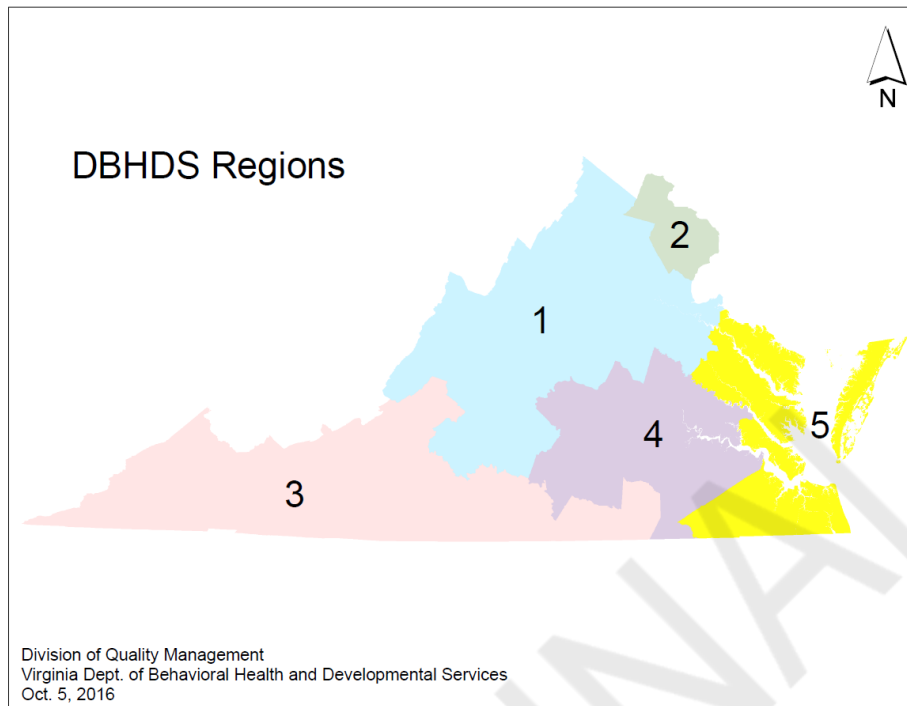
Advocacy: DBHDS central office and state facilities work cooperatively with the disAbility Law Center of Virginia (dLCV) to protect and advocate for the human and legal rights of individuals receiving behavioral health or developmental services. Section 51.5-37.1 of the *Code of Virginia* requires DBHDS 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

The 133 cities or counties in Virginia continue to be vital members of the state-local partnership that enabled the provision of community behavioral health and developmental services to more than 216,000 Virginians in FY 2016. Local governments partner with DBHDS through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs.

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.

Seven regional partnerships 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, including state general funds and federal Community Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) block grant monies allocated to purchase local inpatient psychiatric crisis care and residential substance abuse treatment. 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 2016, DBHDS licensed 1,041 providers of behavioral health (mental health and substance abuse) and developmental services. This included 440 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

Private provider participation is another major strength of the public behavioral health and developmental services system, and this participation has grown dramatically in recent years. The private sector is a vital partner with CSBs in serving people with mental health or substance use disorders, or co-occurring disorders. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example, through various Medicaid-funded services such as inpatient psychiatric treatment and mental health rehabilitation services. Private providers are an especially important source of substance abuse treatment for persons with opiate addiction, as many consumers receiving CSB treatment for opiate addiction, including injection drug users (IDUs), are referred to private providers for methadone or other medication assisted treatment.

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 outreach, individual and group peer support, education on recovery and wellness, assistance with meeting basic

needs, job skill development, employment readiness activities, and social and recreational opportunities.

The Office of Recovery Services, established by DBHDS in January 2015, has coordinated the efforts of multiple organizations involved in creating a peer recovery specialist certification and registration process. Effective July 1, 2017, This certification process allows providers to bill Medicaid for reimbursement for Peer Services. The single certification recognizes the training, knowledge and abilities of peers to provide recovery support services to individuals with either mental illnesses and 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 departments.

In 2017 Virginia will offer 864 Scholarships to the mandatory PRS training, with a target of training over 1,000 people by the end of the year. In July there were 466 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 218 trained supervisors.

The staff of the Office of Recovery Services, supported with federal block grant funds, have had a central role in implementing the SAMHSA Opioid State Targeted Response Grant, 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 2010 U.S. Census, 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 5% 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.

In 2008, DBHDS established the Office of Cultural and Linguistic Competence (OCLC) to address these disparities in Virginia's behavioral health system. The OCLC is leading efforts to provide improved services to multicultural consumers and is working toward eliminating the disparities within our system. OCLC focuses on expanding the number of culturally and linguistically competent service providers, stakeholders, and staff within the public and private sector. DBHDS defines culture in the broad sense, as there are other aspects of an individual in addition to race, language, and ethnicity that contribute to his or her sense of self. These may include specific attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, or homelessness). Multiple memberships in subgroups contribute to an individual's personal identity and sense of "culture". Understanding how these factors affect a person is important to providing culturally competent care.

In 2009, through the OCLC, the DBHDS developed and released its *Position Statement on Culturally and Linguistically Appropriate Services*, which established ten principles as the foundation for providing effective multicultural behavioral and developmental services. The position statement supports recommendations regarding multicultural diversity published in the *Mental Health: A Report of the Surgeon General* (1999) and *Mental Health: Culture, Race, Ethnicity: Supplement to Mental Health: Report of the Surgeon General* (2001), and led to the development of DBHDS's first *Plan for Cultural and Linguistic Competency in Behavioral Health and Developmental Services*, also released in 2009. The Plan was updated in late 2012 and includes the following four major goals for 2013-2014:

Goal 1: Increase the awareness of language services responsibility and the capacity for the provision of language services in behavioral health and developmental disability services.

Goal 2: Provide technical assistance to Human Resources and Workforce Development offices to increase opportunities for diversity and inclusion in Human Resources processes.

Goal 3: Enhance stakeholders' understanding of how systems and organizational planning and development influence culturally and linguistically appropriate services.

Goal 4: Develop activities and resources that help to engage communities and allow providers to advance culturally and linguistically appropriate services in the Commonwealth.

The OCLC, along with DBHDS' multi-agency, multi-disciplinary Cultural and Linguistic Competency Steering Committee, is responsible for implementing the action steps necessary to achieve these goals.

Military Personnel and Their Families

Due to the number of military installations in the state, Virginia has one of the largest active-duty and retired military populations in the nation. In order to address the increasing need for assistance to veterans and their families who have been affected by stress-related injuries or traumatic brain injury, in 2008 the Virginia General Assembly established the Virginia Wounded Warrior Program (VWWP). Now called the Virginia Veteran and Family Support (VVFS) program, it is operated by the Virginia Department of Veterans Services (DVS) in cooperation with DBHDS, the Department of Aging and Rehabilitative Services, and community behavioral health and supportive services providers. The program serves veterans of any service era who are Virginia residents, members of the Virginia National Guard and Armed Forces Reserves not in active federal service, and family members of these veterans and service members. Services provided include specialized outreach to military service members, veterans, and their families, identification of behavioral health, rehabilitative and supportive services needs and care coordination services, and family support. In addition to Resource Specialists, VVFS employs Veteran Peer Specialists (VPS) who are veterans that facilitate peer support groups and provide outreach to other veterans and their families. Resource Specialists and VPS positions often work from or closely with CSBs to ensure that military service members, veterans, and their families (SMVF) who are not able to get care from the U.S. Department of Veterans Affairs (VA) facilities can readily access CSB services. During SFY 2016, VVFS served 2,623 service members, veterans and their families, supported by \$3.7 million in State General Funds. Five regional consortia are supported by one CSB in each region which serves as the lead VVFS provider in that region. The service needs among this population continue to grow; the number of unique individuals served through VVFS and the number of services provided have both increased by 21% since SFY 2014.

DBHDS and DVS operate a joint advisory body on 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 design an Ask the Question Campaign and increase military cultural competency training in Virginia's CSBs to improve services delivery to SMVF. VMVCC is also working with the SAMHSA SMVF TA Center to increase access to peer services for SMVF in CSBs.

Homeless Individuals

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 annual Point in Time Count of individuals experiencing homelessness, nearly 1,000 individuals with SMI are homeless on any given night.. In the 15 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 estimated 1,892 individuals to be served by Virginia PATH during SFY 2013, approximately 80% are estimated to be literally homeless. The majority of Virginia's 15 PATH programs operate in urban areas and spend 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.

Individuals with Criminal Justice Involvement

Research has shown that individuals living with a serious mental illness (or co-occurring disorder) are at high risk for being incarcerated, and often remain incarcerated for longer periods of time than their counterparts in the general population.¹ These frequent and extended periods of incarceration often result in further psychological decompensation, and can serve to increase an individual's risk of re-offending. Intervening early on in a consumer's interaction with the criminal justice system, and 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 2016 Mental Illness in Jails Survey, Virginia's jails held a total of 39,888 inmates during the month of June. Of this count, 25.79% of the females were reported to be mentally ill and of the males, 14.35%. Across Virginia's jails, 16.43% of the population was known or suspected to be mentally ill².

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-

¹ Munetz M.R., Grande T.P., Chambers, M.R., The incarceration of individuals with severe mental disorders. *Community Mental Health Journal*. 37(4):361-72, 2001.

² Compensation Board. 2016 Mental Illness in Jails Report. 2016. Available at: <http://www.scb.virginia.gov/docs/2016mentalhealthreport.pdf>

2016) each provided critical insights into the totality of the problem, specific areas of concern, and recommendations for improvement.

Cross Systems Mapping: Following the conclusion of the Commonwealth's Cross Systems Mapping initiative in 2013, 40 workshops were held across 98 of Virginia's 134 localities and over 1,400 community behavioral health and criminal justice stakeholders representing 73% of Virginia's localities had participated. As a result, dozens of new criminal justice and mental health jail diversion and treatment initiatives were initiated to improve Virginia's multi-system response to individuals with behavioral health disorders involved in the Criminal Justice system.

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 enforcement's capability to respond to situations involving individuals with symptomatic behavioral health issues. In FY2016, 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 33 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 FY2016, Virginia's CIT Assessment Sites provided 9,245 assessments³ to individuals experiencing a behavioral health related crisis who might have otherwise gone to jail.

Jail Diversion Programs: The Department of Behavioral Health and Developmental Services supports a variety of Jail Diversion Initiatives, all of which reside within the Office of Forensic Services. Jail Diversion Initiatives come in a variety of forms, but all essentially strive to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification), divert individuals away from the criminal justice system (or from penetrating more deeply, if identified after arrest/incarceration), and connect individuals to meaningful services and treatment (as early as possible, but often during initial court appearance, during incarceration, or upon release from jail).

