West Virginia

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/11/2025 10.44.37 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	FYXTJT2PJ4Q1

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	West Virginia Department of Human Services
Organizational Unit	Office of the Secretary
Mailing Address	One Davis Square, Suite 100 East Office of the Secretary
City	Charleston
Zip Code	25301

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Elliott
Last Name	Birckhead
Agency Name	West Virginia Department of Human Services
Mailing Address	350 Capitol Street, Room 350
City	Charleston
Zip Code	25301
Telephone	(304) 352-5558
Fax	304-558-1008
Email Address	elliott.h.birckhead@wv.gov

State CMHS Unique Entity Identification

Unique Entity ID	FYXTJT2PJ4Q1

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

Agency Name	West Virginia Department of Human Services
Organizational Unit	Office of the Secretary
Mailing Address	One Davis Square, Suite 100 East Office of the Secretary
City	Charleston
Zip Code	25301

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

First Name	Elliott
Last Name	Birckhead
Agency Name	West Virginia Department of Human Services
Mailing Address	350 Capitol Street, Room 350
City	Charleston
Zip Code	25301
Telephone	(304) 352-5558
Fax	
Email Address	elliott.h.birckhead@wv.gov

III. Third Party Administrator of Mental Health Services

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

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name	Melissa
Last Name	Mullins
Telephone	304-352-5608
Fax	304-558-1008
Email Address	Melissa.D.Mullins@wv.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Alex J. Mayer

Signature of CEO or Designee[1]: _____

Title: Cabinet Secretary Date Signed: mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

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Fiscal Year 2026

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Title XIX, Part B, Subpart II of the Public Health Service Act		
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Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Alex J. Mayer

Signature of CEO or Designee[1]: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Alex J. Mayer

Title

Cabinet Secretary

Organization

West Virginia Department of Human Services

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

West Virginia DOES NOT have lobbying activities pursuant to 31 U.S.C. 1352 to be disclosed.

Planning Steps

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

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public 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 SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

The Bureau for Behavioral Health (BBH) Commissioner's Office provides direction and communicates the goals of West Virginia (WV) Department of Human Services (DoHS), BBH to the community to ensure continuity of services. Deputy Commissioners oversee 2 sections (Programs and Policy, and Administration and Operations). Programs and Policy section staff provide development, implementation, and oversight of the statewide community-based behavioral health system of care to ensure that individuals with mental health, substance use, or developmental disorders have meaningful treatment and support services to maximize their abilities to function as productive and stable citizens of WV within the least restrictive environments suitable to their needs, in accordance with federal and state programmatic regulations, requirements, and standards. Funding is provided to comprehensive community behavioral health centers and other providers to provide a statewide continuum of care and support for individuals in need of prevention, intervention, treatment and recovery.

The Programs and Policy section is composed of four (4) offices.

The Office of Adult Mental Health Services priorities include development and expansion of peer and family supports; the West Virginia Leadership Academy; recovery education, housing and homeless outreach to individuals with mental health issues; coordination and delivery of services for veterans and their families; integrated, whole-person primary care and mental health services; the West Virginia Behavioral Health Planning Council; and access to community services and supports for individuals with complex support needs.

The Office of Adult Substance Services (SUD) includes statewide programs associated with the Block Grant and the federal State Opioid Response, including a division specific to services for pregnant women and women with dependent children (PWWDC). Collaborations include work with the state Office of Drug Control Policy, the Medicaid agency (on implementing WV's SUD 1115 waiver), and the Division of Justice and Community Services (on offender reentry services).

The Office of Children, Youth and Families oversees the prevention set-aside of the SUPTRS Block Grant (including the Synar program); representation of the state in the National Prevention Network; and the crisis (BHCS) and First Episode Psychosis (FEP)/Early Serious Mental Illness (ESMI) set-asides of the MHBG. Key initiatives include enhancing collaboration on the 988 Suicide & Crisis Lifeline; the state's system of care (SOC); and Kids Thrive Collaborative through services such as: Children's Mental Health Wraparound, Children's Mobile Crisis Response and Stabilization, Positive Behavior Support, 24/7 Children's Crisis and Referral Line, and Expanded School Mental Health. Other initiatives include: Family Advocacy, Support, and Training (FAST) Program and Regional Youth Service Centers with community-based mental health and substance use services, now with Family Coordinators through WV's SOC grant.

The Office of Policy, Planning, and Research oversees strategic planning; behavioral health workforce; access and consumer affairs with statewide and intermediary organizations; program data and policy analysis; training and technical assistance.

Administration section staff are responsible for budgeting, reporting, and administrative policy. Fiscal Division staff are responsible for allocation of grant funds to community behavioral health centers and other community-based service providers.

BBH's data and technology needs – including related to a comprehensive data set pertaining to SAMHSA-required data such as demographics and service data – are administered through the WV Office of Management Information Services (MIS). Additional aspects of BBH data needs are conducted by BBH's data vendor (e.g., related to electronic data submission from WV community providers, and basic validations of data, such as data field and format). (See Attachment A.)

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

As the federally designated Single State Agency (SSA) and State Mental Health Authority (SMHA) for mental health (MH), substance use, and intellectual/developmental disabilities in West Virginia (WV), Bureau for Behavioral Health (BBH) administers the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and Community Mental Health Services Block Grant (MHBG). Through the block grants (BG) and other federal and state funding awarded to 123 providers through 370 grants, BBH supports comprehensive behavioral health (BH) prevention, promotion, early intervention, treatment, and recovery programs statewide. As of 2024, BBH operates under the Department of Human Services (DoHS). BBH collaborates extensively with other state entities, e.g. on data, with the Governor's Council on Substance Use Prevention and Treatment, the Department of Health, Bureau of Public Health, and the Department of Health Facilities (over state-operated adult psychiatric hospitals). BBH integrates BH in WV's Emergency Operations Plans and FEMA's National Response Framework.

BBH provides state Continuum Enhancement Funds and Charity Care to meet remaining county-level need for essential BH services not billable through third-party payors. BBH also provided $5,759,471 for uncompensated care (FY24-25). WV expanded Medicaid in 2014. With WV's SUD 1115 waiver and $20M in opioid settlement funds, WV's residential treatment infrastructure grew from 281 to 1000+ SUD residential treatment beds (ASAM 3.1-3.7) today. In 2018, SUD waiver services (e.g., residential treatment, peer support, and methadone) increased, and again in 2019 after waiver services transferred to MCOs. In 2025 CMS approved WV's renewal, which expands to include peer support in new locations (e.g., the ER); supported housing and employment; re-entry services and post-overdose Quick Response Teams (QRTs).

SOR funds allowed new work with state partners, e.g., Bureau of Family Assistance uses SOR funds to subsidize childcare for people in SUD treatment. WV's medical schools use SOR funds to provide direct OUD/SUD services collaborating with graduate healthcare programs. WV Division of Corrections and Rehabilitation provides 2 OUD treatment initiatives; SOR funds medication for OUD (MOUD), naloxone, and Peer Recovery Support Specialists (PRSS) in all 10 regional jails. SOR supports transportation for West Virginians not eligible for the Non-Emergency Medical Transportation (NEMT) Medicaid program through a grant with WV Public Transit Association; in 2023, BBH started its pilot for transport to treatment with BG funds for people ineligible for NEMT or the SOR transport project.

WVDoHS and BBH connect the state's System of Care for children experiencing serious emotional disturbance (SED) and young adults experiencing serious mental illness (SMI) and co-occurring needs, and their families, e.g., the statewide, 24/7 Children's Crisis and Referral Line (CCRL). Through braided state, SAMHSA, Medicaid, and other funding, WVDoHS coordinates services for children and youth in their homes and communities.BBH partners with First Choice Services' call center on statewide call lines: 988; HELP4WV (SUD-related); peer warmline; CCRL; 1-900-GAMBLER.

In 2018 WV Association of Recovery Residences (WVARR), a state affiliate of the national alliance (NARR), certified 34 recovery residences; in 2025, there are 108 certified recovery residences. BBH supported a peer workforce training hub for PRSS training; 9 WV Leadership Academy trainings reaching 370+ participants (2021-2024).

The BBH Synar Program coordinator oversees tobacco retailer education on WV and federal laws and annual tobacco compliance inspections with the WV State Police and community partners. WV's 2024 legislation increased the age to purchase tobacco from 18 to 21 ("Tobacco 21"). BBH has the state's contract for the FDA Family Smoking Prevention and Tobacco Control Act to enforce the federal Tobacco 21 law.

SSA/SMHA Roles: Comprehensive statewide planning to provide an appropriate array of community- based behavioral health (BH) services and continuum of care; Integration/coordination of the public BH system; State-level program funding decisions based on BH indicators and program evaluation data; Prioritization and approval of expenditures of funds administered by BBH; Oversight of community support activities (such as Care Coordination and group homes); Partnership with Bureaus for Family Assistance, Social Services, Medical Services, and Public Health on evidence-based support for children, families, and communities, including licensure and regulation of BH professionals, programs, and facilities (e.g., WV Certification Board for Addiction & Prevention Professionals); Promotion of education to improve the quality of BH services; Recruitment and retention of BH professionals and access to BH programs and services; Implementation of the responsibilities related to BH required by state law, as referenced in West Virginia Code, Chapter 27, Article 1A et seq., and all applicable legislative rules.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in

providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

BBH collaborates at the regional, county, and local level. West Virginia (WV) has 0 federally recognized tribes. For behavioral health (BH) planning, sub-granting, and programming, BBH organizes WV's 55 counties in 6 regions. Six Regional Prevention Lead Organizations (PLOs) [Youth Services System, Inc.; Potomac Highlands Guild; Westbrook Health Services; WV Prevention Solutions; Prestera Center; and Community Connections] provide training and technical assistance to county coalitions to serve individuals in need of primary substance use prevention (PP).

The treatment system uses the same 6 regions for people with SUD, SMI, or co-occurring mental health and SUD. In 2024 6 of WV's Comprehensive Behavioral Health Centers (CBHCs) certified as WV Certified Community Behavioral Health Clinics (CCBHCs) to provide integrated, coordinated mental health (MH) and substance use services: FMRS Health Systems, Prestera Health Services, Seneca Health Services, Southern Highlands Community Mental Health Center, Valley Healthcare System and Westbrook Health Services. BBH mentors WV's 7 additional publicly funded CBHCs (Appalachian Community Health Center, Inc.; EastRidge Health Systems; HealthWays, Inc.; Mountain Laurel Integrated Healthcare; Northwood Health Systems, Inc.; Potomac Highlands Guild; and United Summit Center, Inc.) and other licensed BH providers seeking CCBHC status. Each CBHC & CCBHC operates offices in each catchment county, providing screening, assessment, crisis response (BHCS), outpatient services (with referral for Intensive Outpatient available), and medication management. WV's moratorium on opioid treatment programs (OTPs) restricts the number to the current 9. SOR-funded MOUD expansion efforts focus on Office-based medication assisted treatment (OBMAT). While federally some barriers to office-based MOUD have been removed, 2016 W. Va. Code R. § 69-12-7 further regulates WV OBMATs; WV has 218.

To serve persons in need of recovery support services for SUD (PRSUD) and MH: Across WV 8 Peer Centers support adults with SMI and individuals with SUD. BBH is helping centers certify as Recovery Community Organizations (RCO) to gain sustainability. In 2025, there are 1106 certified SUD - Peer Recovery Support Specialists (PRSS) and 61 MH-PRSS in WV; 34 FTEs serve as Recovery Coaches/Peer Mentors. Community Engagement Specialists staff in 19 WV agencies provide support to avoid unnecessary psychiatric hospitalizations.

BBH requires MHBG and SUPTRS BG requirements be addressed in its subgrant agreements and training, to include prioritizing people whose experience puts them at risk: pregnant women and women with dependent children (PWWDC), service members, veterans and their families, transition-aged youths, persons who inject drugs (PWID), individuals transitioning from a higher level of care, and persons experiencing homelessness. With SUPTRS, state, and Medicaid dollars, WV's infrastructure to support PWWDC has grown to 400+ recovery beds and 160+ treatment beds. BBH emphasizes outreach and case management in Projects for Assistance in Transition from Homelessness (PATH). BBH funds the WV Coalition to End Homelessness, whose work includes rural homeless issues; Regional Transition Navigators (serving ages 12-25) focus on SED, SMI, SUD, and housing. BBH partners with WV Bureau for Senior Services on program development; training on best practices; and funds CCBHCs/CBHCs to provide MH services for older adults requiring in-home services.

Initiatives on WV crisis services (BHCS) and Early Serious Mental Illness (ESMI) include 988; system of care; Children's MH Wraparound, Children's Mobile Crisis, Positive Behavior Support, Children's Crisis and Referral Line, and Expanded School Mental Health (currently in 82 WV schools, ESMH includes prevention, early intervention, and MH treatment). BBH partners with Voluntary Organizations Active in Disaster, Disaster Spiritual Care Programs, and CBHCs in BHCS.

All BBH grantee statements of work (SOW) require provision of, or arrangement for, tuberculosis (TB) services including testing for TB, treatment, and referral if a person is not admitted for BH services.

Now 72.5% of opioid settlement funds go to WVFF, 24.5% of funds go to Local Governments and 3% to the WV Attorney General for enforcement, compliance, and coordination. BBH collaborates with private funders like WV First Foundation, which uses these funds for prevention, treatment, and recovery initiatives. In 2024, WVFF awarded ~$17M to 94 WV projects. WVFF reports local expenditures yearly.

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Footnotes:

WV BLOCK GRANT - ATTACHMENT A: RELEVANT WEBSITES FOR MORE INFORMATION

WV Bureau for Behavioral Health (BBH) https://dhhr.wv.gov/bbh/
Kids Thrive Collaborative https://kidsthrive.wv.gov/
Positive Behavior Support https://pbs.cedwvu.org/
WV Office of Drug Control Policy Data Dashboard
https://dhhr.wv.gov/officeof-drug-control-policy/datadashboard/Pages/default.aspx

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

WV's Substance Use Primary Prevention Plan
https://helpandhopewv.org/docs/WV-Substance-Use-Primary-Prevention-Strategic-Plan_2025-2030_FINAL.pdf

Children's Crisis & Referral Line https://www.help4wv.com/ccl
WV Behavioral Health Training Center https://wvbhtraining.org
BBH Clearinghouse https://clearinghouse.helpandhopewv.org/request-program-review/

WV Statewide Epidemiological Outcomes Workgroup (SEOW)
https://dhhr.wv.gov/BBH/data/SEOW/Pages/default.aspx

Behavioral Health Integrated Disaster Efforts
https://dhhr.wv.gov/BBH/getconnected/Pages/Support-Disaster-RecoveryEfforts.aspx.

Children's Serious Emotional Disorders Waiver (CSED)
https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/default.aspx

West Virginia First Foundation https://wvfirst.org/

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

The Bureau for Behavioral Health (BBH) uses multiple methods, both formal and informal, to identify needs, determine adequacy of services, and identify gaps and challenges in service delivery and prevention.

The BBH recognized that there were gaps in data needed to understand the need for substance use disorder (SUD) and mental health services in the state, as well as use of existing services. The BBH partnered with the state's Medicaid agency, Bureau for Medical Services (BMS), and West Virginia University (WVU) Health Affairs Institute (HAI) to develop and implement a statewide survey to address data gaps. This collaboration led to the Mountain State Assessment of Trends in Community Health (MATCH) survey. A population-based survey to better understand behavioral health at both the state and county level. To increase use of the data multiple data products have been developed for both BBH and public use. Currently there are county profiles, a findings report, and web query tool for data access. The results of the second fielding of the survey are expected to be public in the fall. The third fielding kicked off in August of 2025.

The BBH is an active participant in the West Virginia Behavioral Health Provider Association (WVBHPA) committees. Committees address various topics centered around behavioral health services in the state, from children services, to SUD services, to data, to state and provider leadership. This allows the BBH to hear concerns and needs directly from behavioral health providers in the state, which allows more real time responses on emerging issues, as well as provide a framework to address ongoing initiatives with the providers in WV. Essentially this provides a forum for a continuous ability to hear provider concerns and work towards solutions to ensure quality and adequate services in the state.

In addition to the WVBHPA, the BBH supports and participates in the West Virginia Behavioral Health Planning Council (WVBHPC) . The primary purpose of the WVBHPC is to advocate for and evaluate the provision of community based behavioral health services. Through the multiple voices represented on the WVBHPC the BBH hears about needs and gaps in services in the state as well as potential solutions.

Over the past five years the BBH has started to increase the data capacity within the bureau. This is leading to multiple initiatives to provide better data access to BBH personnel. Currently the epidemiology team presents various data sources every other week. The entire BBH is invited. Data sources to date have included Youth Risk Behavior Surveillance System (YRBSS) , MATCH , Treatment Episode Data Set (TEDS) , Uniform Reporting System (URS) , American Community Survey (ACS) , death certificate data , 988 data, and WV specific NAS data . One of the struggles is that each program/initiative may require different data. By having biweekly meetings, the BBH is able to provide a larger breadth of data in a more digestible manner to programmatic personnel. Many of these sources are the sources that are used for the needs assessment.

The BBH also has quarterly State Epidemiological Outcomes Workgroup (SEOW) meetings which bring together various partners across state agencies, university partners, and community providers to highlight data, initiatives, and to share information and viewpoints across organization types to allow strengths and expertise to be shared.

The Department of Human Services (DoHS) funds an evaluation of children's mental health services in the state . Various stakeholders lend their voice to the evaluation including behavioral health providers, caregivers, children/youth, and judicial systems. The evaluation and other reports helps to understand the most at risk children in the state for behavioral health services, as well as experiences using behavioral health services. The BBH is active in the work being done around mental health services for children and youth in the state.

The BBH also funds the fielding of the MHSIP, the YSS, and the YSS-F to understand the experience of individuals accessing behavioral health services in the state. These findings are also shared with the WVBHPC.

The BBH is also expanding expectations of providers and partners to perform local needs assessments, and community scans. This not only allows our partners to have a more specific plan related to their needs and environment, but it also helps those partners to communicate to us gaps in services. Current initiatives that require formal needs assessments are Certified Community Behavioral Health Clinics (CCBHCs) and the organizations that are charged with leading prevention throughout the state, the Prevention Lead Organizations (PLOs).

Typically within any given year the BBH is involved in special projects related to understanding different populations we serve or different aspects of behavioral health services in the state. One recent project was an analysis of homelessness in the state . A current one is a network analysis of the substance use disorder treatment services in the state. Part of that analysis used the Widler Collaboration assessment to understand collaboration within the provider community around services.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

See the attached document.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

1. (MHBG) Comprehensive community-based mental health services for adults with SMI and children with SED:

Children with SED*
BBH funds 13 Comprehensive Behavioral Health Centers (CBHC) for safety net mental health and SUD services in the state. Additionally, the bureau has worked closely with the Bureau for Medical Services (BMS) (WV's Medicaid agency) to implement Certified Community Behavior Health Centers (CCBHC). Six of the 13 CBHCs are now CCBHCs with an implementation date of October 1, 2024. Providing children's services is a requirement for CCBHCs. BBH also supports additional programs for children with SED. BBH established the Assessment Pathway to identify children with SED and link them to the Children with Serious Emotional Disorder (CSED) Medicaid waiver program. In West Virginia the child's income level is used as part of the eligibility process to help increase access to the CSED program. If a child does not meet SED criteria they are referred to other community programs and resources. BBH also provides interim wraparound services and other supports as families move through the CSED application process, as well as for children that have a SED but do not qualify for the CSED program. BBH collaborates with community behavior health centers through the federal Children's Mental Health Initiative/SOC grant that service to both children and their families such as Family Coordinators. BBH also collaborates to provide services for youth with SED and are at risk of touching the juvenile justice or criminal justice systems through our Youth and Young Adult Early Diversion Program.

