Exhibit I FY2022-2023: Behavioral Health Wellness/Prevention Services

I. Behavioral Health Wellness/Prevention Services

A. Required SABG Prevention Set-Aside Frameworks

1. **Strategic Prevention Framework (SPF):** The CSB, in partnership with local community coalitions, shall use the data driven Strategic Prevention Framework (SPF) planning model to: complete a needs assessment using community, regional, and state data; build capacity to successfully implement prevention services; develop logic models, inclusive of CSB only programs and coalition partnership efforts, and a strategic plan with measurable goals, objectives, and strategies; implement evidenced-based programs, practices, and strategies that are linked to data and target populations; evaluate program management and decision making for enabling the ability to reach outcomes; plan for the sustainability of prevention outcomes; and utilize culturally appropriate strategies throughout all aspects of the SPF process.

   The CSB shall work with OMNI Institute, the Department's evaluation contractor, to develop an evaluation plan for its SABG prevention set aside-funded prevention services, Suicide Prevention and Mental Health First Aid strategies.

2. **Institute of Medicine (IOM) and Center for Substance Abuse Prevention (CSAP) Six (6) Strategies**: The CSB shall use the IOM model to identify target populations based on levels of risk: universal, selective, and indicated. The CSB shall utilize the CSAPs evidenced- based strategies: information dissemination, education and skill building, alternatives, problem identification and referral, community-based process, and environmental approaches. Community-based process/coalitions and environmental approaches that impact the population as a whole are keys to achieving successful outcomes and are Department priorities.

3. **Evidence Based Prevention Practice:** The Department prioritizes programs, practices, and strategies that target the prevention of substance use disorders and suicide and promotes mental health wellness across the lifespan using data to identify specific targets. The current prevention model best practice and a Department priority is environmental strategies complemented by programs that target the highest risk populations: selective and indicated (refer to subsection 5.b).

   All programs, practices, and strategies must link to a current local needs assessment and align with priorities set forth by the Department. Remaining Departmental resources may be utilized to meet additional locally identified needs in the CSB catchment area. Programs, practices, and strategies can be selected from the following resources: Office of Juvenile Justice and Delinquency Prevention Effective, Blueprints Model Programs, Blueprints Promising Programs, Suicide Prevention Resource Center Section 1, Centers for Disease Control and Prevention Evidence-Based Practices and other sources of evidenced based prevention practice.

   The CSB must select them based on evidence and effectiveness for the community and target population. All programs, practices, and strategies must be approved by the Department prior to implementation.

   Substance abuse prevention services may not be delivered to persons who have substance use disorders in an effort to prevent continued substance use.

B. DBHDS Behavioral Health Wellness Priorities

1. **SYNAR Strategies- Merchant Education and Counter Tools:** In July 1992, Congress enacted P.L. 102-321 section 1926, the SYNAR Amendment, to decrease youth retail access to tobacco. Beginning in FY 2003, the Department allocated $10,000 annually to the CSB to complete SYNAR-related tasks. To stay in compliance with the SABG, states must meet and sustain the merchant retail violation rate (RVR) under 20 percent or face penalties to the entire SABG, including funds for treatment. Merchant education involves educating local merchants about the consequences of selling tobacco products to youth. This strategy has been effective in keeping state RVR rates under the required 20 percent. The CSB shall conduct merchant education activities with all merchants deemed by the Alcoholic Beverage Control Board to be in violation of selling tobacco products to youth in the CSB's service area. Other merchants shall be added if deemed to be at higher risk due to factors such as being in proximity to schools.

   The CSB, itself or in collaboration with the local coalition, shall continuously update the verified list of tobacco retailers, including all retailers selling vapor products, by conducting store audits and recording the data into the Countertools system.

   The CSB shall conduct store audits of and merchant education with 100 percent of tobacco retailers in its service area over a two year period. All store audit and merchant education activities shall be documented in the Counter Tools system and recorded in the prevention data system. Tobacco education programs for youth with the goal of reducing prevalence or use are not to be identified as SYNAR activities.

2. **Adverse Childhood Experiences (ACEs) Self-Healing Communities**:
   ACEs have been connected to physical, emotional and behavioral health consequences in youth and adults to include substance use disorder, depression, anxiety and suicide. The self-healing communities' model builds the capacity of communities to define and solve problems most relevant to their localities to address ACEs and prevent and reduce the impact.

   This model starts with training and then expanding leadership in each community. Research shows there is a significant connection between ACEs and suicides and drug overdoses. Helping communities understand the impact of ACEs will expand the leadership capacity necessary to do just that.

3. **Mental Health First Aid (MHFA) and Regional Suicide Prevention Initiatives:** In the FY 2014 budget, an ongoing appropriation was made to expand and support Suicide Prevention and Mental Health First Aid initiatives across the Commonwealth of Virginia in an effort to prevent suicide and reduce the stigma of mental illness and encourage seeking help**.**

   The CSB shall work with the regional MH/Suicide prevention team to provide a regionally developed suicide prevention plan using the Strategic Prevention Framework model.

   The plan developed by the team shall identify suicide prevention policies and strategies using the most current data to target populations with the highest rates of suicide. If selected by the region, the CSB shall act as the fiscal agent for the state funds supporting the suicide prevention services. MHFA may be offered by individual CSBs and/or as a part of the regional effort.

C. SABG Prevention Proposed Performance Contract Measures

To reflect the performance in the above-named categories, we will use the following measures as a minimum requirement:

Priority Strategy	Proposed FY21 and FY22 Performance Contract Measures

General Capacity Requirements	• Each CSB must complete an evaluation plan which is revised and approved annually and includes:
	  o A logic model which includes all of the required priority strategies all CSBs must implement and any discretionary strategies the CSB has elected to implement.
	  o A measurement plan documenting how all required metrics will be tracked and reported.
	• All prevention programs, practices, and strategies must be evidence-based and approved by the DBHDS OBHW team. Only strategies that align with the state-identified priorities and/or the CSB's logic model outcomes will be approved.
	• Each CSB must maintain a license for the Performance-Based Prevention System (PBPS) and record all implemented strategies in the PBPS.
	• Each CSB must maintain a minimum of 1 FTE Prevention Lead position. This position leads and ensures compliance and implementation of all Prevention priority strategies.
	• Prevention funding should be used for prevention staff to attend at least one national prevention-related conference per year. Any national conferences outside of the NPN Prevention Research Conference, NATCON, CADCA National or Mid-Year Conferences must have prior DBHDS approval. Each CSB receives $3000 in their base allocation to help support this capacity building effort.

Community Coalition Development	**1.** The CSB shall be involved in a minimum of 6-10 coalition meetings a year. **2.** The CSB should maintain membership in CADCA and/or CCoVA each year. **3.** The CSB and its associated coalition should ensure youth engagement in the coalition either as a sub-group of the coalition or a separate youth coalition. **4.** The CSB should maintain a social media presence to publicize prevention activities and messaging (Facebook page, Instagram, website, etc.) Websites should be updated monthly at a minimum and social media bi-weekly to ensure information and resources remain relevant and engages the community. **5.** Every 2 years, each CSB must complete a coalition readiness assessment and an assessment of representation in the coalition of the following 12 sectors: youth; parents; businesses; media; school; youth-serving organizations; law enforcement; religious/fraternal organizations; civic and volunteer organizations; healthcare professionals; state, local and tribal governments; and other organizations involved in reducing illicit substance use.
SYNAR: Merchant Education and Counter Tools	**1.** The CSB shall conduct store audits of and merchant education with 100 percent of tobacco/nicotine retailers in its service area over a two-year period. Any retailer to be found in violation in the previous year is to be given priority for merchant education. **2.** The CSB also must maintain and update a list of tobacco/nicotine retailers in its catchment area over the two-year period. **3.** Data must be entered into the Counter Tools and PBPS systems. **4.** Tobacco education programs for youth with the goal of reducing prevalence of use are not to be identified as SYNAR activities.
ACEs Self-Healing Communities	**1.** All CSBs should ensure there are at least 2 ACEs master trainers in their catchment area at all times. **2.** All CSBs must conduct at least 12 ACEs trainings annually. **3.** All ACEs training data (including number of trainings held and number of people trained) must be reported in PBPS. **4.** CSBs which are designated as Self-Healing Communities and are receiving additional funding to address ACEs must complete all items noted above *and* the following: **5.** Maintain an ACEs self-healing community advisory committee made up of a cross-section of community partners, meets at least quarterly, reviews the Self-Healing Communities logic model and provides ongoing feedback and recommendations on how to best achieve the logic model goals.

Priority Strategy	Proposed FY21 and FY22 Performance Contract Measures
	6. Create a logic model specific to the ACEs work that is planned and implemented in the community. **7.** Submit a quarterly report on all ACEs strategies and measures. **8.** Engage in a local Trauma-Informed Community Network (TICN) or other trauma-centered coalition.
MHFA/Suicide Prevention Planning and Trainings	**1.** The CSB shall work with the regional MH/suicide prevention team to provide a regionally developed suicide prevention plan using the Strategic Prevention Framework model. **2.** The plan developed by the team shall identify suicide prevention policies and strategies. Strategies should be determined using the most current data and there should be strategies in the plan that are for the community as a whole as well as strategies that target subpopulations with the highest rates of suicide. The plan should also identify the CSB's marketing plan to ensure community groups (schools, faith groups, businesses, etc.) and community members are aware of the mental health and suicide prevention trainings the CSB is providing. **3.** Each MHFA trainer must provide a minimum of 3 Youth and/or Adult MHFA trainings annually. **4.** The CSB should ensure a minimum of 45 community participants are trained annually in MHFA (across all MHFA trainers at the CSB; there is no minimum number of trainees for each certified trainer). **5.** In addition to the required MHFA trainings, a minimum of 3 suicide prevention trainings *per trainer* must be provided annually. These 3 trainings may be a combination of any of the approved trainings below: a. ASIST b. safeTALK c. suicideTALK d. QPR **6.** Every year, each CSB will be required to submit a mid-year (April) and end-of-year (September) report which should contain details on trainings implemented, including the number of different groups and community members participating in the trainings.
Lock & Talk	**1.** CSBs participating in the Lock and Talk Initiative shall develop an implementation plan that best meets the needs of their respective communities (including strategies to address target populations.) At a minimum CSBs are expected to implement components 1 & 2 below, and strongly encouraged to implement the Gun Shop Project and/or partner with their medical community (pharmacies, medical practices) if the Gun Shop Project is not an appropriate fit for their community. **2.** Lock and Talk Components: a) Media Campaign Materials (bus ads, posters, billboards, PSA, etc.) b) Medication Lock Box/Cable Lock/Trigger Lock Distribution at Event c) Gun Shop Project