In total, 17 CSB's across the Commonwealth have received Jail Diversion funding between 2007 and 2017. 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

³CIT Assessment Site and CIT Programs: A Report on Status FY2016. Available at:
<http://www.dbhds.virginia.gov/library/forensics/fofo%20-%20fy2016%20cit%20assessment%20site%20annual%20report.pdf>

the FY15 Jail Diversion Annual Report⁴. In FY16, 4,118 individuals were screened for eligibility, and 1,031 were enrolled in a Jail Diversion Program. Overall, 1,381 individuals were served in some capacity through a Jail Diversion Initiative in FY16. FY17 data is still pending at this time.

Center for Behavioral Health and Justice: In October 2014, the Governor's Task Force for Improving Mental Health Services and Crisis Response sent Governor Terry McAuliffe a set of 25 recommendations designed to help expand access to Virginians with mental health needs, strengthen administrative processes and to improve quality of services throughout the Commonwealth. A key component of those recommendations was a proposed Center for Behavioral Health and Justice (The Center): a virtual center of excellence and an interagency collaborative to better coordinate behavioral health and justice services by identifying and utilizing Virginia's resources more effectively.

The focus of the Center is on diverting individuals with behavioral health issues away from the criminal justice system (when appropriate and safe to do so), and appropriately addressing the behavioral health needs of those already involved in any aspect of the state's criminal justice system. The Center is directed by an executive leadership team which is comprised of representatives from the Office of the Lt. Governor, the Office of the Secretary of Health and Human Resources, the Office of the Secretary of Public Safety and Homeland Security, the Department of Behavioral Health and Developmental Services, and the Department of Criminal Justice Services.

The work of the Center is informed by a Center Advisory Group (CAG), which is comprised of a diverse group of behavioral health and criminal justice stakeholders that provide input on the existing needs of the target population and provide counsel on the priorities and projects of the Center.

Current activities of the Center include:

- Preparations for the 2018 General Assembly
- Implementation of our 2017-2018 Strategic Plan
- Awaiting approval of a federal grant submitted by the Center to provide the following support to Virginia's local and Regional Jails in 2018:
 - Training on mental health screening (a train the trainer model)
 - Cross System Summit on responding to individuals requiring further evaluation
 - An evaluation of the degree to which MH screening is used with fidelity
 - Updates to the LIDS/CORIS data system to ensure relevant data can be collected beyond the life of the grant.

⁴ Jail Diversion Initiatives Program Review (2007-2015). Available at: <http://www.dbhds.virginia.gov/library/forensics/fofo%20-%20updated%20jail%20diversion%20annual%20report%20fy15.pdf>

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 held in July and August and a recording of the training will be made available for viewing after the live trainings have 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 will have attended the training.

Sexual Minority Groups

Many individuals who are Lesbian, Gay, Bisexual, Transgendered, or Questioning (LGBTQ) have special behavioral health needs. LGBTQ individuals experience mental health issues such as depression, anxiety, and suicide ideation much more frequently than their heterosexual counterparts, and these are frequently linked to substance abuse as a means of “self-medicating”. Virginia’s CSBs and state hospitals serve LGBTQ individuals and communities equally, and addresses issues of sexual orientation in the context of individual and group therapy, supportive services, and other behavioral health care.

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. Twenty-four of the 40 CSBs are located in primarily rural areas. During SFY 2016, these rural boards served 53% of all mental health consumers and 47% of those receiving substance abuse treatment.

Individuals in need of behavioral health services in rural areas face special challenges. CSBs vary according to budget size and population density, and many in rural areas do not have the infrastructure to support the services that are needed in the community. Access to transportation, especially for individuals ineligible for Medicaid, is often an issue. 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.

⁵ Jail Mental Health Screening Instrument (language only):
<https://budget.lis.virginia.gov/amendment/2017/1/HB1500/Introduced/CR/70/1c/>

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.

NOT FINAL

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 behavioral health 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 behavioral health 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.

The state's priorities and goals must be supported by a data-driven process. 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](#), the annual [State and National Behavioral Health Barometers](#), 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.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. 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](#)¹ 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.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

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

Data Sources

Data to support Virginia's behavioral health needs assessment and planning processes are available from several sources on a routine and ad hoc basis. These sources encompass the full spectrum of available data sources on mental health and substance use disorders, from wide-scope sources such as 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 these data to assist in the identification of needs and gaps in the Commonwealth's behavioral health service continuum. These data sources are 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.

Medicaid – 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 measures 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 partners 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

Other state agencies that DBHDS have or are working to have data sharing efforts in place with include 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 has initiated a transformation process that includes a comprehensive review of the state behavioral health and developmental services system. This effort will focus on access, quality, stewardship of resources, and accountability. This transformation process is grounded in the principles of recovery, resiliency, self-determination, and wellness for everyone we serve. The ultimate goal is to become a model system that achieves DBHDS' vision of "A life of possibility for all Virginians". To begin this transformation period, the Commissioner has convened four transformation teams and a transformation team stakeholder group. The initial areas of focus are:

- Adult behavioral health services;
- Adult developmental services;
- Child and adolescent behavioral health services; and
- Services to individuals who are justice-involved.

Each of the transformation teams will analyze Virginia's behavioral health and developmental disabilities services system and develop strategic proposals for services, delivery and infrastructure. The stakeholder group serves as a review and consultation group for transformation teams. The stakeholders will provide input on team proposals and offer recommendations and refinements. The public comment period has consisted of three statewide town-hall style meetings. DBHDS posts the latest transformation team updates on the DBHDS website to provide the public opportunity to review the proposals developed by the teams and provide feedback.

The Commissioner will finalize recommendations and present them to legislative committees, task forces (as appropriate) and the State Board of Behavioral Health & Developmental Services.

Virginia's behavioral health system faces many challenges including: 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 are compounded by broader, external factors including an aging workforce, inadequate resources, 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, DBHDS engaged national consultants, the Public Consulting Group (PCG), to conduct a community needs assessment to help determine the eight CSBs' 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. The community needs assessment includes three key components:

1. Update and augmentation of the existing population analysis, including condition prevalence, service utilization, and risk factors within the population;
2. Review of CSB operations to assess access, cultural competency, ability to serve special populations, and ability to link with needed social services and other supports; and,
3. Documentation of services currently provided, including the application of evidence based practices, staffing, and eligibility, and a comparison matrix of all eight CSBs.

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. In most cases, findings and assessment results were based on information self-reported by the CSB rather than independently verified information. Also, 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 currently 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.

Resource Requirements

The following chart provides an example of a funding timeline for STEP-VA services. The services may be implemented incrementally, and the chart below samples an eight year implementation along with resource requirements for the first three services. Cost estimates for additional services are currently being developed. The chart does not include additional, largely one-time, infrastructure needs such as data service integration and consumer technology, current state and gap analysis, implementing a performance base critical support staff.

Example Funding Timeline for STEP-VA (as of December 1, 2016)

Service	FY 2016 – FY 2020	FY 2020 – FY 2024
Same Day Access	\$17.3M GF (ongoing)	
Outpatient Services <i>(Includes Medication Assisted Treatment and In-Home Children's Services)</i>	\$49M GF (ongoing)	
Primary Care Integration	\$7.44M GF (ongoing)	
Detoxification	Fund at 100%	
Care Coordination	Fund at 100%	
Peer Services		Fund at 100%
Rehabilitative Services		Fund at 100%
Targeted Case Management		Fund at 100%
Veterans Services		Fund at 100%
Person-Centered Treatment		Fund at 100%
Mobile Crisis		Fund at 100%

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.

Services for Pregnant and Parenting Women

DBHDS requires that programs provide substance abuse 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 abuse 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 DBHDS to request assistance to develop an alternate service plan for the woman.

As part of the DBHDS audit and 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 oversight and monitoring staff also address this expectation as part of their routine monitoring and oversight efforts.

DBHDS uses the performance contract and various oversight and monitoring efforts referenced to inform programs that they must admit pregnant women within 48 hours of their request. Programs are also directed to provide interim services and contact DBHDS's Women's Coordinator to develop an alternate care plan whenever they are unable to admit a woman to treatment within the required timeframe. The Women's Coordinator checks for compliance through chart review and her oversight and monitoring efforts.

DBHDS requires that programs have policies and procedures that direct staff to contact DBHDS for assistance whenever they are unable to provide substance abuse services to a pregnant woman. Their policy must also detail the type of interim services they are required to provide. 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.

The number of CSBs that serve parenting women is the same as those that serve pregnant women; however, lack of funding makes it more difficult for parenting women to access MAT. Pregnant women have priority and CSBs usually absorb the cost of MAT for pregnant women; consequently they have fewer funds available to spend on these services for postpartum and/or parenting women. .

DBHDS oversees 40 CSBs which provide substance abuse services. All are required to provide outpatient services to pregnant and parenting women. Three CSBs provide residential services for pregnant and parenting women and are able to admit women from other CSBs.

Services for Individuals who Inject Drugs

VaDBHDS 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 have reported that Virginia is one of four states in the mid-Atlantic region, along with Kentucky, Tennessee, and West Virginia, where new hepatitis C infections in young adults more than quadrupled from 2006 to 2012, with many cases linked to injection-drug use. Opiate IVDUs were treated in OTPs, in office-based settings using Suboxone, and in drug-free settings. Non-opiate IVDUs were treated in other modalities (e.g., outpatient, intensive outpatient, day treatment, case management, and residential). During SFY 2014, 9,448 individuals receiving substance abuse services from the state's community services boards reported some degree of opiate use.

All 40 CSBs offer outpatient medication assisted services to opiate dependent individuals who enroll in treatment services; however the ability to access these services varies by community. Virginia has four public and 26 private opiate 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 and the Richmond Behavioral Health Authority (RBHA) offer residential treatment for pregnant women and ensure that opiate dependent women enrolled in their residential program are able to access methadone services. Opiate dependent pregnant women enrolled at HNN CSB's Southeastern Family Project receive methadone services through HNN CSB's OTP. RBHA refers women to a contract provider for residential substance abuse services and a contracts OTP to provide methadone services for women who require MAT.

Accessing MAT is difficult in Virginia due to the scarcity of programs and lack of funding. Virginia's four public opiate treatment programs accept Medicaid reimbursement; however the private OTPs will not bill Medicaid and instead require payment from the CSB or the consumer.

There are pockets throughout the Commonwealth where access to MAT varies from poor to non-existent. Although DBHDS licensed 10 additional OTPs between 2011 and 2015, opiate-dependent individuals who live in the catchment areas for Alleghany Highlands, Eastern Shore, District 19, 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 2016, this sum equaled \$761,859 which is multiplied by the percent of drug-related TB cases (9.0%), yielding a total TB MOE of \$68,948. In 2016 the Virginia Department of Health determined that there were a total of 205 positive TB cases statewide. Because of the decline 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 M. tuberculosis infection.