Adults with SMI* including Older Adults
BBH funds 13 Comprehensive Behavioral Health Centers (CBHC) for safety net mental health and SUD services in the state. Additionally, the bureau has worked closely with Medicaid to implement Certified Community Behavior Health Centers (CCBHC). Six of the 13 CBHCs are now CCBHCs with an implementation date of October 1, 2024. BBH is working with partners as they start implementing same-day or walk-in availability of lifespan services. BBH participates in the NASMHPD older persons committee, seeking to implement any emerging practices shared by other states.

Individuals with SMI or SED in rural areas and among those experiencing homelessness, as applicable*
Due to the rurality of the state as a whole, each of the CBHCs have rural areas within their catchment area. The CBHCs are required to have a satellite location in each of their designated counties and provide services there at least once a week.

Individuals who have an Early Serious Mental Illness (ESMI) * (10 percent MHBG set aside)
The BBH supports five providers to implement the First Episode Psychosis (FEP)/ESMI program, which uses the Coordinated Specialty Care framework, statewide. The current priorities focus on expansion and fidelity to the Quiet Minds model. Other BBH initiatives also help support and link people with ESMI to services like the Help4WV and 988 call-lines, as well as adopting the CCBHC model within the state.

Individuals in need of behavioral health crisis services (BHCS) * (5 percent MHBG set aside)
BBH continues to work with BMS to expand children and adult mobile crisis teams in the state. Mobile crisis teams are also a core requirement of the CCBHCs.

BBH supports First Choice Services for implementation of various call lines, including 988, Help4WV and the Children's Crisis and Referral line as part of Help4WV.

BBH continues to work with partners to expand the crisis continuum in the state. Identified areas to address include establishing workflows and protocols between the various providers in the state that are part of crisis response, to include the 988 center, behavioral providers, 911 centers/Public Safety Answering Points (PSAPs), law enforcement, and other first responders, including increasing the number of Crisis Intervention Teams (CIT) in the state.

2. (SUPTRS BG) Treatment and Recovery Support Services for persons with substance use disorder:
Pregnant women and women with dependent children*

BBH requires MHBG and SUPTRS BG requirements be addressed in its subgrant agreements and training, to include prioritizing pregnant women and women with dependent children (PWWDC). BBH supports a wrap around program for women who are pregnant and have a SUD. Expansion of this program continues to be a priority. BBH continues to support services for the PWWDC population through the Drug Free Moms and Babies Program as well as the WEAVE program, which addresses the intersectionality of intimate partner violence (IPV) and SUD. BBH also supports recovery residences that provide safe recovery housing for women with dependent children.

Persons who inject drugs*
BBH requires MHBG and SUPTRS BG requirements be addressed in its provider subgrant agreements and training, to include prioritizing persons who inject drugs (PWID). BBH, in partnership with the University of Charleston, has established a direct drop-ship program for naloxone distribution to various community programs. This has expanded access to naloxone. The expansion of this initiative remains a priority.

Persons in need of recovery support services for substance use disorder*
Through the State Opioid Response (SOR) grant the state funds programs to support treatment and recovery, such as transportation and day care funding. BBH also supports the state National Alliance for Recovery Residences affiliate, the WV Alliance for Recovery Residences (WVARR), to increase the number of and maintain the quality of certified recovery residences in the state. BBH also continues to work with partners such as BMS and the West Virginia Certification Board for Addiction & Prevention Professionals to increase the use of and number of certified peers in the state.

Individuals with a co-occurring mental health and substance use disorder*
BBH funds 13 Comprehensive Behavioral Health Centers (CBHC) for safety net mental health and SUD services in the state. Additionally, the bureau has worked closely with BMS to implement Certified Community Behavior Health Centers (CCBHC). Six of the 13 CBHCs are now CCBHCs, with an implementation date of October 1, 2024. In addition to required mental health services, CCBHCs also must either provide or establish a formal relationship with other providers to provide SUD services.

Persons experiencing homelessness*
BBH requires MHBG and SUPTRS BG requirements be addressed in its subgrant agreements and training, to include prioritizing persons experiencing homelessness. BBH manages the SAMHSA PATH program and the Statewide PATH Contact (SPC) is located in the Office of Adult Services. BBH supports permanent supported housing and plans to expand access.

Services for persons with SUD who have or are at risk of Tuberculosis*
All BBH grantee statements of work (SOW) require provision of, or arrangement for, tuberculosis (TB) services, including testing for

TB, treatment, and referral if a person is not admitted for behavioral health services, TB, treatment, and referral if a person is not admitted for behavioral health services.

(SUPTRS BG) Services for individuals in need of substance use primary prevention*
BBH funds schools for Expanded School Mental Health (ESMH). There are 89 schools with either ESMH or the WV Department of Education Project AWARE. The BBH uses state general revenue dollars and works closely with the Department of Education to align school mental health programs across funding streams. These programs have a three-tiered approach providing primary prevention, early intervention, and treatment within these schools. In addition to this program, BBH funds six regional Prevention Lead Organizations (PLOs) to not only implement evidence based primary activities in their region, but to also fund and work with county prevention coalitions for evidence based prevention statewide.

Further details of programs and services for the various populations of focus are contained in the respective sections under Environmental Factors and Plan

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Footnotes:

Step 2 Question 2

West Virginia has 55 counties with populations that range from 173,906 to 4,924 residents. West Virginia has been losing population and is currently at an estimated 1.79 million people. In general birth rates are falling and the population is aging. The median age in WV is 42.8 years compared to 39.2 years for the nation. Children under 18 make up 19.9% of WVs population compared to 21.7% for the nation[1]. According to the 2020 census, 55% of the state's population lives in a rural area. The state has a higher poverty rate (16.7%) compared to the nation (12.5%)[2]. The state also has a lower employment rate at 51.7% compared to the nation at 60.6%. The state has more people with health care coverage with 5.9% without health care coverage compared to 7.9% for the United States (US)[3]. Other sources indicated that of those with insurance 32% reported Medicare, 26.3% Medicaid, and 57.1% reported Other Insurance[4].

Mental Health

According to SAMHSA estimates West Virginia has between 100,654 and 52,454 adult residents with a serious mental illness (SMI) and between 24,550 and 20,773 children with serious emotional disorder (SED)[5].

Overall, there are high spots and low spots related to mental health in West Virginia. When asked about their health, 24.2% of adult West Virginians reported fair or poor general health which is comparable to fair or poor mental health (21.9%). In the past 12 months when asked "thinking about when you were at your worst emotionally, how much did your emotions interfere with..?" for household chores, social life, relationships with friends and family, and performance at work or school, "A Lot" was indicated by 19.7%, 22.7%, 19.1%, and 15.7% of people respectively. Furthermore, when people were asked if they have serious difficulty performing daily activities, 20.4% of adults in the state indicated yes. When those people were asked if it was due to mostly mental health, physical health, or both equally, 27.1% reported both equally, 15.7% reported mental health mostly, and the remaining 57.1% reported primarily physical health. When WV adults were surveyed about life satisfaction, 41.7% reported satisfied or extremely satisfied with life. When asked how often do you get the emotional support you need, 58.6% reported always or usually, 21.0% reported sometimes or rarely, and 20.4% reported never. Approximately a third (34%) of adults in WV experienced difficulty sleeping in the past two weeks either Always or Usually.

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[1] https://data.census.gov/profile/West_Virginia?g=040XX00US54#populations-and-people
[2] https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html
[3] https://data.census.gov/profile/West_Virginia?g=040XX00US54#populations-and-people
[4] https://wvmatchsurvey.org/data/
[5] SAMHSA estimation methodology: Released 2024

Nearly a quarter of adults in WV (24.3%) reported that a healthcare provider has told them that they have depression, anxiety, or post-traumatic stress disorder (PTSD). In the past two weeks 14.1% reported severe psychological distress, and just over a quarter of adults, 27.5%, in WV have either thought about or attempted suicide. West Virginia loses nearly one person a day to suicide. Historically WV has fallen round the 10th highest state for suicide rate, with some years a little higher and some a little lower. In 2023, WV is tied for 13th highest state for suicides by crude rate. Provisional 2024 data indicates that WV may be seeing a decrease in suicide deaths.

While COVID-19 is now part of normal life, in 2021, 21% of people reported experiencing long-term emotional or mental health effects related to COVID-19. Like many things post-pandemic behavioral health in WV is finding a new normal that is a mix between pre-pandemic and post-pandemic.

Nearly two-thirds, (65.7%), of WV adults reported being ever asked about their mental health by a healthcare provider. Nearly a third (31.2%) reported that there was a time in the past 12 months when they felt they might need to see a healthcare provider for mental health. Of those indicating a need for mental health services over half (56.7%) received needed mental health care. When asked who they saw for mental health services in the past 12 month, 64.6% reported a primary care giver, while 54.3% reported seeing a counselor/psychologist/psychiatrist (categories were not mutually exclusive). When asked about not receiving needed mental health services 23.1% indicated cost, 34.3% were concerned about what would happen, 53.0% reported they were not comfortable, 27% reported scheduling issues, and14.8% reported a bad experience. When asked why they were no longer receiving counseling or therapy, 18.5% said it wasn't helping, 21.7% reported not enough time, 12.0% reported no transportation, and 23.3% reported they got better, 23% indicated a reason not listed. Overall, just over a quarter (28.7%) of adults reported having a prescription for mental health in the past 12 months[6].

The drug crisis has impacted every facet of life in the state, particularly with our children. As of June 2025, 6132 children are in state custody. The largest age group are 13-17 year olds, 1,955 youth. Many of these youth are in residential placements[7].

It was well reported that during the COVID-19 pandemic the proportion of emergency department (ED) visits for mental health increased. The Agency in partnership with WVU Health Affairs Institute (HAI) has started using ED visits to understand changing trends in mental health needs associated with children and youth 21 years old and younger. Overall, the percentage of mental health visits to the ED increased from the last half of 2022 (8.3%) to the first half of 2023 (11.4%). Some of the original research

[6] https://wvmatchsurvey.org/data/
[7] https://dhhr.wv.gov/Pages/childwelfaredatadashboard.aspx

that noted the increase in ED visits for mental health during the pandemic, also noted a decrease in overall ED visits. One interpretation is that people decreased the use of EDs for other reasons beyond mental health visits. Something similar was found from the last half of 2022 to the first half of 2023 in WV. The number of visits between these two periods for all ED services, regardless of visit type, decreased by 1% (197,642 visits vs 195,271 visits), while the number of mental health visits increased by 35% (16,431 to 22,232)[8]. The residential mental health treatment facility (RMHTF) average monthly point-in-time census also increased sharply from the last half of 2022 to the first half of 2023, with the average census going from 800 to 842, a 5.3% increase[9].

Nearly half, 47.5%, of WV high school students reported that they felt sad or hopeless for almost every day for 2 or more week in a row compared to 42.3% for the nation. In the past 12 months 27.8% of WV high schoolers seriously considered attempting suicide, with 12.1% attempting suicide, compared to 22.2% and 10.2% respectively for the nation[10].

Crisis

Youth and young adults are the most frequent users of 988 in WV, with approximately a third of individuals accessing the call line under the age of 18 that disclose age, with another 20% under the age of 25. West Virginia also has a Children's Crisis and Referral Line as part of 304Help4WV. In the most recent state fiscal year, there were over 1,000 calls from unique individuals. The BBH in partnership with the Medicaid bureau continues to build out crisis services in the state.

Substance Use Disorder

West Virginia (WV) has had the highest fatal overdose rate in the nation for years. Prior to the COVID-19 pandemic the state started to see decreases from 2017 to 2019. However, during the pandemic numbers increased to the highest ever crude rate of 88.5 per 100,000 population in 2021, with a slight decrease to 79.1 in 2022, and 2023 was comparable to 2022 with a crude rate of 79.6. Provisional data from 2024 indicate a dramatic decrease of 40% in fatal overdoses compared to 2023. To put this in context, in 2023 the next highest state had a rate of 52.4 compared to 79.6 in WV. The decrease in 2024 puts WV comparable to the next highest state with a rate of 48 per 100,000[11].

[8] https://kidsthrive.wv.gov/DOJ/Documents/July%202024%20DoHS%20Semi-Annual%20Report_FINAL.pdf
[9] https://kidsthrive.wv.gov/DOJ/Documents/July%202024%20DoHS%20Semi-Annual%20Report_FINAL.pdf
[10] https://www.cdc.gov/yrbs/index.html
[11] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as

West Virginia will likely still be the highest rate after data is finalized, but if progress continues WV will soon no longer be the highest in the nation. While this is good news continued focus on prevention, treatment, recovery, and support services for substance use disorder (SUD) continues to be a priority for WV to reach pre drug crisis rates of less than 10 per 100,000.

Most drugs found in a fatal overdose decreased from 2023 to 2024. Any opioid present decreased from 86% of all overdoses to 77% in 2024. Fentanyl was found in 82% of overdoses in 2023, while in 2024 it was present in 67% of fatal overdoses. While the number of overdoses that had methamphetamine decreased from 760 in 2023 to 452 in 2024, presence in fatal overdoses was comparable between 2023 (54%) and 2024 (55%). The state saw its first xylazine involved overdoses, 6, in 2019, which grew to a high of 125 in 2023. The early data from 2025 indicates that xylazine deaths continue to decrease[12]. West Virginia continues to monitor substances contributing to fatal overdoses to adapt to changing needs in prevention, treatment, and recovery to continue to address the drug crisis.

In 2021, 6.9% of adult West Virginians, approximately 94,622 people, reported heavy drinking in the past 30 days. Binge drinking was reported in 16.0%, or 219,825 people, in the past 30 days. Approximately 286,147 or 20.6% of adults in WV currently smoke cigarettes. Marijuana use in the past 30 days was reported by 9.9% or 136,388 of adult West Virginians, with 13.0% or 179,101people reported use in the past 12 months. Use of cocaine, methamphetamine, heroin, or MDMA was reported by 2.5% of adults or 33,879 people in the past 12 months. Of people that reported taking an opioid prescription in the past 12 months, 9.3% (10,551 people) reported that they took it in a way that was not prescribed. Ever overdosed was reported in 3.2% (44,359 people) of adults in WV. While 4.6% reported that an immediate family member had overdosed in the past 12 months. While we often focus on fatal overdose data it is important to note that no substance use was reported in the majority of people, 74.1%[13].

Nearly 38,000 people or 2.8% of adults reported needing to see a healthcare provider in the past 12 months because of alcohol or drug use. Of those that reported needing to see a healthcare provider because of alcohol or drug use, 65.1% or approximately 24,428 people received treatment. An ongoing concern when talking about the drug crisis in the state is the number of people that experience chronic pain in the state; 26.1% of adults in the state report they have been told they have chronic pain by a healthcare provider[14].

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compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html August 2025

[12] West Virginia Health Statistics Center, Vital Statistics System, July 14, 2025.

[13] https://wvmatchsurvey.org/data/

[14] https://wvmatchsurvey.org/data/

In 2023, 74.7% of fatal overdoses in WV had at least one potential opportunity for intervention. A potential bystander was present in 55.3% of cases, with 9.1% of cases of fatal drug use witnessed. Indication of a prior overdose was found in 16.7% of fatal cases. Current SUD treatment was found in 9.4% of cases. Almost a quarter, 23.5%, of cases also had evidence of a mental health diagnosis. Recently released from an intuitional setting was found in 6.5% cases[15].

It is nice to think that exposure to and use of drugs does not occur until adulthood, but that unfortunately is not accurate. High school students who tried marijuana for the first time before age 13 years was 6.5% in WV compared to 4.9% in the US. In 2021 in WV, 16.4% of high school students currently used marijuana, which was slightly higher than the national number of 15.8%, with 30.6% WV high schoolers reported ever using and overall in the nation 27.8% reporting having ever used. Ever took a prescription pain medication without a prescription or differently than prescribed was comparable between WV, 12.3%, and the US, 12.2%. In general in contrast to the state's fatal overdose data, WV high school students ever trying illicit drugs is comparable to the nation. Ever used cocaine indicated in 2.4% of high schoolers in WV and 2.5% in the US. Ever used heroin 1.0% in WV compared to 1.3% nationally. Ever injected any illegal drug 1.3% of WV high schoolers, and 1.4% overall in the nation. Ever used ecstasy was reported in 3.2% of WV high schoolers compared to 2.9% in the US[16].

One area WV continues to be higher than the nation is use of electronic vapor products. Currently used an electronic vapor product in WV high school students was 27.5% compared to 18.0% in the US. This is also seen when asked about frequently using electronic vapor products with 13.2% in WV and 7.3% in US. Cigarette smoking indicators also tend to be higher in WV than in the US overall. More WV high school students smoked cigarettes before age 13, 15.5%, than compared to the nation, 6.3%. Currently smoked cigarettes were reported in 7.6% of WV high school students, while only 3.8% nationally[17].

Pregnant and Post-Partum Women and People with Dependent Children

Much like fatal overdoses WV has led the nation in infants diagnosed with neonatal abstinence syndrome (NAS), a withdrawal syndrome associated with exposure to certain drugs during gestation. In 2008, the rate of NAS in WV was 9.4 per 1,000 birth hospitalization, compared to 2.2 for the US. WV continued to increase, with a large increase from 2012 to the peak of 53.5 in 2017. While the national peak occurred at the

[15] https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html#cdc_data_surveillance_section_1-about-this-dashboard
[16] https://www.cdc.gov/yrbs/index.html
[17] https://www.cdc.gov/yrbs/index.html

same time, the rate was much lower at 7.1. West Virginia's NAS rate decreased to 38.4 in 2021 in comparison to the national rate of 5.9[18].

In 2013 in WV, the age range with the highest fatal overdose was 35-44 (176.5 per 100,000), followed by 45-64 (147.1), and then 25-34 (136.9)[19]. This indicates that the ages that are having and raising children are at the most risk. It even becomes more complex when considering the safety net role parents can play in young adult lives as they start to establish their own families. Without that safety net, young vulnerable families could be at more risk without their own parents. There are an estimated 19,253 grandparents in the state raising their own grandchildren[20]. While there are many kids in state care a large percentage are in either certified kinship/relative placement, 34.5%, or with in kinship/relative placement, 16.2%[21].

HIV and People Who Inject Drugs

In the past six years WV has experienced two HIV clusters associated with injection drug use one in 2019 in Cabell County and another in Kanawha County in 2021. A third cluster occurred in 2023 in Monongalia County among men who have sex with men[22].

In 2022, the state's prevalence rate (150 per 100,000) was lower than the national rate (388), as well as the new diagnoses rate, WV 9 per 100,000 vs US 13 per 100,000. In general, in WV, new diagnosis cases are more commonly associated with injection drug use (65.9%). Compared to other transmission categories people that contract HIV through injection drug use show longer and lower linkages to medical care, with 47.3% connected to care within one month, and 78.0% connected within one year. All other transmission categories have a 100% linkage to care within a year. In fact, in 2022, the within one year linkage for injection drug use was lower than all other categories linkage within one month[23].

Tuberculosis

West Virginia has a low incidence of tuberculosis, with only 11 cases being reported in 2022. The WV rate is 0.59 per 100,000 population compared to 2.50 for the US[24].

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[18] https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures
[19] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2023, and from provisional data for years 2024 and later, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html August 2025
[20] https://www.census.gov/acs/www/about/why-we-ask-each-question/grandparents/
[21] https://dhhr.wv.gov/Pages/childwelfaredatadashboard.aspx June 2025
[22] https://oeps.wv.gov/hiv-aids/Pages/default.aspx
[23] https://oeps.wv.gov/hiv-aids/Documents/data/WV_HIV_Surveillance_Summary_2022.pdf
[24] https://oeps.wv.gov/tuberculosis/Documents/data/TB%20Profile%20Report%202022.pdf

Homelessness

During the 2023 WV Legislative session Senate Bill 239 was passed, which mandated the BBH to conduct an analysis of homelessness in the state. The BBH partnered with WVU HAI to conduct the study. Due to the different definitions of homelessness a consensus building activity was conducted. Five at risk groups were identified by at least of 70% of panelists: veterans, those fleeing from or attempting to flee domestic violence, those facing imminent risk of homelessness, those staying in emergency shelter and/or transitional housing, and those having no legal right or access to the place they are staying. An additional four metrics were identified for monitoring by at least 50% of panelists: unaccompanied youth under 25, victims of human trafficking, staying with others, and lacking affordable housing[25].

