Department of Behavioral Health and Developmental Services (DBHDS)

Comments & DBHDS Response: 2024-25 SAMHSA Combined MH & SA Block Grants Application

Stage	Annual Application – Request for Public Comment
Window:	**Aug 1, 2024 – September 1, 2024**

*Data is primarily based on 2023 annual reporting as 2024 data has not reached total completion across all programs

#	Commenter Name	Commenter Organization	Date	Comments	DBHDS Response to Questions and Requests *Comments without questions or requests are noted for public record
1	Susan Fincke	Representing Self	8/27/2024	Issue # 1 See Appendix A	Pregnant women and women with dependent children is a priority area mandated by SAMHSA for the SUPTRS Block Grant and DBHDS follows this mandate in regard to establishing policy, managing programs, and maintaining expenditures for special services for pregnant women and women with children at or above the level established during the base year (1993) as guided by SAMHSA. These services entail direct provision or community referral including case management, linkage to prenatal care, substance use disorder services, residential treatment, medication-assisted treatment, withdrawal management, mental health outpatient services, group therapy, intensive outpatient treatment, evidence-based trauma group, parenting program, and linkage to childcare and transportation services to attend treatment services. Infants and children are referred for developmental screenings and therapeutic interventions as deemed appropriate. DBHDS previously received a revision request from SAMHSA SUPTRS Project Officer that indicated that priority areas regarding the general population could not also include target populations like pregnant and parenting women despite that population also receiving targeted case management or SUD interventions. DBHDS shared in the 2024 SUPTRS Block Grant Report the following explanation for why targets were not met regarding Priority Area 3: While Virginia has not met the state goal this past fiscal year, Virginia has continued to improve from the previous year's actual goal of 72% in FY22. *Many of the Community Services Boards (CSBs) continue to experience workforce development issues, especially with licensed eligible and licensed clinicians which have impacted the ability to provide services to pregnant women within 48 hours. Since, the state of emergency due to the COVID-19 pandemic, CSBs are utilizing strategies to hire and retain clinicians to provide behavioral health and substance use disorder (SUD) services to individuals. In FY24, The Department will provide technical assistance to the 40 CSBs on*

					adhering to the block grant standards of ensuring that current and new hires are aware of providing services to pregnant and parenting women within 48 hours as well as technical assistance on providing interim services to the PPW population with 30 days until they can receive services. Additionally, the Department will ensure that the block grant reviews for FY24 with the CSBs stress the regulations and requirements of the PPW populations for the state of Virginia and that it is included in the CSBs' policies and procedures. DBHDS is providing ongoing technical assistance to the CSBs to address adherence to federal guidelines. Workforce issues are ongoing and new workers that are hired face a steep learning curve in terms of meeting local and federal regulations for their work and their reporting. DBHDS continues to expect to see gradual improvements in meeting target goals with continued technical assistance and process improvements that allow more free-flowing information exchange between the CSBs and DBHDS that ensures eliminating many misconceptions that occur in program delivery. DBHDS agrees that there are issues regarding access to and outreach for services. In particular, CSBs that cover rural parts of the Commonwealth have large catchment areas where individuals must travel large distances to be able to receive outpatient services. These regions rely heavily on private providers who are often not captured in state or federal data. A number of federal reports including NSDUH (National Service on Drug Use and Health) identify enormous aggregate need for SUD services and a small percentage in those actually receiving those services. In regard to Table 8b, the calculation of expenditures for PWWDC does not includes state general funds or Medicaid. The SUPTRS funds which DBHDS administer are also dependent on fluctuations to the federal awards. DBHDS agrees that there is an enormous impact of SUD regarding a number of areas including very notably social services programs which include foster care. The return on investment for both prevention and treatment of PWWDC is significant. DBHDS' Project Link served 289 more individuals regarding treatment and support around SUD related issues between 2022 and 2023. In 2023, DBHDS was able to add two new sites in Region 1 and Region 3 for Project Link. and plans to continue to expand services as resources allow. The recommendations will be shared with the internal offices that address the issues identified.
2	Susan Fincke	Representing Self	8/27/2024	Issue # 2 See Appendix A	DBHDS acknowledges the MHA ranking of mental health services for youth. Some of the data since that measure has changed or was unaccounted for in that ranking but it highlights some very important issues.