DBHDS continued to make available tuberculosis screening protocols and continued to require subrecipients to utilize them to screen persons entering publicly-funded substance abuse treatment programs. VaDBHDS continued to work closely with the Virginia Department of Health (VDH) to review existing protocols for efficacy. DBHDS staff were 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 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) will be convening a 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. Risk factors linked to Adverse Childhood Experiences (ACE) will be included. This data is essential in creating state and local planning, target determination and outcome achievement. Virginia SEOW participation will include attending three working meetings over the summer and early fall 2015 to identify and access behavioral health indicator data housed within each agency, and to work collaboratively to examine these indicators to identify priorities for subsequent analysis. This analysis will examine the relationships between risk and protective factors with subsequent behavioral health outcomes, and will identify areas of focus and opportunity for prevention efforts. Following the Epidemiological Workgroup meetings, the identified indicators will be organized into an online data dashboard that will provide centralized access to behavioral health information, as well as disseminated in written reports.

Restricting youth retail access to new tobacco products has been identified as an area of unmet need as result of a number of factors. In 2014, SB96 identified smokeless tobacco, cigarillos, e-cigarettes and other vapor products as tobacco products to be included in SAMHSA youth retail access inspections. During a pilot project with 5 CSBs to identify these types of outlets, it was noted that the majority are not included on any type of list or identified uniformly through a coding process. Staff participating in the pilot observed an increase in youth access to these products.

Support Services for Children

The Virginia Office of Comprehensive Services conducted its *Service Gap Analysis* from 2008-2011, surveying 131 local community policy and management teams. The analysis demonstrated the lack of a complete array of children's services in all areas of the State. It identified the following top 10 service gaps: crisis intervention and stabilization, intensive substance abuse services, transportation, psychiatric assessment, career technical and vocational education, emergency shelter care, wraparound services, medication follow-up and psychiatric review, parenting/family skills training, and attendance support.

Services for Veterans

According to a study done by the National Council for Behavioral Health in 2012, Virginia has 10,949 veterans of the Iraqi and Afghanistan wars that have unmet PTSD and depression treatment needs. Requests for behavioral health services are far below what would be expected given this level of unmet need. Many unmet needs are the result of lack of capacity at the Veterans Administration (VA), and National Guard service members must receive services in community mental health centers if they are not eligible for services at the VA.

Some CSBs have become VA Choice Providers in order to help address capacity issues so that VA-eligible veterans can receive care in their local CSB rather than a VA facility however the Choice program is not permanent at this stage and a long-term community care reimbursement program is still needed at the Federal level.

DBHDS worked with DVS and CSBs to improve services delivery to SMVF and data quality within the CSBs through an 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 VA, DVS, military installations etc. A total of 4,695 veterans were served in CSBs in SFY16 (combined military service members, retired, and discharged veterans). Veterans and families are accessing primarily mental health outpatient, case management, emergency, and assessment and evaluation services in CSBs. However, in SFY16 there were 32,686 client records where military/veteran status was not collected. The Ask the Question Campaign will help address this specific gap in CSB data collection.

PLANNING TABLES

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: Percent of all individuals admitted to substance use disorder services program area during the previous 12 months who received at least one valid substance use disorder or mental health service of any type, except residential detox, and those services provided in jails or juvenile detention centers, in the month following admission (denominator) who received at least one valid mental health or substance use disorder service of any type, except those services provided in jails or juvenile detention centers, every month for at least the following two months (numerator).

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.

Data issues/caveats that affect outcome measures::

None at this time.

Indicator #: 2

Indicator: Percent of all individuals admitted to the substance use disorder services program area during the previous 12 months who received at least one valid substance use disorder or mental health service of any type, except residential detox and those services provided in jails or juvenile detention centers, in the month following admission (denominator) who

received at least one valid mental health or substance use disorder service of any type, except those services provided in jails or juvenile detention centers, every month for at least the following five months (numerator).

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.

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: 31.42 FTE

First-year target/outcome measurement: 35 FTE

Second-year target/outcome measurement: 40 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: 89.01 FTE

First-year target/outcome measurement: 100 FTE

Second-year target/outcome measurement: 110 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: Percent of adults admitted to the substance abuse use disorder services program area during the previous 12 months who received 45 minutes of outpatient services after admission (denominator) who received at least an additional 1.5 hours of outpatient services within 30 days of admission (numerator).

Baseline Measurement: 71%

First-year target/outcome measurement: 72%

Second-year target/outcome measurement: 73%

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 case management services.

Objective:

Increase the frequency of treatment sessions for children receiving mental health case management 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 STEP-VA is implemented, focus on strategic initiatives to fill gaps in the STEP-VA array of services for children. Presently, case managers with limited caseloads has been identified as the priority need. (This strategy is contingent on state and federal funding.)
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 case management services within 30 days of admission (denominator) who received at least two additional hours of case management services within 60 days of admission (numerator).
Baseline Measurement: 72%
First-year target/outcome measurement: 73%
Second-year target/outcome measurement: 74%
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. Provide training and consultation to service providers to increase affordable housing and appropriate supports by leveraging housing resources and implementing supportive housing models.
3. 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: 131

First-year target/outcome measurement: 141

Second-year target/outcome measurement: 151

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, lived in stable housing and had no arrests and no more than one psychiatric hospital admission.

Baseline Measurement: 74%

First-year target/outcome measurement: 75%

Second-year target/outcome measurement: 76%

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: 211

First-year target/outcome measurement: 500

Second-year target/outcome measurement: 760

Data Source:

Data source of the number of individuals housed is the DBHDS contracted Permanent Supportive Housing providers; projected outcome measures for Years 1 and 2 are based on projections of funding available for new Permanent Supportive Housing units.

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 case management

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the intensity of engagement of adults with SMI in mental health case management.

Objective:

Increase the frequency of treatment sessions for adults with SMI receiving mental health case management.

Strategies to attain the objective:

1. Continue to offer the DBHDS online case management training curriculum, including modules on effective engagement interventions.
2. Require that new CSB case management staff complete the case management curriculum within 30 days of employment.
3. Monitor and report online training completions to CSBs.
4. Pursue the implementation of case management caseload sizes (this strategy would require new resources).

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 case management services within 30 days of admission (denominator) who received at least three additional hours of case management services within 90 days of admission (numerator).

Baseline Measurement: 73%

First-year target/outcome measurement: 74%

Second-year target/outcome measurement: 75%

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:

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 key sector representation on each collaborative throughout Virginia

Strategies to attain the objective:

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:

Priority #: 9

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

Priority Type:

Population(s): Other

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:

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

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		\$0	\$0	\$0	\$0	\$0	\$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary			\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$881,733	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$0	\$0	\$0
7. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$7,494,731	\$202,677,674	\$0	\$368,749,745	\$0	\$0
9. Administration (Excluding Program and Provider Level)		\$440,866	\$0	\$440,866	\$0	\$0	\$0
10. SubTotal (1,2,3,4,9)	\$0	\$440,866	\$0	\$440,866	\$0	\$0	\$0
11. SubTotal (5,6,7,8)	\$0	\$8,376,464	\$202,677,674	\$0	\$368,749,745	\$0	\$0
12. Total	\$0	\$8,817,330	\$202,677,674	\$440,866	\$368,749,745	\$0	\$0

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

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

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	\$31,417,389		\$0	\$0	\$49,417,892	\$0	\$58,576
a. Pregnant Women and Women with Dependent Children**	\$4,188,985		\$0	\$0	\$1,379,866	\$0	\$0
b. All Other	\$27,228,404		\$0	\$0	\$48,038,026	\$0	\$58,576
2. Primary Prevention	\$8,377,971		\$0	\$862,200	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$8,377,971		\$0	\$862,200	\$0	\$0	\$0
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$25	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$1,235,681	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$2,094,493		\$0	\$334,618	\$0	\$0	\$0
10. SubTotal (1,2,3,4,9)	\$33,511,882	\$0	\$0	\$334,618	\$50,653,598	\$0	\$58,576
11. SubTotal (5,6,7,8)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12. Total	\$41,889,853	\$0	\$0	\$1,196,818	\$50,653,598	\$0	\$58,576

* Prevention other than primary prevention

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

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

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	\$31,417,389		\$0	\$0	\$49,417,892	\$0	\$58,576
a. Pregnant Women and Women with Dependent Children**	\$4,188,985		\$0	\$0	\$1,379,866	\$0	\$0
b. All Other	\$27,228,404		\$0	\$0	\$48,038,026	\$0	\$58,576
2. Primary Prevention	\$8,377,971		\$0	\$862,200	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$8,377,971		\$0	\$862,200	\$0	\$0	\$0
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$25	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$1,235,681	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$2,094,493		\$0	\$334,618	\$0	\$0	\$0
10. SubTotal (1,2,3,4,9)	\$33,511,882	\$0	\$0	\$334,618	\$50,653,598	\$0	\$58,576
11. SubTotal (5,6,7,8)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12. Total	\$41,889,853	\$0	\$0	\$1,196,818	\$50,653,598	\$0	\$58,576

* Prevention other than primary prevention

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

ENVIRONMENTAL FACTORS AND PLAN

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ 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.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

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.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ 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.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health 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.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² 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 behavioral health include: developing models for inclusion of behavioral health 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.³³ 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 behavioral health 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 homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health 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.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ 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.³⁹ 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.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health 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.⁴² 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 behavioral health 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.⁴³ 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.⁴⁴ 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.

²⁵ 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; 91:1027123 <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): 52777

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nlm.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ 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/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.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>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://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/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

³⁶ 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>

³⁷ 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); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁸ 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>

³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁰ 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

⁴¹ 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

⁴² 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>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁴³ 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>

⁴⁴ 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 the attached narrative titled "Virginia 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 the attached narrative titled "Virginia 1 - The Health Care System, Parity and Integration."

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? jn Yes jn No

and Medicaid? jn Yes jn No

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

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

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education jn Yes jn No

b) Health risks such as

i) heart disease jn Yes jn No

ii) hypertension jn Yes jn No

viii) high cholesterol

☐ Yes ☒ No

ix) 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?

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

Please see the attached narrative titled "Virginia 1 - The Health Care System, Parity and Integration."

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:

NOT FINAL

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.

In 2015, the Commonwealth of Virginia applied for and was awarded the SAMHSA Certified Community Behavioral Health Clinic planning grant. Although Virginia did not go onto apply for the CCBHC Implementation grant, the model developed during the planning year by DBHDS and community partners is being used to provide direction for further developing and providing community based behavioral health services including integration of behavioral health and primary care. This model is called System Transformation Excellence and Performance in Virginia, or STEP VA.

STEP VA promotes nine services, including rapid access for assessment and person centered treatment planning; 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 gained support from many 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 rapid access, also known as same-day access, and primary care screening. It also states that by July 1, 2021, the other seven services indicated above will be provided. However, it is important to note that, to date, the General Assembly has allocated funds for only 22 of the 40 Community Services Boards (CSBs) to provide rapid or same-day access to assessment. The other services remain an unfunded mandate at this time.