West Virginia has four Continuums of Care: Cabell-Huntington-Wayne (CHW), Kanawha Valley Collective (KVC), Northern Panhandle (NPH), and Balance of State (BoS). They all share a central data system which allowed service data to be used. From January 1, 2018, to December 31, 2023, there were 28,651 individuals with a project entry date. Projects included: HUD funded shelter, street outreach, and permanent housing. Of those with a project entry data 76% reported they were experiencing literal homelessness. The average yearly number of people experiencing literal homelessness was 3,624, which is higher than the point in time (PIT) estimates, which averaged 1,318 people per year for the same time period. This is expected due to methodology and different data sources. Almost half (48%) experiencing literal homelessness were between 25 and 44 years, with 23% 24 years or less. Most people interacting with the CoCs did not have any source of income, 84%, which included cash benefits. Mental health disorders were reported in 35% of those with a project entry date between 2018 and 2023. Prevalence rates were different based on CoC, with CHW having the highest at 52%, and KVC the lowest at 27%. Substance use disorder was reported in 22% of individuals. This also showed variability but not as much as mental health. For SUD CHW once again had the highest at 32% and KVC the lowest at 15%. The report in general highlighted differences across the state in populations and services, but one consistent theme was there was no one thing that resulted in homelessness, but instead just a combination of life factors [26].

Behavioral Health Planning Council

As part of the April 2025 WV Behavioral Health Planning Council quarterly meeting, the Council requested that a BBH staff member facilitate a short session on strengths and challenges that people are seeing in their communities.

[25] https://www.wvlegislature.gov/legisdocs/reports/agency/H16_CY_2024_26389.pdf
[26] https://www.wvlegislature.gov/legisdocs/reports/agency/H16_CY_2024_26389.pdf

One of the major Strengths mentioned was the long-standing recovery community in various parts of the state, as well as the certification and evidence-based programs that the recovery community supports and is supported by, including but not limited to WV Alliance for Recovery Residences, mental health support peers, and SUD peer paraprofessionals. Other strengths named included tuition reimbursement programs for mental health professionals, the existing and future opportunities provided through telehealth, recent legislation to help principals become educated about IEPs for youth with mental health needs, and other partnerships between mental health and schools. The Council also acknowledged the tremendous strides that have occurred in increasing access to behavioral health with 6 CCBHCs being certified in late 2024 in WV.

Challenges that were named at the Council meeting included:

a) provider shortages, especially providers who will accept Medicaid; rural pediatric behavioral health professionals; and reports were made of providers charging clients more for telehealth than in-person services as well as limited telehealth for mental health in nursing homes.

b) transportation challenges ran the gamut from shrinking public transportation systems that are running reduced hours and routes in the more populated areas where there actually is public transportation; to issues reported with Medicaid non-emergency medical transport (NEMT) vendor and its system of drivers; lack of transportation to the full continuum of recovery care and lack of transportation beyond NEMT to doctors visits, such as needed stops at the pharmacy, grocery store, etc.

c) community and social factors that impact health outcomes, such as lack of access to daycare; lack of enough juvenile justice diversion programs; reports of delayed access to Birth to Three and other early childhood intervention and home visiting programs; help needed for people in intimate partner violence situations (e.g., switching over the name on utility bills) and a shortage of safe, secure shelter without a waitlist, including for adults who need support to live independently. Technology and privacy challenges are reported with SNAP cards and I/DD waiver system accounts.

d) need for behavioral health service types including: behavioral health services appropriate for children with I/DD, some schools that do not have adequate school-based on-site or telehealth for mental health; trauma-informed behavioral health services; behavioral health support for youth whose caregiver has SUD or is in recovery or is grieving the loss of a caregiver due to SUD. Support is also reported to be needed with the implementation stage of behavioral health programs.

Consumer Feedback

As part of the MH block grant the BBH partners with a vendor, Acentra, to conduct the MHSIP for adults receiving behavioral health services and the YSS and YSS-F for children and youth receiving behavioral health services in the state. For adults, of those responding, 88.4% reported greater social connectedness, and 87.8% indicated greater functioning. For YSS-F the findings were a bit more mixed, with 88.4% reporting increased social connectedness, and 66.0% reporting increased functioning. Overall, adult consumers reported a more positive experience: 89.3% reported positively about access, 91.5% positive for quality and appropriateness, 85.1% positive about outcomes, 90.8% positive about their participation in treatment planning, and overall general satisfaction was 90% positive. In the past five year children services have expanded rapidly and may be affecting some of the results. For the YSS-F/YSS 59.4% were positive about access, 61.3% reported positively about general satisfaction, 65.9% were positive about the outcomes, 55% reported positively for participation in the treatment plan, and 73.3% reported high cultural sensitivity of staff[27].

[27] 2024 Community Mental Health Services Block Grant (MHBG) Consumer Satisfaction Survey Report. Prepared by Acentra Health for BBH, September 2024.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

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

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

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

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): Approximately 500 kids were receiving services in 2022, end of year State FY on 2025 we served 927 youth

First-year target/outcome measurement (Progress to the end of 2026): Increase our numbers our number of youth by another 5% by end of 2026

Second-year target/outcome measurement (Final to the end of 2027): Increase our number of youth served by 10% by end of 2027

Data Source:

Kids Thrive semi annual report and month data reporting received by BBH

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of regional Family Coordinators

Baseline measurement (Initial data collected 12 Regional Family Coordinators

prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026): Maintain those 12 coordinators consistently

Second-year target/outcome measurement (Final to the end of 2027): Add 6 new Family Coordinators

Data Source:

Regional Youth Service Center Reporting and grant agreements

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 3

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

Baseline measurement (Initial data collected prior to and during 2026): Data from 2024

First-year target/outcome measurement (Progress to the end of 2026): Increase number served by 5%

Second-year target/outcome measurement (Final to the end of 2027): Increase number served by 10%

Data Source:

RYSC FEP data reporting and grant agreements

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #: 4

Indicator: Number of students receiving Tier 3 therapeutic services through Expanded School Mental Health (ESMH) from BBH or WV Department of Education or WV Department of Education

Baseline measurement (Initial data collected prior to and during 2026): 89 total schools with BBH grants or WV Department of Education Project AWARE grants in 2025

First-year target/outcome measurement (Progress to the end of 2026): Increase percentage of students receiving Tier 3 servces by 2.5% in ESMH schools.

Second-year target/outcome measurement (Final to the end of 2027): Increase percentage of students receiving Tier 3 services by 5% in ESMH schools.

Data Source:

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

Description of Data:

BBH reporting

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Crisis Continuum of Care

Priority Type: BHCS

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

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of adults with access to adult mobile crisis teams

Baseline measurement (Initial data collected prior to and during 2026): 69.70%

First-year target/outcome measurement (Progress to the end of 2026): 70

Second-year target/outcome measurement (Final to the end of 2027): 75

Data Source:

BBH Program Reporting

Description of Data:

Providers will report as implemented

Data issues/caveats that affect outcome measures:

Indicator #: 2

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

Baseline measurement (Initial data collected prior to and during 2026): 7 active teams in 2024

First-year target/outcome measurement (Progress to the end of 2026): Medicaid SPA approved and 4 additional teams.

Second-year target/outcome measurement (Final to the end of 2027): Increase number of staff by at least 3 staff in each team therby increasing the number of teams available

Data Source:

WV Bureau for Medical Services state plan and claims data.

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 3

Priority Area: Comprehensive Adult Mental Health Services

Priority Type: MHS

Population(s): SMI, Other

Goal of the priority area:

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

Strategies to attain the goal:

1) Establish and implement the Certified Community Behavioral Health Center (CCBHC) model.
2) Increase access to mobile crisis services.
3) Promote best practices for priority populations among CCBHC's.
4) Expand permanent supported housing access.
5) Improve quality of peer support services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of comprehensive behavioral health centers participating in the CCBHC program

Baseline measurement (Initial data collected prior to and during 2026): 6

First-year target/outcome measurement (Progress to the end of 2026): 8

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

WV CCBHC advisory committee

Description of Data:

Progress reporting

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Number of new clinics with same-day or walk-in availability at comprehensive behavioral health centers

Baseline measurement (Initial data collected prior to and during 2026): New Initiative - No Baseline

First-year target/outcome measurement (Progress to the end of 2026): 3

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

BBH program reporting

Description of Data:

Provider reporting

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Number of Permanent supported housing slots

Baseline measurement (Initial data collected prior to and during 2026): 85

First-year target/outcome measurement (Progress to the end of 2026): 95

Second-year target/outcome measurement (Final to the end of 2027): 105

Data Source:

BBH Reporting

Description of Data:

Provider reporting the availability of slots

Data issues/caveats that affect outcome measures:

Indicator #: 4

Indicator: Number of Council on Accreditation of Peer Recovery Support Services (CAPRSS) Peer Programs

Baseline measurement (Initial data collected prior to and during 2026): New Initiative - No Baseline

First-year target/outcome measurement (Progress to the end of 2026): 3

Second-year target/outcome measurement (Final to the end of 2027): 6

Data Source:

Council on Accreditation of Peer Recovery Support Services (CAPRSS) Accreditation Review Committee

Description of Data:

BBH will receive a report of programs that have received accreditation

Data issues/caveats that affect outcome measures:

Priority #: 4

Priority Area: Primary Substance Use Prevention for All Ages

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

1. Maintain regional Prevention Lead Organizations (PLOs) which will provide support, training, and technical assistance to local level county coalitions.

Read more about the prevention network at https://helpandhopewv.org/prevention-works.html.
2. Ensure the implementation of effective and evidence-based prevention strategies, programs, and practices through prevention training, including Prevention Ethics, Strategic Prevention Framework, What Works and Doesn't Work in Prevention, Stigma, and BBH EBP Clearinghouse.
3. Involve youth and older adults in prevention coalitions and planning to help and inform prevention activities focused on youth and older populations.
4. Obtain available data, including through the State Epidemiological Outcomes Workgroup (SEOW) to inform the needs and overall SPF process to focus prevention efforts for all populations.
5. Support youth-led peer support and leadership initiatives, such as Students Against Destructive Decisions or Youth Move, to promote protective factors and positive alternatives to substance use.
6. Collaborate with schools, juvenile residential facilities, and other initiatives (e.g. Expanded School Mental Health, Collegiate Initiative to Address Substance Use, and the WV Department of Education) to implement effective prevention strategies/programs with schools, higher education institutions, and community partners.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): 50

First-year target/outcome measurement (Progress to the end of 2026): 100

Second-year target/outcome measurement (Final to the end of 2027): 200

Data Source:

BBH Prevention Lead Organizations

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Total number of direct prevention materials distributed and number of community organizations served

Baseline measurement (Initial data collected prior to and during 2026): 50,000 direct prevention materials and reach 50 organizations

First-year target/outcome measurement (Progress to the end of 2026): 55,000 direct prevention materials and reach out to 55 community organizations

Second-year target/outcome measurement (Final to the end of 2027): Distribute 105,000 direct prevention materials and reach out to 105 community organizations

Data Source:

BBH Grantee Reporting

Description of Data:

All BBH grantees must report on programmatic activities and groups served

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of organizations implementing evidence-based prevention programs

Baseline measurement (Initial data collected prior to and during 2026):	250 organizations implementing evidence-based prevention programs
First-year target/outcome measurement (Progress to the end of 2026):	500 organizations implementing evidence-based prevention programs
Second-year target/outcome measurement (Final to the end of 2027):	750 organizations implementing evidence-based prevention programs

Data Source:

BBH Prevention Reporting

Description of Data:

All BBH grantees must report on programmatic activities and groups served

Data issues/caveats that affect outcome measures:

None

Indicator #:	4
Indicator:	Create standardized, customized prevention messaging and disseminate through state and local social media platforms
Baseline measurement (Initial data collected prior to and during 2026):	170,000 page views and/or social media prevention messaging
First-year target/outcome measurement (Progress to the end of 2026):	Baseline increase page views and prevention messaging dissemination by 10%
Second-year target/outcome measurement (Final to the end of 2027):	Baseline increase page views and prevention messaging dissemination by 15%

Data Source:

BBH Prevention Reporting Portal

Description of Data:

All BBH grantees must report on programmatic activities and groups served

Data issues/caveats that affect outcome measures:

None

Indicator #:	5
Indicator:	Number of youth participating in youth led activities and coalitions
Baseline measurement (Initial data collected prior to and during 2026):	500 youth participating in youth led activities and coalitions
First-year target/outcome measurement (Progress to the end of 2026):	Increase youth participation by 15%
Second-year target/outcome measurement (Final to the end of 2027):	Increase youth participation by 20%

Data Source:

BBH Data Reporting Portal

Description of Data:

All BBH grantees must report on programmatic activities and groups served

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Comprehensive Substance Use Disorder Services

Priority Type: SUT

Population(s): PP, Other

Goal of the priority area:

Ensure West Virginians have access to SUD treatment services.

Strategies to attain the goal:

1. Expand access to MAT/MOUD by increasing the number of MAT providers.
2. Develop a training initiative to enhance and support QRTs, increase success, and improve data collection.
3. Increase the number of Intensive Outpatient Programs Statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of MAT prescribers

Baseline measurement (Initial data collected prior to and during 2026): 475

First-year target/outcome measurement (Progress to the end of 2026): 2%

Second-year target/outcome measurement (Final to the end of 2027): 3%

Data Source:

So far in 2025, the Interim SOTA has sent 8 letters of support to open OBMATs.

Description of Data:

In 2024, there were 2 letters of support sent. There has ben a statewide OTP moratorium in place since 2007.

Data issues/caveats that affect outcome measures:

In 2024 the legislature passed SB 2028. which allows for the limited purposes of clinical trials approved by an IRB. Marshall Health POACT was licensed on 6/6/25 for a clinical trial. This supports the lower reduction target.

Indicator #: 2

Indicator: Number of Training Opportunities to enhance QRT skills and data collection.

Baseline measurement (Initial data collected prior to and during 2026): There was not a QRT Summit in 2024.

First-year target/outcome measurement (Progress to the end of 2026): 1

Second-year target/outcome measurement (Final to the end of 2027): 2

Data Source:

There was not a QRT Summit in 2024.

Description of Data:

Number of QRT Summits

Data issues/caveats that affect outcome measures:

NA

Indicator #: 3

Indicator: Number of Intensive Outpatient Programs

Baseline measurement (Initial data collected prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026): Develop a system to accurately track IOPs in WV

Second-year target/outcome measurement (Final to the end of 2027): Increase by 1

Data Source:

Office of Health Facilities and Licensure

Description of Data:

Number of IOP programs currently open and taking patients

Data issues/caveats that affect outcome measures:

Some IOPs have open and closed secondary to staffing and funding issues.

Priority #: 6

Priority Area: Improve health outcomes for pregnant women and women with dependent children.

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

1. Increase the number of providers and service professionals who screen pregnant and postpartum women for mental health and substance use disorders for referral to services/treatment.
2. Increase access of PWWDC services through DFMB program.
3. Educate SUD providers and service professionals on the intersection of SUD and domestic violence (DV)/intimate partner violence (IPV).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Bed usage statewide specifically available for PWWDC.

Baseline measurement (Initial data collected prior to and during 2026): 161 available

First-year target/outcome measurement (Progress to the end of 2026): establish baseline

Second-year target/outcome measurement (Final to the end of 2027): 5%

Data Source:

Bed reports

Description of Data:

Percent of beds that are utilized

Data issues/caveats that affect outcome measures:

There is no current funding for increasing beds specific to PWWDC.

Indicator #: 2

Indicator: PWWDC who receive services through DFMB program.

Baseline measurement (Initial data collected prior to and during 2026): FY24 there were 478 new women enrolled and 1047 total in the program.

First-year target/outcome measurement (Progress to the end of 2026): 10%

Second-year target/outcome measurement (Final to the end of 2027): 10%

Data Source:

Birthrate/Maternal Health and Direct Program Reports

Description of Data:

Number of women enrolled in the program. Will also be monitoring birthrate.

Data issues/caveats that affect outcome measures:

Birthrate is declining in WV.

Indicator #: 3

Indicator: Number of trainings for providers and service professionals on the intersectionality of SUD and DP/IPV.

Baseline measurement (Initial data collected prior to and during 2026): FY 24 12 Trainings

First-year target/outcome measurement (Progress to the end of 2026): Increase by 10%

Second-year target/outcome measurement (Final to the end of 2027): Increase by 10%

Data Source:

Direct Program reports.

Description of Data:

Number of trainings that are available.

Data issues/caveats that affect outcome measures:

Will monitor for saturation; limit on how many can be provided in a year.

Priority #: 7

Priority Area: Improve health outcomes for persons who inject drugs (PWID)

Priority Type: SUP, SUT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SOR funded harm reduction programs.

Baseline measurement (Initial data collected prior to and during 2026): 9

First-year target/outcome measurement (Progress to the end of 2026): Increase by 1

Second-year target/outcome measurement (Final to the end of 2027): Increase by 1

Data Source:

SOR program reporting.

Description of Data:

Number of SOR funded harm reduction programs.

Data issues/caveats that affect outcome measures:

It is difficult to open a harm reduction program due to WV Code, Syringe Services Program 16-64-2 requires (9) Provide a written statement of support form a majority of the members of the county commission and a majority of the members of a governing body of a municipality in which it is located or is proposing to locate and (4) Shall distribute syringes with a goal of a 1:1 model.

Indicator #: 2

Indicator: Number of Naloxone kits distributed.

Baseline measurement (Initial data collected prior to and during 2026): 98,548 in 2024

First-year target/outcome measurement (Progress to the end of 2026): Increase by 10%

Second-year target/outcome measurement (Final to the end of 2027): Increase by 10%

Data Source:

Naloxone distribution data / program reporting.

Description of Data:

Naloxone kit tracking reports maintained in reporting via program reports.

Data issues/caveats that affect outcome measures:

The hope is that eventually we need less of these but for now we are adding resources.

Priority #: 8

Priority Area: Support Recovery Services so that individuals with SUD can improve their health and wellness.

Priority Type: SUR

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

Goal of the priority area:

Increase support for recovery services with to improve the health and wellness of individuals in WV with SUD.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of WVARR certified recovery residences.

Baseline measurement (Initial data collected 107

prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026): Increase by 10%

Second-year target/outcome measurement (Final to the end of 2027): Increase by 10%

Data Source:

WVARR and BBH reports.

Description of Data:

WVARR certification reports.

Data issues/caveats that affect outcome measures:

Current baseline for certified RR is 107. However OHFLAC (licensing) has 207 registered.

Indicator #: 2

Indicator: Increase the number of certified PRSS.

Baseline measurement (Initial data collected prior to and during 2026): Current total count is 903

First-year target/outcome measurement (Progress to the end of 2026): Increase by 10%

Second-year target/outcome measurement (Final to the end of 2027): Increase by 10%

Data Source:

Bureau of Medical Services and Bureau of Behavioral Health Services reporting.

Description of Data:

Number of certified PRSS.

Data issues/caveats that affect outcome measures:

The mode of reporting is now through a contractor Gainwell working with BMS.

Priority #: 9

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

Priority Type: SUT

Population(s): TB

Goal of the priority area:

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

Strategies to attain the goal:

1.TB grant compliance at 100%

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: TB grant compliance for providers serving individuals receiving SUD treatment.

Baseline measurement (Initial data collected prior to and during 2026): Confirm policy and procedures related to TB for all grantees.

First-year target/outcome measurement (Progress to the end of 2026): Maintain 100% provider compliance.

Second-year target/outcome measurement (Final to the end of 2027): Maintain 100% provider compliance.