					DBHDS also recognizes the importance of the services identified in the recommendations (see appendix A). Many of these recommendations are integrations of services that take time, money, staff, and organizational infrastructure to achieve. Nevertheless, there has been progress in many of these areas. Regarding trained and certified Peer Recovery Specialist (PRS) workforce; In 2023, there were 1,113 individuals in active Certified Peer Recovery Specialist (CPRS) status with the Virginia Certification Board compared to 863 in 2022 and 576 of those were registered with the Board of Counseling as compared to 413 in 2022. Several of those individuals continued towards becoming family support partners. In addition, 966 people took the DBHDS 72-hour Peer Recovery Specialist training in FY 2023. Over 4,560 people have completed the training since January 2017. The trainings include peer staff within the public behavioral health system, recovery communities, non-profit organizations, and private providers. Trainings in evidence-based practices include but are not limited to: DBHDS 72-Hour PRS Training, Action Planning for Prevention and Recovery (APPR), Peer Support in the Workplace, Ethical Decision-Making, Trauma Informed Peer Supervision, Peer Group Facilitation, CPRS Prep Exam Training, and Crisis Services. DBHDS agrees with the need for more family support partners and youth support partners particularly for under-served communities. DBHDS funds and partners with the Virginia Wraparound Implementation Center (VWIC) which provides wraparound services to children and family and integrates family support partners and in some cases youth support partners in their recovery-oriented work. Establishing evidence-based practices across program areas has been long-term goals for DBHDS and the CSBs. The Division of Clinical and Quality Management provides cross disability clinical and technical expertise and support across all program areas of the agency, to aid in leading system-wide transformation and enhance cross disability collaboration. The aim of the division is to support the agency in ensuring that all individuals receive high quality care and the integration of evidence-based practices and data driven decision making to inform behavioral health and developmental disability policy and identify opportunities and implement solutions for system enhancement. The offices within Clinical Quality Management and Community Quality Improvement have provided technical assistance to over 60 CSBs, licensed service providers, and DBHDS central office personnel across 600 instances of technical assistance throughout the year. They have also developed and distributed an array of resources to help enhance DBHDS employee, CSB, and licensed provider quality improvement process

					and procedural knowledge and skills. Nevertheless, more outcome measures and fidelity measures are needed for EBPs to be successful and sustainable. Many program areas have implemented these types of measures in the planning, implementation, and sustainment of evidence-based practices in the Commonwealth. Workforce issues have made sustaining fidelity to EBP models challenging with new workers entering the workforce and several CSBs struggling to hire for some of their evidence-based practices such as Coordinated Specialty Care. The DBHDS division of Administrative Services has developed a DBHDS workforce planning framework, an internal Workforce Steering Committee, and an external behavioral health workforce collaborative to improve workforce development. These strategies have included: • Creating HR dashboards to help streamline reporting for vacancies, disciplinary actions, hires/transfers, workers compensation. • Implementing a new recruitment management system, Page Up • Working with DHRM to change the pay bands of Counselor I and Counselor II roles many of which are located at CSBs in order to create a pay scale and social work and counseling career ladder that is similar to nursing. DBHDS agrees with the need for meaningful outcome data for school-based mental health services and that type of data is a component of the grant that has helped fund pilots and implementation. Some of the data can be seen in this report and more data will be publicly available in 2024 to identify progress in outcomes. DBHDS agrees with recruitment and retention of bi-lingual staff. Our agency workforce initiatives include this type of recruitment, and efforts are being made to increase language-access. The recommendations will be shared with the internal offices that address the issues identified.
3	Susan Fincke	Representing Self	8/27/2024	See Issue #3 Appendix A	DBHDS agrees that the growing tuberculosis rates are concerning, and that testing is needed. DBHDS partners with VDH to provide testing resources and the Division of Clinical and Quality Management oversees that licensed providers required to conduct TB testing are conducting testing within the regulations provided. The data collection for the TB measure is certainly needing improvement and those caveats were acknowledged. Virginia was not considered a designated state for TB set aside and this has been a recent requirement to add a performance indicator for this area. This data collection involves collaboration with other agencies as well as the localities and there will be work over the next

					year to improve measuring testing rates.
4	Susan Fincke	Representing Self	8/27/2024	See Issue #4 Appendix A	In order for DBHDS to collect data for a new demographic, it requires significant infrastructure buildout including local community services boards requesting that information from clients and then documenting that in their electronic health records and then DBHDS building a new measure in the data extract system. DBHDS has been working on replacing the data extract which is an intensive process but in recent years DBHDS has started to collect data on gender identity across services. DBHDS agrees with establishing culturally and linguistically competent workforce recruitment and retention strategies. Over the last 2+ years, DBHDS has worked to achieve goals outlined in the Governor's Right Help Right Now Plan in regard to this area. Updates can be seen in the 2023 Diversity, Opportunity, and Inclusion Annual Report in regards to Access & Success, Welcoming & Respectful Culture, and State Agency DOI Infrastructure & Training. The accomplishments include: - ODOI Leadership provided in-person and virtual training and coaching sessions across the Commonwealth, supporting workforce members at DBHDS facilities, as well as Virginia Community Service Boards (VACSB) partners. - Leaders, managers, and workforce members were coached on strategies for creating inclusive workplace cultures, that embrace global diversity, while enhancing accessible, respectful patient care. ○ Topics included: Organizational Readiness for Diversity Equity Inclusion (DEI), Inclusive Leadership, Communication: Impact vs. Intention, Understanding Access and Belonging and Recognizing Barriers to Culturally Relevant Patient Care. While there is not a specific budget item allocated to identifying and remediating disparities in M/SUD care, activities towards reducing these disparities can be found in the block grants application under Environmental Factors and Plan 2. Health Disparities: - DBHDS continued our partnership with VCU Center on Society and Health to transform The Behavioral Health Equity Index into a data visualization platform, now being referred to as the Virginia Wellbeing Dashboard which predicts mental health and substance use disorders using statistical modeling and data from communities across Virginia.

					- Several workforce development opportunities have been provided to behavioral healthcare providers across the state including: ○ Crisis Response & Criminalization ○ The Rise of Eating Disorders in Marginalized and Overlooked Populations. ○ A statewide focus group and needs assessment was completed on identity-based discrimination in school settings ○ Two day Supporting Socially Marginalized Youth Summit that emphasized health racial and ended identity development among marginalized identities. ○ Behavioral health equity grants providing funding to implement equity oriented behavioral health programing in their communities. ○ Virginia Refugee Healing Partnership held behavioral health interpreter training ○ Expansion of Youth Substance Use Prevention ○ Language Access Conference ○ Community mental health awareness training in collaboration with community trainers and refugee resettlement
5	Susan Fincke	Representing Self	8/27/2024	See Issue #4 Appendix A	State Block Grant Planner will work the federal grants manager to review these categories and determine whether the formula used to capture these categories within the myriad of funding line items and contracts accurately captures these categories and whether updates need to be made to address this.
6	Heather Peck	Heather Peck Associates LLC	8/28/2024	See Appendix B	DBHDS appreciates the well-researched concerns and recommendation outlined in this public comment. A significant portion of block grant funds go to targeted case management services which include supported employment activities. Supported employment is also identified in Pillars 3 and 4 of the Governor's Right Help Right Now Plan. Nevertheless, there is a significant need for evidence-based supported employment services for individuals in recovery and navigating mental illness. The block grants provide funding for programs, administration, infrastructure, data evaluation and monitoring for services to individuals and families that are not covered under Medicaid and other insurances. A $5,000,000 allocation would constitute roughly 25% of the Mental Health Block Grant and 11% of the Substance Use Prevention Treatment and Recovery Services Block Grant which would be a very significant increase to supported employment services. Considerations have to be made as to how a significant increase of that magnitude would affect other core programs and initiatives. The recommendations including the IPS model and research conducted in South Carolina will be shared with the internal offices that address the issues identified and considered in regard to resource allocation.

7	Mara Rosen, MS	Representing Self		See Appendix C	The behavioral health system in Virginia is as the public comment alluded to, made up of a number of complex interrelated systems many of which do not always interact seamlessly especially depending upon the locality in which an individual or family resides. The resources as well as the need for them differ greatly and can greatly impact how well those systems coordinate and while efforts are constantly made to create synergy between systems, needs and gaps in programs and services remain. In terms of discharge, the Office of Patient Continuum Services provides development and oversight of state hospital admissions and discharges, including management of the hospital waitlists, and discharge planning and community integration of individuals discharging from state hospitals. The team assists and trains state hospital admissions staff, CSB preadmissions screeners, state hospital social workers, and CSB discharge planners. The team administers Discharge and Diversion funding, including Discharge Assistance Plan (DAP) funds and Local Inpatient Purchase of Service (LIPOS) funds. The Discharge AP is a major tool for overcoming barriers to discharge for individuals in state mental health hospitals who are clinically ready to leave but unable to do so due to the lack of needed community services. Total DAP funding amount is approximately $86 million. In FY 2023, DAP funds served nearly 1,700 individuals, of which approximately 530 were new discharges from state hospitals. Additional projects and partnerships included: o Supported 145 assisted living facility beds in three locations. o Supported 110 transitional group home beds in locations throughout the state. All of these beds are used exclusively for individuals discharging from or diverting from state hospitals. o Served 122 individuals in transitional group homes. o Served 173 individuals in assisted living facilities. o Serve approximately 65 individuals through partnerships with Mount Rogers CSB and Western Tidewater CSB to provide enhanced behavioral support at local nursing homes for individuals discharging from state hospitals. o Supported three programs that focus on assisting individuals with dementia who have been hospitalized at or are at risk of state hospitalization, and their families and caregivers in Northern Virginia, Southwest Virginia, and Tidewater.

Appendix A

August 27, 2024

Nathanael Rudney, State Block Grant Planner
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23219

Mr. Rudney,

I respectfully submit the following comments and recommendations regarding the 2024-2025 Combined MH/SUPTRS Block Grant Application and the 2024 Combined MH/SUPTRS Block Grant Report. I submit these as a private citizen representing only myself. Thank you for this opportunity and your careful consideration.

ISSUE #1

DBHDS has consistently identified Pregnant Women and Women with Dependent Children (PWWDC) as a Population in the Priority Areas and Annual Performance Indicators required in the grant.

- In the FY 2024 Block Grant Report, 11 (79%) of the 14 Priority Areas included PWWDC as a Population.
- In the FY 24/25 Block Grant Application six (35%) of the 17 Priority Areas included PWWDC as Population.

In the FY 2024 Report of the 14 Priority Areas, three (21%) failed to achieve the identified outcome measure in either Year 1 or Year 2. Priority 3 is one of those Priority Areas. The populations for Priority 3 are PWWDC and PP. (Page 8 of Report)

Priority #3
Priority Area: Adherence to the standard that pregnant women receive priority admission for SUD services being seen within 48 hours of their request for services

Priority Type: SAT

Populations: PWWDC, PP

Goal: Increasing percentage of pregnant women in Virginia who are receiving priority admission for SUD services at the CSBs.

Indicator 1
In the last 12 months, percent of pregnant women seen within 48 hours of their request for a valid SUD service

Baseline = 79%
Year 1 target = 80% (not achieved)
Year 2 target = 81% (not achieved)

The response given for not achieving the target include “misconceptions of the definitions and requirements” and “new hires being made aware” of the standard. In addition to the persistent workforce shortages, the lack of established policy and procedures at CSBs is also cited.

While I’m sure the data is available, I do not know the actual number of women who requested SUD services or the number who received priority admission within 48 hours. However, the larger question and perhaps more concerning issue is the number of PWWDC in Virginia who need SUD services who are not getting treatment.

Based on the data in Table 3, (Page 163 of Application) less than 7% of the aggregate number of pregnant women in need of SUD treatment are in treatment. Less than 4% of the aggregate number of women with dependent children in need of treatment are in treatment. For certain, a percentage of these individuals lack the motivation to seek treatment. However, this data may also indicate other issues related to outreach and/or accessibility to services.

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

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

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

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,873	337 6.9%
2. Women with Dependent Children	102,075	3,237 3.2%
3. Individuals with a co-occurring M/SUD	228,123	39,151
4. Persons who inject drugs	83,660	5,449
5. Persons experiencing homelessness	3,824	1,417

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

Our Data and Evaluations Coordinator, Benjamin Marks reviewed the survey data SAMHSA asked DBHDS to reference (NDSDUH) for the first column and the topics they covered were not available or not able to be located.

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

Table 8b below (Page 48 of the Report) provides the **state** and SUBG funds expended on specialized SUD treatment services for PWWDC. Base on the data, the actual expenditures from state and SUBG grant funds for services to PWWDC has decreased since SFY 2021. Given the unmet need for treatment, this would appear to be unwise.

Table 8b - Expenditures for Services to Pregnant Women and Women with Dependent Children

This MOE table provides a report of state and SUBG funds expended on specialized SUD treatment services for pregnant women and women with dependent children for the state fiscal year immediately preceding the FFY for which the state is applying for funds.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

Base

Period	Total Women's Base (A)
SFY 1994	$ 3,953,867.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2021		$ 6,095,376.00	
SFY 2022		$ 6,063,724.00	
SFY 2023		$ 5,831,915.00	◉ Actual ○ Estimated

Enter the amount the State plans to expend in SFY 2024 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women's Base (A) for Period of (SFY 1994)): $ 4,715,501.00;

While the sheer numbers of women not in treatment are unsettling, the downstream effects of lack of SUD services are equally disturbing. According to data from the Virginia Department of Social Services captured on 9/15/2023, parental drug abuse is the second leading cause or conditions of last removal for children being placed in foster care. A total of 1,538 children, 30.7 % of the total number, were in custody of the Department of Social Services at that time.

Virginia spends an average of $835,000 per day ($350 million annually for 5,000 children and youth) on foster care. Providing timely, effective SUD treatment for PWWDC could potentially save the Commonwealth valuable child welfare resources and prevent inter-generational trauma, requiring more and effective treatment for families and children.

Conditions of Last Removal		
Child's Behavior Problem	903	18.03%
Neglect	2560	51.11%
Caretaker's Inability to Cope	234	4.67%
Relinquishment	376	7.51%
Physical Abuse	714	14.25%
Parent's Drug Abuse	1538	30.70%
Inadequate Housing	674	13.46%
Parent's Alcohol Abuse	330	6.59%
Sexual Abuse	255	5.09%
Abandonment	227	4.53%
Child's Disability	93	1.86%
Incarceration of Parent	301	6.01%
Child's Drug Abuse	129	2.58%
Death of Parent	58	1.16%
Child's Alcohol Abuse	41	0.82%

Recommendations:

1. Expand Project Link to all CSBs.

2. Explore opportunities to remove barriers to treatment for women i.e. childcare.

3. Rather than "universal" marketing strategies, explore innovative ways to reach PWWDC such as directed or targeted outreach using "trusted community messengers".

4. Institute client-centered decision making in SUD services for women.

5. Incentivize consistency in policies and procedures regarding SUD priorities across CSBs.

6. Recruit, training and utilize female Certified Peer Recovery specialists in underserved areas.

ISSUE #2

The following is taken from Page 142 of the Application

The Virginia Office of Children's Services conducted its Service Gap Analysis from FY2022, surveying local community policy and management teams. The survey analysis demonstrated the lack of a complete array of children's services in all areas of the State. It identified the following seven statewide gaps by services: community based behavioral health, residential, crisis, evidence based, foster care, family support, and educational. The survey also identified increased or new barriers for FY2022. These gaps include provider availability, staffing, wait (lists/times), transportation, foster care homes, evidence-based, funding and multi-lingual services. Within the top three broad categories the following services were identified:

Category	Services
Family Support Services	• Respite • Parent coaching • Intensive Care Coordination
Community Based Behavioral Health Services	• Trauma Focused/Informed Services • Applied Behavioral Analysis • Medication Management
Foster Care	• Family Foster Care Homes • Therapeutic Foster Care Homes • Independent Living Services

The Commonwealth has acknowledged Mental Health America's ranking of 48th among the states in mental health services for youth. The investment in school-based mental health services represents the efforts to address the crises. While this strategy is to be applauded, it is insufficient to address the magnitude of the crises. While the shortage of clinical staff to address the mental health needs of children and youth continues to impact services, there are alternatives for interventions.

Recommendations:

1. Fully integrate Family Support and Youth Peer services particularly in under-served communities.

2. Vigorously enhance recruitment, training, certification, and reimbursement for family support and youth peer services.

3. Continue intense training and follow-up in trauma-informed and -focused services, not only for clinical staff but the full staff at all CSBs.
4. Measure fidelity to evidence-based practices and programs in a random sample of CSBs annually.
5. Work with DOE to establish meaningful outcome data for school-based mental health services. For example, reduction in chronic absenteeism, fewer disciplinary actions, etc.
6. Prioritize recruitment and retention of bi-lingual staff.

ISSUE #3

The following is found on Page 140 of Application

Services for Persons at Risk for Tuberculosis
DBHDS began systematically screening and recording data for all individuals admitted to Substance Use Disorder services in SFY2021 (beginning July 1, 2020). If an individual is screened at-risk, the person is referred to the local public health department. The MOE calculation is based on the number of positive TB cases during the year. The MOE base and annual compliance figure is calculated by totaling state general fund expenditures for TB Prevention and Control, TB Drugs, TB Outreach and TB Drugs-Resistance. In 2022, the latest year of available TB data, the CDC determined that there was a total of 195 positive TB cases statewide which was an increase from 2021.[2] Virginia's incidence of contracting tuberculosis also increased in 2022. Due to the increase of positive cases over the last several years, finding and treating at-risk-for-latent TB testing has continued to be a high priority.

Most private SUD treatment facilities and programs require clients to tested for TB. Testing for high-risk populations has been a best practice for several years. Consider the following statement from the U.S. Preventive Services Task Force.

The CDC, together with the American Thoracic Society and the Infectious Diseases Society of America, recommends screening for LTBI to identify persons who may benefit from treatment before progression to active tuberculosis infection.[25,41] Joint guidelines from the American Academy of Pediatrics and American College of Obstetricians and Gynecologists recommend screening for latent tuberculosis in early pregnancy for women at high risk for tuberculosis, including those with recent tuberculosis exposure, HIV infection, risk factors increasing risk of progression to active disease (such as diabetes, lupus, cancer, alcoholism, and drug addiction), use of immune-suppressing drugs such as tumor necrosis factor inhibitors or chronic steroids, kidney failure with dialysis, homelessness, living or working in long-term care facilities such as nursing homes and prisons, being medically underserved, and being born in a country with high prevalence of tuberculosis.[42] The American Academy of Family Physicians supports the 2016 USPSTF recommendation on screening for LTBI.[43]

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/latent-tuberculosis-infection-screening

The following Planning Table is found on Page 161 of the Application. The table provides the planned expenditures from the SUPTRS grant and other sources for the services covered by the SUPTRS grant, including Tuberculosis services.

Table 2 State Agency Planned Expenditures [SUPTRS]

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

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

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$71,353,480.50		$25,979,188.80	$36,851,947.58	$146,225,598.66	$0.00	$0.00		$26,705,699.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$7,907,134.00		$0.00	$0.00	$2,759,732.00	$0.00	$0.00		$3,953,867.00	
b. Recovery Support Services	$2,860,966.00		$0.00	$5,547,051.21	$3,800,000.00	$0.00	$0.00		$1,280,000.00	
c. All Other	$60,585,380.50		$25,979,188.80	$31,304,896.37	$139,665,866.66	$0.00	$0.00		$21,471,832.00	
2. Primary Prevention[d]	$19,027,594.80		$0.00	$4,759,873.18	$0.00	$0.00	$0.00		$10,675,000.00	$0.00
a. Substance Use Primary Prevention	$19,027,594.80		$0.00	$4,759,873.18	$0.00	$0.00	$0.00		$10,675,000.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
6. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$2,471,362.00	$0.00	$0.00		$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$4,756,898.70		$6,543,891.07	$3,825,195.96	$20,030,273.81	$0.00	$344,415.32		$1,967,405.00	
12. Total	**$95,137,974.00**	**$0.00**	**$32,523,079.87**	**$45,437,016.72**	**$168,727,234.47**	**$0.00**	**$344,415.32**	**$0.00**	**$39,348,104.00**	**$33,982,454.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

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

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

The following Planning Table is found on Page 162 of the Application. The table provides the planned expenditures from the MH grant and other sources for the services covered by the MH grant, including Tuberculosis services.

Table 2 State Agency Planned Expenditures [MH]

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

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

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$4,881,142.00	$0.00	$0.00	$8,000,000.00	$0.00	$0.00	$2,071,846.10		$3,106,653.00	$140,000.00
4. Other Psychiatric Inpatient Care			$15,098,398.00	$0.00	$45,940,525.00	$0.00	$0.00	$0.00		$0.00	$0.00
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$68,348,614.00	$6,117,853.00	$887,140,015.00	$0.00	$6,030,760.00	$0.00		$0.00	$0.00
8. Other 24-Hour Care		$0.00	$4,054,337.00	$0.00	$29,841,476.00	$0.00	$0.00	$0.00		$0.00	$0.00
9. Ambulatory/Community Non-24 Hour Care		$39,049,134.00	$207,696,215.00	$33,595,519.00	$726,495,706.00	$0.00	$0.00	$2,636,367.42		$20,506,788.00	
10. Crisis Services (5 percent set-aside)[f]		$2,440,571.00	$1,017,058.00	$5,425,742.00	$35,465,098.00	$0.00	$0.00	$2,360,130.00		$1,544,151.00	$1,258,428.00
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$2,440,571.00	$35,827,344.00	$5,693,970.00	$141,958,914.00	$0.00	$1,885,650.00	$372,018.08		$1,324,084.00	$0.00
12. Total	**$0.00**	**$48,811,418.00**	**$332,041,966.00**	**$50,833,084.00**	**$1,874,841,734.00**	**$0.00**	**$7,916,410.00**	**$7,440,361.60**	**$0.00**	**$26,481,676.00**	**$1,398,428.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

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

The lack of resources allocated from any sources to address Tuberculosis is not consistent with the statement that testing is a priority. It appears state general funds are used for TB Prevention and Control, Drugs, Outreach and Drugs Resistance. Yet despite these funds being available, the outcome measure related to screening is not met in the first year. See Priority 1 Indicator 3 (Page 5 in the Report). Furthermore, the low percentages established as a successful outcome goal appears insufficient to fully determine and treat latent TB in this high-risk population. Essentially, the outcome goal is for 1 in 4 people to be tested.

Indicator #:	3
Indicator:	In the last 12 months, percentage of individuals who completed TB Screenings within 30 days after being admitted to SUD Treatment Services in order to identify those individuals who are at high risk of becoming infected
Baseline Measurement:	25%
First-year target/outcome measurement:	26%
Second-year target/outcome measurement:	27%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

CCS3 (Community Consumer Submission- data extract)

New Data Source*(if needed)*:

Description of Data:

total # of individuals who received TB screenings (numerator) after SUD Tx Program admission/ total # of individuals admitted to SUD Tx Program (denominator)

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None at this time

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Due to workforce and workload issues, we were not able to fully build out a measure in our data extract for measuring the percentage of individuals who completed TB screenings 30 days after being administered into SUD Treatment Services.

We did, however, have our block grant specialists perform site reviews of the CSBs and reviewed their existing policies toward TB screening. We were hoping to change this indicator in the next report to measure the compliance of CSBs in having policies in place at their agencies for ensuring individuals completion of TB screenings 30 days after admission.

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Recommendations:

1. Invest block grant funds in the Tuberculosis screening of all persons receiving SUD services.

2. Strongly Incentivize CSBs to implement policies and procedures related to screening and to prioritize screening all persons receiving SUD services within 30 days

ISSUE #4

The following table is under the Section on Unmet Needs (Page 185 of the application).

Please respond to the following items:

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

Printed: 6/26/2024 3:05 PM - Virginia - OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024 Page

Item	Yes	No
a) Race	(●)	( )
b) Ethnicity	(●)	( )
c) Gender	(●)	( )
d) Sexual orientation	( )	(●)
e) Gender identity	(●)	( )
f) Age	(●)	( )
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?	(●)	( )
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?	( )	(●)
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?	( )	(●)
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?	( )	(●)
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?	( )	(●)
7. Does the state have any activities related to this section that you would like to highlight?		

Virginia does not capture sexual orientation data and has no plans to implement this data field according to previous documents. Without collecting this data, there is no way to measure whether Virginians of different sexual orientations are being under-served and/or served effectively.

Despite the Service Gap Analysis identifying the need for multi-lingual services, there are no plans to identify, address, and monitor linguistic disparities/ language barriers (Item 3 above).

Recommendations:

1. Collect sexual orientation data for clients receiving services.

2. Address and monitor linguistic disparities/language barriers.

3. Develop and implement a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically component outreach, engagement, prevention, treatment and recover services for diverse populations.

4. Identify and remediate disparities in MH/SUD services.

ISSUE 5

The table below identifies the allocations of MH block grant and other federal funds across all expenditures identified as Non-Direct Services/ System Development. (Page 174 of the Application)

Except for COVID funds, all expenditures are identical for FY 2024 and FY 2025.

Planning Tables

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

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

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

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems	$171,439.00	$145,538.00	$251,383.00	$20,554.00	$171,439.00	$0.00	$251,383.00	$20,554.00
2. Infrastructure Support	$403,881.00	$342,862.00	$592,217.00	$48,422.00	$403,881.00	$0.00	$592,217.00	$48,422.00
3. Partnerships, community outreach, and needs assessment	$852,946.00	$724,082.00	$1,250,687.00	$102,262.00	$852,946.00	$0.00	$1,250,687.00	$102,262.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$24,081.00	$0.00	$0.00	$0.00	$24,081.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$138,581.00	$117,644.00	$203,203.00	$16,615.00	$138,581.00	$0.00	$203,203.00	$16,615.00
7. Training and Education	$215,095.00	$182,598.00	$315,397.00	$25,788.00	$215,095.00	$0.00	$315,397.00	$25,788.00
8. Total	**$1,806,023.00**	**$1,512,724.00**	**$2,612,887.00**	**$213,641.00**	**$1,806,023.00**	**$0.00**	**$2,612,887.00**	**$213,641.00**

The activity receiving the highest amount of block grant funding in FY 2024 and FY 2025 is 3 Partnerships, Community Outreach and Needs Assessment. Without an adequate definition of those terms, it is difficult to assess the outcomes of those activities and tax-payers'return on the investment (ROI).

The activity receiving the lowest amount of block grant funding is 5 Quality Assurance and Improvement, an issue often acknowledged within the 2024 Report as a challenge. Yet, the amount allocated is zero.

The percentage of non-direct expenditures in each activity in Virginia varies significantly from the national averages. This data available in the Uniform Reporting System accessible on WebGas. In fact, the highest percentage of these expenditures in Virginia is allocated to Partnership, Community Outreach, and Needs Assessment as opposed to the highest percentage nationally allocated to Infrastructure Support. The Partnerships, Community Outreach and Needs Assessment Activity category receives 47.2% compared to 14.7% nationally.

Recommendations

1. Identify meaningful and measurable outcomes for Partnership, Community Outreach and Assessment to justify expense. Considering the substantial investment, tax-payer should have a significant return on their investment in these activities.

2. Invest block grant funding in Quality Assurance and Improvement to address acknowledged gaps and insufficiencies in outcome measures and data collection.

3. Allocate funds from the SUPTRS grant to the federally mandated Behavioral Health Advisory Council to fully staff and train citizen members to be effective advocates.

I deeply appreciate this opportunity and acknowledge I may have gaps in data and information. Certainly, the budget is complicated and sources are intertwined. I look forward to learning more about the budgeting process.

Respectfully,

Susan M. Fincke

Appendix B

Public Comment MHSA Block Grant + Wishing you well Mr. Nathanael Rudney

From Heather Peck <heatherwpeck@gmail.com>
Date Wed 8/28/2024 1:07 PM
To Rudney, Nathanael (DBHDS) <nathanael.rudney@dbhds.virginia.gov>; heatherwpeck@gmail.com <heatherwpeck@gmail.com>

Caution: This is an **External message**. Do not open attachments or click links without verifying that it is from a trusted source and you know the content is safe.

Thank you Mr. Nathanael Rudney for including the following comments in your efforts to build out a Block Grant application which delivers the highest return on investment for all Virginians:

Please increase by $5,000,000 the Virginia Block Grant application budget supporting the implementation of IPS Supported Employment and Education (IPS). The funds would strengthen the DARS and DBHDS infrastructure to begin to grow Virginians' access to IPS. This modest investment will deliver massive increases in the return on investment for taxpayers, individuals who build Virginia careers, their families, and Virginia employers. Our neighbors in South Carolina delivered research showing well over 500% return on investment through delivering IPS Supported Employment, http://www.state.sc.us/dmh/consumer_employment.htm

Virginians recover from serious mental health, addiction, and justice system involvement challenges and live healthy lives thanks to Employment and Education Support. I served as Executive Director of Laurie Mitchell Empowerment and Career Center (LMECC) until June 30, 2024. LMECC was an agency founded and operated by and for people in long term recovery delivering IPS Supported Employment and Computer Empowerment classes.

Since 2017, when we operationalized IPS Supported Employment, ipsworks.org, an international evidence based practice, LMECC supported over 600 people in recovery to start and sustain jobs, training, and education programs. We advocated to and supported DARS and DBHDS to invest in State Facilities, CSB's, and private providers who deliver IPS Supported Employment and Education. DARS and DBHDS have a new and strong partnership bringing IPS Supported Employment to Virginians.

However, compared to South Carolina, Georgia, and Tennessee, to name a few, Virginia IPS Employment and Education Support is majorly underfunded on a per capita basis. Very, very few Virginians in recovery from serious mental health and addiction challenges currently have access to IPS Employment and Education Support.

Please increase by $5,000,000 the Virginia Block Grant application budget supporting the implementation of IPS Supported Employment and Education. This modest investment will deliver massive increases in the return on investment for taxpayers, individuals who build Virginia careers, their families, and Virginia employers. Our neighbors in South Carolina delivered research showing well over 500% return on investment of delivering IPS Supported Employment, http://www.state.sc.us/dmh/consumer_employment.htm

Heather Peck
Heather Peck Associates LLC
(434)989-8266
760 Lexington Ave.
Charlottesville, VA. 22902
"Building a bridge to recovery, careers, and living healthy lives"

Appendix C

Block Grant application comments

From Mara <mararosen09@gmail.com>
Date Tue 8/27/2024 5:34 PM
To Rudney, Nathanael (DBHDS) <nathanael.rudney@dbhds.virginia.gov>

> **Caution:** This is an **External message**. Do not open attachments or click links without verifying that it is from a trusted source and you know the content is safe.

Mr. Rudney,

I am writing to share opinions/comments with you regarding the block grant application for 2024/2025.

Just for perspective of my comments, I work in pharmaceutical sales, selling medications for adults with serious mental illness to hospitals, community mental health centers, group homes and private practice psychiatry offices. This gives me a unique perspective on the mental health system in Virginia as I interact with providers and staff in most settings of care. Prior to my work in the pharmaceutical industry, I worked in a local jail setting and in a forensic hospital within the state.

With that being said, I have seen and heard a lot about our system being very broken and wanted to provide some comments regarding the block grant application. There is always a need for funding in mental health. I do realize this money is to be used as last resort for patients/services not funded.

* There is mention in the grant on page 107 about ONE system. This is very far from accurate - our system is very broken up. When a patient is discharged from a private hospital in the state, the records remain within that hospital system, possibly to be shared with a private practice or CSB provider upon request - if that patient had been to a provider before. If a patient is hospitalized numerous times and the first bed law is utilized, that patient could potentially be seen in multiple systems and previous records are not available to the treating provider. If a patient is in crisis they are usually unable to share what medications/treatments had been used prior. We are far from one system. Money needs to be spent on discharge planning services to ensure patients do not fall through the cracks.
* CONSIDER: centralized discharge planners that would interact with all healthcare systems in the state of VA that provide mental health care
* CONSIDER: an automatic look back on VA Medicaid for medications that have already been prescribed to move the patient forward in care, not backwards. In many cases, providers are forced to use generic medications or medications covered by Medicaid, but the patient may have already tried and failed those medications in the past. If VA Medicaid had the look back capability, some of this could be prevented - research shows that for every relapse in bi-polar or in schizophrenia, brain matter is lost and the patient becomes harder and harder to treat

* Unfortunately the goal in most hospitals is simply stabilization - once a patient is ok to walk out the door, they are discharged. Most hospital providers do not discharge with a prescription. If the patient does not have a provider in the community, it can take weeks to get additional treatment. Even with

the Rapid Access programs at the CSB's, the patient will be given a case manager, but will not necessarily see a medication provider, therefore leaving a gap in treatment. In many cases, the patient does not go to a CSB, but to a private practice provider and it could be weeks if not months to be seen.
* CONSIDER: At least 1-2 months of medication if a patient is being discharged into the community to ensure stabilization until seeing a provider in the community

* Mobile crisis units are a fabulous resource, but these units need to go where there is a need first - rural communities that lack resources should take priority. The community needs to know this is a resource. We need more attention brought to the 988 system as well as these units. There are psychiatric providers that are not even aware of the resources.

* There are many references in the block grant application to first episode treatments/clinics in the application, but very few areas have a first episode clinic. There are no protocols in place in the clinics that exist. There should be State wide protocols implemented for these patients to ensure the best outcome.
* CONSIDER: The State of South Carolina - the department of BH has implemented a flag system in their state hospitals. The patient chart is flagged for schizophrenia and should be for bipolar disorder as well. The flag indicates a prior hospitalization due to a First Episode so the correct treatment can be offered/given if there is another hospitalization. One problem in implementation is use only within the state system, but could potentially be mandated to all hospitals operating in the state of Virginia to ensure consistency. Again, discharge planning would be essential to share this information to the next site of care due to the lack of continuity in EMR systems.

* Medicaid overhaul around Behavioral Health - Medicaid is run by the state of VA, but then managed by private companies. There are step edits and prior authorizations in place for so many treatments used in Behavioral Health to save money, but at the expense of the patient being treated. If a more aggressive approach was taken in Behavioral Health, many patients would be able to live successful, healthy lives rather than live within our system due to inappropriate care. Again, the more relapses a patient has, the harder they are to treat. Hospitalization costs a lot more than treating someone correctly the first time around. This idea is standard in many other specialities of medicine, but patients living with behavioral health issues continue to be treated extremely conservatively, preventing them from ever getting better and living a healthy life.

Thank you for allowing public comments on these important topics. I do realize that many of the topics I am writing about may not fall under this block grant application. I am hoping the topics will be considered by DBH. I am available to share more detail if requested.

Sincerely,

Mara J. Rosen, MS
804-721-9233