The STEP VA model is inclusive of all populations seeking behavioral health services, and comes from a person-centered, trauma-informed, and recovery-oriented approach. The services listed above are or will be available across the life span for individuals with mental health, substance use, and co-occurring disorders. Specific to the integration of behavioral and physical health, many public providers have already established programs and services to address physical health issues in conjunction with behavioral health issues. The approaches being used vary and include full-service health clinics embedded in a CSB, primary care screening being done in the CSB with referral to services for identified risks, and CSB behavioral health staff working in a Federally Qualified Health Center. While Virginia has made progress towards physical and behavioral health integration, such services are not offered consistently or uniformly across the Commonwealth. Part of what STEP VA hopes to promote is a minimum standard of care incorporating the nine services identified in the model.

As stated above, rapid or same-day access to assessment for anyone seeking services from a CSB in Virginia is the new baseline for accessibility to services. Part of the rapid access process is an assessment that addresses the needs of the whole person in regard to mental health, substance abuse and co-occurring issues. Based on that assessment and the identified needs, the individual or family is

connected to the services that will best meet those needs. In regard specifically to children and families, the needs of children and adolescents are addressed using a family and caregiver-driven, youth guided and developmentally appropriate approach that comprehensively address family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues. Services are provided in office or as intensive in-home services. Child psychiatry services are accessible face-to-face or via telemedicine in some areas.

Funding streams supporting the services in Virginia vary in regard to how they do or do not support integrating our system of care for those needing behavioral health services. 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 provided for specific populations or programs. For example, the General Assembly has provided funding for over 20 Programs for Assertive Community Treatment (PACT). PACT by nature is meant to address the whole person including co-occurring disorders for those impacted most severely by mental illness. The Commonwealth promotes integration of care and addressing co-occurring disorders through technical assistance and training provided. The degree to which each CSB provides integrated care varies across the state.

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](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health 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)⁴⁸.

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."⁴⁹

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 status⁵⁰. 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 populations⁵¹. 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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSEExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵¹ http://www.whitehouse.gov/omb/fedreq_race-ethnicity

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, LGBT, 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 behavioral health 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) standard? ☐ Yes ☒ No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ☐ Yes ☒ No
7. Does the state have any activities related to this section that you would like to highlight?

The state has recently developed a Behavioral Health Equity Team to build capacity to address behavioral health equities. Additionally, there is discussion on creating a full time position as well. The state has recently enhanced its epidemiological data collection and expanded the demographic categories to better identify behavioral health disparities.

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery 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 outcome 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.

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). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). 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 CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the 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)? j n Yes j n No
2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? j n Yes j n 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.
The Commonwealth has implemented the EBP of Coordinated Specialty Care for transition-age youth and young adults experiencing their first episode of psychosis.
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?

Because of the importance of early identification and intervention of SMI, DBHDS encourages community services boards (CSBs) and other providers to utilize and promote screening and assessment of individuals experiencing the possible signs of ESMI so they can receive prompt, appropriate treatment.
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? j n Yes j n No
5. Does the state collect data specifically related to ESMI? j n Yes j n No
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? j n Yes j n No
7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

See attached narrative titled "(ESMI)".
8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

Please see attached narrative titled "Virginia 4 - Evidence Based Practices to Address ESMI."

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

Please see attached narrative titled "Virginia 4 - Evidence Based Practices to Address ESMI."

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

Based on DSM-5 diagnostic categories, Virginia has identified Schizophrenia Spectrum and Other Psychotic Disorders, including, in some cases, Bipolar Disorder with Psychotic features, for our ESMI programs. As stated above, these programs focus on treating individuals experiencing first-episode psychosis.

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

Please see attached narrative titled "Virginia 4 - Evidence Based Practices to Address ESMI."

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

None at this time.

Footnotes:

NOT FINAL

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

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

Since 2015, eight 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 in State General Funds allocated by the Virginia General Assembly annually to address emerging serious mental illness in young people. Virginia's CSC teams began providing CSC services between May and November 2015 depending on provider, and several have reached the point at which some service participants are "graduating" from the program, participation in which is generally limited to a two- to three-year period.

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

DBHDS plans for our current CSC initiative to continue for FFY 2018-2019, and during the summer of 2017, we were in discussion with a ninth provider who was interested in starting up a new CSC team. However, our ability to continue services at the current level, much less to expand, is in question at this time; the President's introduced budget for FFY 2018, if passed, would result in a \$3,061,000 cut, or 30%, to our MHBG allocation for the fiscal year. Because Virginia did not expand Medicaid under the Affordable Care Act, our state Medicaid plan for adults still requires that an adult be aged, blind or disabled, as well as earn an income of 80% of the federal poverty level, to be Medicaid-eligible. Most of the young people being served in CSC are not eligible under these rules, and as a result, Medicaid reimbursement for these services is scarce. If Virginia sustains a 30% cut to our MHBG allocation, we will have no choice but to severely reduce funding, which could result in the elimination of some of these programs. Until we have our final FFY 2018 MHBG allocation, however, we are planning to continue the program at its current level of service delivery.

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

During 2015, DBHDS created a CSC Data Workgroup to develop data collection and reporting measures for this initiative, and this group has continued to meet by phone periodically to discuss data collection and reporting. The workgroup is comprised of CSC clinical program and Quality Assurance/Improvement staff at the eight partner CSBs, and DBHDS Central Office staff in the Office of Adult Community Behavioral Health and the Office of Support Services (responsible for state-level evaluation and data support). Working collaboratively, DBHDS and the CSB staff identified the eight outcome areas which we will use to evaluate the impact of CSC services on young adults with First Episode Psychosis. The identified outcome areas include the following:

1. Increased participation in education and/or employment
2. Decreased utilization of crisis services, such as hospitalization and crisis stabilization
3. Decreased involvement in the criminal justice system (arrest and/or incarceration)
4. Increased self-report of family engagement by both the young adult and family
5. Improved social functioning

6. Decreased negative impact from symptoms
7. Positive self-report of recovery
8. Decreased use of alcohol or other drugs, as applicable

Current Data Reporting Process

Data reporting began in March 2016 with two mechanisms. First, DBHDS and the CSBs are using two 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. With the unique client identifier, DBHDS is able to access data on CSC services provided to the cohort of individuals currently enrolled in the eight CSC programs across the state.

Plans for 2019-2019

DBHDS and CSB staff are currently in discussion about the development of a framework for CSC data analysis. At least two frameworks are necessary – one to report back to the CSB providers on the outcomes achieved by their own participants, with comparisons to the Virginia CSC service population as a whole; and one for reporting to the Virginia General Assembly on this effort. DBHDS is required to report back to the General Assembly annually on the outcomes of this effort since approximately 75% of the funding for Virginia's CSC initiative is State General Funds allocated by the General Assembly. We anticipate having these data analysis frameworks developed by the fall of 2017, and for 2018-2019, to provide regular outcome report-back to both the providers and the General Assembly. Again, however, given the uncertainty at this time about our MHBG allocation for 2018-2019, services may be decreased or even eliminated in some areas due to funding cuts.

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 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, 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.
Please see the attached narrative "Virginia 5 - Person Centered Planning."
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
Please see the attached narrative "Virginia 5 - Person Centered Planning."
4. Describe the person-centered planning process in your state.
Please see the attached narrative "Virginia 5 - Person Centered Planning."
Does the state have any activities related to this section that you would like to highlight?
Please see the attached narrative "Virginia 5 - Person Centered Planning."
Please indicate areas of technical assistance needed related to this section.
None at this time.

Footnotes:

5. Person Centered Planning (PCP)

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

In June 2010, DBHDS released its multi-year strategic plan [*Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*](#), which placed emphasis on integrating person-centered planning into the behavioral health system in Virginia. Efforts to fully integrate person-centered planning into services in Virginia initially began with individuals with intellectual and developmental disabilities, but as indicated in the *Creating Opportunities* strategic plan, has moved into the behavioral health sector in our system. It is now an expectation that public behavioral health providers approach assessment, treatment planning, and service delivery from a person-centered approach. In the Commonwealth's new strategic initiative [*System Transformation, Excellence and Performance in Virginia*](#) (STEP VA), which has been described elsewhere in this application, the future expectation is that all services must integrate not only person-centered planning but also trauma-informed and recovery-oriented approaches as a standard of care. In recent years, Virginia has made great strides in the area of recovery-oriented approaches, and these approaches complement person-centered planning. In 2015, DBHDS created the peer-led Office of Recovery Services, which is instrument to the development of our vision of a recovery-oriented system of care, and in 2016, that Office finalized a peer certification process, in part to enable Medicaid reimbursement for peer support in Virginia's Medicaid plan. As of July 1, 2017, Virginia Medicaid is now reimbursing services delivered by peer recovery coaches in both mental health and substance use work. These accomplishments reinforce the person-centered value of individuals making their own decisions about receiving support from those with lived experience, as well as participating in decision making about needed care 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.

There is no specified person-centered planning process policy in Virginia. As stated above, DBHDS believes that person-centered planning is a best practice to ensure individuals in our system receive recovery-oriented, trauma-informed services of their choosing that meet their individual needs, and we will continue to work with our providers to make this practice a reality in our state.

NOT FINAL

Environmental Factors and Plan

7. 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 behavioral health 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 behavioral health 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 behavioral health 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 programs requirements, including quality and safety standard? ☒ Yes ☐ No

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

Please see attached narrative "Virginia 7 - Program Integrity."

Please indicate areas of technical assistance needed to this section

None at this time.

Footnotes:

7. 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 2018/2016 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 subgrantees 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 drug 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 provide technical assistance to ensure compliance. For the MHBG, the offices of Mental Health Services (OMHS) 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, OMHS and OSAS provide ongoing technical assistance to not-for-profit contractors to ensure compliance with all federal regulations.

NOT FOR PUBLICATION

Environmental Factors and Plan

9. 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:

- *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;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *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;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *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

- ☒ Data on consequences of substance using behaviors
- ☒ Substance-using behaviors
- ☒ Intervening variables (including risk and protective factors)
- ☒ Others (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.

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

The state's 40 provider networks, Community Services Boards (CSBs), have each just completed a comprehensive needs assessment after intensive capacity building strategies to include the development and use of our Virginia Social Indicator Dashboard that houses data collected by the Virginia SEOW and also extensive training and technical assistance by our evaluation contractor, OMNI Institute.

Please indicate areas of technical assistance needed related to this section

None

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:

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

Capacity Building

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

If yes, please describe

The 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.

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

With all CSBs conducting the community readiness assessment and coalition capacity assessment , it allows the state to identify gaps in capacity and target our effort with specific strategies.

Please indicate areas of technical assistance needed related to this section

None

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

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

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? j n Yes j n 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) j n Yes j n No j n 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? j n Yes j n 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? j n Yes j n 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.
Does the state have any activities related to this section that you would like to highlight?

The EBWG has been active and visible on both the SABG and the PFS SPF and STR in order to give them a viable role in all prevention work across programs to maintain consistency in approach.

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

None

NOT FINAL

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

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
 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 SBIRT 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
 Al'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!