Data Source:

BBH Statements of Work and Provider Policies and Procedures related to TB screening, referral, and monitoring.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$11,794,749.00		$10,000,000.00	$68,064,726.00	$7,930,514.00	$0.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$610,000.00			$1,500,000.00	$2,467,620.00			
b. All Other	$11,184,749.00		$10,000,000.00	$66,564,726.00	$5,462,894.00			
2. Recovery Support Services[c]	$960,000.00			$24,000,000.00	$3,354,000.00			
3. Primary Prevention[d]	$3,453,959.00			$3,268,000.00	$4,400,000.00			
4. Early Intervention Services for HIV[e]	$0.00							
5. Tuberculosis	$0.00							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$197,598.00							
13. Administration[g]	$863,490.00			$900,000.00	$600,000.00			
14. Total	**$29,064,545.00**		**$20,000,000.00**	**$164,297,452.00**	**$24,215,028.00**	**$0.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

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

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$1,010,477.00						$65,681.00
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care		$8,083,814.00	$36,006,914.00	$14,644,672.00	$83,274,674.00			
11. Crisis Services (5 percent Set-Aside)[c]		$505,238.00			$9,384,704.00			$375,000.00
12. Other Capacity Building/Systems Development								
13. Administration		$505,238.00			$697,531.00			
14. Total		**$10,104,767.00**	**$36,006,914.00**	**$14,644,672.00**	**$93,356,909.00**	**$0.00**	**$0.00**	**$440,681.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

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

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

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	1489	479
Women with Dependent Children	2274	785
Individuals with a co-occurring M/SUD	148000	751
Persons who inject drugs	126400	18889
Persons experiencing homelessness	21775	19784

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

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unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.
1.A. WV ODCP data the most recent IUSE (Intrauterine Substance Exposure) rate is 8.8%. CDC referenced 16,929 births in 2024. 1.B. BG program reports for BBH WV 2.A. Estimated 785 CPS Cases add to total in 1.A. Pregnant Women. 2.B. Conservative estimate based on CPS cases of 785 3.A. Table 107B NSDUH WV Data 2023. 3.B. Estimated from TEDS and internal program report data(potentially low) 4.A. Table 107A NSDUH WV Data 2023. 4.B.WV Census 18 + per 2023: ACS 1-Year Estimates Data Profiles is 1,418,429. Table 28 2022 NSDUH SAE report 7.88% of population in WV 18 + in treatment.(111,772). Treatment Episode Data Set (TEDS) 2022: Admissions to and Discharges from Substance Use Treatment Figure 3.A.9 :Percentage of Admissions to Substance Use Treatment Services by Top 10 Primary Substances in 2022 notes 16.9% for Heroin.5.A.West Virginia Homelessness Demographic Report 2024 Presenting a Breakdown of Homelessness Demographic Information throughout West Virginia and Regionally - From Jan. 1, 2018, through Dec. 31, 2023, there were 28,651 individuals with a project entry date for a HUD-funded shelter project, street outreach project, or permanent housing project in West Virginia. Of those clients, more than three in four (76%) were experiencing literal homelessness. 5.B. WV Census 18 + per 2023: ACS 1-Year Estimates Data Profiles is 1,418,429. Table 28 2022 NSDUH SAE report 7.88% of population in WV 18 + in treatment. NOMS Among Substance Use Treatment Admissions and Discharges 17.7% homelessness while in treatment. Table 5.1a. Admissions aged 12 years and older, by Census region, Census division, and state or jurisdiction: Number, 2011-2021 (number admissions 12+ years in 2021 is 89 per 10,000 adjusted.
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Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$4,001,514.00
2 . Recovery Support Services[b]	$480,000.00
3 . Substance Use Primary Prevention[c]	$3,622,840.00
4 . Early Intervention Services for HIV[d]	
5 . Tuberculosis Services	
6 . Other Capacity Building/Systems Development[e]	$98,799.00
7 . Administration[f]	$431,745.00
8. Total	**$8,634,898.00**

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	
1b. Crisis Services for Adults	
1c. CSC/ESMI program for Adults	
1d. Other outpatient/ambulatory services for Adults	5101807.00
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	5101807.00
3. Services for Children	
3a. EBPs for Children	1010477.00
3b. Crisis Services for Children	505238.00
3c. CSC/ESMI program for Children	
3d. Other outpatient/ambulatory services for Children	
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	1515715.00
5. Other Capacity Building/Systems Development[a]	2982008.00
6. Administrative Costs[b]	505238.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**10104768.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$253,598
	Selective	$54,343
	Indicated	$54,343
	Unspecified	
	Total	**$362,284**
2. Education	Universal	$452,856
	Selective	$226,427
	Indicated	$226,427
	Unspecified	
	Total	**$905,710**
3. Alternatives	Universal	$181,142
	Selective	$181,142
	Indicated	$181,142
	Unspecified	
	Total	**$543,426**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	$181,142
	Total	**$181,142**
	Universal	$452,856
	Selective	$226,427

5. Community-Based Processes	Indicated	$226,427
	Unspecified	
	Total	**$905,710**
6. Environmental	Universal	$181,142
	Selective	$181,142
	Indicated	$181,142
	Unspecified	
	Total	**$543,426**
7. Section 1926 (Synar)-Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	$181,142
	Total	**$181,142**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Budget		**$3,622,840**
Total Award [a]		**$8,634,898**
Planned Primary Prevention Percentage		**41.96%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$1,086,854
2. Universal Indirect	$797,024
3. Selective	$869,481
4. Indicated	$869,481
5. Column Total	**$3,622,840**
6. Total SUPTRS Award[a]	**$8,634,898**
7. Primary Prevention Percentage	**41.96%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☑
American Indian/Alaska Native	☑
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☑
Native Hawaiian/Pacific Islander	☑
Asian	☑
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$17,295.00	$81,504.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$17,295.00	$81,504.00	$0.00
8. Total	**$17,295.00**	**$81,504.00**	**$0.00**

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Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support		
3. Partnerships, Community Outreach, and Needs Assessment	$1,708,000.00	
4. Planning Council Activities	$111,000.00	
5. Quality Assurance and Improvement	$1,000,000.00	
6. Research and Evaluation		
7. Training and Education	$163,008.00	
8. Total	**$2,982,008.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

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

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

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

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

West Virginia's (WV) Department of Human Services (DoHS), Bureau for Behavioral Health (BBH) and Bureau for Medical Services (BMS) have been working collaboratively toward establishing Certified Community Behavioral Health Clinics (CCBHCs) to serve people of all ages across the state. BBH and BMS have worked with other cross systems agencies to identify four priorities to address through the planning grant to expand state and provider capacity, increase access and services, including:
1) Expand behavioral healthcare coverage statewide
2) Prioritize populations that demonstrate significant need or are traditionally underserved
3) Build additional state capacity to collect, analyze and report data
4) Prepare to submit proposal to participate in the Demonstration Program

WV currently now has six certified CCBHCs.

WV's 13 Comprehensive Behavioral Health Centers (CBHCs) are Licensed Behavioral Health Centers (LBHCs) with designated catchment areas and are responsible for delivering publicly funded mental health and SUD treatment and for children and adults. CBHCs receive a variety of state and federal funding support from BBH. While WV has approximately 275 LBHCs and hundreds of outpatient and residential SUD programs, the CBHCs provide the state's safety net for behavioral health care.

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

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

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

WV's current planning leverages its CBHC system to support the adoption of the CCBHC model. CBHCs are required to make the following essential services available and accessible in each catchment: Assessment, Outpatient Services, Information and Referral, and Medication Management. State Continuum Enhancement Funds are provided by the BBH to engage people where they are and cover needed services which are not Medicaid billable. Indigent care state general revenue funds are also provided to ensure that no one is turned away based on inability to pay.

a. Please describe how this system differs for youth and adults.

Mental health screenings, and subsequent referrals to the Assessment Pathway for further evaluation and connection to services, conducted as part of early intervention via multiple avenues including Youth Services (YS), Child Protective Services (CPS), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthCheck wellness visits, Division of Corrections and Rehabilitation-Bureau of Juvenile Services (BJS), and Probation Services, have increased since 2019. Screening via EPSDT/HealthCheck wellness visits continues to be an area of focus with establishment of an EPSDT/HealthCheck wellness visit Performance Improvement Project (PIP) team to review and address low screening rates.

The implementation of the Children's Crisis and Referral Line (CCRL) in October 2020 created a resource for children and families in crisis to access needed support and created an avenue for anyone seeking information on available services and supports. The CCRL is available 24 hours per day, 7 days per week. Calls to the CCRL are answered within 14 seconds, on average. In October 2021, DHHR implemented the Assessment Pathway, creating a "no wrong door" approach to streamline and facilitate access to assessment and connection to home and community-based services (HCBS) for children and families. As part of this process, children and families are assessed for and given the option of applying for the Children with Serious Emotional Disorder (CSED) Waiver, which offers treatment and supportive services in the home and community-based setting and includes Wraparound Facilitation services for children with SED. In early 2023, the five-year CSED Waiver renewal was approved, extending the waiver through January 2028. These significant enhancements to the children's mental health system remain in the implementation phase and continue to be monitored by DoHS through continuous quality improvement (CQI) efforts.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

The BBH does not fund IT-COD specific programming.

c. How many IT-COD teams do you have? Please explain.

N/A

d. Do you monitor fidelity for IT-COD? Please explain.

N/A

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

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

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

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

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

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

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

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

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

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

While CCBHCs will increase access to services for all of the sub-populations listed, a few examples are as follows. a) Adults with serious mental illness will be a focus via the Assertive Community Treatment team requirement. Five of West Virginia's six regions have active ACT teams currently; building capacity for the sixth region's ACT team has been a long-time focus. Staff have engaged in capacity-building efforts with several organizations in the state's eastern panhandle and have begun focusing on one organization in particular that is working on CCBHC certification. b) Pregnant women with SUD are a focus of the MOM model program in West Virginia, with outreach and engagement shared between the MOM model and Drug Free Mom and Babies for individuals with SUD that does not include opioid use disorder. The MOM Model focuses on providing perinatal care as well as

SUD care for the parent-baby dyad. f) Among its efforts, WV participates in the SAMHSA Region III Learning Collaborative. In the State's correctional system, WV in 2022 utilizes the same medical and behavioral health vendor, which supports integrated health for persons with SUD in the justice system.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

WV's Bureau for Behavioral Health (BBH) serves as the state authority for mental health, substance use disorders, and intellectual and developmental disabilities. BBH's Office of Adult Services ensures access to services for adults with co-occurring needs like mental health and IDD. Children's Mental Health Wraparound services provides resources and support to children (ages 0-21) with a mental health diagnosis or a combination of IDD and a serious behavioral or mental health concern. It also helps families plan and access the support their children need while staying in their homes and communities.

WV utilizes various programs and initiatives to provide integrated services and support for individuals with co-occurring mental health and intellectual/developmental disabilities (IDD). The main way WV supports this population is through the IDD Waiver Program. This program provides home and community-based services as an alternative to institutional care, aiming to maximize independence and self-sufficiency. It includes services like annual functional assessments, behavioral support professionals, education and technical assistance, and case management. WV Medicaid offers a range of behavioral health services through Licensed Behavioral Health Centers, independent practitioners, and targeted case management. Targeted case management assists individuals with mental illness, substance-related disorders, and IDD not enrolled in the IDDW program to access needed services.

WV's 13 Comprehensive Behavioral Health Centers (CBHCs) are Licensed Behavioral Health Centers (LBHCs) with designated catchment areas and are responsible for delivering publicly funded mental health and SUD treatment and for children and adults. The CBHC's also provide I/DD services and work with I/DD specialized providers in community behavioral health for referral and screening.

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

N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care	5.00
	0.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,010,477.00	1,010,477.00

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

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

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

Currently we have 7 programs Our model emulates the Coordinated Specialty Care Model. We have teams to include psychiatrist, therapist, supportive employment, supportive education, Recovery coaching/ youth peer supports, and case management and family
psycho-education. The goal is to facilitate early identification and treatment of psychosis in a collaborative, recover-oriented approach involving individuals experiencing first episode psychosis, therefore reduce the disruption to the young person's functioning and psychosocial development.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

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

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

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

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

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

1. Work with Medicaid to see how we are able to make FEP more billable to increase sustainability and help use those excess funds to further expand the program

2. During the middle of 2025, WV partnered with OnTrackNY to provide coordinated specialty care training to the teams. It was meant to be refresher training and to look for opportunity to better align with the model to improve fidelity. The WV teams will work to implement what is learned through the training to improve service delivery to better help families. The WV Bureau for Behavioral Health will review the implementation manual and make updates to better align with the coordinated specialty care model and provide guidance for the teams.

3. The WV Bureau for Behavioral Health attended webinars and learned more about data collection in relation to the coordinated specialty care model. As a result, the following data fields were added to our data collection duration for untreated psychosis, new hospitalizations, new arrests, medication compliance, and maintaining employment and school. At the end of this year, the new data collection will be used to help set more specific benchmark goals using the data to drive decision making.

4. With the training guidance, the WV Bureau for Behavioral will review marketing strategies and complete updates to program materials, so they are more effective and tailored to reach the population of focus. It will include updating the Quiet Minds WV website to create family and provider focused content. A power point will be created to be used as a tool the state and the teams will use for community education and outreach. The intent will be to identify more individuals earlier and connect them with services.

In 9/21 our teams began using the The First Episode Psychosis Services Fidelity Scale (FEPS-FS) as a self reporting tool. From 9/21-

10/22 all teams self reported information and began a second year in 10/22 which will end on 09/23. In January of 2023, the teams took the data that had been collected and identified 5 common areas across the state to target for improvement. At the end of 9/23 they will have 5 months of data from these 5 areas. During FY 2024 & 25 they will continue to collect this data and using a continuous quality improvement process will make changes as needed to improve statewide services with the goal of reducing the areas from 5 common areas to 2 or 3 common areas. For FY24 and 25 we had a goal of reducing our common areas from 5 by 2 or 3 and we have reduced those areas by 3 leaving only 2 common areas.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

Eligibility criteria includes:
14-30 years of age and their families who are experiencing FEP
Residents of WV
DSM-5 diagnostic criteria: schizoaffective disorder and schizophreniform disorder, as well as other specified/unspecified schizophrenia spectrum and other psychotic disorders Individuals having experienced psychotic symptoms lasting at least one week but less than two years Individuals who have had not more than 18 months of prior cumulative treatment with anti psychotic medication

Rules out:
substance/medication-induced psychotic disorder
psychotic disorder due to another medical condition
bipolar disorder with psychosis
psychotic disorder due to another medical condition
bipolar disorder with psychosis
depressive disorders with psychotic features* serious or chronic medical illness significantly impairing function independent of psychosis
intellectual disability evidenced by an IQ of less than 70

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

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

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

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

12. Please indicate area of technical assistance needs related to this section.

As one of our goals is to work with Medicaid to see how we are able to make FEP more billable to increase sustainability and help use those excess funds to further expand the program, we would like to receive additional training from Medicaid on how we might go about increasing our billable services and what if any criteria have to be met to do so

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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

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

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

BBH has long supported consumer, family, and provider training and development in the use of evidence-based approaches, such as Motivational Interviewing, Wellness Recovery Action Planning (WRAP) and Positive Behavior Supports (PBS). Over the past 15 years the state has sponsored trainings and conferences that include seminars and workshops on Motivational Interviewing, has provided financial support for people in recovery to become WRAP trainers, and has awarded grant funding to WVU Center of Excellenc3e for operation of their statewide Positive Behavior Support (PBS) program. For example, PBS provides person-centered planning to individuals receiving services as well as agencies working with individuals with disabilities. West Virginia has a number of existing statewide pr5ograms for people with disabilities, including people with mental health issues, which emphasize and require self-direction, including the state Medicaid agency's three Home and Community-Based Waivers (IDD, TBI, and Aged and Disabled) and Money Follows the Person/Take Me Home WV program for people transitioning from nursing facilities, the Ron Yost state funded personal care service program, and the Bureau for Senior Service's Lighthouse in home service programs. The WV Bureau for Senior Services provides in person and on-line training for Aged and Disabled Waiver funded providers in Person-Centered Planning.
BBH children's services uses engagement with the youth and families as a standard by following the system of care approach to services. Youth and families are included in decision making for their services and can decline any service that they do not wish to engage in. They are brought to the table along with anyone they wish to bring to help them with making those decision. We utilize this through programs such as Children's Mental Health Wraparound, Positive Behavior Support, Family Coordinators, Early Diversion and others. The state also utilizes a Family Advisory Board where parents and caregivers of youth who have or have experienced SMI come together to look a statewide services and the provision of those services to get feedback on what is needed and how the families see those services and being provided. Finally we fund an advocacy agency that provides services free to families for issues that they feel there is a need for additional help. Those advocates are trained peers and go with the family to ensure their voice is heard if they are not and this is especially effective with the school systems. These peers are trained parent professionals who have family members who have smi or an intellectual/developmental disability.

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

The WVU Center of Excellence describes person-centered planning as "a fun interactive eight-step process that focuses on the individual's dream and what they want for their future. It helps particpants develop goals and create an action plan for achieving their goals and increase their quality of life." PBS staff use tools such as Making Action Plans (MAPS) and Planning Alternative Tomorrows with Hope (PATHS) to graphically facilitate person-centered planning with the participant and their team.

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

The use of Psychiatric Advance Directives is promoted through the Bureau for Behavioral Health funding programs including Peer

Centers, Peer Coaches, and self-advocacy training programs such as the West Virginia Leadership Academy. Advance Directives are also a frequent topic of discussion at the WV Behavioral Health Planning Council Meetings.
Additionally, BBH and the Bureau for Medical Services (WV Medicaid) continue to work together to assist Certified Community Behavioral Health Centers (CCBHC) develop their full potential in West Virginia. The national standards for CCBHCs offer their services "in a person-centered and family-centered manner." Program requirements for WV CCBHCs include staff training on person-centered care; care coordination, and the scope of services of peer and family services.
Finally, BBH models the person-centered approach in all of it's grant documents, guidance, reporting, and grant training that puts people first.

6. Please indicate areas of technical assistance needs related to this section.

None

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

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

The West Virginia Department of Human Services' Bureau for Behavioral Health (BBH) is committed to maintaining the integrity, accountability, and transparency of all activities funded through the The Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG or SUBG) and the Community Mental Health Services Block Grant (MHBG). BBH has implemented a comprehensive program integrity plan designed to prevent fraud, waste, and abuse; ensure full regulatory compliance; and promote effective fiscal and programmatic oversight.

BBH operates under established policies and procedures to ensure the proper administration and compliant use of block grant funds. As part of its oversight strategy, BBH conducts pre-award risk assessments and applies a tiered monitoring framework that includes monthly invoice reviews, quarterly financial reconciliations, quarterly program reporting reviews, desk audits, and on-site visits to evaluate both fiscal accountability and programmatic performance.Training and technical assistance are integral components of this approach, with targeted support provided to subrecipients—particularly those identified as higher risk—to

build organizational capacity and strengthen long-term compliance. Through these processes, BBH clearly conveys federal program requirements to subrecipients, contracted providers, and other intermediaries through funding agreements, monitoring protocols, guidance materials, and ongoing technical assistance efforts. When deficiencies are identified, Corrective Action Plans (CAPs) are issued and closely monitored to ensure timely and effective resolution. BBH continuously refines its compliance and audit protocols to verify client eligibility, monitor service utilization, and uphold confidentiality standards across all funded programs.

BBH also prioritizes data sharing and collaboration to enhance transparency, improve oversight, and track performance outcomes. Through these coordinated efforts, BBH remains dedicated to the responsible administration of SAMHSA funds and the delivery of quality behavioral health services to the people of West Virginia.

4. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

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

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

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

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

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

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

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

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

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☑ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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

The needs assessments along with community readiness assessments are the first step in the Strategic Planning Framework and are utilized to helpdetermine the specific needs/barriers within communities related to substance use primary prevention. This first step identifies populations vulnerable to substance use and gaps at the individual and societal level. During this assessment process, preventionists begin making decisions based on a clear understanding of the local level prevention needs, it is at this intial step of the SPF, relationship building begins with those who collect/maintain data and stakeholders who have important roles of supporting and sustaining local level prevention.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve 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 primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

WV Certification Board of Addiction & Prevention Professionals (WVCBAPP) currently is the sole credentialing body for professionals working in the substance use prevention field. WVCBAPP currently credentials Levels 1 and 2 Prevention Specialists. The state's regional Prevention Lead Organizations (PLOs) have the capacity building skill set trainings to increase the certified prevention workforce. PLOs provide trainings on prevention ethics, prevention certification core competencies, strategic prevention framework, social norms, stigma, and evidence-based programs and practices. Trainings to community members and stakeholders are determined by community needs that reflect identified risk and protective factors. Read more at https://www.wvcbapp.org/.

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

a) If yes, please describe mechanism used.

All grantees have the same requirements within their statements of work t6hat outlines to them as to the mandatory trainings they must meet annually for their primary substance use prevention workforce. BBH created Help and Hope WV as a resource for prevention professionals; see https://helpandhopewv.org/, including the prevention section at https://helpandhopewv.org/prevention-works.html. Regular trainings and TA is also offerred through various state partners, Region 3 PTTC, and SAMHA's SPTAC. Examples of state trainings also can be found at https://wvbhtraining.org/trainings/.

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

a) If yes, please describe mechanism used.

WV utilizes the Tri Ethnic Center for Prevention Research's Community Readiness Survey to complete Community Readiness Assessments (CRAs) on a routine basis. This CRA measures attitudes, knowledge, efforts and activities, leadership, and

resources within a community. Community capaqcity is determined through the Strategic Prevention Framework model. Building capacity also involves promoting public awareness and support for evidence-based prevention and engaging partners and cultivating champions who are vital to the success and sustainability of local level primary prevention efforts.

Narratve Question

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The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Please see attached.
Can also access online at https://helpandhopewv.org/docs/WV-Substance-Use-Primary-Prevention-Strategic-Plan_2025-2030_FINAL.pdf.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

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

a) Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

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

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

An Evidence-Based Workgroup has been established that reviews evidence-based programs and strategies per their Institute of Medicine (IOM) level of prevention; universal, selective, and/or indicated. This group consists of membership from each of the prevention lead organizations, BBH, subject matter experts (SMEs), and other prevention stakeholders. The Bureau for Behavioral Health Clearinghouse utilizes a thorough review process to ensure each program/practice submitted to the Clearinghous receives a rating commensurate with standards established by the Clearinghouse. AFter receiving specialized training, subject matter experts and graduate assistants work together to review existing research and determine ratings for those programs and practices reviewed. GAs utilize academic electronic libraries, program websites, and other clearinghouses to obtain pertinent research related to the program/practice. GA's prioritize research conducted in the last 5-10 years. In cases where it seems necessary or appropriate, GAs receive approval from SMEs to utilize older research. Randomized Controlled Trials (RCTs) and meta-analysis are prioritized over other research, but quasi-experimental, pre-test/post-test, retrospective chart review and case studies can be reviewed if RCTs and meta-analysis are unavailable. GAs complete and send summaries of each research article reviewed to the SMEs, and then together they assign a rating for the program/practice. The ratings provide guidance but not definitive judgment as to whether a program should be implemented in a specific community or circumstances. The ratings based on the available evidence at the time the program was reviewed. The Bureau for Behavioral Health Clearinghouse is located here https://clearinghouse.helpandhopewv.org/.

Narratve Question

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

Implementation

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

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Health Fairs, Drug Take Back events, Community Forums, Prevention Guide training and distribution, Rack Cards, Brochures, Food banks, WV Students Against Destructive Decisions, Social Media Campaigns, Job Fairs, School events, higher education events, Tobacco Free Days, Prevention Day at Legislature, Loved Ones, Prom Promise, Red Ribbon Week, Prevention Week activities, Blessing Boxes, Save a Life Day, Resource Directories, Media Campaigns, Radio/TV public service announcements, Speaking engagements, and Overdose Awareness events.

b) Education:

WV Stubstance Use Trends, classroom and/or small group sessions (all ages), parenting and family management classes, Peer leader/helper programs, children of substance use groups, Drug Take Back Events, Community Forums, Prevention Guide Training, Synar Traing and Merchant Education, Training for Intervention Procedures (TIPS), Fetal Alcohol Spectrum Disorders, Marijuana training, Generation Rx, Underage Drinking, Synthetic Drugs, PDMP training, SBIRT, Risk and Protective Factors, Stigma Training, Keep a Clear Mind, All Stars, Healthy Alternatives for Little Ones, Too Good for Drugs, Too Good for Violence, PAX Good Behavior Game, Not on Tobacco, Positive Action, Botvin Lifekills, Second Step, Mind Yeti, Safe Drug Disposal, Strengthening Families, Strategic Prevention Framework, SAPST, Prevention Ethics, Teen Intervene, Tiple P, Alcohol Literacy Challenge, Cook Kids, Coping Cat, Incredible Years, BBH Clearinghouse, Keepin it Real, Lions Quest, Resilence Builder, Catch My Breath, Building Assets Reducing Risks, Caring School Community, Celebrating Families, Ripple Effects, Project Alert and Mental Health First Aid.

c) Alternatives:

Students Against Destructive Decisioins, Loved Ones, Youth Move, Youth Coalitions, Kidding Around Yoga, Afterschool activities, Afterschool Programs, Mindfulness, Drug Free All Starts, Boys and Girls Clubs, community drop-in centers, youth/adult leadership activities, substance-free community events.

d) Problem Identification and Referral:

Employee Assistance Programs, Student Assistance Programs, Driving While Under the Influence/driving while intoxicated education programs, Teen Courts, Juvenile Drug Courts, Synar Compliance Checks, Alcohol Compliance Checks, and Expanded School Mental Health

e) Community-Based Processes:

Community Resource Meetings, Family Resource Meetings, Regional Coalition Meetings, State Prevention Steering Team Committee, Health Children and Families Meetings, Youth Move, WV Collegiate Initiative Against Substance Use (WVCIA), collaboration with higher education, Head Start Policy Council Meetings, Office of Drug Control Policy Meetings, Expanded School Mental Health (ESMH) Leadership Teams, Prevention Consortiums, Community Readiness Assessments, Needs Assessments, Systematice planning, accessing services and funding, community team-building, and Strategic Action Planning.

f) Environmental:

Promoting the establishment or review of alcohol, tobacco, and drug policies in schools, techncial assistance to communities to maximize local enforcemtn and other drug use. Modifying alcohol and tobacco advertising practices and product pricing strategies. Signage for underage and/or substance use, community gardens, drug take back events, deterra bags, social hosting ordinances, naloxone training,

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

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

Narratve Question

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

Evaluation

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

If yes, please attach the plan in WebBGAS

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 prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes 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 describe):
- **g)** ☐ Not applicable/no prevention evaluation plan

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES
Bureau for Behavioral Health

ONE STATE ONE VISION

West Virginia Substance Use Primary Prevention Strategic Plan 2025-2030

Together, we can–and we will–prioritize prevention in West Virginia.

Acknowledgements

It takes a village to create a positive environment in which people can thrive, and so is true with the diverse stakeholders who came together to draft *One State One Vision West Virginia Substance Use Primary Prevention Strategic Plan.*

The development of this plan is a result of a collaborative process among various bureaus within the West Virginia Department of Human Services (DoHS), West Virginia Department of Education (WVDE), WV GameChanger, Prevention Lead Organizations (PLOs), Marshall University, School of Excellence in Recovery, West Virginia University, and local, public, and private prevention organizations throughout the state. Through the implementation of this Strategic Primary Prevention Plan, West Virginia can continue to build the prevention infrastructure and the health and wellness of individuals, families, schools, and communities within our great state.

We would like to thank all the planning team members without whom the development of this plan would not be possible. Each team member brought valuable knowledge, expertise, and passion to the table. Your commitment to achieving our shared goals is greatly appreciated.

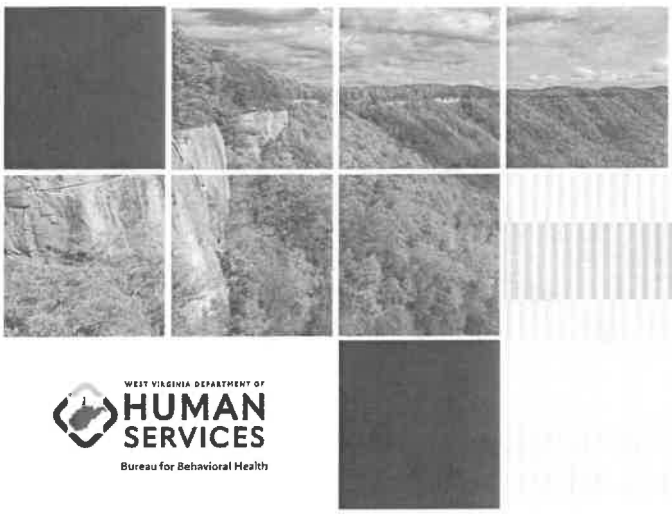
A special thank you is extended to the following individuals for their assistance in facilitating, moderating, or presenting during the planning sessions: Christina Mullins of DoHS; Jenny Lancaster of Terzetto Creative; Martha Minter of Community Access, Inc.; Jessica Smith of DoHS's Office of Drug Control Policy (ODCP); and Dr. Sarah Sanders of DoHS's Bureau for Behavioral Health (BBH). A complete list of participants can be found in *Appendix 1: Strategic Planning Team Members*.

Additionally, we are grateful to Christina Mullins, DoHS Deputy Secretary of Mental Health and Substance Use Disorders, and Nicholas Stuchell, DoHS Bureau for Behavioral Health Interim Commissioner for their leadership and support in this endeavor. Their recognition of the importance and need for increased collaborative and unified prevention efforts provided continual encouragement throughout this process.

Finally, we would like to thank all the individuals who reviewed this plan and provided valuable input and comments during the draft period. Your contributions are appreciated. Together, we can and together we will prioritize prevention in West Virginia.

Tahnee I. Bryant, Program Manager II
WV Department of Human Services
Bureau for Behavioral Health
Office of Children, Youth and Families

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



ONE STATE ONE VISION

West Virginia Substance Use Primary Prevention Strategic Plan 2025-2030

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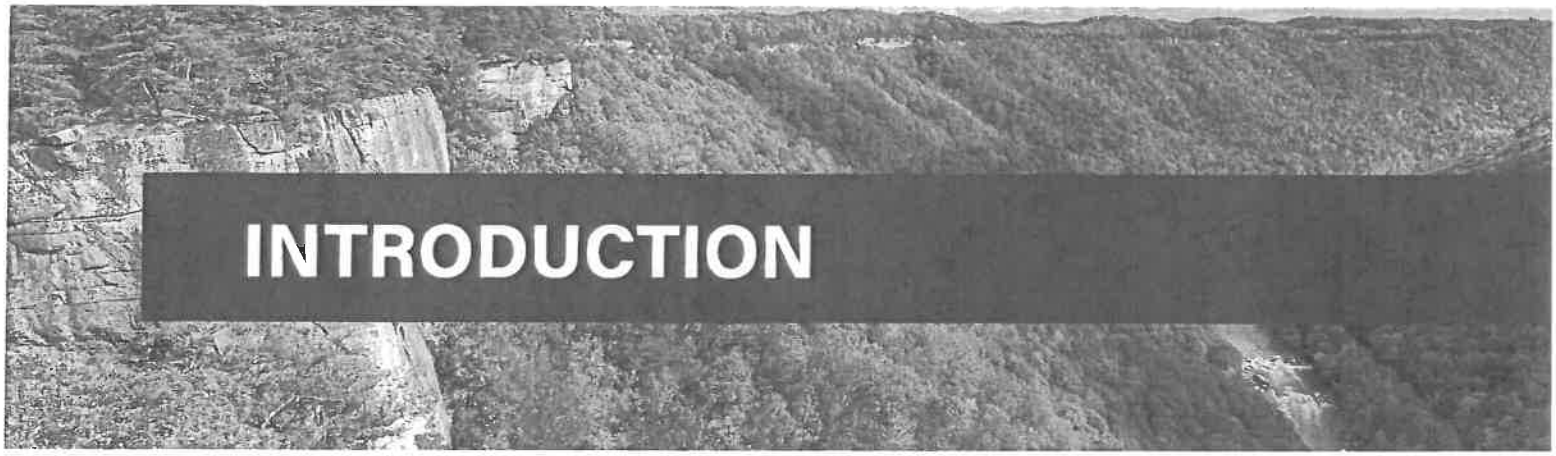
Bureau for Behavioral Health



INTRODUCTION

The West Virginia Department of Human Services (DoHS), Bureau for Behavioral Health (BBH) was awarded a five-year, $1.25 million grant award from the Substance Abuse and Mental Health Services Administration (SAMHSA), underscoring the ongoing commitment to proactively address substance use and misuse and promote mental health across the state.

The FY 2024 Strategic Prevention Framework-Partnerships for Success for States (SPF-PFS) grant will significantly bolster efforts to reduce the onset and progression of substance misuse. The grant will empower the development and delivery of state and community-based substance misuse prevention and mental health promotion services, fostering a healthier future for individuals and families throughout West Virginia. By enhancing the capacity of local community prevention providers to implement evidence-based programs, this initiative will play a critical role in preventing substance use across the state. This grant requires a strategic prevention plan. BBH also needed to update the *WV Prioritizing Prevention Strategic Plan* that recently expired.

On October 23, 2024, BBH held a primary prevention strategic planning meeting to develop a unified, comprehensive, statewide primary substance use and misuse prevention plan that will help strengthen and sustain West Virginia's (WV) current primary prevention infrastructure. The purpose of this meeting was to prioritize common goals and objectives, identify key strategies for implementation, and develop an initial draft of the prevention strategic plan.

The intended audience for this plan includes legislators and other policy makers, governmental agencies, community-based prevention organizations/coalitions, primary and secondary schools, higher education institutions, media, businesses, law enforcement, civic and volunteer groups, youth-serving organizations, and funding partners. *One State One Vision West Virginia Substance Use Primary Prevention Strategic Plan* will be launched January 1, 2025, and overseen by the Governor's Council Prevention subcommittee and the existing Prevention Steering Team facilitated by BBH.

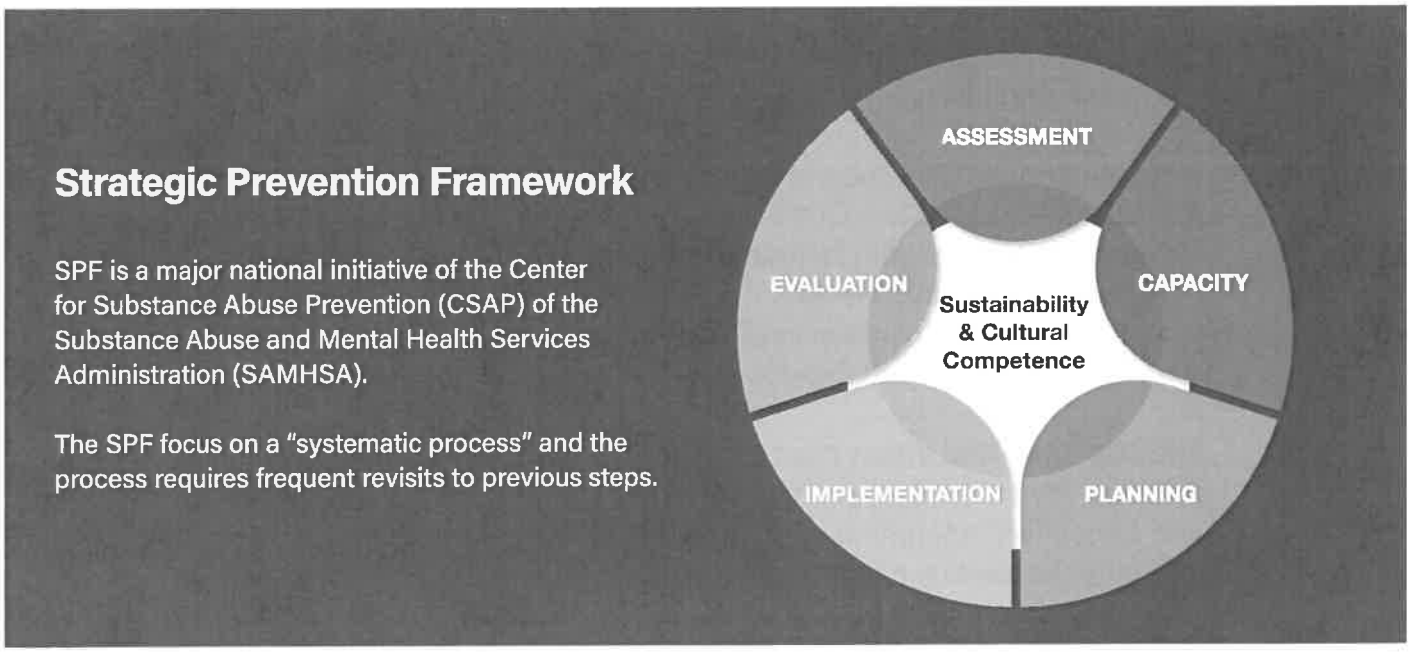
Prior to the meeting, state staff reviewed previous plans from BBH, Office of Drug Control Policy (ODCP), their prevention partners. Common goals and objectives

were identified, and participants were asked to review and comment on those prior to the meeting. The participants' responses were then compiled and shared with the group during the in-person planning meeting. BBH staff and the meeting facilitator also met with stakeholders in advance to understand barriers and challenges that might arise, and facilitator tools were developed based on this feedback. Additionally, the following tools were sent to participants to help them prepare and were shared during the strategic planning process:

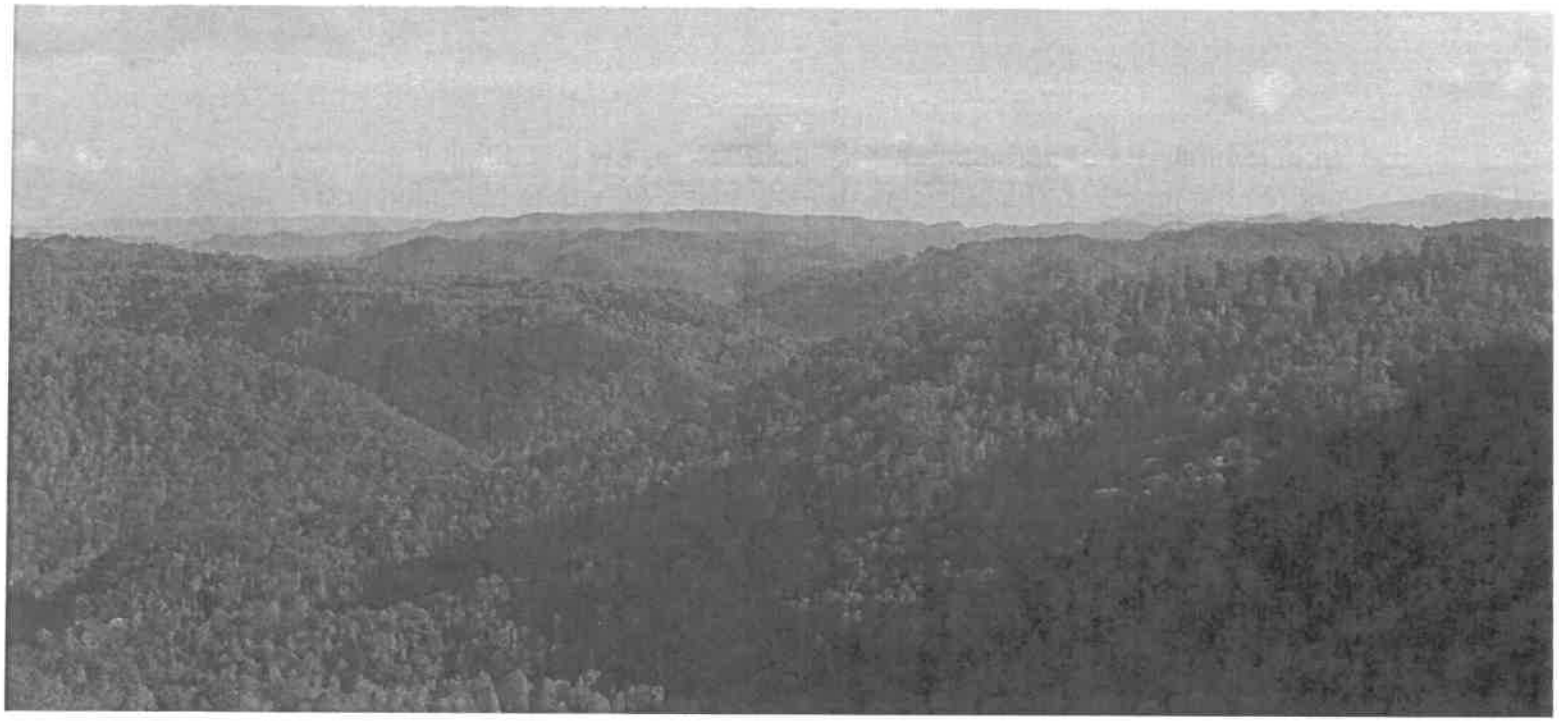
- Institute of Medicine's levels of prevention,
- Social Ecological Model,
- Risk and Protective Factors,
- Center for Substance Abuse Prevention (CSAP) six prevention strategies, and
- SAMHSA's Guide to the Strategic Prevention Framework (SPF).

Participants were informed of the meeting purpose of prioritizing common goals and objectives, identifying key strategies for implementation, and development of a primary prevention strategic plan which will update older, expired state plans. New partnerships were also identified, such as WV GameChanger as well as current prevention partners – Marshall University School of Excellence in Recovery, WV Department of Education, West Virginia University, ODCP, local school systems, Prevention Lead Organizations, and local level prevention coalitions.

The SPF developed by SAMSHA was the overall planning framework utilized for the development of this plan.



https://www.samhsa.gov/sptac/strategic-prevention-framework



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

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

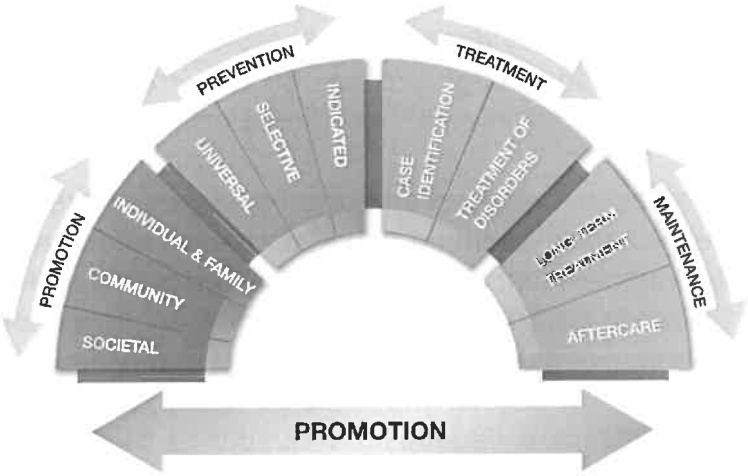
In addition to the SPF, theoretical or conceptual frameworks that support the premise of the *One State One Vision West Virginia Substance Use Primary Prevention Strategic Plan* include the following:

- Social Ecological Model;
- Social Determinants of Health; and
- Adverse Childhood Experiences.

The *One State One Vision West Virginia Substance Use Primary Prevention Strategic Plan* aims to approach substance use and misuse by addressing the risk and protective factors that predict and protect against substance use, misuse, and other behavioral health problems across the lifespan.

EXECUTIVE SUMMARY

What is prevention? Merriam-Webster defines prevention as the act of preventing or hindering.[1] What is meant by prioritizing prevention in West Virginia? This overview will answer this question and discuss the delivery of effective evidence-based programs and prevention strategies for substance use/misuse.



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

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

Universal, selective, and indicated prevention interventions can be integrated into an overall public health approach in primary healthcare settings, schools, work sites, churches, and other

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

community settings.[4] Studies have shown the benefits of integrated primary and behavioral healthcare. The links between mental illness and physical illness are well documented, as risk factors for poor health outcomes are also the same risk factors for substance use/misuse and behavioral health disorders. Prevention is an important piece of this continuum of care, and preventionists can work together to deliver interventions in a coordinated way. Understanding the interconnections of individual prevention interventions as a system and how a systematic perspective works is critical as West Virginia moves forward to build and strengthen its prevention infrastructure.

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

The Health Policy Institute of Ohio defines "evidence-based practice" and "evidence-based public health" as broad terms, often used interchangeably, that refers to the process of using scientific evidence to identify health problems and effective health improvement strategies.[5] Evidence-based practice involves making prevention decisions on the best available scientific evidence and data; applying program and planning frameworks; engaging the community in the decision-making and implementation; conducting sound evaluation; and disseminating what is learned. Federal funders, such as SAMHSA and the U.S. Centers for Disease Control and Prevention (CDC), require grantees to utilize evidence-based programs and practices in prevention, treatment, and recovery services and programs.

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

Implementing an evidence-based program is widely considered a "best practice" strategy for community health promotion/prevention. Evidence-based programs add value in many ways:[6]

- They are more likely to positively impact the health of program participants.
- Funders increasingly require programming to be based on solid evidence.
- Agency leaders can focus limited resources on proven programs.
- Program managers can prioritize program delivery over program development, enabling them to reach a larger population and achieve greater impact.
- Older adults are discerning and prefer to invest their time and money in programs with proven effectiveness.

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

[5] Health Policy Institute of Ohio. Guide to evidence-based prevention. Retrieved from https://nnphi.org/wp-content/uploads/2015/08/GuideToEvidence-BasedPrevention.pdf.

[6] Enhance. What is an Evidence-Based Program. Retrieved from https://projectenhance.org/what-is-an-evidence-based-program/.

- Demonstrated outcomes make evidence-based programs appealing to community members and potential partners, fostering community buy-in and partnership development.

It is important to note the distinction between *research-based* and *evidence-based*. It is a common misconception that programs based in research fit the criteria to be an evidence-based program, but just because a program contains research-based content, or was guided by research, that does not mean the program itself has been proven effective. As noted above, the program must be tested and shown to be effective to qualify as an evidence-based program.

The Social Ecological Model is a theory-based framework, endorsed by the CDC, for understanding how the social determinants of health influence and maintain health and health-related issues.[7] The Social Ecological Model moves beyond a focus on individual behavior and towards an understanding of the wide range of factors that influence health outcomes. The model illustrates how factors influence each other at different levels.[8]

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

The Social Ecological Model is used within prevention frameworks to understand the multiple contexts in which risk and protective factors exist. Individuals have biological and physical

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

characteristics that can put them at greater risk or protect them from the effects of emotional, mental, and behavioral health problems:

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

This figure illustrates the five levels of the model:

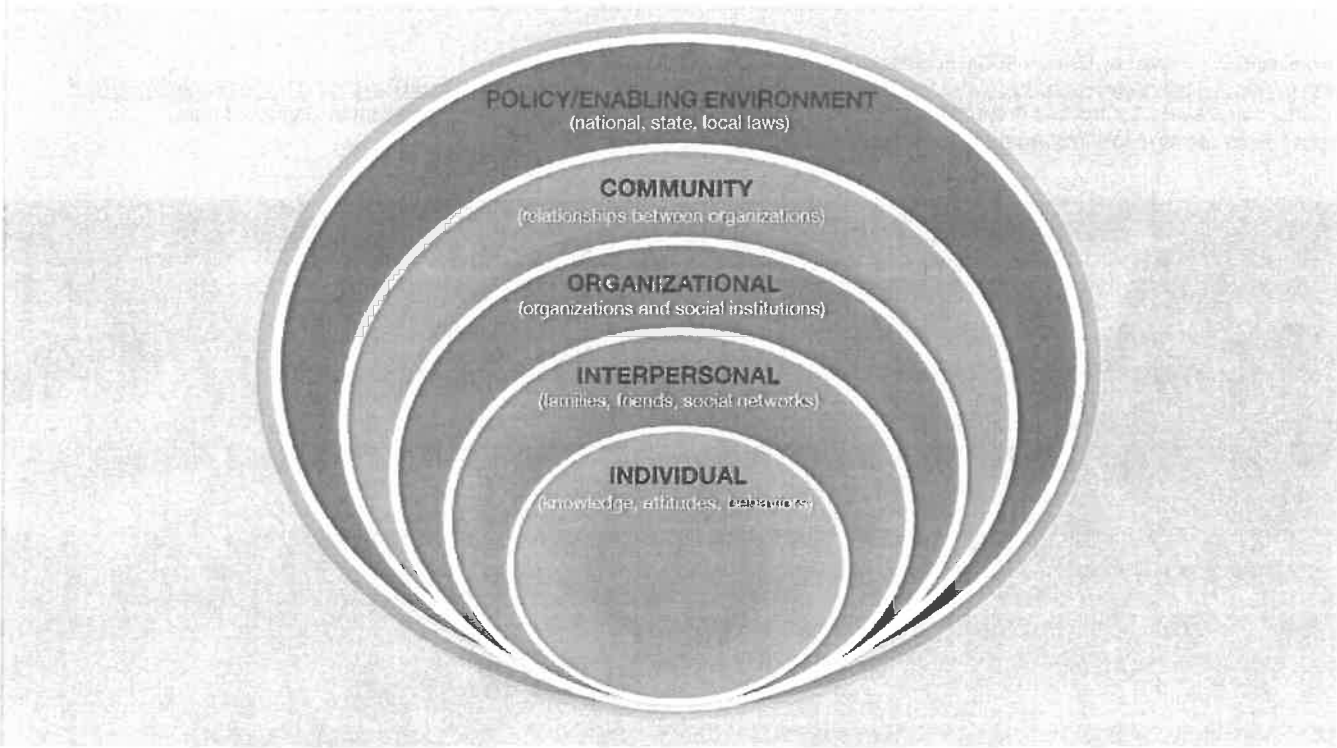
- **Individual/Intrapersonal:** The individual characteristics that influence behavior, including knowledge, skills, motivation, and personality traits.

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

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

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

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



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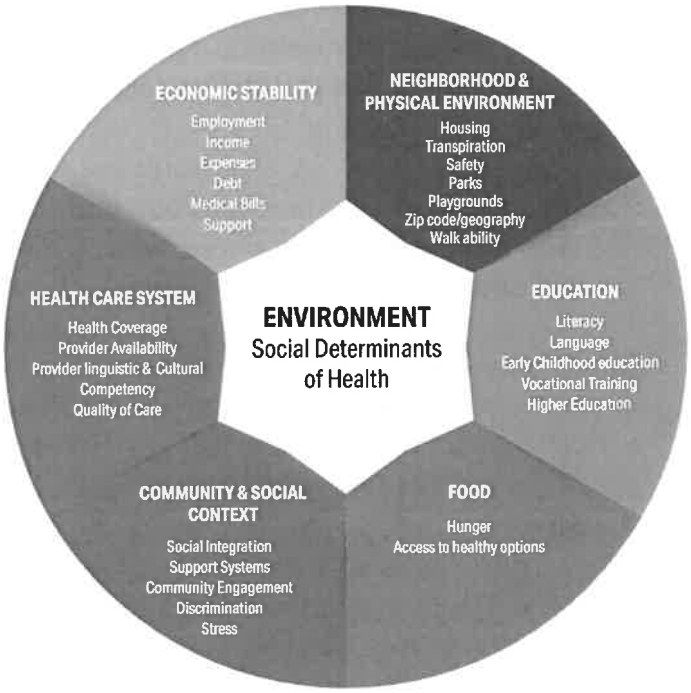
The Social Ecological Model explains factors affecting behavior and provides guidance for developing successful programs through social environments. Furthermore, the model emphasizes multiple levels of influence and the idea that behaviors both shape and are shaped by the social environment. The principles of the model are consistent with social cognitive theory concepts, which suggest that creating an environment conducive to change is important to making it easier to adopt healthy behaviors.[9]

Social determinants of health (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[10]

Research by the CDC on SDOH topics expands the scientific evidence that will help build the pathway to health equity. Based on specified criteria, the following categories have been published by Healthy People 2020 utilizing a place-based framework to identify SDOHs.[11] Each of these five determinant areas reflects a number of key issues that make up the underlying factors in the arena of social determinants of health:

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



[9] Social and Behavioral Theories. e-Source Behavioral and Social Sciences Research. Retrieved from http://www.esourceresearch.org/Default.aspx?TabId=736.
[10] Social Determinants of Health. Healthy People 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
[11] Social Determinants of Health: Know What Affects Health. CDC Research on SDOH. Retrieved from https://www.cdc.gov/socialdeterminants/research.html?Sort=Article%20Date%3A%3Adesc&Category=Economic%20Stability.

MISSION

The mission of the *One State One Vision West Virginia Substance Use Primary Prevention Strategic Plan* is to strengthen and sustain WV's prevention systems through collaboration, innovation, education, and prevention science.

SHARED VISION

One State One Vision West Virginia Substance Use Primary Prevention Strategic Plan envisions a proud West Virginia comprised of healthy, resilient communities, where all individuals are supported, purposeful and hopeful throughout their lifespan.

CORE VALUES

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

- Empower families and communities
- Data driven with stakeholder engagement
- Consistent, transparent communication
- Implementation of evidence-based programs, practices, strategies with fidelity
- Adherence and focus on ethical prevention and practice
- Recognition of prevention certification
- Utilization of best prevention research and continual education on new and emerging prevention science
- Increasing resiliency and protective factors
- Youth advocacy, empowerment, and voice
- Support innovation in prevention
- Cultural humility and competence

Based upon the current prevention landscape, strategic goals and objectives were identified in addition to expected results to be achieved over the next five years. There was consensus that over the next five years prevention partners will seek to focus collaborative efforts on the five priority goal areas listed in the following section.

BBH's Lead Epidemiologist, Dr. Sarah Sanders, shared publicly available relevant data to guide the planning team's selections of goals, objectives, and strategies. Focusing on a data-driven process, the planning team identified the following priority areas:

- Vaping
- Underage drinking
- Cannabis/marijuana
- Commercial tobacco use
- Opioids, both prescribed and illicit, other prescription drugs, and stimulants
- Young adult/adult alcohol misuse
- Depression and anxiety

The infographics on the next pages summarize key data utilized in the development of this strategic plan.

PREVENTION RISK FACTORS KEY DATA

RISK FACTOR:

ADULT TOBACCO

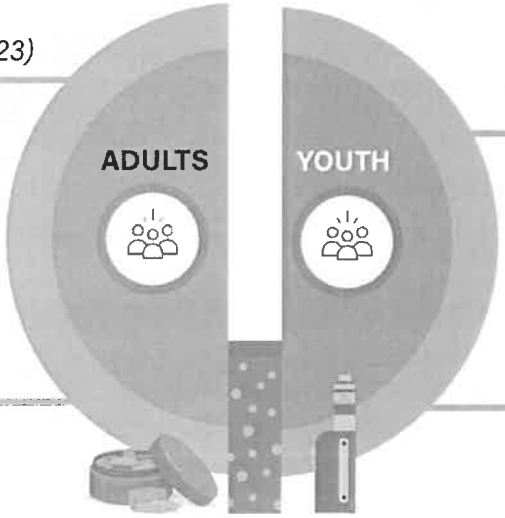
Adult Smoking Status *(2023)*

Former Smoker 29%
Smoke Everyday 16%
Smoke Some Days 4%

Adult Smokeless Tobacco Use *(2023)*

Every Day 5%
Some Days 3%

Source: BRFSS



RISK FACTOR:

YOUTH TOBACCO

Smoked a Cigarette at Least One Day in the Past Month *(2021)*

US High Schoolers 4%
WV High Schoolers 8%
WV Middle Schoolers 4%

Currently Use Electronic Vapor Products *(2021)*

US High Schoolers 18%
WV High Schoolers 28%
WV Middle Schoolers 12%

Source: YRBS

High School ALCOHOL USE

Current Alcohol Use (2021)

U.S. 22.7%
WV 23.8%

Source: YRBS

High School MARIJUANA USE

Current Marijuana Use (2021)

U.S. 15.8%
WV 16.4%

Source: YRBS

High School PRESCRIPTION PAIN MEDICATION MISUSE

Current Prescription Pain Medication Misuse: Use (2021)

U.S. 12.2%
WV 12.3%

Source: YRBS

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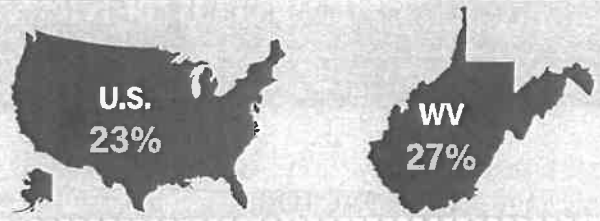
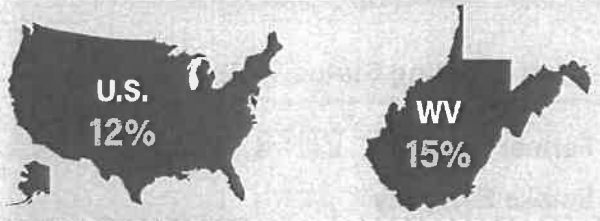
Risk Factors:

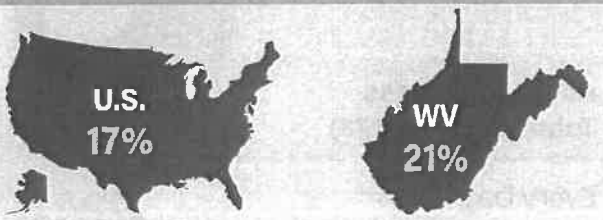
EMOTIONAL/BEHAVIORAL/ DEVELOPMENT CONCERNS: Children Who Have One or More Emotional, Behavioral, or Developmental Conditions *(2020-2021)*



ANXIETY/DEPRESSION: Children and Teens with Anxiety or Depression *(2020)*



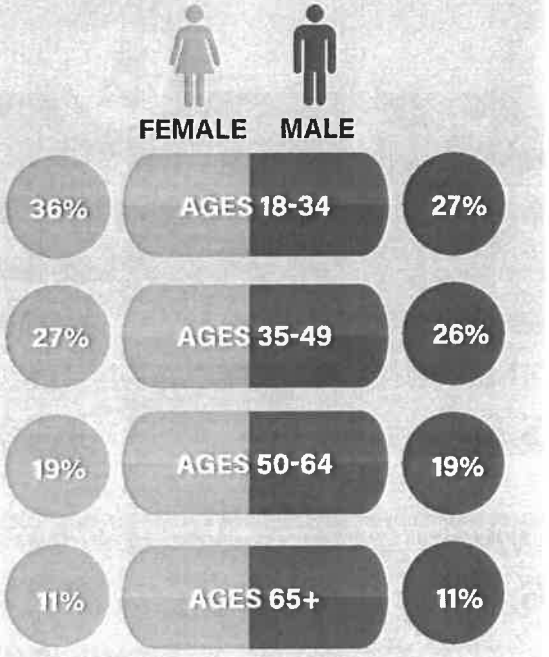
ACEs: Children Who Have Experienced Two or More Adverse Experiences *(2020-2021)*



Source: Child Trends analysis of data from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health, analyzed by Annie E. Casey Foundation

ADULT REPORTED MENTAL HEALTH STATUS

Fair or Poor Mental Health



Data Source: West Virginia Department of Human Services. Mountain State Assessment of Trends in Community Health (MATCH) Survey Data. Charleston, West Virginia: West Virginia Department of Human Services, 2021.

POVERTY:

Percent of Children by Federal Poverty Level

Sources: U.S. Census Bureau, American Community Survey, analyzed by West Virginia Center on Budget and Policy; https://aspe.hhs.gov/sites/default/files/documents/7240229f28375f54435c5b83a3764cd1/detailed-guidelines-2024.pdf

Overdose Age-Adjusted Mortality Rates *(2022)*

Data Source: National Center for Health Statistics, Division of Vital Statistics Notes: 2021 data are preliminary. 2022 data are cumulative.

Substance Use Primary Prevention
Five-Year Strategies

2025-2030

BBH and the Prevention Steering Committee look forward to the implementation of this primary prevention strategic plan over the next five years. Following are the five goals which includes measurable SMART (specific, measurable, achievable, relevant, and time-bound) objectives, and key strategies.

GOAL 1: Strengthen Capacity to Implement and Sustain Evidence-Based Prevention Programs

Objective 1: Annually provide at least one training to agency/provider staff in each of the six regions on how to identify and select EBPs for local use, how to use logistics for program training, and how to begin implementation.

- **Strategy 1:** Establish one new **mentorship program per region annually** where experienced prevention specialists or organizations support emerging community-based organizations.
- **Strategy 2:** Link a minimum of two new on-demand training modules and virtual technical assistance on Help and Hope WV's website annually and review quarterly at Prevention Steering Team Committee meetings.
- **Strategy 3:** Annually recognize a minimum of three organizations adopting evidence-based programs and new innovative programs incorporating evidence-based strategies.

Objective 2: Expand implementation of evidence-based programs to a minimum of one new organization per region across all counties by leveraging standardized data annually.

- **Strategy 1:** Develop and implement a tracking system for a program(s) adoption and effectiveness, enabling data-informed decision-making that is updated and reviewed quarterly by the Prevention Steering Committee.
- **Strategy 2:** Identify at least six high need communities based on adverse childhood experiences (ACEs) and social determinants of health data to prioritize and implement evidence-based programs and strategies by the end of 2025.

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Objective 3: Develop and maintain user-friendly resources and toolkits for local partners to support program implementation and communication.

- **Strategy 1:** Create customizable toolkits with culturally relevant materials tailored to rural and underserved communities and disseminate to a minimum of 50 community-based organizations annually.
- **Strategy 2:** Engage a minimum of six youth in the design of resources to ensure developmental and cultural relevance that are reviewed and updated annually.
- **Strategy 3:** Provide peer-led intervention models and training to promote youth engagement in evidence-based programs to a minimum of 100 youth annually.

GOAL 2: Establish a Comprehensive Data and Evaluation System

Objective 1: Provide training and technical assistance with available data platforms.

- **Strategy 1:** Develop a secure, user-friendly platform for data visualization and reporting.
- **Strategy 2:** Ensure platform accessibility through a minimum of one training session annually and technical assistance for local organizations.

Objective 2: Standardize data collection tools for statewide consistency, incorporating feedback from regional and local stakeholders.

- **Strategy 1:** In the first year of this plan, the Prevention Steering Team Committee and PLOs will review and develop a list of recommended standardized tools for data collection.
- **Strategy 2:** Provide a minimum of one training annually and technical support to ensure proper use of data collection tools.

Objective 3: Use data to create accessible, regularly updated regional and county profiles for informed decision-making and communication.

- **Strategy 1:** Publish regional and county profiles annually to provide insights into community needs and program impacts.
- **Strategy 2:** Incorporate ACEs and other relevant metrics into profiles to guide targeted interventions and update annually.

GOAL 3: Foster Strategic Collaboration and Communication

Objective 1: Strengthen coalition roles by aligning local, regional, and statewide efforts with clear expectations, responsibilities, and funding strategies.

- **Strategy 1:** Develop a prevention partner network directory to connect community organizations with resources and expertise.
- **Strategy 2:** Conduct quarterly capacity-building forums to enhance collaboration and problem-solving among coalitions.

Objective 2: Implement a unified communication strategy that incorporates both cross-system collaboration and public-facing media campaigns.

- **Strategy 1:** Establish a centralized communication hub to streamline information sharing among partners and the public.
- **Strategy 2:** Develop joint media campaigns that reflect statewide priorities and are customizable for local needs.

Objective 3: Align prevention programs with educational and community systems through joint initiatives and networking events.

- **Strategy 1:** Partner with schools to embed prevention messaging and activities into curricula.
- **Strategy 2:** Facilitate networking across 12 public health sectors to build relationships and coordinate prevention efforts.

GOAL 4: Increase and Align Investments in Prevention Infrastructure

Objective 1: Educate on sustained funding and policy reforms to support prevention programs, focusing on data-driven priorities.

- **Strategy 1:** Launch educational campaigns emphasizing the cost-effectiveness and long-term benefits of prevention.
- **Strategy 2:** Collaborate with state leaders to secure dedicated funding streams for prevention initiatives.

Objective 2: Promote resource-sharing and technical assistance among communities to enhance program implementation.

- **Strategy 1:** Establish a resource-sharing framework to facilitate collaboration between schools and community organizations.
- **Strategy 2:** Provide information on available funding resources to support high need in communities launching prevention programs and provide technical assistance to organizations to apply for the funding.

Objective 3: Build workforce capacity by providing clear pathways for prevention specialist certification and professional development.

- **Strategy 1:** Explore incentives to recommend for professionals seeking prevention certification.
- **Strategy 2:** Partner with universities to develop a prevention internship program that supports community-based organizations.

GOAL 5: Develop Unified Messaging for Substance Use Awareness and Education

Objective 1: Create standardized, customizable prevention messaging that reflects state values and is informed by stakeholder input.

- **Strategy 1:** Conduct focus groups with youth and community stakeholders to ensure messaging resonates with target audiences.
- **Strategy 2:** Design culturally specific campaigns addressing the unique needs of underserved populations.

Objective 2: Establish formal media partnerships to disseminate messaging broadly and measure impact through evaluation metrics.

- **Strategy 1:** Collaborate with local media outlets to co-create and distribute content that promotes prevention.
- **Strategy 2:** Develop an evaluation framework to assess media campaign reach and effectiveness.

Appendix 1: Strategic Planning Team Members

Facilitator:

Christina Mullins
Deputy Secretary of Mental Health and Substance Use Disorders
WV Department of Human Services

Presenters:

Tahnee Bryant
Program Manager
WV Bureau for Behavioral Health

Sarah Sanders
Epidemiologist
WV Bureau for Behavioral Health

Attendees:

Joe Boczek
Executive Director
GameChanger

Alison Browning
Youth Services Division Director
Westbrook Health Services

Shawna Chapman
Portfolio Director
WVU Health Affairs Institute

Maryann Corsello
Director of Programming and Evaluation
GameChanger

L'Louise Fox
Executive Assistant
WV Department of Human Services

Lori Garrett-Bumba
Project Director
Marshall University Research Corporation

Joshua Grant
Coordinator
WV Department of Education

Jonnie Kifer
Community Programs Manager
WV Prevention Solutions Inc.

Allison Lambert
Program Manager 1
WV Bureau for Behavioral Health

Kim Legg
Director of Program Implementation
GameChanger

Barbra Masih
Region 2 Prevention Lead Organization Coordinator
Potomac Highlands Guild

Raj Masih
Regional Drug Control Policy Coordinator/ Prevention Specialist
Potomac Highlands Guild

Paige Mathias
Director of Prevention
GameChanger

Jo Anne McNemar
Partnerships for Success Program Director
WV Bureau for Behavioral Health

Shelly Mize
Director of Prevention
GameChanger

Travis Mollohan
AVP for Government Relations and Strategic Engagement
West Virginia University

Joshua Murphy
Prevention Liaison
Mingo County Prevention Coalition

Alyssa Parker
Prevention Program Director
Westbrook Health Services

Sara Payne Scarbro
Associate VP of Government Relations and External Engagement
Marshall University

Tiffany Pittman
School MH Coordinator
Marshall University School Health TA Center

Dara Pond
Director of Prevention
Youth Services System, Inc.

Larry Puccio
Chairman of the Board
GameChanger

Greg Puckett
Executive Director
Community Connections, Inc.

Michelle Rohde
Director of Prevention
Youth Services System, Inc.

Michael Ryan
Director of Student Supports and Diversity
Monongalia County Schools

Amy Saunders
Associate Vice President, MURC and Managing Director Center of Excellence for Recovery
Marshall University

Nathan Settle
Prevention Program Coordinator
Westbrook Health Services

Elizabeth Shahan
Executive Director
WV Prevention Solutions Inc.

Kimberly Shoemake
Prevention Lead Region Five
Prestera

Jessica Smith
Outreach and Outcomes Program Manager
WV Office of Drug Control Policy

Nick Stuchell
Interim Commissioner
WV Bureau for Behavioral Health

Jamie Styons
Assistant Director
Community Connections, Inc

Kristin Willard
Director
Morgan County Partnership

Natalie Wilson
Assistant Director of Research Support
WVU Health Affairs Institute

Suzanne Wood
Drug Free Communities Program Director
Fayette Prevention Coalition

Staff:

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Assistant Director
Community Access, Inc.

Jenny Lancaster
Terzetto Creative

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Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

West Virginia's publicly-funded community based behavioral health system is anchored by thirteen (13) Comprehensive Behavioral Health Centers (CBHC's), operating full service and/or satellite offices in each of the counties located in the center's catchment area. Public behavioral health services provided by a CBHC are for all populations and all ages at risk for, or have a diagnosis of, mental illness, substance abuse, intellectual/developmental disability, or a co-occurring/co-existing disorder. CBHC's are charged with ensuring the following "essential services" are available and accessible in each county: Screening, Assessment, Crisis Response, Outpatient services (with referral for Intensive Outpatient Services (IS) as may be assessed/needed), Information and Referral capacity, and Medication Management.

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

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

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

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

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational services	(●) Yes ( ) No
g)	Substance use prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Recovery Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No

k) Services for persons with co-occuring M/SUDs (●) Yes ( ) No

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

BBH funds each of the 13 regional Comprehensive Behavioral Health Centers (CBHCs) and a number of independent community agencies to provide community based supports to people with mental health issues, substance use disorders and nonwaiver funded individuals with intellectual developmental disabilities. Indigent Care funds are available to support people who are uninsured and/or underinsured seeking Medicaid eligible treatment services from the 13 regional CBHCs. The mechanism of coordination varies by each provider's capacity with some providing services directly while others coordinating services through referral and resource coordination.

3. Describe your state's case management services

BBH uses State general revenue funds to support Community Engagement Specialists (CES) at both the CBHCs and also with independent providers. Community Engagement is a service which identifies, connects and/or provides personal and community supports to individuals with a diagnosis of mental illness, substance use, or co-occurring disorders, and who are committed, have a history of commitment, or are in danger of commitment to a state psychiatric, private diversion facility, or correctional facility. Engagement and integrated community supports are necessary for individuals to achieve and sustain recovery in the community.

The Community Engagement program is intended to support all individuals who have a history of and/or are at risk of involuntary commitment such that they can live in local communities of their choosing. This program's work is supported by CES staff who serve as the stewards of the programs implementation efforts. The CES are the brokers and facilitators of a wide range of community based and collaborative efforts and strategies designed and intended to support the varying needs of those served.

The CES works in the community to assist individuals with serious mental illness, substance use, co-occurring or co-existing disorder(s) that are at risk of psychiatric hospitalization or are currently committed. Any individual at risk who resides in or is from the grantee's area is eligible for assistance from the CES; individuals do not have to be an active consumer of the grantee to be eligible for this service as a significant focus is placed on identification and engagement. The CES engages and collaborates with all available community resources to prevent the need for involuntary commitment, improve community integration, and promote recovery by addressing the often complex needs of eligible individuals.

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

BBH funds multiple programs whose primary goal is to reduce hospitalizations. These programs include the previously mentioned CES program, BBH's primary programmatic approach to reducing hospitalizations. Other key programs include group homes, day support programs, Peer Centers, and Permanent Supportive Housing Programs.

Additionally, BBH funds and supports for West Virginia's 988 initiative.

5. Please indicate areas of technical assistance needs related to this section.

N/A

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	76,882	11,532
2.Children with SED	24,770	37,716

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

BBH uses prevalence data provided by NRI based on SAMHSA estimation methodology. BBH uses this data to complete annual reporting as required by SAMHSA. This data is then used for planning purposes in the following ways:

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

3. Please indicate areas of technical assistance needs related to this section.

None at this time

Criterion 3: Children's Services

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

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	● Yes	○ No
b)	Educational services, including services provided under IDEA	● Yes	○ No
c)	Juvenile justice services	● Yes	○ No
d)	Substance use prevention and SUD treatment services	● Yes	○ No
e)	Health and mental health services	● Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

None needed at this time

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

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

West Virginia is a rural State and is the only State that is entirely considered part of Appalachia by the Appalachian Regional Commission. West Virginia's rural nature has meant that rural services are part of every behavioral health system. However, additional steps have been taken to ensure that services are targeted to rural areas. CBHC's maintain offices in each of WV's 55 counties. Mobile services are provided to reach particularly isolated mountain areas. There is an active transportation workgroup that meets to coordinate transportation resources for consumers. Rural outreach and targeted services is also a focus area for BBH's emerging CCBHC Initiative.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

PATH
BBH receives the annual Projects for Assistance in Transition from Homelessness (PATH) grant. All 6 regions of the state have a PATH provider in addition to the WV Coalition to End Homelessness who oversees the Balance of State. Each Continuum of Care (CoC) is represented in the program. BBH emphasizes outreach and case management in the PATH program. The Statewide PATH Contact (SPC) is actively involved with MHBG Program planning.

Continuums of Care (CoC)
West Virginia utilizes the Continuum of Care (CoC) model. These are groups of individuals, organizations, and policymakers who gather under a formal structure to develop local systems and strategies for delivering housing and services. The overall approach is based on the concept that homelessness is more than a lack of shelter, but involves a variety of underlying, unmet physical, economic, and social needs. West Virginia's model is administered through four regional organizations: Cabell-Huntington-Wayne CoC, Kanawha Valley Collective CoC, Northern Panhandle CoC, and Balance of State CoC.

West Virginia Coalition to End Homelessness (WVCEH)
BBH directly funds the WVCEH to support their statewide mission of ending homelessness. In addition to functioning as the Balance of State CoC, WVCEH provides an array of services for individuals experiencing homelessness and coordinates the statewide management of the Homeless Management Information System (HMIS).

Integrated Behavioral Health Care Project
BBH funds West Virginia Health Right to provide integrated behavioral health care services in Charleston as a part of their free clinic's service array. People experiencing homelessness are a priority population for this project and West Virginia Health Right maintains a location at Covenant House specifically targeted for homelessness services.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

West Virginia's Bureau for Senior Services is responsible for services including transportation, meals, exercise classes, and in-home services.
BBH partners with the Bureau for Senior Services to assist with analysis of need and consultation with development of services.
BBH funds mental health services for older adults who are unable to travel to their local behavioral health center that require in-home services through the 13 Comprehensive Behavioral Health Centers. BBH also promotes best practices for services to older adults by dedicating staff time and resources to offering trainings and presentations.

d. Please indicate areas of technical assistance needs related to this section.

N/A

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

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

1. Describe your state's management systems.

ADMINISTRATION

BBH includes two interrelated sections which are Programs and Policy, and Administration. Administration is responsible for fiscal management, technology and shared data systems. Programs and Policy provides oversight and coordination of planning, development, funding, and monitoring of community behavioral health services and supports. BBH engages in contractual grant agreements with each provider who receives Block Grant funding.

DISASTER PREPAREDNESS FOR SPECIAL POPULATIONS

BBH coordinates with the Bureau for Public Health (BPH), the West Virginia State Red Cross Chapter, West Virginia Division of Homeland Security, State Emergency Management, and West Virginia Voluntary Organizations Assisting in Disasters (VOAD), to develop processes, policies, plans and annexes for inclusion of those with access and functional needs in the State's various Emergency Operations Plans and for the activities listed in The National Response Framework (NRF) under Emergency Support Function #6. This includes mass care, sheltering, housing and human resources, as well as the transition into the Health and Human Resources Recovery Support Function under the National Recovery Support Framework.

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

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

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

3. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

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

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

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

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

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

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

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a) 90 percent capacity reporting requirement? (●) Yes ( ) No

b) 14-120 day performance requirement with provision of interim services? (●) Yes ( ) No

c) Outreach activities? (●) Yes ( ) No

d) Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) Yes ( ) No

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

a) Electronic system with alert when 90 percent capacity is reached? ( ) Yes (●) No

b) Automatic reminder system associated with 14-120 day performance requirement? ( ) Yes (●) No

c) Use of peer recovery supports to maintain contact and support? (●) Yes ( ) No

d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? (●) Yes ( ) No

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

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

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

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

a) Business agreement/MOU with primary healthcare providers? (●) Yes ( ) No

b) Cooperative agreement/MOU with public health entity for testing and treatment? (●) Yes ( ) No

c) Established co-located SUD professionals within FQHCs? (●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Bureau for Behavioral Health provides funding, via grants, to a variety of organizations for the implementation and delivery of services. Each grantee agrees to a Statement of Work (SOW), and the SOW requires the grantee to deliver specific services while meeting certain requirements to achieve benchmarks in order to receive the funds. The grantee is required to provide progress reporting on the specific services provided to the identified population. BBH program staff review and monitor progress reports to track overall programmatic progress. BBH has a Compliance Division, and along with the assigned Program Manager, they share responsibility for ensuring that grantee reporting is being submitted and reviewed. Staff may perform desk reviews and/or site visits to address grant compliance. If the grantee does not meet reporting and progress requirements or there are indications that

services are not being provided as agreed, the compliance issues will be addressed with the grantee, and a corrective action plan will be developed to remedy the issues. Technical assistance may also be offered to help the organization reach an appropriate level of service to meet the needs of its clients. If compliance issues are not resolved, funding may be delayed or discontinued.

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

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

○ Yes ◉ No

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

a) Establishment of EIS-HIV service hubs in rural areas?

○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services?

○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?

○ Yes ○ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?

◉ Yes ○ No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

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

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

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

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? (●) Yes ( ) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

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

a) Review and update of screening and assessment instruments? ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions? ( ) Yes (●) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

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

a) Training staff and community partners on confidentiality requirements? ○ Yes ● No

b) Training on responding to requests asking for acknowledgement of the presence of clients? ○ Yes ● No

c) Updating written procedures which regulate and control access to records? ○ Yes ● No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ○ Yes ● No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ● Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

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

a) Development of a quality improvement plan? ○ Yes ● No

b) Establishment of policies and procedures related to independent peer review? ○ Yes ● No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ○ Yes ○ No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ○ Yes ● No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

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

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ◉ Yes ○ No

c) Performance-based accountability? ◉ Yes ○ No

d) Data collection and reporting requirements? ◉ Yes ○ No

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

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

a) A comprehensive review of the current training schedule and identification of additional training needs? ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) SMI Adviser ○ Yes ◉ No

c) Addiction TTC? ◉ Yes ○ No

d) State Opioid Response Network? ◉ Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ◉ Yes ○ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

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

https://ohflac.wvdhhr.org/

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

BBH is collecting data, but has several challenges associated with reporting data and is in the process of addressing these concerns via a change in scope and duties of current data partners. For community providers, thirteen comprehensive behavioral centers and two IDD providers, the state’s mental health safety net providers that BBH funds submit four files electronically to a data vendor, Acentra. After basic validations via Acentra that data is then passed onto the Office of Management Information Systems (MIS) within the Office of Shared Administration. MIS built and maintained the BBH database. The data then undergoes additional advanced validations. The data is also compiled into a structure to allow tracking of unique individuals at a state level,

even if the client receives services from multiple providers. The state psychiatric hospitals follow a different process with some data coming from their EHR and some from a custom program built and maintained by MIS. MIS is responsible for all of their data processes either directly or via vendors.

The current data process collects data at the client, program, provider, and payor level. The BBH has a rudimentary ability to report treatment episodes. Even though a process or data field is in place, BBH cannot always report at the levels that data is collected. The BBH is working towards a solution for reporting.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Originally the BBH data was part of a larger agency initiative to establish a standardized data set for behavioral health services. This is one of the reasons why BBH has additional files to achieve the full data set required. The primary file was originally across not only BBH but the sibling bureaus that are charged with Medicaid and Child Welfare functions. As priorities have changed, initiatives focusing on agency wide data processes have shifted. Currently BBH reporting and prior authorization for Medicaid fee for service for behavioral health services are the only initiatives that are still using the current data reporting process. Also of note is that the behavioral health infrastructure, including which agencies BBH funds, has changed substantially since the implementation of the current system. Part of the long-term BBH data plan is to incorporate all relevant providers. There is also renewed interest in an agency level data set for behavioral health, particularly for SUD treatment.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

BBH is part of an agency that also is charged with Medicaid, Child Welfare, and Family Assistance Services. The ability to share data within the agency is strong, but currently it is primarily on a project-to-project basis and not a full systems integration. For one initiative, data from Medicaid, child welfare, and BBH are linked for a more holistic look at children receiving services. As part of the implementation of CCBHCs in the state, BBH and BMS have been partnering with the health information network in the state (WVHIN), to allow for the necessary protections and permissions to allow behavioral health data to be shared between providers. It is anticipated that this work will also lead to the agency receiving a more complete clinical picture. The two bureaus are also exploring additional client level data as part of CCBHC implementation. BMS has a data warehouse that BBH anticipates incorporating data into after current concerns are addressed. There are many initiatives occurring and BBH anticipates big changes within the next five years.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

Currently the structure of data reporting potentially allows for reporting of both EBPs and outcomes. However, additional codes and data fields would need to be added. BBH submitted a corrective action plan for SUD TEDS reporting. BBH is taking the opportunity to address all identified data gaps. Data field mapping, i.e. what data is required and what data BBH collects, will be conducted for all required data submissions including TEDS, URS, and now MH-CLD. This process will help BBH to not only identify what data gaps exist but allow for identification of solutions. Additionally, there are issues reporting data to SAMHSA that providers submit to BBH. Over the past three years BBH has attempted to identify and correct these concerns using current data partners and systems. Although some progress has been made, BBH still cannot submit data. Therefore, BBH is in the process of changing the scope and duties of its data partners, to address the current data reporting concerns BBH has, including capturing all required data and data access. In addition, the nature of crisis services and response impacts BHCS reporting. When crisis services are needed, a person may not be an established client of the agency providing the services, and the client may not provide information needed for reporting purposes or follow-up care during or after the crisis for tracking outcome data. WV’s single 988 call center also reports low response rates when attempting to follow-up. Regardless o the challenge associated with collecting outcomes, BBH should have y increased capacity to report outcome data in the next six months while identifying data gaps in current processes.

5. Briefly describe the limitations of the SMHA 's existing data system.

Overall, the current approach and process has many benefits. However it was heavily reliant on institutional knowledge. Also, when the current process was built, data governance as a concept, much less as best practice, was in its infancy. One of the consequences is that roles and responsibilities were not documented as fully as is considered standard practice today, leaving gaps in maintenance of the system as staff turnover occurred. A consequence of this is inability to remain current with data needs and consistent data quality. As BBH moves forward to address data concerns, these hard learned lessons will be used to help mitigate these concerns from occurring in the future.

Providers add required data fields to their system(s), then extract data files and submit to BBH via a vendor. This means that any changes needed are reliant on the ability of the provider to implement them. There are various abilities at the provider level to be able to modify their systems and queries to accommodate any changes. If it takes their system vendor to implement changes, timelines are starting to reach 6 months plus for implementation. Historically a three-month time period was the expectation, but few have been able to meet that timeframe recently; primarily because they must engage with vendors for changes. When BBH needs with their vendor to define and update all systems and documents plus the time for the provider to implement in their EHRs and processes; the system is not able to be responsive in a timely manner. However, the current system does allow for customizations needed for reporting that can only be found with a custom system and process.

6. What strategies are being employed by the SMHA to enhance data quality?

BBH has a biweekly meeting with current data partners to address concerns. Providers submit data files to a BBH vendor, Acentra,

who then passes them on to the BBH database that is maintained by MIS. Acentra has developed a report to monitor file submissions from providers. The BBH has taken this report and built provider specific reports to identify any concerns with data processes. Due to ongoing concerns, the BBH is shifting roles and responsibilities of current data partners, Acentra and the Office of Management Information Services (MIS). Acentra will be taking over reporting responsibilities from MIS. After access to data has been reestablished the BBH plans to build internal dashboards to monitor data quality and submissions. Another initiative the BBH plans to implement in the next two years is to develop policy(s) that help align data and program guidance. It is anticipated that this will help standardize data across providers as well as identify additional concerns around data quality.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

One of the biggest concerns about improving data quality is the impact on the behavioral health providers. Changes will likely result in providers incurring costs with their data vendors to updatr data fields or processes. Any change in data requirements takes funding at both the state and provider level. Additionally, as expectations about using data in program decision making continues to increase, the systems need to evolve with those expectations, as well as increase access to the data as well as the staff with the ability to help interpret the data. BBH is working to build out internal data capacity with both positions and general knowledge. However, staff positions are often associated with discretionary grants which continue to leave gaps in the ability of the bureau to effectively address block grant needs and systems change. Additionally, some grants require a position to be filled at time of application. This means current resources must be split to meet the data needs of not only existing but future projects too. There are current concerns about the IT infrastructure that BBH plans to address with the changes in roles currently being implemented . These will continue to be a concern, because of the complexity of the data.

8. Please indicate areas of technical assistance needs related to this section.

TA is needed related to IT infrastructure, for technology positions as well as data infrastructure for programmatic staff . Program and IT staff have different skills and vocabulary, but for data to be useful and high quality both sides need to understand each other. Normalizing and expanding the ability of program and IT staff to understand how to communicate about data would be beneficial in setting the expectation that both are responsible for data.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

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

A crisis response system has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

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

Current West Virginia Crisis System Core Services/Elements
A. Access to Local Crisis Call Centers (Someone to talk to)
BBH funds the state's single 988 Suicide & Crisis Lifeline center through First Choice Services, which has been operating the state's Lifeline since 2017, with the five-percent MHBG set-aside, supplemental MHBG funding, and a SAMHSA 988 Capacity grant. The WV 988 center answers in-state calls, chats, and texts. First Choice Services is also a national 988 backup center and operates the following complementary state lines:
• the state's 24/7 mental health and substance use helpline, Help4WV, which links people of all ages with behavioral health services and children

and youths up to age 21 with mobile crisis response and stabilization services through the Children's Crisis and Referral Line;
• WV211, to help people locate social services in their communities;
• Jobs & Hope WV, to link West Virginians in recovery with opportunities to obtain career training and meaningful employment;
• the Problem Gambling Network of WV, a 24/7 helpline for referrals to gambling addiction specialists and support groups; and
• the Tobacco Quitline.

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

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

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

This year we added 5 children's mobile crisis teams through Medicaid via the Medicaid State Plan Amendment(SPA)

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

Crisis Intervention Teams (CIT) have been growing across the state with the first 988 and CIT Summit taking place in June 2023 for an audience largely of law enforcement leaders and behavioral health providers. The BBH 988/Crisis/Disaster Coordinator, WV 988 Planning Coalition, and WV 988 center continue to provide outreach to first responders and other partners to increase diversion of individuals experiencing mental health and co-occurring behavioral health crises to 988 and community behavioral health services from 911, the criminal justice system, and emergency departments.

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

Prevent Suicide WV, the American Foundation for Suicide Prevention WV chapter, and a dozen BBH and SAMHSA-funded regional youth and adult suicide intervention specialists undertake multiple suicide prevention, intervention, and postvention initiatives and directives throughout the state. These professionals collaborate with communities, schools, hospitals, behavioral health professionals, law enforcement, and other prevention professionals on several evidence-based practices and programs, including Applied Suicide Intervention Skills Training (ASIST), SafeTALK, Counseling Access to Lethal Means (CALM), More than Sad, Signs of Suicide Prevention Program (SOS), Lifelines, and It's Real: College Students and Mental Health. The WV Behavioral Health Workforce and Health Equity Training Center also provides several suicide prevention trainings, include Question, Persuade, Refer (QPR).

Currently we have 110 community engagement specialists (CES) assist individuals with serious mental illness, substance use, co-occurring, or co-existing disorders who are at risk of psychiatric hospitalization or are currently committed.

C. Availability and Utilization of Short-Term Crisis Receiving and Stabilization Centers (Place to go)
For children and young adults up to age 21 and their families, Children's Mobile Crisis Response and Stabilization teams offer short-term Crisis Respite Services. These services are currently funded by a SAMHSA Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (System of Care or SOC) grant.
Psychiatric Residential Treatment Facilities (PRTFs) with more than 100 beds for children and youths up to age 17 are also available through private insurance and Medicaid funding.
The state has more than 100 adult crisis stabilization unit (CSU) beds.

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

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

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

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

3. Briefly explain your stages of implementation selections here.

Someone to talk to: WV's 988 Suicide & Crisis Lifeline Center is established and answering the majority of in-state calls, chat, and texts. 844-HELP4WV provides a state-specific, 24/7 call, chat, and text option. The state continues to raise awareness of these helplines. Someone to respond: Children's Mobile Crisis Response teams are statewide, and Adult Mobile Crisis Response teams cover about half of the state. Mobile Crisis services for individuals of all ages will continue to expand with a new Medicaid state plan amendment (SPA) for mobile response services and r Certified Behavioral Health Clinics (CCBHCs).

Safe place to go or to be: BBH has developed more outpatient options for children and adults and will have quicker access with the establishment of CCBHCs. BBH is working with the WV Bureau for Medical Services and Bureau for Social Services to open more intensive outpatient programs (IOPs), as well as a children's crisis center and additional children's crisis beds. The BBH Office of Adult Services released two funding opportunities for psychiatric urgent care centers. Due to no response to these funding opportunities, BBH is currently evaluating next steps while continuing to collaborate with WV Medicaid to encourage sustainable funding streams.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

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

In September 2025, BBH has funded Marshall University to have a multi day training which will focus on using the crisis system to enhance services to increase the diversion of youth from the juvenile justice system by working more closely with law enforcement and using the leverage and rapport that has been built by the CIT to break down the barriers previously encountered with law enforcement. We will also provide specific training track that will be geared towards recruiting and training youth peers to mentor.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 1

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 1

c. Estimated percent of 911 calls that are coded out as BH related: 5

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 7
b. Integrated with public safety first responder structures (police, paramedic, fire): 0
c. Number that utilizes peer recovery services as a core component of the model: 6

Safe place to be

a. Number of Emergency Departments: 0
b. Number of Emergency Departments that operate a specialized behavioral health component: 1
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 0

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

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

7. Please indicate areas of technical assistance needs related to this section.

None at this time. West Virginia has received extensive technical assistance (TA) from the University of Connecticut Innovations Center, including through the Mobile Response and Stabilization Services (MRSS) quality learning collaborative and System of Care TA. SAMHSA discretionary grants, including 988 Capacity and CCBHC planning, also provide TA. The state will also explore the resources of the new SAMHSA Crisis Systems Response Training and Technical Assistance Center (CSR-TTAC). At this time we will have access to this TA service until 09/27.

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

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

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

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

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

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

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

6. Please indicate areas of technical assistance needs related to this section.

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

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

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

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

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

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

d) The resilience of children and youth with SUD? ◉ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ◉ Yes ○ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Concerns about access to and availability of community-based mental health services for children and youth with serious

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

BBH uses SAMHSA block grant funding for Regional Youth Service Centers, which
include outpatient mental health and substance use treatment and peer support services for youth and young adults; statewide early serious mental illness (ESMI) or first-episode psychosis (FEP) services called Quiet Minds WV; and newer Regional Transition Navigators to provide support, training, and linkages to youth and young adults aged 14-25 who are experiencing, have experienced, or are at risk of experiencing SED, mental illness, or substance use disorders, with an emphasis on individuals who are experiencing homelessness, are aging out of foster care or juvenile detention, or are at risk for human trafficking.

BBH continues to provide a training system for providers at no cost to them for Wraparound and mobile crisis response provider training, WV receives technical assistance from the now-University of Connecticut Innovations Center.
Prevention and early invention services have also flourished in WV. More than 71 schools receive grants to implement multi-tiered Expanded School Mental Health (ESMH), including 18 sites funded through two SAMHSA Project AWARE grants to the WV Department of Education. BBH expanded its substance use prevention workforce with SAMHSA block grant, Partnerships for Success, and State Opioid Response funding. BBH also funds Prevent Suicide WV The state's
prevention infrastructure includes six regional prevention lead organizations, county coalitions, and an overarching WV Prevention Strategic Plan addressing risk and protective factors that transcend types of prevention, including child abuse and neglect, sexual violence, and suicide.

In 2023, we added Youth and Young Adults Early Diversion program which serves age 14 and up and seeks to prevent individuals from accessing juvenile justice and criminal justice systems.

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

System of Care approach: The state has created a network of services to support children and youth with SED and SMI and their families, including WV Wraparound and mobile crisis response services. These services can be accessed through the Children's Crisis and Referral Line (844-HELP4WV). The Regional Youth Service Centers provide outpatient SUD, SED/SMI, FEP, and co-occurring treatment for youth and young adults.
Collaboration with child- and youth-serving organizations. BBH and the state agencies serving children and youth continue to enhance the state system of care with the Kids Thrive Collaborative, , https://kidsthrive.wv.gov/Pages/default.aspx. BBH works with child welfare and juvenile justice agencies on diversion, drug court, and juvenile competency remediation initiatives.
BBH also holds regular meetings with grantees and convenes collaborative groups that provide feedback, including the Family Advisory Board. In 2025 we now have 28 family members represented on the Family Advisory Board DHHR also established a data quality office that regularly reviews data on certain programs; those data
reports may be found at https://kidsthrive.wv.gov/DOJ/Pages/default.aspx.
Evidence-Based Training: BBH continues to provide training on Wraparound and mobile crisis services to maintain fidelity and is free of cost to all providers across the state who provide these services. In 2023, the BBH Children's
office also established the BBH Clearinghouse (https://clearinghouse.helpandhopewv.org/) to help guide practitioners, funders, and families on selecting effective programs.
Several BBH programs focus on transitioning youth, including the Regional Youth Service Centers,
Quiet Minds WV (FEP), and the new Regional Transitional Navigators (https://rtn.cedwvu.org/), who provide information, training, and resources/services to youth and young adults 14-25 years of age who are at risk of or experiencing SED/SMI, SUD, co-occurring disorders, and housing insecurity.
Finally our newest program which is Early Diversion for Youth and Adults. This program serves individuals age 14 and up who are at risk of or who have already had contact with the juvenile or criminal justice systems. The purpose to prevent the individual from either coming in contact with these systems and reduce recidivism if they have already been involved.

8. Please indicate areas of technical assistance needs related to this section.

none needed

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

BBH funds the Prevent Suicide WV for suicide prevention training, early intervention and postvention. Suicide preventionists work with community partners, schools, emergency departments to train on suicide prevention programs, practices, connect individuals with services, and provide postvention services for families, schools, and communities affected by suicide. Read more at https://preventsuicidewv.com.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ◉ Yes ○ No

If yes, please describe how barriers are eliminated.

Suicide preventionists and Certified Community Behavioral Health Centers work on continuity of care with emergency departments and other residential placements to help families understand restriction on lethal means and connect youth with follow-up services.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

To build capacity for suicide prevention, intervention and postvention services throughout the state. BBH has a 988/Crisis/Disaster Coordinator to help with the continued outreach of WV 988 Suicide and Crisis Lifeline, crisis continuum of care, and behavioral health disaster planning and readiness. The state continues to work on enhancing collaboration for the crisis continuum to include more Crisis Intervention Teams, 988, and exploring expansion of NAMI within the state. The Governor's Challenge and Prevent Suicide WV continues to work in WV address suicide prevention, early intervention and postvention.

6. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

WV has identified and developed a new partnership with the WV Workforce agency, Workforce West Virginia. Starting with a few introductory emails and phone calls as part of the state's National Association of State Mental Health Program Directors (NASMHPD) Transformation Transfer Initiative (TTI) Workforce award, staff shared information on areas such as the growing peer workforce, the SSA's virtual Polysubstance Summit6, and Workforce WV's new data dashboard, and now Workforce WV has joined the SMHA's Peer Learning Collaborative team on Direct Service Workers.

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.

A recent example of outreach conducted with the State's workforce agency is that BBH has been developing it's working relationship with Workforce WV. Thus far this had included phone calls to discuss existing federal grants, recommendations about grants in the peer worker space, and new data dashboards about employment by sector within the state. Because WV has the lowest workforce participation in the country, this partnership is useful in terms of sustained recovery for individuals finding their purpose, and for treatment providers in their recruitment and retention of employees. To help children and youth thrive in their homes, schools, and communities, BBH funds a wide array of services, such as behavioral support services through the West Virginia University Center for Excellence in Disabilities, Positive Behavior Support (PBS) Program, including support with Individual Education Plans (IEPs).

4. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

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, letter from the Council Chair etc.)

The Director of the Bureau's Office of Planning spoke to the West Virginia Behavioral Health Planning Council (WVBHPC) on July 17, 2025 on the current year Block Grant planning process. A Draft of the application is distributed to the WVBHPC for comment and review prior to the submission of the application.

The letter from the Council Chair is attached to the application.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — ( ) Yes (●) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

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

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

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

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

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The mission of the West Virginia Behavioral Health Planning Council (WVBHPC) is to improve the behavioral health service system and advocate for positive change. The WVBHPC is federally mandated to review and comment on the State mental health plan, monitor, review, and evaluate allocation and adequacy of mental health block grant services, and advocate for services for individuals with mental illness and co-occurring substance abuse issues. The members of the WVBHPC and its subcommittees, including the Executive, Membership, Children and Families Services, Adult Services, Housing and Olmstead Committees, work collaboratively with the member state agencies to solicit input from the applicable stakeholders and provide input on agency priorities and plans, including but not limited to the Combined Block Grant application. The WVBHPC accomplishes this by: meeting at least quarterly in different areas of the State; developing strategies to accomplish Council goals pursuant to the federal mandate; actively participating in a wide range of state and local initiatives that impact behavioral health, homelessness, and community services; and, partnering with the BBH to assure the availability of person centered, high quality behavioral health services throughout the State and conducting independent assessments of need which are reported to the BBH.

7. Please indicate areas of technical assistance needs related to this section.

N/A

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Misty Adams	State Employees			
Shawn Allen	Parents of children with SED			
Michelle Angus	State Employees			
Vickie Ashcraft	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Elliot Birckhead	State Employees			
Elizabeth Brooks	Parents of children with SED			
Carolyn Canini	Providers			
Ardella Cottrill	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Joe Deegan	Providers			
Nancy Deming	Persons in Recovery from or providing treatment for or advocating for SUD services			
Karen Donato	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Allison Flanagan	Providers			
Julie Gomez	Providers			
Hannah Gowarty	Youth/adolescent representative (or member from an organization serving young people)			
Jennifer Gower	State Employees			

Heather Hoelscher Garcia	Providers			
Jennifer Keener	Parents of children with SED			
Tammy Ketchem	Providers			
Brenda Lamkin	Providers			
Carmen Maniak	State Employees			
Reed Mason Byers	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
John McAtee	Parents of children with SED			
Autumn McCraw	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Patrick Mirandy	State Employees			
Aaron Morris	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Donna Moss	Parents of children with SED			
Cynthia Parsons	State Employees			
Linda Pauley	Persons in Recovery from or providing treatment for or advocating for SUD services			
Cathy Reed	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Phil Reed	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
James Ruckle	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
David Sanders	State Employees			
Nate Siggers	Persons in Recovery from or providing treatment for or advocating for SUD services			
Natasha Stout	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Lisha Tignor	State Employees			
Vanessa Vangilder	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			

Richard Ward	State Employees			
Julie Williams	Providers			
Lisa Wilson	Parents of children with SED			
Wesley Wood	Persons in Recovery from or providing treatment for or advocating for SUD services			

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

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	8	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	6	
4. Vacancies (individuals and family members)	3	
5. Total individuals in recovery, family members, and parents of children with SED	**20**	**45.45%**
6. State Employees	10	
7. Providers	8	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**18**	**40.91%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	4	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	1	
13. Advocates/representatives who are not state employees or providers	0	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	1	
15. Total non-required but encouraged members	**6**	**13.64%**
16. Total membership (all members of the council)	**44**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

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

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

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

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

d) Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

WV does not use or plan to use SUPTRS funding for SSP.