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

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

d) Problem Identification and Referral:

Identification & Referral Services

Information and Referral

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

e) Community-Based Processes:

Coalition

Above the Influence Club

Adult Mental Health First Aid

Advisory Board

AI's Pals Technical Assistance

Applied 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 Force

Collaboration-- SAP

Community Builder's Network

Community 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 Program

Kognito: At-Risk for High School Educators

Kognito: At-Risk for Middle School Educators

Kognito: Step In, Speak Up!

Lead and Seed

Lethal Means Restriction Trainings

Local Law Enforcement Trainings

Mental Health First Aid - Adults

Mental Health First Aid - Youth

More Than Sad

Prescription 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:

Merchant Education (Tobacco)

Alternative Red Ribbon Week

Be The REAL You

Coalition Sponsored Campaigns

Community Restoration Task Force

DMV 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 Lethal Means Restriction Campaign and Resources Lethal Means Restriction Resources Local Employer Collaboration Lock and Talk Suicide Prevention Campaign 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 Regional Suicide Prevention Initiatives (SPAN) Rx Abuse Prevention Initiative RX Permanent Drop Off School Policy Revision Secure Meds Campaign Social Host Ordinance Social Norms Campaign Suicide Prevention Activities Suicide Prevention Alliance of Northern Virginia (SPAN) Talk They Hear You Campaign Tobacco and Alcohol Compliance Checks Tobacco Free School Policies Tobacco Social Norms Campaign TTYL Media Campaign Underage Use Campaign We Don't Support Underage Use Zero Suicide Zero Tolerance Policy

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.

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

Both logic models and strategic plans must be approved at the state level before initiation of programming.

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

None

NOT FINAL

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

Evaluation

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

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

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

10. Statutory Criterion for MHBG - Required 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.

Virginia's public behavioral health system provides a wide variety of mental health services and supports to individuals with SMI and/or co-occurring SUD as indicated by the checked services below. 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 provide the following services under comprehensive community-based mental health service systems?

- | | |
|---|---|
| a) Physical Health | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Mental Health | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Rehabilitation services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| d) Employment services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Housing services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| f) Educational Services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| g) Substance misuse prevention and SUD treatment services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| h) Medical and dental services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| i) Support services | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| k) Services for persons with co-occurring M/SUDs | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

Please describe 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 to some extent, with the possible exception of housing and educational services. The CSBs do offer psychoeducation to individuals and families.

Physical Health: Many of Virginia's 40 CSBs partner with local community health clinics or providers to offer primary care services to consumers. Primary care services are 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.

Rehabilitation Services: All 40 Virginia CSBs offer psychiatric rehabilitation services to individuals with SMI. These programs often 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.

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

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 are offered in the community and are designed to prevent or ameliorate psychiatric crisis. For adults with SMI in particular, important services include psychiatric and medication management services, psychosocial rehabilitation, peer supports, and permanent supportive housing.

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 behavioral health 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	345,666	5.4% of adult population
2.Children with SED	94,127	10%-20% of children and youth

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 and incidence data above for adults with SMI, and prevalence of children with SED, are provided to the state by NRI/National Association of State Mental Health Program Directors. Virginia currently has no methodology for estimating the incidence of SED in children; the National Institute of Mental Health estimates that one 1 in 5 children, either currently or at some point during their life, have had a seriously debilitating mental disorder. Peer reviewed studies put the percentage at between 10 and 20 percent.

Narrative Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

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

Describe your state's targeted services to rural and homeless populations and to older adults

RURAL COMMUNITIES: The Commonwealth of Virginia covers a wide range of geographic regions. Depending on its location, one Community Services Board (CSB) might serve a combined population of urban, suburban and ex-urban or rural areas. Twenty-four of the 40 CSBs are located in primarily rural areas; during SFY 2016, these boards served 53% of all mental health consumers and 50% of those receiving substance abuse treatment.

Individuals in need of behavioral health services in rural areas face special challenges. CSBs vary according to budget size and population density, and many in rural areas do not have the infrastructure to support the services that are needed in the community. Access to transportation, especially for individuals ineligible for Medicaid, is often an issue. 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.

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 operate in urban areas and spend 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.

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.

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 totalled \$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: 39.5% of award

CSB MH Services for Children with SED: 24.6% of award, based on Children's Set-Aside

First Episode Psychosis Services: 11.2% (includes ESMI 0% Set-Aside)

Peer and Family Workforce Support and Education: 10.5% of award

Contracted Peer Support Services: 7.7% of award

DBHDS Administrative Set-Aside: 5.0% of award

Program Evaluation and Data Reporting: .9%

Whether these ratios will continue for FFY 2018 depends upon Virginia's final MHBG allocation for the fiscal year. The President's FFY 2018 budget includes a deep cut to the MHBG program which, if sustained in Virginia, would cut our MHBG award by 30%, or just over \$3 million. A cut of this magnitude would require that we make deep cuts to MHBG-funded services; decisions about if and what to cut will be made when SAMHSA informs DBHDS of our final allocation.

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i) Screening ☐ Yes ☐ No

ii) Education ☐ Yes ☐ No

iii) Brief Intervention ☐ Yes ☐ No

iv) Assessment ☐ Yes ☐ No

v) Detox (inpatient/social) ☐ Yes ☐ No

vi) Outpatient ☐ Yes ☐ No

vii) Intensive Outpatient ☐ Yes ☐ No

viii) Inpatient/Residential ☐ Yes ☐ No

ix) Aftercare; Recovery support ☐ Yes ☐ No

b) Are you considering any of the following:

Targeted services for veterans ☐ Yes ☐ No

Expansion of services for:

(1) Adolescents ☐ Yes ☐ No

(2) Other Adults ☐ Yes ☐ No

(3) Medication-Assisted Treatment (MAT) ☐ Yes ☐ 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. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? ☒ 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. Are you considering 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, custody issue ☒ 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.

See attached narrative titled "Virginia 11 - Substance Use Disorder Treatment, Criteria 3."

11. Substance Use Disorder Treatment, Criterion 3

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.
 - ❖ Women's children 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 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;
 - 2) pregnant substance users;
 - 3) injecting drug users; and
 - 4) all others.”
- Boards must publicize that they provide substance abuse treatment services to pregnant woman and that pregnant women in need of substance abuse services receive treatment priority. Boards may publicize substance abuse services for pregnant 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:

Martha Kurgans LCSW, Women’s Services Coordinator Office of
Substance Abuse Services
Department of Behavioral Health and Developmental Services Email:
Martha.kurgans@dbhds.virginia.gov
Phone: (804) 371-2184
 - ❖ 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.

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. Are you considering 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 (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.
Please see attached narrative titled "Virginia 11 - Substance Use Disorder Treatment Criteria 4, 5 and 6."

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. Are you considering 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.
Please see attached narrative titled "Virginia 11 - Substance Use Disorder Treatment Criteria 4, 5 and 6."

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

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ☐ Yes ☒ No
2. Are you considering 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.A§ 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

NOT FINAL

Substance Abuse Prevention and Treatment Block Grant Criteria 4, 5 and 6

Persons Who Inject Drugs (PWID)

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 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 requirement 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

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 Regional 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 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

Criterion 8,9&10

Syringe 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. Are you considering 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 service 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. Are you considering 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, e.g. 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. Are you considering any of the following:
 - a) Notice to Program Beneficiaries ☐ Yes ☒ No
 - b) Develop an organized referral system to identify alternative providers ☐ Yes ☒ No
 - a) Develop 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. Are you considering 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 j n Yes j n No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background j n Yes j n No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? j n Yes j n No
2. Are you considering any of the following:
- a) Training staff and community partners on confidentiality requirements j n Yes j n No
- b) Training on responding to requests asking for acknowledgement of the presence of clients j n Yes j n No
- c) Updating written procedures which regulate and control access to records j n Yes j n No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure j n Yes j n 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? j n Yes j n 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. Are you considering any of the following:
- a) Development of a quality improvement plan j n Yes j n No
- b) Establishment of policies and procedures related to independent peer review j n Yes j n No
- c) Develop long-term planning for service revision and expansion to meet the needs of specific populations j n Yes j n No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? j n Yes j n 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? j n Yes j n No
2. Are you considering 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 j n Yes j n No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing j n Yes j n 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 j n Yes j n No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services j n Yes j n No
 - c) Performance-based accountability j n Yes j n No
 - d) Data collection and reporting requirements j n Yes j n No
2. Are you considering any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs j n Yes j n No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services j n Yes j n No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services j n Yes j n 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 j n Yes j n 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 j n Yes j n No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis j n Yes j n No
 - b) Early Intervention Services Regarding HIV j n Yes j n No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment j n Yes j n No
 - b) Professional Development j n Yes j n No
 - c) Coordination of Various Activities and Services j n Yes j n No

Please provide a link to the state administrative regulations, which 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 2017 and 2018 Community Services Board Administrative Regulations: <http://www.dbhds.virginia.gov/library/community%20contracting/17%20pc%20csb%20administrative%20rqmts%20final.pdf>

4. State Fiscal Year 2017 and 2018 Community Services Performance Contract: <http://www.dbhds.virginia.gov/library/community%20contracting/17%20pc%20csb%20administrative%20rqmts%20final.pdf>

NOT FINAL

Environmental Factors and Plan

12. 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 2016-FFY 2017? ☒ Yes ☐ No

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

Please see the attached narrative "Virginia 12 - Quality Improvement Plan."

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

Footnotes:

12. 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;
- Implementing a process in collaboration with CSBs to ensure at least five percent of community mental health and substance use disorder programs receive independent peer reviews annually to review the quality and appropriateness of services;
- 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/library/community%20contracting/18-pc-contract-final-may-12.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 2018 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 create a real time, web-based incident reporting system to monitor and investigate any suspected or alleged incident of abuse or neglect, serious injury, or deaths. A mortality review team monitors unexplained or unexpected death reported through the CHRIS system. Following review, the team prepares a report with recommendations, and identifies case, program or system level trends for quality improvement purposes.

DBHDS ~~has~~ established and supports a state Quality Improvement Committee and ~~will be establishing~~ five Regional Quality Councils to review and monitor key indicators. *[Comment: If you want additional information about the QIC and the RQCs, Dev Nair can provide it.]*

In collaboration with the Office of the Secretary of Health and Human Resources, DBHDS ~~has~~ ~~implemented~~ produces a monthly data dash board that includes the following ~~metrics~~ measures to track positive or negative movement toward the accomplishment of agency strategic goals.

Measure
<i>Community Services Boards</i>
Intensity of engagement in mental health case management services
Intensity of engagement in substance abuse outpatient services
Intensity of engagement in child mental health case management services
Retention in community substance abuse services, three months
Retention in community substance abuse services, six months

Measure
<i>Community Services Boards State Hospital Bed Utilization</i>
Adult civil temporary detention order (TDO) admissions to state hospitals per 100k population
Adult forensic TDO admissions to state hospitals per 100k population
Adult civil TDO state hospital bed utilization by CSB per 100k population
Adult forensic TDO state hospital bed utilization by CSB per 100k population
Total civil state hospital bed utilization by CSB per 100k population
Total forensic state hospital bed utilization by CSB per 100k population
<i>State Hospitals</i>
Forensic state hospital bed utilization

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ 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 behavioral health 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 behavioral health. 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 behavioral health 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 behavioral health 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 Trauma⁶¹ paper.

60 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.*

61 *Ibid*

Please respond to the following items

- Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No
- Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ☐ Yes ☐ No
- Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ☐ Yes ☐ No
- Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No
- Does the state have any activities related to this section that you would like to highlight.
Please see narrative attachment "Virginia 13 - Trauma" for additional information.
Please indicate areas of technical assistance needed related to this section.
None at this time.

Footnotes:

13. Trauma

DBHDS's Office of Child and Family Services (OCFS) offers opportunities for both public and private providers to increase their capacity to deliver trauma-specific interventions through a Children's Behavioral Health Academy 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. 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.

Specific trauma trainings include:

Training	Date	Location
Trauma Informed Policy Academy	December 2015	Richmond
Trauma Informed Learning Collaborative	June 2016	Richmond
Think Trauma	July 2017	Roanoke
Think Trauma	August 2017	Richmond
Think Trauma	August 2017	Hampton-Newport News

Environmental Factors and Plan

14. 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.⁶²

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.⁶³

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 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.

⁶² 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 Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csqjusticecenter.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 behavioral health 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, behavioral health 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 behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health 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 behavioral health 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?
Please see the attached narrative "Virginia 14 - Criminal and Juvenile Justice."
Please indicate areas of technical assistance needed related to this section.
None at this time.

Footnotes:

14. Criminal and Juvenile Justice

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 behavioral health services?

Adult System

Virginia supports a variety of jail diversion initiatives. These initiatives strive to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification), divert individuals away from the criminal justice system (or penetrating, if identified after arrest/incarceration), and connect individuals to 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, while 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 seven juvenile drug treatment courts and 30 adult treatment courts currently operating in Virginia. These courts operate in communities as diverse as the City of Richmond, a highly urban setting, 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 youth adjudicated through these courts.

In addition to the juvenile and adult drug treatment courts, there are two 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 early 2016, DBHDS began to partner with the Office of the Executive Secretary of the Supreme Court of Virginia, both in its own Mental Health Docket Workgroup, as well as on the Problem-Solving Docket Advisory Group convened by the Chief Justice of the Supreme Court of Virginia. This group produced The Essential Elements of Mental Health Dockets in Virginia, a resource for communities exploring the creation of a mental health docket in their locality.

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. VDOC re-entry or transition specialists contact the CSB for the area in to which the inmate will be released. VDOC has utilized grant funds in some communities to support a visit from CSB staff while he or she is incarcerated to begin to establish relationships. Local CSB participate Regional Re-Entry Community Collaboration Councils that are 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 exploring collaboration with VDOC to improve dissemination of this CBT among CSBs. Many CSBs also utilize Moral Reconation Therapy, another EBP appropriate for individuals who are involved with the criminal justice system.

As a result of legislation passed in the 2017 Session of the Virginia General Assembly, the role of DBHDS, via the CSBs, in providing mental health services in criminal justice settings will increase. HB1784 directs DBHDS to develop a comprehensive plan to provide forensic discharge planning services at local and regional correctional facilities for persons with SMI who are scheduled for release. House Joint Resolution 779 directs the Joint Commission on Health care to study the impact of CSBs to provide mental health services in jails.

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.

DBHDS is an active partner on the Virginia Advisory Committee on Juvenile Justice. This committee advises the Board of the Department of Criminal Justice Services, 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, as well as other juvenile justice-related grant applications, and makes recommendations on them to the Board.

Virginia's Department of Juvenile Justice is one of only six states to be awarded a juvenile re-entry planning grant by the Department of Justice. This grant provides Virginia with the opportunity to develop comprehensive approach to juvenile re-entry.

DJJ is using the grant for two primary purposes:

- (1) To retain the services of an outside expert to assess the effectiveness of its current reentry services and recommend necessary changes; and
- (2) To convene a multi-agency taskforce to develop a comprehensive, statewide plan responsive to the expert recommendations.

The taskforce includes representatives from such agencies as the Departments of Criminal Justice Services, Education, Motor Vehicles, Social Services, Behavioral Health and Developmental Services, and the Virginia Community College Systems, and local judicial districts. It will also include family representatives and stakeholders from various judicial districts.

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

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 the narrative attachment titled "Virginia 15 - Medication Assisted Treatment."
Please indicate areas of technical assistance needed to this section.
None at this time.
**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.*

Footnotes:

15. 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, as well as to the annual meeting of the American Association for the Treatment of Opioid Dependence. Evidence-based practices are discussed at both of these meetings and DBHDS often sponsors a speaker to address EBP.

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

16. 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 behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ 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 behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"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 behavioral health 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. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

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) ☐ WRAP Post-Crisis
- b) ☒ Peer Support/Peer Bridges

- c) ☐ Follow-up Outreach and Support
- d) ☐ Family to Family Engagement
- e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- f) ☐ Follow-up crisis engagement with families and involved community members
- g) ☐ Recovery community coaches/peer recovery coaches
- h) ☐ 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 to this section.

None at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health 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 behavioral health 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, 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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

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?
Please see attached narrative "Virginia 16 - Recovery".
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.
Please see attached narrative "Virginia 16 - Recovery".
4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
Please see attached narrative "Virginia 16 - Recovery".
5. Does the state have any activities that it would like to highlight?
Please see attached narrative "Virginia 16 - Recovery".
Please indicate areas of technical assistance needed related to this section.
Not at this time.

Footnotes:

17. Recovery

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, a person with lived experience with mental health challenges, reports directly to the Commissioner of DBHDS, and her position is funded with a combination of SAPT and MH block grant dollars. As of this writing, ORS has two full-time staff members with lived experience, one with addiction recovery and with mental health recovery. ORS staff facilitates the refinement and development of strategies that use person-centered, participant-led care in the public and private sectors of our system, including peer-run organizations.

Individuals and families with lived experience participate on a variety of state-level councils, committees and work groups, and the same happens at the local level. One important mechanism for to ensure this happens is the requirement outlined in [Title 37.2 of the Code of Virginia](#) 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). 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

Organization	Constituency
	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

In 2012, 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. Members of the team that attended the Academy represented the DBHDS leadership, staff from the offices of Substance Abuse Services and Mental Health (now combined to form the Office of Adult Community Behavioral Health), the Department of Medical Assistance Services, the CSBs, state hospital leadership, peers working in facilities or CSBs, and statewide MH and SUD peer and/or advocacy groups such as VOCAL and the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA). This initiative focused 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. Education about peer services and developing them was one important aspect of the Academy, as well as changing the organizational and treatment culture, and evaluation. 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.

As part of this effort, DBHDS BRSS-TACS state-level team, now called the Virginia Recovery Initiative (VRI), 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, and others. Perhaps the most important achievement in our system since our last Block Grant application in 2015 is our Certified Peer Recovery Specialist initiative and Medicaid reimbursement for peer support in behavioral health services. 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.

In April 2015, DBHDS launched its Peer Recovery Certification process as part of the efforts to promote and enable the robust use of peer recovery support specialists and recovery coaches throughout the behavioral health care delivery system. Certification standards are essential to developing peer support services as reimbursable mainstream service options in our system, and as such, 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 were developed, and an 18-month "grandparenting" phase was implemented which enabled peer supporters who met certification criteria to obtain a provisional certification. This option provided a wide doorway to certification. Criteria became more standardized in the second year of the certification process in order to establish uniformity and credibility to the valuable recovery services offered by peer specialists. The performance contract between DBHDS and the CSBs includes the use of CPRSs 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 nine providers, seven of whom are consumer-owned and –operated non-profit 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 Recovery Coach Academies to train individuals interested in serving as recovery coaches.

As described in Section 5, Person Centered Planning, an important component of DBHDS's move to a person-centered, recovery-oriented system of care is Virginia's Advance Directives Initiative. This 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.

Children with SED and Their Families

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 seven parent groups in three of the five regions across the state (five in Northern Virginia, one in Tidewater/Virginia Beach, and one in Central Virginia/Richmond), and another group in the Southwest Virginia region in development. 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 now has a Youth MOVE state chapter. 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, in recent years 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 seven recovery support programs, and as of this writing, the Office of Recovery Services is preparing to release a Request for Proposals to solicit applications for the development of additional Peer Resource Centers or Recovery Community Organizations. These will be funded with State general funds.

Addiction Recovery Treatment Services Medicaid Waiver

Through the ARTS initiative, Virginia Medicaid will reimburse organizations eligible for ARTS reimbursement for peer 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.

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health 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 community⁶⁶. 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 24⁶⁷. 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 death⁶⁸.

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 21⁶⁹. 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 costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ 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 behavioral health 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).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, 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.

⁶⁸Centers 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.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department 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 <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹ 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 behavioral health 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 behavioral health 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.)
See the attached narrative "Virginia 19 - Children and Adolescents' Behavioral Health Services."
- Does the state have any activities related to this section that you would like to highlight?
See the attached narrative "Virginia 19 - Children and Adolescents' Behavioral Health Services."
Please indicate areas of technical assistance needed related to this section.
Not at this time.

Footnotes:

19. Children and Adolescents Behavioral Health Services

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

Virginia works to incorporate systems of care principles in all programs and initiatives affecting children and families. There are two initiatives in Virginia that specifically focus on providing services through the system of care. Those initiatives are discussed in detail below.

System of Care (SOC) Expansion Grant

Four years ago Virginia received a SOC Expansion Implementation Grant and through this grant has expanded the System of Care approach through the use of Intensive Care Coordination to provide High Fidelity Wraparound (HFW). HFW is a family driven; strengths based care coordination process that embodies the SOC values and principles at the service level for children and families facing mental health challenges. Although the state has made progress, some communities remain reluctant to purchase Intensive Care Coordination or are not practicing HFW to fidelity.

Most recently, Virginia was awarded a SOC Expansion & Sustainability Grant. This grant focuses on the following 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 will continue 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 will be 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. Primary goals of Virginia’s strategic plan include the following: Goal 1: Develop Services and Supports Based on the System of Care Philosophy, Goal 2: Behavioral Health Workforce Development, and Goal 3: Quality Improvement Methodologies, Data Mining and Management Improvements.

Children’s Services Act (CSA)

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. Although considerable progress has been achieved with each of these, there is a continued need for infrastructure development to increase the capacity to implement, sustain and improve effective mental health services 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 children who would have been served by one of the funding streams placed in the pool are targeted for services through CSA. The children who would have been served by the education funds and/or the foster care funds placed in the pool are considered "mandated" for service. This is because there is "sum sufficient" language attached to them in the Federal law and/or the Code of Virginia. These special education and foster care children are the only population's state and local governments are required to appropriate sufficient funds to serve.
- 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. It is comprised of two General Assembly members, the Governor's Special Advisor for Children's Transformation, the state government agency heads from DOE, DSS, Department of Health (DOH), DBHDS, Department of Medical Assistance Services (DMAS), DJJ, the Office of the Executive Secretary of the Supreme Court, three local government officials (cities and counties), parents, three service providers (one public and two private), and the chair of the State and Local Advisory Team.
- 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.

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

In addition to the system of care activities that have already been described, DBHDS has several other activities to promote a robust system of care for children. Those activities are discussed below.

State Board Policy 1007 Behavioral Health and Developmental Services for Children and Adolescents and Their Families

State Board Policy 1007 addresses behavioral health and developmental services for children and adolescents and their families. It is the policy of the Board that children and their families in need of services shall have access to an integrated system of child-centered and family-focused behavioral health and developmental prevention, early intervention, treatment, and habilitation services. The Board recognizes the quality of life and cost saving benefits of providing services for children as early as possible to address identified needs or individual risk factors. It is also the policy of the Board that programs for children and their families be specialized and flexible and be delivered by specially trained staff so to meet the individual needs of the child and family in community settings. Community settings are construed broadly in this policy to include public or private inpatient or residential treatment facilities, which are part of the overall continuum of care. The policy includes, but is not limited to, the following principles:

- Children and their families are able to access individualized services that are tailored to build on their unique strengths and to meet their changing needs.
- Services are sensitive and responsive to the cultural and linguistic diversity and special requirements of children and their families.
- Families and surrogate families are consistently and integrally involved as partners in all aspects of planning, delivering, and evaluating services for their children.
- All participants in the services system are responsive and accountable to each other.

System Transformation, Excellence, and Performance (STEP-VA)

Applicable to all populations, the STEP-VA model, which was described in the Planning Steps section of this application, promises to address a challenge cited in every study of children's services – inadequate access to services, an inconsistent array of services, and variable quality of services across the state. Requiring the following services deemed essential in STEP-VA, plus care coordination and wellness programs, the model will provide standardization across Virginia in available services and assure access to these essential services for children and families. Same-day access for initial assessment with follow-up appointment within 7 days is part of the model's operational approach. STEP-VA services and their applicability to child and adolescent services is as follows:

1. Behavioral Health Crisis Services

The following four types of crisis services provided by staff with children's services expertise and access to child psychiatry:

- Emergency Crisis Intervention Services
- 24-hour mobile crisis teams
- Ambulatory Crisis Stabilization Services
- Residential Crisis Stabilization Services

Services are provided in home and community. Assure family and caretaker involvement and incorporate appropriate developmental approaches.

Screening, Assessment, Diagnosis, and Risk Assessment, including Same Day Access

The following will be available to children, in the clinic or in homes and schools:

- Screening, Initial Assessment, and Risk Assessment

The screening and risk assessment process will include and consider age and developmentally appropriate issues including pertinent family and caretaker information.

Comprehensive Assessment, Diagnosis, and Risk Assessment

- Competency in understanding the impact of developmental and family/caretaker issues is required.

2. Person Centered Treatment Planning, Risk Assessment and Crisis Planning: Treatment planning for children will include parents and family members in planning.

3. Outpatient Mental Health and Substance Use Services: Children and adolescents are treated using a family and caregiver-driven, youth guided and developmentally appropriate approach that comprehensively addresses family and caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues. Services are provided in office or as intensive in-home services. Child psychiatry services are accessible face-to-face or via telemedicine.

4. Outpatient Clinic Primary Care Screening and Monitoring: The CSB assures children receive age-appropriate screening, monitoring, and preventive interventions including, where appropriate, assessment of learning disabilities. The CSB has consultative relationships with pediatric providers and can refer children for pediatric follow-up. CSB child psychiatrists and pediatricians are able to consult through telephone and telemedicine approaches. Many behavioral health problems are first brought to the attention of pediatricians and coordination is assured through consultation.

5. Targeted Case Management: Currently covered in State Medicaid Plan for children with or at-risk of SED.

6. Psychiatric Rehabilitation Services: While not used for young children, this service may be applicable to transition-age youth.

7. Peer Support and Family Support: Parent/family peer support partners with lived experience will provide support to parents and families. Youth peer support specialists may provide peer support to

other transition-age youth. Family and youth peer specialists will be certified through the DBHDS peer certification process as Certified Peer Recovery Specialists.

8. Intensive Community-Based Mental Health Care for Members of the Armed Forces and Veterans: Supports military and veterans who are parents and caregivers of children under 18.

Care Coordination

Provided through Intensive Care Coordination using the best practice High Fidelity Wraparound model, this process is reimbursable by the Children's Services Act and training is provided for providers and parent peers. In working with families to develop individualized care plans, Care Coordinators shall consider additional services, such as intensive in-home services and others, to supplement the nine services above.

Young Adult Substance Abuse Treatment (YSAT) Planning and Implementation Grants

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 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. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is addressing these needs through a data-driven and client-informed strategic plan to enhance treatment options for transition-age youth and their families through structures that engage youth and families in the treatment and recovery system. The SAMHSA Young Adult Substance Abuse Treatment Planning Grant provided resources to develop the plan, and services will be implanted in the second phase of this effort, supported by SAMHSA's Young Adult Substance Abuse Treatment Implementation Grant. This strategic plan is spearheaded by a Statewide Interagency Council consisting of public and private community stakeholders, financing agencies, and transition-age youth and their families. The Statewide Interagency Council has two subcommittees that focus on planning and workforce development, two aspects which are integral to the development of sustainable system change. The Council and its subcommittees are organized and lead by a full-time Youth Substance Abuse Treatment (YSAT) Project Coordinator.

Specifically, DBHDS is leveraging established pathways and lessons learned from past infrastructure development efforts, such as Virginia's SAMHSA-funded Co-Occurring State Infrastructure Grant (COSIG) project which concluded in 2009. By collaborating with other public and private providers and agencies that serve transition-age youth and their families, the Commonwealth of Virginia is making a systemic change to our service system in the treatment of substance abuse and co-occurring disorders among this underserved age group. Implementation of this initiative enables the Commonwealth to build on 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, by developing a sustainable infrastructure to address the specific substance abuse treatment needs of this population.

Workforce Development

In its Final Report to the General Assembly on Appropriations Item 304.M. “A Plan for Community-Based Children’s Behavioral Health Services in Virginia, DHBDS included workforce development as one of five recommendations of the Final Report:

Recommendation #3: Establish a children’s behavioral health workforce development initiative to be organized by DBHDS.

Even if funding were available to expand services, finding qualified providers for all parts of the Commonwealth would still be a challenge. Currently, training for professionals in the children’s behavioral health field is fragmented and reliant on individuals and separate agencies to seek out the training they need on their own. In order to support quality service provision and assure consistency, training is needed to assure that service providers have the knowledge and skills that are required to be effective. Without statewide training, there is no way to assure that the comprehensive service array will be implemented according to best practice standards. There are areas of training expertise in Virginia, including some CSBs, public and private community providers, universities, the children’s services transformation and the support of the Annie E. Casey Foundation, the CSA, and the CCCA. However, there is not a coordinated approach to training that could harness and share this expertise.

Through a variety of funding streams, DBHDS has implemented a Children’s Behavioral Health Academy to address workforce needs. Recent Children’s Behavioral Health Academy workforce development initiatives include:

Training Event	Date	Location
The Impact of Substance Abuse on the Family Structure	November 10, 2015	Richmond, VA
Trauma Informed Policy Academy	December 7-9, 2015	Hampton-Newport News, VA
Trauma, Domestic Violence and Substance Abuse in Adolescents and Young Adults	April 28-29, 2016	Richmond, VA
Understanding, Assessing and Treating Aggressive and Antisocial Youth	May 17, 2016	Charlottesville, VA
Trauma Informed Learning Collaborative	June 13-14, 2016	Hampton-Newport News, VA
High Fidelity Wraparound Conference	September 19, 2016	Richmond, VA
Substance Use Disorders and Young People: Epidemiology, Impact, Treatment and Recovery	March 8, 2017	Charlottesville, VA
Ethical Exploration	June 28, 2017	Richmond, VA

DBHDS is committed to growing the statewide system of care for children and young adults through targeted initiatives, workforce development, and strengthened relationships with other child serving agencies.

Environmental Factors and Plan

20. Suicide Prevention - Required 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 behavioral health 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 through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health 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.

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).

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? | j n Yes j n No |
| 4. | Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? | j n Yes j n No |
| 5. | Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? | j n Yes j n No |

If so, please describe the population targeted.

The state has hired 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.

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

The State has created 6 regional infrastructures (Suicide Prevention Coalitions) that cover all geographic areas of the state. These coalitions utilize the Strategic Prevention Framework for planning and identification of target populations and strategies. They are comprised of key stakeholder groups to include: survivors, providers, universities, health and other entities that represent the communities they serve.

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

None noted at this time

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required 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 behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? j n Yes j n No
2. Has your state identified the need to develop new partnerships that you did not have in place? j n Yes j n No
If yes, with whom?
Not applicable.
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 narrative "Virginia 21 - Support of State Partners."
Does the state have any activities related to this section that you would like to highlight?
Please see attached narrative "Virginia 21 - Support of State Partners."
Please indicate areas of technical assistance needed related to this section.
None at this time.

Footnotes:

21. 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.

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)** – For the last two years, DBHDS has been working intensely with the Department of Medical Assistance Services (DMAS) to prepare and apply to CMS for an 115(b) waiver for Substance Use Disorder Services. This included assisting DMAS with a successful budget request to the Virginia General Assembly for an annual additional appropriation of \$8 million to cover the entire continuum of care described in the American Society of Addiction Medicine Criteria (Third Edition) as well as funds to support the inclusion of Certified Peer Recovery Services (CPRS) in these settings. This resulted in the Addiction, Recovery and Treatment Services (“ARTS”) initiative that began implementation April 1, 2017 (with CPRS coverage initiating July 1, 2017). To help providers prepare for participation in Medicaid reimbursement, DBHDS funded two-day training in ASAM Criteria for over 600 treatment professionals. For additional information about the ARTS Initiative, please see http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.
- **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 was an active partner with VDH when the VDH Commissioner declared a public health emergency and made naloxone available without a prescription (this permission has since been codified). 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. VDH hosts the state’s website for information about the opioid crisis and DBHDS staff edit the Treatment pages of that website. 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 is also making naloxone available through all local health departments, and DBHDS will be providing funding (from STR Opioid funds) to support this project. DBHDS is represented on the Virginia Violent Death Reporting System Advisory Council, and the Child Fatality Review Team. DBHDS has collaborated with VDH on developing recommendations that resulted from specific studies of infant, child and maternal mortality related to parental substance use.
- **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 the implementation of REVIVE! and 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 Wounded Warrior Program (which will be called Virginia Veteran and Family Support, effective October 1). 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. DBHDS is participating on a legislative study led by DSS related to the impact of the opioid epidemic on the foster care system and has developed training curriculum for local social services workers to assist them in working with families affected by SUD.
- **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 frequently requests the assistance of DBHDS in reviewing its Requests for Proposals for Byrne Grant funds that support SUD treatment in jails and prisons. DCJS and DBHDS recently partnered in applications for 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. DBHDS and DCJS co-sponsored a conference for local law enforcement officers to enhance their knowledge about alternatives to arrest for individuals with opioid use disorder who are arrested.
- **Department of Corrections (DOC)** – DBHDS frequently provides training to DOC Probation and Parole Officers about working with individuals with SUD. Currently, DBHDS and DOC are partners in a National Governors Association project focused on improving treatment for individuals with OUD who are in custody of or under supervision of DOC.
- **State Supreme Court (SCV)** – DBHDS is providing technical assistance to SSC-Drug Court Administrator as several local drug treatment courts implement MAT, including a pilot with extended release naltrexone.
- **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, DSS, and the Office of the Inspector General for Behavioral Health and Developmental Services 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 participated in the Governor’s Coordinating Council on Homelessness with other housing and support agencies such as the Departments of Housing and Community Development, DSS, DOC, DCJS, and others.
- **Employment** – DMAS and DARS have been involved in developing Plan goals for this area.
- **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.
- **Commonwealth Council on Childhood Success**- This Council focuses on improving the health, education, and well-being of our youngest children.
- **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.
- **Virginia Prisoner and Juvenile Offender Re-Entry Council** – This is a cross-agency gubernatorial initiative to improve services, supports and outcomes for people returning to Virginia communities from prisons and jails. DBHDS is a partner in this effort.
- **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 (DUI intervention), Medical Assistance Services, Social Services, and Alcoholic Beverage Control. Also included are representatives from the drug court association, the sheriffs’ association, substance abuse provider organizations, consumer advocacy organizations, and the Virginia General Assembly.
- **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 is chaired by the Chief Justice of the Supreme Court of Virginia and the 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.

- **Mental Health Law Reform** – DBHDS collaborates with the University of Virginia Institute of Law, Psychiatry and Public Policy (ILPPP) to conduct research and policy development relating to the ongoing reform of Virginia’s emergency and crisis response system and related mental health treatment laws. Specific projects include ongoing analysis and reporting of court data on the operations of the involuntary commitment process in Virginia; completion of ad hoc surveys and special studies in areas of particular strategic or policy interest (such as the impact of new laws on service utilization and the quality individual experiences of persons served). DBHDS also collaborates with the ILPPP to support increased use of psychiatric advance directives in routine care delivered within Virginia’s public Behavioral Health system

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.

- **Commonwealth Council on Childhood Success**- This Council focuses on improving the health, education, and well-being of our youngest children.
- **Virginia Prisoner and Juvenile Offender Re-Entry Council** – This is a cross-agency gubernatorial initiative to improve services, supports and outcomes for people returning to Virginia communities from prisons and jails. DBHDS is a partner in this effort.
- **Department of Juvenile Justice Reentry Task Force** - Provide recommendations on mental health and substance abuse needs of juvenile offenders returning to the community from incarceration. Also provide consultation on best practice treatment models and therapy needs of this population.
- **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 18,000 infants and toddlers were served in the Part C – Early Intervention program in State Fiscal Year 2017. 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 SPF) 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

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or 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 a Behavioral Health Advisory/Planning Council (BHPC). 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 BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁷²

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 behavioral health 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.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
Please see attached narrative "Virginia 22 - Behavioral Health Advisory Council."
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ☒ 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 indicate 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.
Please see attached narrative "Virginia 22 - Behavioral Health Advisory Council."
Does the state have any activities related to this section that you would like to highlight?
Please see attached narrative "Virginia 22 - Behavioral Health Advisory Council."
Please indicate areas of technical assistance needed related to this section.
DBHDS is currently engaged in Council technical assistance under SAMHSA's contract with Advocates for Human Potential.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There 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.

Footnotes:

22. State Behavioral Health Advisory Council

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 is to review expenditures and budgets in the state system for mental health and substance abuse services.

The Council's membership is diverse and includes racial/ethnic minority group members, LGBT members, and representation from urban and rural areas of the state. However, the BHAC has been challenged in achieving its mission in recent years for several reasons. First, the due to membership transitions and an inability to engage representation from important constituencies such as parents of children with mental health challenges, the Council's membership is lacking some important perspectives which are essential to its success. Second, as a result of membership transitions and inconsistency, which have been exacerbated by the lack of a fully realized role for the Council in providing its input to DBHDS into the state's behavioral health system and use of MHBG funding, in recent years, Virginia's Council has not fully participated in the development of the state plan. In order to address the lack of a clearly defined role for the Council in achieving the requirements set forth in federal statute, over the past year, DBHDS staff and Council leadership have been participating in technical assistance (TA) provided by Advocates for Human Potential (AHP) under contract to SAMHSA. The end goal of the technical assistance effort is to develop a multi-year strategic plan for the Council's operation which will fully realize its role as an advisory body. In recent months, the AHP consultant has conducted on-site TA with the Council to conduct a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis as the first step to developing its strategic plan. The Council has also identified a need to review the mechanism the Commonwealth currently uses to allocate MHBG funds. In order to undertake this review, the Council has requested that DBHDS provide the membership with information about how it:

- Provides the public with access to the application, including time to review and provide feedback to DBHDS;
- Prioritizes program recipients of funds;
- Identifies and supports implementation of new initiatives;
- Collaborates with local entities, task forces and agencies to develop a coordinated and consistent state, regional and local response;

- Works with federal, state and private entities to leverage existing resources, including grant opportunities that would supplement MHBG funding; and
- Integrates and analyzes data from healthcare, law enforcement, and other sources to increase understanding of, and improve response to, the challenges in the state behavioral health system.

As of this writing, DBHDS is in the process of drafting a response to the Council's request, and will continue working with the Council and the AHP TA provider to fully develop the Council's role.

With respect to providing input into the 2018-2019 Block Grant application and plan, this section will be completed prior to submission of the final application on September 1, after the Council has had the opportunity to review and comment on the plan.

NOT FINAL

Virginia Behavioral Health Advisory Council (BHAC)
c/o Mental Health America of Virginia
2008 Bremon Road, Suite 101
Richmond, VA 23226



Dr. Jack Barber, Interim Commissioner
Virginia Department of Behavioral Health and Developmental Services (DBHDS)
1220 Bank Street
Richmond, VA 23219

July 14, 2017

Dr. Barber:

Since its inception, the Virginia Behavioral Health Advisory Council (BHAC, formerly the Mental Health Planning Council) has met faithfully in order to fulfill requirements mandated by 42 U.S. Code §300x-3 as established by the United States Department of Health and Human Services Substance Addiction and Mental Health Services Administration (SAMHSA) to establish and maintain a State mental health planning council in accordance with the following conditions:

- (1) to review plans provided to the Council pursuant to section 300x-4(a) of this title by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

In recent meetings it has been brought to our attention that mental health block grant funds in Virginia may be more efficiently and effectively distributed among providers of programs addressing the Commonwealth's continued complex issues associated with gaps in Medicaid coverage, ability to address the opioid crisis, and more, including new, progressive evidence-based programs and services reflective of what works and doesn't work for individuals living in recovery today.

We are, therefore, requesting information in response to this concern. A BHAC Stakeholder Leadership Team will focus on the allocation of mental health block grant funds for services within the state and will require the following information from your department in order to complete its mission, that pertaining to the procedures for:

- (1) Providing the public with access to the application, including time to review and provide feedback to the Virginia DBHDS.
- (2) Prioritizing program recipients of funds
- (3) Identifying and supporting implementation of new initiatives
- (4) Collaborating with local entities, task forces and agencies to develop a coordinated and consistent state, regional and local responses
- (5) Working with federal, state and private entities to leverage existing resources, including grant opportunities that would supplement mental health block grant funding
- (6) Integrating and analyzing data from healthcare, law enforcement, and other sources to increase understanding of and improve response to this dynamic challenge.

Please provide us with the information by August 1, 2017 so that it may be reviewed in preparation for the presentation of Virginia's block grant application in the fall.

Thank you so much for your time and attention to this request.

Calendria Brown-Jones, CPRS, President
Virginia Behavioral Health Advisory Council

NOT FINAL

Environmental Factors and Plan

23. 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
 - c) Other (e.g. public service announcements, print media) ☐ Yes ☒ No

If yes, provide URL:

Footnotes:

NOT FINAL

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

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)			
Sherry Confer	State Employees	Virginia Department of Medical Assistance Services		sherry.confer@dmas.virginia.gov
Bruce Cruser	Others (Not State employees or providers)	Mental Health America of Virginia		anne.edgerton@mhav.org
Jane Ellis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			jane@vocalvirginia.org
Shatada Floyd-White	Parents of children with SED			shatada.floyd-white@va.gov
Rita Girard	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health America of Fredericksburg		
Robin Hairfield	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Catherine Harrison	State Employees	Virginia Department of Aging and Rehabilitative Services		catherine.harrison@dars.virginia.gov
William Hart	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jenny Heilborn	Others (Not State employees or providers)	disAbility Law Center of Virginia		
Katharine Hunter	State Employees	Virginia Department of Behavioral Health and Developmental Services		katharine.hunter@dbhds.virginia.gov
Livia Jansen	State Employees	Virginia Department of Juvenile Justice		livia.jansen@djj.virginia.gov
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)			
	Individuals in Recovery (to			

Betsy Lalla	include adults with SMI who are receiving, or have received, mental health services)			
Kathleen S. Levenston	Providers	Help Your Way		klevenston@helpyourway.com
Amanda Long	Others (Not State employees or providers)	NAMI Virginia		along@namivirginia.org
Lynn Lull	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Bonnie Neighbour	Leading State Experts	VOCAL		bonnie@vocalvirginia.org
Sandy O'Dell	Others (Not State employees or providers)	Virginia Substance Abuse Services Council		
Patricia Parham	State Employees	Virginia Department of Corrections		patricia.parham@vadoc.virginia.gov
Lee Peebles	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Malaina Poore	Others (Not State employees or providers)			
Ron Pritchard	Leading State Experts	Virginia Association of Addiction Professionals		ronpritchard@verizon.net
Amanda Rode	Family Members of Individuals in Recovery (to include family members of adults with SMI)			arode@interceptyouth.com
Heather Seaman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			heather@rrs4hope.com
Rhonda Thissen	State Employees	Virginia Department of Behavioral Health and Developmental Services	1220 Bank Street Richmond VA, 23219 PH: 804-786-2316	rhonda.thissen@dbhds.virginia.gov
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)	Substance Abuse and Addiction Recovery Alliance of Virginia		

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	38	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	10	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	29	76.32%
State Employees	7	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	1	
Total State Employees & Providers	9	23.68%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	5	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

This information will be provided in the final draft of the application to be submitted to SAMHSA on September 1, 2017.

Footnotes: