FFY 2018-2019 Block Grant Application

Community Mental Health Services Block Grant (MHBG)
Plan and Report

Substance Abuse Prevention and Treatment Block Grant (SABG)
Plan and Report

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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FFY2018-2019 Block Grant Application

I. INTRODUCTION

This is an application for SAMHSA's Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) as authorized by sections 1911-1920 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.CF.§§ 300x-300x-9) and sections 1921-1935 of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C.§ 300x-21-35), respectively, and sections 1941-1956 of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§§ 300x-51-66). This block grant application includes four major parts: introduction; submission of application and plan timeframes; behavioral health assessment and plan; and report requirements. These sections include discussions and planning around the following policy topics: health care system, parity and integration; health disparities; innovations in purchasing decisions; evidence-based practices for early intervention (e.g., serious mental illness (SMI)); person centered planning and self direction; program integrity; tribes; primary prevention for substance misuse, statutory criteria for MHBG; substance use disorder treatment; quality improvement; trauma; criminal and juvenile justice; medication-assisted treatment; crisis services; recovery; community living and Olmstead; children and adolescents behavioral health services; suicide prevention; support of state partners; state behavioral health planning/advisory council; and public comment .

A. Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees two major block grants: the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG). These block grants give states[1] maximum flexibility to address the unique behavioral health[2] needs of their populations. The MHBG and SABG differ in a number of their practices (e.g., targeted populations) and statutory authorities (e.g., method of calculating maintenance of effort (MOE), stakeholder input requirements for planning, set-asides for specific populations or programs, etc.).[3] As a result, information on the services and clients supported by block grant funds has varied by block grant and by state.

SAMHSA believes it is vital to collect, report, and analyze data at the state and federal levels to ensure the nation's behavioral health system is providing the highest quality and most cost effective treatment and other services. State block grant expenditures should be based on the best possible evidence and program quality and outcomes should be carefully tracked. Ultimately, such data will lead to

[1] The term "state" means each of the several states, the District of Columbia and each of the territories of the United States. The term "territories of the United States" means each of the Commonwealth of Puerto Rico, Virgin Islands, American Samoa, Commonwealth of the Northern Marianas Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands and the Republic of Palau.

[2] The term "behavioral health" in this document refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support.

In addition to statutory authority, SABG is detailed by comprehensive regulation. http://www.samhsa.gov/grants/block-grants/laws-regulations

improvements as science and circumstances change.

Better alignment of the MHBG and SABG applications will help block grant recipients improve data collection and coordination between programs. In fiscal year (FFY) 2011, SAMHSA redesigned the FFY 2012-2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Tribal Law and Order Act (TLOA). The new design offered states the opportunity to complete a combined application for mental and substance use disorder[4] (M/SUD) services, submit a biennial versus an annual plan[5],[6] and provide information regarding their efforts to respond to various federal and state initiatives. The new design also reflects the increasing trend among states to integrate their mental health, substance misuse prevention, SUD treatment and recovery administration.

Almost two-thirds of the states took advantage of this streamlined application during FFY 2016-2017 application process and submitted combined plans for M/SUD services. Nearly all the states provided specific information requested by SAMHSA regarding strategies to respond to a variety of areas including primary care and behavioral health integration, recovery support services, and parity implementation.

The FFY 2018-2019 Block Grant Application furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. The FFY 2018-2019 Block Grant Application continues to allow states to submit an application for both MHBG and SABG funds and a biennial plan for mental and substance use disorder services. This application also reflects the health care system's strong emphasis on coordinated and integrated care along with the need to improve services for persons with mental and substance use disorders.

1. Leading Change 2.0 – SAMHSA's Six Strategic Initiatives

SAMHSA has updated and streamlined its strategic plan to align with the evolving needs of the behavioral health field, individuals and families with behavioral health conditions, and the changing fiscal environment. Issued in late FFY 2014, *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015 – 2018*, reflects SAMHSA's programmatic priorities and policy drivers, including the new HHS strategic plan and full implementation of the Affordable Care Act.

Behavioral Health is an essential part of health service systems and effective community-wide strategies that improve health status and lower costs for families, businesses, and governments. Through practice improvement in the delivery and financing of prevention, treatment, and recovery support services, SAMHSA and its partners can advance behavioral health and promote the nation's health. In order to continue to support this goal, SAMHSA emphasizes an updated set of Strategic Initiatives (SI) to focus its work on improving lives and capitalizing on emerging opportunities.

[4] The term "substance use disorder" means substance-related and addictive disorder as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association.
[5] State Plan for Comprehensive Community Mental Health Services for Certain Individuals (Sec. 1912 of Title XIX, Part B, Subpart I of the Public Health Service (PHS) Act (42 USC § 300x-2)
[6] State Plan (Sec. 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x- 32(b))

These include:

1. *Prevention of Substance Abuse and Mental Illness:* Focuses on substance misuse prevention, SMI and severe emotional disturbance (SED)[7] by maximizing opportunities to create environments where individuals, families, communities, and systems are motivated and empowered to manage their overall emotional, behavioral, and physical health. This SI includes a focus on several populations of high risk, including college students and transition-age youth, especially those at risk of first episodes of mental illness or substance misuse; American Indian/Alaska Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals.

2. *Health Care and Health Systems Integration:* Focuses on integration in health care including systems of particular importance for persons with behavioral health needs such as community health promotion; health care delivery; specialty prevention; treatment and recovery; and community living needs. Integration efforts seek to increase access to appropriate high-quality prevention, treatment, recovery and wellness services and supports; reduce disparities between the availability of services for persons with mental illness (including SMI/SED) and substance use disorders compared with the availability of services for other medical conditions; and support coordinated care and services across systems.

3. *Trauma and Justice:* Focuses on trauma and justice by integrating a trauma-informed approach throughout health, behavioral health, human services, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities. Activities under this SI include integrating trauma informed approaches across service sectors; assisting communities in the preparation for, response to, and recovery from traumatic events that include disasters; and understanding the effects of community trauma. This SI also supports the use of innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems including diversion practices; strategic links with community based providers and correctional health; and effective reentry.

4. *Recovery Support:* Promotes partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.

5. *Health Information Technology:* Ensures that the behavioral health system – including states,

[7] For purposes of block grant planning and reporting, SAMHSA has clarified the definitions of SED and SMI, which were first, identified in the 1993 Federal Register them (May 10, 1993; 58 FR 29422-29425). States may have additional elements that are included in their specific definitions, but the following provides a common baseline definition. Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

community providers, patients, peers, and prevention specialists – fully participates with the general healthcare delivery system in the adoption of health information technology (Health IT). This includes interoperable electronic health records (EHR) and the use of other electronic training, assessment, treatment, monitoring, and recovery support tools, to ensure high-quality integrated health care, appropriate specialty care, improved patient/consumer engagement, and effective prevention and wellness strategies.

6. *Workforce Development:* Supports active strategies to strengthen and expand behavioral health workforce. Through technical assistance, training, and focused programs, the initiative will promote an integrated, aligned, competent workforce that enhances the availability of substance misuse prevention, M/SUD treatment and recovery services; strengthens the capabilities of behavioral health professionals; and promotes the infrastructure of health systems to deliver competent, organized behavioral health services. This initiative will continually monitor and assess the needs of peers, communities, and health professionals in meeting behavioral health needs in America's transformed health promotion and health care delivery systems.

B. Impact on State Authorities and Systems

SAMHSA seeks to ensure that State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) are prepared to address the priorities discussed throughout this document. By addressing these environmental factors, SMHAs and SSAs will enhance their ability to decrease the prevalence and impact mental and substance use disorders and/or improve the health of individuals with mental illness and addictions, improve how they experience care, and reduce costs. The FFY 2018-2019 Block Grant application incorporates several key assumptions:

States are strategic in their efforts to purchase services.

The continued advancement of evidenced-based approaches coupled with the focus on quality and outcomes of care require states to rethink what services they purchase as well as how those services are purchased. Value-based purchasing contracts are rapidly replacing both grant-based and fee-for-service as a means of procuring prevention, treatment and recovery support services. Although access to Medicaid and private insurance has increased, certain gaps in coverage remain for specific populations and services[8]. SMHAs and SSAs need to continue to identify which populations and services are covered by various coverage options available through the Marketplaces, Medicaid and other payers. Secondly, within the different insurance packages, states have to consider the extent to which specific mental or substance use disorder (M/SUD) services will remain uncovered. To identify gaps in the continuum of services, SMHAs and SSAs will need to determine what specific M/SUD services they should cover in addition to or above what is covered by insurers and other payers. States will continue to expand their efforts to identify individuals in their systems that may qualify, but are not currently enrolled in the Children's Health Insurance Plan (CHIP), Medicaid, and Medicare programs. Accordingly, states may want to look at outreach opportunities to enroll those qualified for these programs, as well as Qualified Health Plans (QHPs) offered through Health Insurance Marketplaces or other commercial insurance plans.

[8] Census Bureau American Community Survey statistics http://www.census.gov/newsroom/press-releases/2016/cb16-159.html

The block grant authorizing legislation and implementing regulations prohibit the provision of financial assistance to any entity other than a public or nonprofit entity and require that the funding be used only for authorized activities.[9] In response to the issue raised in several states of the impact of high deductibles on access to services, SAMHSA has released guidance to the states on these issues. SAMHSA Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States that choose to do this will need to develop specific policies and procedures for ensuring compliance with this guidance.

States leverage their block grant funding and strive to diversify funding sources.

When developing strategies for purchasing services, SMHAs and SSAs should identify other state and federal sources available to purchase services. States should assist providers in the development of better financial strategies that will allow providers to be less dependent on SMHA and SSA funding only. Funding available from the Centers for Medicare & Medicaid Services (CMS), such as CHIP, Medicaid and Medicare may play an important role in the states' financial strategy. There are also national demonstration projects and programs (e.g., Health Homes, Clinical Practice Transformation, Innovation Accelerator Program, State Innovation Models, Comprehensive Community Behavioral Health Centers, and Financial Alignment Initiative for Medicare-Medicaid Enrollees) that support efforts to provide behavioral health services. In addition, behavioral health services supported through the Health Resources and Services Administration (HRSA) must be considered as states develop these strategies. For example, HRSA has significantly expanded access to health and behavioral health services through its Health Center Program. HRSA has also made available funding and other opportunities to increase and enhance the quality of the behavioral health workforce (e.g., loan forgiveness program, National Health Service Corps, training grants, etc.). Both TRICARE and the Department of Veterans' Affairs (VA) have enhanced their behavioral health services as well. This means that SMHAs and SSAs (as well as public health authorities responsible for prevention) will need to engage and collaborate with these partners at the federal, state and community levels. Persons eligible for such services should be assisted in accessing these services as appropriate.

States think more broadly about their impact on special populations that they have historically served through federal block grants and other funding.

In addition to populations currently targeted for the block grants, other populations have evolving needs that may be addressed. These populations include military families, youth who need substance use disorder services, individuals who experience trauma, increased numbers of individuals diverted or released from correctional facilities, diverse racial and ethnic minority groups, American Indians and Alaska Natives, and LGBT individuals.

The context of service delivery has also significantly changed. Services should be delivered in a manner that promotes recovery and resiliency. Individuals who have lived experiences with M/SUD are playing an increasingly important role in the delivery of recovery-oriented systems of care. Services should take into account culturally specific services for racial and ethnic minorities. Services should also address the unique needs of tribal populations and the role of tribal governments in planning and delivering services.

[9] http://www.samhsa.gov/grants/block-grants/laws-regulations

The use of technologies may support better access to services, especially those more likely to be comfortable with these new technologies. Advances in technology have changed significantly since SAMHSA's inception in 1992. Technology is playing a growing role in how individuals learn about, receive, and experience their health care services. Interactive Communication Technologies (ICT) are being used more frequently to deliver various health care and recovery support services by providers and to report health information and outcomes by individuals.

States continue to design and develop collaborative plans for health information systems. Health care payers will seek to promote electronic health records (EHR) and interoperable health information technology (HIT) systems that allow for the effective exchange and use of health data.

Providers of M/SUD services should adopt HIT and systems that meet the standards and certifications required for interoperable health information technology as issued by the Office of the National Coordinator for Health Information Technology (ONC)[11]. In addition to meeting common standards and certification, these systems should support the privacy and security of patient information across all HIT technologies. Such systems should be used to collect information on provider characteristics, client enrollment, demographics, and treatment. Current laws will require these systems to comply with national standards such as national provider numbers, International Classification of Diseases (ICD-10), Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT), normalized names for clinical drugs (RxNorm), Logical Observation Identifiers Names and Codes (LOINC), and Current Procedural Terminology (CPT)/Healthcare Procedure Coding System (HCPCS) codes. The information technology systems will also have to be interoperable with providers across the continuum of care, as well as health information exchanges (HIE), health information organizations (HIOs), and payers (e.g., Medicaid, Medicare, and private insurance plans, etc.). SAMHSA believes it is important for public behavioral health purchasers to continue to collaborate and discuss system interoperability, electronic health records, federal information technology requirements, and other related matters. Additional information can be found at http://www.samhsa.gov/health-information-technology (SAMHSA) and http://www.healthit.gov/ (ONC).

States continue to form strategic partnerships to provide individuals with access to effective and efficient service systems.

SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system reform in their states. 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, 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 expansion, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

On October 18, 2016, the Office of the Assistant Secretary for Health (OASH) released its report, *Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure*. Public Health 3.0 (PH3) is a significant upgrade in public health practice to a modern version that emphasizes cross-sectorial environmental, policy- and systems- level actions that directly affect the social determinants of

health. SAMHSA and OASH are encouraging all public health authorities to adopt Public Health Accreditation Board (PHAB) criteria. Further, public health department accreditation should be enhanced and supported so as to best foster Public Health 3.0 principles, as we strive to ensure that every person in the United States is served by nationally accredited health departments

State authorities focus their system goals on recovery.
People can and do recover from mental and substance use disorders, and services and supports must foster individual and family capacity for self-directed recovery. Recovery benefits both the individual with a behavioral health condition and the community, leading to a healthier and more productive population. SAMHSA is committed to assisting states, providers, people with M/SUD, families, and others in promoting recovery.

State authorities continue to monitor the coverage of behavioral health services offered by QHPs and Medicaid to ensure that individuals with behavioral health conditions have adequate coverage and access to services.

Some states have contracted with managed care organizations (MCO) or Administrative Services Organizations (ASO) to oversee and provide behavioral health services. State legislatures, state Marketplace entities, and state insurance commissioners have developed policies and regulations related to Affordable Care Act and Electronic Handbooks. SMHAs and SSAs should be involved in these efforts to ensure that M/SUD services are appropriately included in plans, and that M/SUD providers are included in networks.

States continue to make primary substance misuse prevention a priority.
To respond to the primary prevention set-aside requirement of the SABG, states should keep in mind that the backbone of a prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences. The system must also be able to use this data to identify areas of greatest need, and to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in all communities.

State authorities are strategic in leveraging scarce resources to fund prevention services.

States need to make the most efficient use of funds for substance misuse prevention and be prepared to report on the outcomes of these efforts. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data-driven substance misuse prevention system. Specifically, SAMHSA recommends that states align the 20 percent set-aside for primary prevention of the SABG with other federal, state, and local funding that will aid the state in developing and maintaining a comprehensive substance misuse prevention system, as well as collaborate with and assure that behavioral health is part of the state's larger public health prevention activities.

State authorities monitor the Marketplace to ensure that individuals with behavioral health conditions are aware of their eligibility, able to enroll, and able to remain enrolled.

State legislatures, state Marketplace entities, and state insurance commissioners have developed policies

and regulations related to the coordination between the Marketplace, Medicaid, and CHIP. This includes the role that community-based organizations will play in providing outreach and enrollment assistance. SMHAs and SSAs should be involved in these efforts to ensure that outreach and enrollment assistance is available to help individuals with M/SUD who may not have or who may lose their coverage. Historically, individuals who have the most difficulty navigating the public health insurance eligibility determination and enrollment process have disproportionately high rates of behavioral health conditions.

State authorities use evidence of improved performance and outcomes to support their funding and purchasing decisions.

SMHAs and SSAs are well positioned to understand and use the evidence regarding various behavioral health services as critical input for making purchasing decisions and influencing coverage offered in their state through commercial insurers and Medicaid/Medicare. In addition, states may also be able to use this information to educate policymakers and to justify their budget requests or other strategic planning efforts. States may also want to consider undertaking a similar process within their state to review local programs and practices that expand treatment technologies and show promising outcomes.

State authorities ensure that they comport with changes in quality reporting.

The National Behavioral Health Quality Framework (NBHQF) provides a mechanism for states to examine, prioritize, and report on approaches to prevention, treatment, and recovery processes through the block grant as well as discretionary and formula grantees. In addition to this tool, SAMHSA has been working with states and state representative organizations to identify and implement a core set of measures, which include approved quality measures to assess outcomes and quality in programming. This effort has sought to both guide and align the measurement requirements of other major service purchasers, such as Medicaid and Medicare, and thus facilitate efficiencies in state reporting of behavioral health quality measures to federal entities. It is anticipated that once implemented, states will develop an implementation plan – both general to all states and unique to their particular state – regarding the specifics and realities of how these measures are being collected and reported, as well as how this effort is being coordinated with required reporting activities from Medicaid, Medicare, and other public payers. SAMHSA's collaboration with CMS on the Certified Community Behavioral Health Center (223) project[10] represents a significant stride toward enhanced inclusion of quality measures in SAMHSA programming that is expected to continue and grow for the future data collection efforts.

States authorities monitor implementation status and activities under the federal parity law to ensure that individuals with behavioral health conditions are receiving the mandated coverage and access.

Plans and issuers subject to MHPAEA[11] that offer M/SUD coverage as part of the overall health benefits packages must comply with the requirements regarding coverage of M/SUD benefits in relation to medical/surgical benefits. Parity requires that the plans that offer M/SUD benefits do so at the same level of benefit as for physical conditions; it does not require a plan to offer M/SUD benefit. M/SUD

[10] http://www.samhsa.gov/section-223
[11] http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act

disorder services are among the ten categories of service elements that serve as components of the essential health benefits package that are offered in marketplaces. Whether it is federal- or state-level parity, continued efforts for education are instrumental in increasing awareness of the benefits of mental health and addiction services and open the door to appropriate services, especially for potential first-time users. Some states have taken steps to enforce parity, and are building on lessons learned. This active involvement to increase awareness helps to ensure that consumers receive quality behavioral health prevention, treatment, and recovery services within their state and are aware of what protections and resources exist in their state should their claim be denied inappropriately by insurance companies.

State authorities are key players in behavioral health integration activities.

Strong partnerships between SMHAs and SSAs and their counterparts in health, public health, and Medicaid 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. For instance, CMS and SAMHSA strongly suggest that SMAs include SMHAs and SSAs in designing their approaches for health homes under Section 2703 of the Affordable Care Act. SMHAs and SSAs are in the best position to offer their Medicaid 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 Medicaid agency 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 behavioral health 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 behavioral health 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 behavioral health system is actively engaged in these public health efforts.

In addition, states play a key role in developing strategies for reducing smoking among individuals with a behavioral health condition. States should strongly consider implementing strategies for reducing smoking, including moving towards tobacco-free M/SUD facilities and grounds, and screening, referring, and/or treating tobacco use.

Population changes in many states have created a demographic imperative to focus on improving M/SUD prevention, treatment, and recovery for diverse populations with the goal of reducing disparities.

States are increasingly recognizing the value in addressing health disparities, realizing that failure to take action results in continued excess costs and spending and lost lives. States have developed plans to

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address these disparities through incentives in health insurance plans, training initiatives and requirements for language access, targeted quality improvement and cost containment plans, cost and impact estimates for the most vulnerable populations, and tracking mechanisms to evaluate progress in improving health equity[12]. Few of these plans, however, have focused specifically on behavioral health. SSAs and SMHAs need to better track access, service use, and outcomes for these subpopulations to develop targeted outreach, engagement, enrollment, and intervention strategies to reduce such disparities.

State authorities are encouraged to implement, track, and monitor recovery-oriented, quality behavioral health services.

The four dimensions of recovery:

1. **Health: overcoming or managing one's disease(s) or symptoms — for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem — and for everyone in recovery making informed and healthy choices that support physical and emotional wellbeing.**

   - Promote treatment, health and recovery-support services for individuals with mental and/or substance use disorders.
   - Promote health, wellness, and resiliency.
   - Promote recovery-oriented service systems.
   - Engage individuals in recovery and their families in self-directed care, shared decision-making and person-centered planning.
   - Promote self-care alternatives to traditional care, where appropriate.

2. **Home: a stable and safe place to live.**

   - Ensure that supported independent housing and recovery housing are available for individuals with mental and/or substance use disorders.
   - Improve access to mainstream benefits, housing assistance programs, and supportive services for people with mental and/or substance use disorders.
   - Build leadership, promote collaborations, and support the use of evidence-based practices related to permanent supportive housing and recovery housing.
   - Increase knowledge of the behavioral health field about housing and homelessness among people with mental and/or substance use disorders.

3. **Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.**

   - Increase gainful employment and educational opportunities for individuals with or in recovery from mental and/or substance use disorders.
   - Increase the proportion of individuals with mental and/or substance use disorders who

[12] http://www.samhsa.gov/behavioral-health-equity

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are gainfully employed and/or participating in self-directed educational endeavors.

- Develop employer strategies to address national employment and education disparities among people with identified behavioral health problems.
- Implement evidence-based practices related to employment and education for individuals with mental and/or substance use disorders.

4. **Community: relationships and social networks that provide support, friendship, love, and hope.**

- Promote peer support and the social inclusion of individuals with or in recovery from mental and/or substance use disorders in the community.
- Increase the number and quality of consumer/peer recovery support specialists and consumer-operated/peer run recovery support service provider organizations.
- Promote the social inclusion of people with mental and/or substance use disorders.

These elements - *health, home, purpose, and community* - are central to recovery from mental and substance use disorders. Treatment and formal and informal recovery support services are critical to attain and maintain recovery.

State authorities ensure that their states have a system of care approach to children and adolescents' M/SUD services.

The success of the systems of care approach has shown that interagency coordination centered on serving the unique needs of children, youth, and families is critical. Facilitating and sustaining this approach at the local level requires a parallel effort at the state level. As states adopt a system of care approach, they should address state policies that can support local efforts, identifying financing mechanisms, and enabling a family and youth input to policy at the state level. In addition to identifying the resources needed for services, states will need to develop a realistic planning process for enabling systems of care in their states that includes the necessary staff time and administrative resources.

C. Block Grant Programs' Purposes

SAMHSA's MHBG and SABG provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by substance use disorders and for adults with SMI and children with SED. The purposes of the block grant programs support these service needs and are consistent with SAMHSA's vision for a high-quality, self-directed, and satisfying life.

In order to assure that the block grant program continues to support the needed and necessary services, SAMHSA has indicated that the block grants be used:

1. to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2. to fund those priority treatment and support services not covered by CHIP, Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
3. for SABG funds, to fund primary prevention: universal, selective, and indicated prevention

activities and services for persons not identified as needing SUD treatment; and

4. to collect performance and outcome data to determine the ongoing effectiveness of promotion/SUD prevention, treatment and recovery supports and to plan the implementation of new services.

II. SUBMISSION OF APPLICATION AND PLAN TIMEFRAMES

While the statutory deadlines and block grant award periods remain unchanged, SAMHSA encourages states to turn in their application as early as possible to allow for a full discussion and review by SAMHSA. Applications for the MHBG are due no later than September 1, 2017. The applications for SABG are due no later than October 1, 2017. Single applications for MHBG and SABG are due no later than September 1, 2017. MHBG and SABG Reports are due December 1, 2017. In addition, for the SABG, the annual Synar report is due no later than December 31, 2017

The FFY 2018-2019 MHBG and SABG application(s) include(s) a two year Behavioral Health Systems Assessment and Plan (Plan) as well as projected expenditure tables, certifications and assurances. The Plan will cover a two year period aligning with states' FY budget cycle for SFY 2018/19. States will have the option, but will not be required to amend their Plans when they submit their FFY 2019 application.

States should submit their respective MHBG and SABG application(s) for FFYs 2018 and 2019 based on the guidance provided in this document. The Plan provides a consistent framework for SMHAs and SSAs to assess the strengths and needs of their systems and to plan for system improvement, which is consistent with the strategic planning framework currently used by SAMHSA for various grants. The unique statutory and regulatory requirements of the specific block grants are described in the State Plan section.

The FFY 2018-2019 Plan seeks to collect information from states regarding their activities in response to federal laws, initiatives, changes in technology, and advances in research and knowledge. The FFY 2018-2019 Plan has sections that are required and other sections where additional information is requested but not required. The requested information is necessary for a full understanding of the state system of care design and development and provides a benefit to both the states and SAMHSA. There will be no penalty assessed to states that provide only that information that is required.

The FFY 2018-2019 application requires states to submit a face sheet; a table of contents; a behavioral health assessment and plan;, expenditure, performance, and utilization reports; , executive summary; and funding agreements, assurances, and certifications. In addition, SAMHSA is requesting information on key focus areas that are critical to implementation of provisions related to improving the quality of life for individuals with behavioral health disorders. States are strongly encouraged to respond to each section so that SAMHSA understands the totality of a states' efforts and how the block grant funding fits into the states' overall goals and constraints. The requested sections also help SAMHSA tailor technical assistance to best assist states to achieve their goals. Section III.B, Planning Steps, requires states to undertake a needs assessment as part of their plan submission. This section identifies four key steps: (1) assess the strengths and needs of the service system; (2) identify unmet service needs and critical gaps; (3) prioritize state planning activities to include the required target populations and other priority populations (e.g. youth with substance use disorders); and (4) develop goals, objectives, strategies, and performance indicators. Section III.B, Plan Table 1 (Priority Area and Annual Performance Indicators)

and Plan Table 2 (State Agency Planned Expenditure) and Plan Table 5 (Non-Direct Services/System Development Activities Planned Expenditures) are required for both MHBG and SABG. For the SABG, Plan Table 3 (SABG Planned Expenditures), Table 4a and/or Table 4b (SABG Primary Prevention Planned Expenditures), are also required.

The application requests information on state efforts on certain policy, program, and technology advancements in physical and M/SUD prevention, treatment, and recovery. This information will help SAMHSA understand the whole of the applicant state's efforts and identify how SAMHSA can assist the applicant state in meeting its goals. In addition, this information will identify states that are models and assist other states with areas of common concern.

For the Secretary of HHS, acting through the Administrator of SAMHSA, to make an award under the programs involved, states must submit an application(s) sufficient to meet the requirements described in the authorizing legislation and implementing regulations sufficient for SAMHSA to monitor the states' compliance efforts regarding the obligation and expenditure of MHBG and SABG funds. The funds awarded will be available for obligation and expenditure[13] to plan, carry out, and evaluate activities and services for children with SED and adults with SMI; substance misuse prevention; youth and adults with a SUD; adolescents and adults with co-occurring disorders; and the promotion of recovery among persons with SED, SMI, or SUD.

A grant may be awarded only if a state's application(s) include(s) a State Plan[14] [15] in the proper format containing information including, but not limited to, detailed provisions for complying with each funding agreement for a grant under section 1911 of Title XIX, Part B, Subpart I of the PHS Act (42 U.S.C. § 300x-1) or section 1921 of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-21) that is applicable to a state. The State Plan must include a description of the manner in which the state intends to obligate the grant funds, and it must include a report[16] in the proper format containing information that the Secretary determines to be necessary for securing a record and description of the purposes for which both the MHBG and SABG were expended. States have the option of updating their plans during the two year planning cycle.

States are encouraged to submit a combined MHBG and SABG application. If a state is submitting separate MHBG and SABG plans, it should clarify which system is being described in this section (e.g., mental health, substance misuse prevention, SUD treatment or recovery).

III. BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SAMHSA values the importance of a thoughtful planning process that includes the use of available data to identify the strengths, needs, and service gaps for specific populations. By identifying needs and gaps, states can prioritize and establish tailored goals, objectives, strategies, and performance indicators.

[13] Title XIX, Part B of the PHS Act, http://www.samhsa.gov/grants/block-grants/laws-regulations

[14] Section 1912 of Title XIX, Part B, Subpart I of the PHS Act (42 U.S.C. § 300x-2), http://www.samhsa.gov/grants/block-grants/laws-regulations

[15] Section 1932(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-32(b)), http://www.samhsa.gov/grants/block-grants/laws-regulations

[16] Section 1942(a) of Title XIX, Part B, Subpart III of the PHS Act (42 U.S.C. § 300x-52(a)), http://www.samhsa.gov/grants/block-grants/laws-regulations

In addition, the planning process should provide information on how the state will specifically spend available block grant funds consistent with the statutory and regulatory requirements, environment, and priorities described in this document and the priorities identified in the state's plan.

Meaningful input of stakeholders in the development of the plan is critical. Evidence of the process and input of the Planning Council required by section 1914(b) of the PHS Act (42 U.S.C. § 300x-4(b)) for the MHBG must be included in the application that addresses MHBG funds. States are also encouraged to expand this Planning Council to include prevention and substance use disorder stakeholders and use this mechanism to assist in the development of the state block grant plan for the SABG application. States must also describe the stakeholder input process for the development of both the SABG plan and the MHBG plan, as mandated by section 1941 of the PHS Act (42 U.S.C.§ 300x-51), which requires that the state block grant plans be made available to the public in such a manner as to facilitate public comment during the development of the plan (including any revisions) and after the submission of the plan to the Secretary through SAMHSA. This description should also show involvement of persons who are service recipients and/or in recovery, families of individuals with M/SUD, providers of services and supports, representatives from racial and ethnic minorities, LGBTQ populations, persons with co-existing disabilities, and other key stakeholders. Evidence of meaningful consultation with federally recognized tribes where tribal governments or lands are located within the boundaries of the state are strongly encouraged for both MHBG and SABG..

A. Framework for Planning—Mental Health and Substance Use Prevention and Treatment

States should identify and analyze the strengths, needs, and priorities of the state's behavioral health system. The strengths, needs, and priorities should take into account specific populations that are the current focus of the block grants, the changing health care environment, and SAMHSA's Strategic Initiatives.

The MHBG program is designed to provide comprehensive community mental health services to adults with SMI or children with SED. For purposes of block grant planning and reporting, SAMHSA has clarified the definitions of SED and SMI. States may have additional elements that are included in their specific definitions, but the following provides a common baseline definition. Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; who (1) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Section 1912(b) of the Public Health Act (42 USC § 300x-2) establishes five criteria that must be addressed in state mental health plans. States must describe these in the planning steps. The criteria are defined below:

- *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 M/SUD. States must have 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 individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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

- *Criterion 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 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.

States must submit a plan on how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than the services/principles components of Coordinated Specialty Care (CSC) approach developed via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. In consultation with National Institute of Mental Health (NIMH), as needed, either the proposals will be accepted or requests for modifications to the plan will be discussed and negotiated with the state. This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at risk of SMI or SED.

The SABG program provides substance misuse prevention, SUD treatment and recovery services (and certain related activities) to at-risk individuals or persons in need of SUD treatment. See 42 U.S.C. §§ 300x-300x-66.
Section 1921 of the PHS Act (42 U.S.C.§ 300x-21) authorizes the States to obligate and expend SABG funds to plan, carry out and evaluate activities and services designed to prevent and treat substance use disorders. Section 1932(b) of the PHS Act (42 U.S.C. § 300x-32(b)) established the criterion that must be addressed in the State Plan.

- *Criterion 1*: Statewide Plan for the Substance Abuse Prevention, Treatment and Recovery Services for Individuals, Families and Communities (42 U.S.C. § 300x-21 and 45 CFR § 96.122)

- *Criterion 2*: Primary Prevention (42 U.S.C. § 300x-22(a) and 45 CFR § 96.125)

- *Criterion 3*: Pregnant Women and Women with Dependent Children (42 U.S.C. § 300x-22(b); 42 U.S.C. § 300x-27; 45 CFR § 96.124(c) (e); and 45 CFR § 96.131). The authorizing legislation and implementing regulation established a 5 percent set-aside that was applicable to the FFY 1993 and FFY 1992 SABG Notices of Award. For FFY 1994 and subsequent fiscal years, States have been required to comply with a performance requirement that the States are required to obligate and expend funds for SUD treatment services designed for such women in an amount equal to the amount expended in FFY 1994.

- *Criterion 4*: Persons Who Inject Drugs (42 U.S.C. § 300x-23 and 45 CFR § 96.126). The authorizing legislation and implementing regulation established two performance requirements related to persons who inject drugs: (1) Any programs that receive SABG funds to serve persons who inject drugs must comply with the requirement to admit an individual requesting admission to treatment within 14 days and not later than 120 days; and (2) outreach to encourage persons who inject drugs to seek SUD treatment Additionally, subject to the annual appropriation process, States may authorize such programs to obligate and expend SABG funds for elements of a syringe services program (SSP) pursuant to guidance developed by the HHS' Office of HIV/AIDS an Infectious Disease Policy (OHIDP) ..

- *Criterion 5*: Tuberculosis Services (42 U.S.C. § 300x-24(a) and 45 CFR § 96.127). The authorizing legislation and implementing regulation require any programs that receive SABG funds to, directly or through arrangements with other public and non-profit entities, routinely make available tuberculosis services to each individual receiving SUD treatment services.

- *Criterion 6*: Early Intervention Services Regarding the Human Immunodeficiency Virus (42 U.S.C. § 300x-24(b) and 45 CFR § 96.128). The authorizing legislation and implementing regulation require designated States to set-aside five percent of the SABG to establish 1 or more projects to provide EIS/HIV at the site(s) at which individuals are receiving SUD treatment services.

- *Criterion 7*: Group Homes For Persons Recovering from Substance Use Disorders (42 U.S.C.§ 300x-25 and 45 CFR § 96.129). The authorizing legislation and implementing regulation provide states with the flexibility to establish and maintain a revolving loan fund for the purpose of making loans, not to exceed $4,000, to a group of not more than six individuals to establish a recovery residence.

- *Criterion 8*: Referrals to Treatment (42 U.S.C. § 300x-28(a) and 45 CFR § 96.132(a) and Coordination of Ancillary Services (42 U.S.C. § 300x-28(c) and 45 CFR § 96.132(c). The authorizing legislation and implementing regulation require States to promote the use of standardized screening and assessment instruments and placement criteria to improve patient retention and treatment outcomes.

- *Criterion 9*: Statewide Assessment of Need (42 U.S.C. § 300x-29 and 45 CFR § 96.133) The authorizing legislation and implementing regulation require states to conduct an assessment of need for authorized activities and services.

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- *Criterion 10*: Independent Peer Review (42 U.S.C. § 300x-58(a)(1)(A) and 45 CFR § 96.136). The authorizing legislation and implementing regulation require states to assess the quality, appropriateness and efficacy of M/SUD treatment services.

- *Criterion 11*: Workforce Development (42 U.S.C. § 300x-28(b) and 45 CFR § 96.132(b) The authorizing legislation and implementing regulation requires any programs that receive SABG funds to deliver authorized activities and/or services to provide continuing education in such activities and/or services to the employees of such programs.

At a minimum, the plan should address the following populations as appropriate for each block grant (**Populations that are marked with an asterisk are required to be included in the state's needs assessment for the MHBG or SABG. To the extent that the other listed populations fall within any of the statutorily covered populations, states must include them in the plan)*

1. (MHBG) Comprehensive community-based mental health services for adults with SMI and children with SED:
   - Children with SED and their families*
   - Adults with SMI*
   - Older Adults with SMI*
   - Individuals with SMI or SED in the rural and homeless populations, as applicable*
   - Individuals who have experienced a first episode of psychosis (10 percent MHBG set aside)*

2. (SABG) Services for persons with SMI/SED or persons with or at risk of having substance use disorder:
   - Persons who are intravenous drug users*
   - Adolescents with substance use and/or mental health problems
   - Children and youth who are at risk for mental, emotional, and behavioral disorders, including, but not limited to, addiction, conduct disorder, and depression
   - Women who are pregnant and have a substance use and/or mental disorder*
   - Parents with substance use and/or mental disorders who have dependent children*
   - Military personnel (active, guard, reserve, and veteran) and their families
   - American Indians/Alaska Natives

3. (SABG) Services for persons with or at risk of contracting communicable diseases:
   - Individuals with tuberculosis* and other communicable diseases
   - Persons at risk for HIV/AIDS who may be unaware of the infection status and persons living with HIV/AIDS who are in need of mental health or substance use early intervention, treatment, or prevention services*[17]

[17] For the purpose of determining the states and jurisdictions which are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137),). SAMHSA relies on the HIV Surveillance Report produced by the CDC, National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention. The HIV Surveillance Report, Volume 25, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the 3 years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and

- The National HIV/AIDS Strategy (NHAS) for the United States and NHAS Implementation Plan [18]
- Prevention of HIV among persons who inject drugs; substance use is associated with a greater likelihood of acquiring HIV infection. HIV screening and other comprehensive HIV prevention services should be coupled with SUD treatment programs

4. Services for individuals in need of primary substance misuse prevention *

5. In addition to the targeted/required populations and/or services required in statute, states are encouraged to consider the following populations, and/or services:
   - Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems
   - Individuals with mental and/or substance use disorders who live in rural areas
   - Underserved racial and ethnic minority and LGBT populations
   - Persons with disabilities
   - Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.
   - Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies

In addition, states should consider linking their *Olmstead* planning work in the block grant application, identifying trend data on individuals who are needlessly institutionalized or at risk of institutionalization. There is a need generally for data that will help the state address housing and related issues in their planning efforts. To the extent that such data is available in a state's *Olmstead* Plan, it should be used for block grant planning purposes.

B. Planning Steps

For each of the populations and common areas, states should follow the planning steps outlined below:

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

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the five criteria that must be addressed in state mental health plans. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services.

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expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state whose AIDS case rate is below 10 or more such cases per 100,000 and meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

[18] http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf

The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

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

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[19] HHS has identified a broad set of indicators and goals to track

[19] http://www.healthypeople.gov/2020/default.aspx

and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

Specific to SABG Needs Assessments- Required

Under 42 U.S.C. § 300x-29 and 45 CFR § 96.133, states are required to submit annually a needs assessment. This requirement is not contingent on the receipt of federal discretionary grant funds for needs assessment resources. States are required to use the best available data. Please indicate the sources and dates or timeframes for the data used in making these estimates reported in both forms below. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of state service needs and informs the planning process to address such needs. The specific priorities that the state has established should be reported in Table 1. States' priorities should include, but are not limited to the set of federal program goals specified in Title XIX, Part B, Subpart II of the Public Health Services Act (42 U.S.C. 300x-21-35) and 45 CFR 96.120-137. In addition, provide any necessary explanation of the way your state records data or interprets the indices in columns 6 and 7.

Table A:

TREATMENT NEEDS ASSESSMENT SUMMARY MATRIX

State: Calendar Year _____

1. Substate planning area	2. Total population	3. Total population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other (specify): ____	A. Hepatitis B/ 100,000	B. AIDS/ 100,000	C. TB/ 100,000
												2	

The intent of Table B is to capture in column A the total number of persons in need of substance use disorder treatment and then have this disaggregated among age, gender and race-ethnicity. The total of columns B through H should equal the total reported in column A (this total should also equal the sum of columns I and J).

These data aggregations by race and ethnicity are the categories required by the October 30, 1997 revision of *OMB Statistical Policy Directive No. 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (http://www.whitehouse.gov/omb/fedreg/ombdir15.html)

TABLE B:

TREATMENT NEEDS BY AGE, SEX, AND RACE/ETHNICITY

State:

AGE	A. TOTAL	SEX AND RACE/ETHNICITY																	
		B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 & UNDER																			
2. 18-24																			
3. 25-44																			
4. 45-64																			
5. 65 AND OVER																			
6. TOTAL																			

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Step 3: Prioritize state planning activities

Using the information in Step 2, states should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the core federal goals and aims of the MHBG and SABG programs: ***target populations*** (those that are required in legislation and regulation for each block grant) and ***other priority populations*** described in this document. States should list the priorities for the plan in Plan Table 1 and indicate the priority type (i.e., substance misuse prevention (SAP), substance use disorder treatment (SAT), or mental health services (MHS).

Step 4: Develop goals, objectives, performance indicators and strategies

For each of the priorities identified in Step 3, states should identify the relevant goals, measureable objectives and at least one-performance indicator for each objective for the next two years.

For each objective, the state should describe the specific strategy that will be used to achieve the objective. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, and system improvements that will address the objective. Strategies to consider and address include:

- Strategies that are targeted for children and youth with SED or substance use disorders. States should use a system of care approach that has been well established for children with SED and co-occurring substance use disorders. This approach should be used state wide, coordinating care with other state agencies (e.g., schools, child welfare, juvenile justice, primary care, etc.) to deliver evidence-based treatments and supports through a family-driven, youth-guided, culturally competent, individualized treatment plan. For adolescents with substance use disorders and SED, this approach should be used in conjunction with evidence-based interventions for substance use or dependence.

- Strategies targeted for adults with SMI/SUDs that will identify and intervene early, connect with, or provide the best possible treatment, and design and implement recovery-oriented services.

- Strategies that will promote integration and inclusion into the community: This includes housing models that integrate individuals into the community instead of long-term care facilities or nursing homes and other settings that fail to promote independence and inclusion. This also can include strategies to promote competitive and evidenced-based supported employment in the community, rather than segregated programs.

- Strategies on how technology, especially interactive communication technologies (ICT) will be used to engage individuals and their families into treatment and recovery supports. Almost 40 percent of uninsured individuals are under the age of 30 and use technology as a substantial, if not primary, mode of communication.

- Strategies that result in developing recovery support services, e.g., permanent housing and supportive employment or education for persons with mental and substance use disorders. This includes how local authorities will be engaged to increase the availability of housing, employment, and educational opportunities, and how the state will develop services that will wrap around these individuals to obtain and maintain safe and affordable housing, employment, and/or education.

- Strategies that will enable the state to document the diversity of its service population and providers and to specify the development of an array of culture-specific interventions and providers to improve access, engagement, quality, and outcomes of services for diverse ethnic and racial minorities and LGBT populations. States will be encouraged to refer to the IOM reports,

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Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement[20] and *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*[21] in developing this strategy.

- Strategies that will build the state and provider capacity to provide evidence-based, trauma-specific interventions in the context of a trauma-informed delivery system. Recognizing trauma as a critical factor in the development of mental and substance use disorders, states should build provider competence in using effective trauma treatments. States should ensure that these treatments are provided in systems that understand the impact of trauma on their service population and work to eliminate organizational practices and policies that may cause new or exacerbate existing trauma. SAMHSA has developed "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach" to provide states with a framework for incorporation of trauma informed care into its system.

- Strategies that increase the use of person-centered planning, self-direction, and participant-directed care. This includes measures to help individuals or caregivers (when appropriate) identify and access services and supports that reinforce recovery or resilience. These strategies should also include how individuals or caregivers have access to supports to facilitate participant direction, including the ability to manage a flexible budget to address recovery goals; identifying, selecting hiring and managing support workers and providers; and ability to purchase goods and services identified in the recovery or resilience planning process.

- As specified in 45 CFR § 96.125(b), states shall use a variety of evidence-based programs, policies and practices in their prevention efforts that include:
  - Information dissemination;
  - Education;
  - Alternatives that decrease alcohol, tobacco, and other drug use;
  - Problem identification and referral;
  - Community based programming; and,
  - Environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population

  Prevention strategies should also be consistent with the IOM *Report on Preventing Mental Emotional and Behavioral Disorders*, the Surgeon General's *Call to Action to Prevent and Reduce Underage Drinking*[22], the National Registry of Evidenced-based Programs and Practices (NREPP), and/or other materials documenting their effectiveness. These strategies include:

[20] Institute of Medicine. (2009).*Race, Ethnicity, and Language Data: Standardization for Healthcare quality Improvement.* Subcommittee on Standardization Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Board on Healthcare Services. Cheryl Ulmer, Bernadette McFadden, and David R. Nerenz, Editors, Washington, DC: The National Academies Press

[21] IOM (Institute of Medicine). 2011. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press.

[22] http://store.samhsa.gov/product/Surgeon-General-s-Call-to-Action-to-Prevent-and-Reduce-Underage-Drinking/SGCTA-07

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- Strategies that target tobacco use prevention and tobacco-free facilities that are supported by research and encompass a range of activities including policy initiatives and programs;

- Strategies that engage schools, workplaces, and communities to establish programs and policies to improve knowledge about alcohol and other drug problems, denote effective ways to address the problems, and enhance resiliency.

- Strategies that implement evidence-based and cost-effective models to prevent substance misuse in young people in a variety of community settings, e.g., families, schools, workplaces, and faith-based institutions, consistent with the current science;

- Strategies that follow the Surgeon General's *Call to Action to Prevention and Reduce Underage Drinking,* developed in coordination with the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) which focus on policy and environmental programming to change the community's norms around, and parental acceptance of, underage alcohol use; and

- Strategies that address harder-to-reach racial/ethnic minority and LGBT communities that experience a cluster of risk factors that make them especially vulnerable to substance use and related problems.

SABG primary prevention set-aside funds can only be used to fund strategies that are intended to prevent substance use and abuse. MHBG funds can only be used for prevention activities for adults with SMI and children with SED.

- System improvement activities may be included as a strategy to address issues identified in the needs assessment. System improvement activities should:

  - Allow states to position their providers to increase access, retention, adoption, or adaptation of EHRs, or to develop strategies to increase workforce numbers. These system improvement activities should use federal and state resources currently available and those proposed for the planning period to enhance the competency of the behavioral health workforce. System improvements that seek to expand the workforce should build upon existing efforts to increase M/SUD skill development in a wide range of professions as well as increase the role of people in recovery from mental and substance use disorders in the planning and delivery of services.

  - Support providers to participate in networks that may be established through managed care or administrative service organizations (including affordable care organizations (ACOs)). This may include assistance to develop the necessary infrastructure (e.g., electronic billing and EHRs) and reporting requirements to participate in these networks.

  - Encourage the use of peer specialists or recovery coaches to provide needed recovery support services, which are already delivered by volunteers and paid staff. Peers are trained, supervised, and regarded as staff and operate out of a community-based or recovery organization. A state's strategy should allow states to support peer and other recovery support services delivered under either model. The infrastructure, including paid staff, to coordinate and encourage the use of volunteer- delivered or run services should

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also be supported.

- Increase links between primary, specialty, emergency and rehabilitative care and behavioral health providers working with behavioral health provider organizations for expertise, collaboration, and referral arrangements, including the support of practitioner efforts to screen patients for mental and substance use disorders. Activities should also focus on developing model contract templates for reciprocal health and behavioral health integration and identifying state policies that present barriers to reimbursement. This would include efforts to implement health homes (§2703 of the Affordable Care Act)[23], dual eligible products, ACOs, and medical homes.

- Develop support systems to provide communities with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other resources to foster the development of comprehensive community plans to improve mental, emotional, and behavioral health outcomes.

- Fund auxiliary aids and services to allow people with disabilities to benefit from the M/SUD services and language assistance services for people who experience communication barriers to access.

- Develop benefit management strategies for high-cost services (e.g., youth out of home services and adult residential services). SAMHSA believes that states should align their care management to guarantee that individuals get the right service at the right time in the right amount. These efforts should ensure that decisions made regarding these services are clinically sound.

1. Quality and Data Collection Readiness

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

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and NQS measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of

[23] to http://www.integration.samhsa.gov/integrated-care-models/health-homes

services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

The key to accomplishing tasks associated with data collection for the block grant will be SAMHSA's collaboration with the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of any modifications or changes to data collection and reporting for local service providers and state agencies. This collaboration has resulted in a clarified description of the non-direct services/system support expenditures from the block grants. Similar discussions about reporting of direct services will be undertaken as we move forward.

2. Planning Tables

States should describe specific performance indicators that will be used to determine if the goals for that priority area were achieved. For each performance indicator, the state must describe the data and data source that has been used to develop the baseline for FFY 2018 and how the state proposes to measure the change in FFY 2019. States must use the template (Plan Table 1: Priority Areas by Goal, Strategy, and Performance Indicators) below.

Plan Table #1. Priority Area and Annual Performance Indicators

States should follow the guidelines presented above in Framework for Planning – Mental Health and Substance Use Disorder Prevention and Treatment Planning Steps to complete Plan Table 1. States are to complete a separate table for each state priority area to be included in the MHBG and SABG. Please include the following information when entering into Web BGAS:

1. *Priority area* (based on an unmet service need or critical gap). After this information is completed for the first priority area, another table will appear so additional priorities can be added.

2. *Priority type*. From the drop-down menu, select **SAP –** substance misuse prevention, **SAT –** substance use disorder treatment, or **MHS --** mental health service.

3. *Targeted/required populations*. Indicate the population(s) required in statute for each block grant as well as those populations encouraged, as described in IIIA *Framework for Planning—Mental Health and Substance Abuse Prevention and Treatment*. States must include at least one priority for each required population. From the drop-down menu select:

   a) **SMI**–Adults with SMI,
   b) **SED**–Children with an SED,
   c) **FEP -** Individuals who are diagnosed with their first episode of psychosis\
   d) **PWWDC**–Pregnant women and women with dependent children,
   e) **PP** – persons in need of primary substance misuse prevention
   f) **PWID**–Persons who inject drugs (formerly known as intravenous drug users (IVDU)),
   g) **EIS/HIV**–Persons with or at risk of HIV/AIDS who are receiving SUD treatment services
   a) **TB**–Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or

b) **Other**: Specify (Refer to section IIIA of the Assessment and Plan).

4. *Goal of the priority area*. Goal is a broad statement of general intention. Therefore, provide a general description of what the state hopes to accomplish. *Objective*: Objective should be a concrete, precise and measureable statement.
5. *Strategies to attain the objective*. Indicate state program strategies or means to achieve the stated objective.

6. *Annual Performance Indicators* to measure success on a yearly basis. Each indicator must reflect progress on a measure that is impacted by the block grant. After indicator is completed with the information for the first indicator below, the table will expand to enter additional indicators. For each performance indicator, specify the following components:

a) Baseline measurement from where the state assesses progress
b) First-year target/outcome measurement (Progress to the end of SFY 2018);
c) Second-year target/outcome measurement (Final to the end of SFY2019);
d) Data source;
e) Description of data; and
f) Data issues/caveats that affect outcome measures.

Plan Table 1: Priority Area and Annual Performance Indicators

1. Priority Area:	Priority Type (SAP, SAT, MHS):
3. Population(s) (SMI, SED, FEP, PWWDC, PP, PWID, EIS/HIV, TB, OTHER):	
4. Goal of the priority area:	
5. Objective:	
6. Strategies to attain the objective:	
7. Annual Performance Indicators to measure achievement of the objective: Indicator #1:	
a) Baseline measurement (Initial data collected prior to and during SFY 2018):	
b) First-year target/outcome measurement (Progress to the end of SFY 2018):	
c) Second-year target/outcome measurement (Final to the end of SFY 2019):	
d) Data source:	
e) Description of data:	
f) Data issues/caveats that affect outcome measures:	

SAMHSA will work with states to monitor whether they are meeting the goals, objectives and performance indicators established in their plans, and to provide technical assistance as needed.

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SAMHSA staff will work closely with states during the year to discuss progress, identify barriers, and develop solutions to address these barriers.

If a state is unable to achieve its goals and objectives as stated in its application(s) approved by SAMHSA, the state will be asked to provide a description of corrective actions to be taken. If further steps are not taken, SAMHSA may ask the state for a revised plan, which SAMHSA will assist in developing, to achieve its goals and objectives. States that do not choose to apply for the MHBG or SABG will have their funds redirected to other states as provided in statute.[24]

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[24] http://www.samhsa.gov/grants/block-grants/laws-regulations

Plan Table 2: State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Plan Table 2	State Agency Planned Expenditures						
(Include ONLY funds expended by the executive branch agency administering the SABG and/or the MHBG*)							
Planning Period- From:	To:						
State Identifier:							
	Source of Funds						
ACTIVITY (See instructions for using Row 1.)	A. SABG	B. MH BG	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*	$		$	$	$	$	$
b. All Other	$		$	$	$	$	$
2. Primary Prevention**	$	$	$	$	$	$	$
a. Substance Abuse Primary Prevention	$		$	$	$	$	$
b. Mental Health Primary prevention***			$	$	$	$	$
3. Evidence-Based Practices for Early Intervention (10 percent of total award MHBG)****		$	$	$	$	$	$
4. Tuberculosis Services	$		$	$	$	$	$
5. Early Intervention Services for HIV	$		$	$	$	$	$
6. State Hospital			$	$	$	$	$
7. Other 24-Hour Care		$	$	$	$	$	$
8. Ambulatory/Community Non-24 Hour Care		$	$	$	$	$	$
9. Administration (excluding program / provider level) MHBG and SABG must be reported separately	$	$	$	$	$	$	$

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10. Subtotal (Rows 1, 2, , 4, 5 and 9)	$	$	$	$	$	$	$
11. Subtotal (Rows 3, 6, 7, and 8)	$	$	$	$	$	$	$
12. Total	$	$	$	$	$	$	$

* Prevention other than primary prevention.
**The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.
***While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.
**** Column 3B should include First Episode Psychosis programs funded through MHBG set aside

Plan Table 3: SABG Planned Expenditures.

States must project how they will use SABG funds to provide authorized services as required by the SABG regulations. Plan Table 3 must be completed for the FFY 2018 and FFY 2019 SABG awards.

Plan Table 3 SABG Planned Expenditures		
State Identifier:		
Expenditure Category	**FFY 2018 SA Block Grant Award**	**FFY 2019 SA Block Grant Award**
1. Substance Abuse Prevention* and Treatment	$	$
2. Primary Substance Abuse Prevention	$	$
3. Early Intervention Services for HIV[25]	$	$
4. Tuberculosis Services	$	$

[25] For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will bepublished 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 beare required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involvedfor which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance wouldwill be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

5. Administration (SSA level only)	$	$
6. Total	$	$

* Prevention other than Primary Prevention

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Table 4a and 4b - Primary Prevention Planned Expenditures

States must spend no less than 20 percent of their SABG allotment on substance misuse primary prevention strategies. These strategies are directed at individuals not identified to be in need of treatment. To report on their primary prevention planned expenditures, states must complete either Table 4a or Table 4b or may choose to complete both. If Table 4b is completed, the state must also complete Section 1926 –Tobacco on Table 4a.

Table 4a SABG Primary Prevention Planned Expenditures

The state's primary prevention program must include, but is not limited to, the six primary prevention strategies defined below. On Table 4a, states should list their FFY 2018 and FFFY 2019 SABG planned expenditures for each of the six primary prevention strategies. Expenditures within each of the six strategies should be directly associated with the cost of completing the activity or task; for example, information dissemination should include the cost of developing pamphlets, the time of participating staff or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories, please report them under "Other" in Table 4a.

In most cases, the total amounts should equal the amounts reported on Plan Table 3, Row 2, Primary Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non Direct Services/System Development activities.

If the state chooses to report activities utilizing the IOM Model of Universal, Selective, and Indicated, complete Form 4b. If Form 4b is completed, the state must also complete Section 1926 –Tobacco on Form 4a.

Table 4a SABG Primary Prevention Planned Expenditures

Information Dissemination– This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education - This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

A**lternatives -** This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and drugs through these activities.

P**roblem Identification and Referral -** This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based Process - This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

Environmental - This strategy establishes or changes written and unwritten community standards, codes, and attitudes; thereby, influencing alcohol and other drug use by the general population.

Other - The six primary prevention strategies have been designed to encompass nearly all of the prevention activities. However, in the unusual case an activity does not fit one of the six strategies, it may be classified in the "Other" category.

Section 1926 - Tobacco: Costs Associated with the Synar Program. Per January 19, 1996, 45 CFR Part 96 Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants; Final Rule (45 CFR § 96.130), states may not use the Block Grant to fund the enforcement of their statute, except that they **may expend funds** from their primary prevention set aside of their Block Grant allotment under 45 CFR § 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections.

In addition, prevention strategies may be classified using the IOM Model of Universal, Selective and Indicated, which classifies preventive interventions by the population targeted. Definitions for these categories appear below:

Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels (Adapted from The Institute of Medicine).

States that are able to report on both the strategy type and the population served (universal, selective, or indicated) should do so. If planned expenditure information is only available by strategy type, then the state should report planned expenditures in the row titled Unspecified (for example, Information Dissemination Unspecified).

Plan Table 4a: SABG Primary Prevention Planned Expenditures			
State Identifier:			
Report Period- From:		To:	
	A	B	C
Strategy	IOM Target	FFY 2018 SA Block Grant Award	FFY 2019 SA Block Grant Award
1. Information Dissemination	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
2. Education	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
3. Alternatives	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
4. Problem Identification and Referral	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
5. Community-Based Processes	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
6. Environmental	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
7. Section 1926-Tobacco	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
8. Other	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
9. Total Prevention Expenditures		$	$
Total SABG Award		$	$
Planned Primary Prevention Percentage		%	%

Table 4b SABG Primary Prevention Planned Expenditures

Table 4b Instructions: States that plan their primary prevention expenditures using the IOM model of universal, selective, and indicated should use Table 4b to list their FFY 2018 and FFFY 2019 SABG planned expenditures in each of these categories. The total amount should equal the amount reported on plan Table 3, Row 2, Primary Prevention. Note that if Form 4b is completed instead of Form 4a, the state must also complete Section 1926 - Tobacco on Form 4a. In most cases, the total amounts should equal the amounts reported on Plan Table 3, Row 2, Primary Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non Direct Services/System Development activities.

Institute of Medicine Classification: Universal, Selective, and Indicated:

Universal: Activities targeted to the general public or a whole population group that have not been identified on the basis of individual risk.

Universal Direct. Row 1 - Intervention s directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after-school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
Universal Indirect. Row 2 - Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels (Adapted from The Institute of Medicine).

Plan Table 4b: SABG Primary Prevention Planned Expenditures by IOM Category		
State Identifier:		
Activity	FFY 2018 SA Block Grant Award	FFY 2019 SA Block Grant Award
Universal Direct	$	$
Universal Indirect	$	$
Selective	$	$
Indicated	$	$
Column Total	$	$
Total SABG Award	$	$
Planned Primary	%	%

Prevention Percentage		

Plan Table 4c: SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2018 and FFY 2019 SABG awards.

Targeted Substances	☑
Alcohol	
Tobacco	
Marijuana	
Prescription Drugs	
Cocaine	
Heroin	
Inhalants	
Methamphetamine	
Synthetic Drugs (i.e. Bath salts, Spice, K2)	

Instructions: In the table below, identify the special population categories the state BG plans to targets with primary prevention set-aside dollars.

Targeted Populations	☑
Students in College	
Military Families	
LGBT	
American Indians/Alaska Natives	
African American	
Hispanic	
Homeless	
Native Hawaiian/Other Pacific Islanders	
Asian	
Rural	
Underserved Racial and Ethnic Minorities	

Plan Table 5

Categories for Expenditures for System Development/Non-Direct-Service Activities

Expenditures for these activities may be direct expenditures (involving the time of state or sub-state personnel, or other state or sub-state resources) or be through funding mechanisms with independent organizations. Expenditures may come from the administrative funds and/ or program funds (but may not include the HIV set-aside funds). These include state, regional, and local personnel salaries prorated for time spent and operating costs such as travel, printing, advertising, and conducting meetings related to the categories below.

Non-direct services/system development activities *exclude* expenditures through funding mechanisms for providing treatment or mental health "direct service" and primary prevention efforts themselves. Instead, these expenditures provide support to those activities.

Please utilize the following categories to describe the types of expenditures your state supports with BG funds, and if the preponderance of the activity fits within a category.

> We understand that a particular activity may cross categories, but try to identify the primary purpose or goal of the activity. For example, a state may utilize SABG funds to train personnel to conduct fidelity assessments of evidence-based practices. While this could fall under either training/education and/or quality assurance/improvement – if the primary purpose is to assure the implementation of EBPs, that expenditure would most likely be captured under quality assurance/improvement.

Information systems – This includes collecting and analyzing treatment data as well as prevention data under the SABG in order to monitor performance and outcomes. Costs for EHRs and other health information technology also fall under this category.

Infrastructure Support – This includes activities that provide the infrastructure to support services but for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, and respite services.

Partnerships, community outreach, and needs assessment – This includes state, regional, and local personnel salaries prorated for time and materials to support planning meetings, information collection, analysis, and travel. It also includes the support for partnerships across state and local agencies, and tribal governments. Community/network development activities, such as marketing, communication, and public education, and including the planning and coordination of services, fall into this category, as do needs-assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps.

Planning Council Activities – This includes those supports for the performance of a Mental Health Planning Council under the MHBG, a combined Behavioral Health Planning Council, or (OPTIONAL) Advisory Council for the SABG.

Quality assurance and improvement - This includes activities to improve the overall quality of services, including those activities to assure conformity to acceptable professional standards, adaptation and review of implementation of evidence-based practices, identification of areas of technical assistance related to quality outcomes, including feedback. Administrative agency contracts to monitor service-provider quality fall into this category, as do independent peer-review activities.

Research and evaluation - This includes performance measurement, evaluation, and research, such as services research and demonstration projects to test feasibility and effectiveness of a new approach as well as the dissemination of such information.

Training and education - This includes skill development and continuing education for personnel employed in local programs as well as partnering agencies, as long as the training relates to either substance use disorder service delivery (prevention, treatment and recovery) for SABG and services to adults with SMI or children with SED for MHBG. Typical costs include course fees, tuition, and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.

Please enter the total amount of the block grant expended for each activity.

	Non-Direct-Services/System Development			
	SABG/MHBG Table 5			
	State Identifier:			
	Report Period- From: To:			
Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined *
1. Information Systems	$	$	$	$
2. Infrastructure Support	$	$	$	$
3. Partnerships, community outreach, and needs assessment	$	$	$	$
4. Planning Council Activities (MHBG required, SABG optional)	$	$	$	$
5. Quality assurance and improvement	$	$	$	$
6. Research and Evaluation	$	$	$	$
7. Training and Education	$	$	$	$
8. Total	$	$	$	$

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

C. Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Requested

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[28]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[29] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[30] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[31]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for

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

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

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

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

[30] http://www.samhsa.gov/health-disparities/strategic-initiatives

[31] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

members to assist them in coordinating pediatric mental health and primary care.[32]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[33] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[34] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[35] and ACOs[36] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages

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[32] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf ;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges*. Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

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

[34] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[35] Health homesHomes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

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

SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[37] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[38]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[39] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[40] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[41] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[42] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with

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

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

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

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

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

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

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[43] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[44]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Affordable Care Act

[43] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

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

and Medicaid provisions or are ineligible to participate in certain programs.[45] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

1. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs
   a) ☐ Yes ☐ No
   and Medicaid
   b) ☐ Yes ☐ No
2) Who is responsible for monitoring access to M/SUD services by the QHPs?

3) Is the SSA/SMHA involved in any coordinated care initiatives in the state?
   ☐ Yes ☐ No
4) Do the behavioral health providers screen and refer for:
   a) Prevention and wellness education
   ☐ Yes ☐ No
   b) Health risks such as
      i) heart disease, ☐ Yes ☐ No
      ii) hypertension, ☐ Yes ☐ No
      iii) high cholesterol ☐ Yes ☐ No
      iv) diabetes ☐ Yes ☐ No

5) Recovery supports
   ☐ Yes ☐ No

6) Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?
   ☐ Yes ☐ No

7) Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?
   ☐ Yes ☐ No

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

8) What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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

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

2. Health Disparities - Requested

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[46], *Healthy People, 2020*[47], *National Stakeholder Strategy for Achieving Health Equity*[48], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).[49]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
[47] http://www.healthypeople.gov/2020/default.aspx
[48] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf
[49] http://www.ThinkCulturalHealth.hhs.gov

take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[50]
Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[51] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[52] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical

[50] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
[51] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208
[52] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

Please respond to the following items:

1) Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
   a) race ☐ Yes ☐ No
   b) Ethnicity ☐ Yes ☐ No
   c) gender ☐ Yes ☐ No
   d) sexual orientation ☐ Yes ☐ No
   e) gender identity, ☐ Yes ☐ No
   f) Age? ☐ Yes ☐ No
2) Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?
   ☐ Yes ☐ No
3) Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?
   ☐ Yes ☐ No
4) Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
   ☐ Yes ☐ No
5) If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?
   ☐ Yes ☐ No
6) Does the state have a budget item allocated to identifying and remediating disparities in behavioral health care?
   ☐ Yes ☐ No
7) Does the state have any activities related to this section that you would like to highlight?

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

3. Innovation in Purchasing Decisions - requested

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

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C)**

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national

reports over the last decade or more. These include reports by the Surgeon General,[53] The New Freedom Commission on Mental Health,[54] the IOM,[55] and the NQF.[56] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[57] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office of Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

SAMHSA's Treatment Improvement Protocols (TIPs)[58] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[59] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing

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

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

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

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

[57] http://psychiatryonline.org/

[58] http://store.samhsa.gov

[59] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

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

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

4. ***Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness-requested MHBG***

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more

when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis. The previous five percent set-aside appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of MHBG set aside funds for individuals with early SMI, including those without psychosis. However, the new language for the 10 percent set-aside specifically requires states to focus their efforts only on those who have been diagnosed with a First Episode Psychosis (FEP).

FEP. Nevertheless, SAMHSA is encouraging states to use MHBG general funds to implement evidence based programs for individuals, of any age, in the early stage* of a serious mental illness.

Given this, SAMHSA would like to know:

1. Has the state implemented any evidence based practices (EBP) for those with an early serious mental illness (other than FEP)?
   ☐ Yes ☐ No

   a) If yes, please list the EBP and provide a description of the programs that the state currently funds to implement evidence-based practices for those with early SMI

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

*To clarify, this is not to include primary prevention activities or prodromal stage. MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

First Episode Psychosis Programs (10 percent set aside): required MHBG

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of

individuals with a first episode of psychosis. NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

Beginning in federal fiscal year 2014, Congress allocated additional funds to SAMHSA for states to implement programs for persons with early SMI. States must set aside 10 percent of their allocation for implementing programs showing strong evidence of effectiveness for individuals with a FEP. States must report the programs that are getting the MHBG set-aside funds for FEP, in URS Table 10

1. Does the state have policies for addressing first episode psychosis? ☐Yes ☐ No

2. How does the state promote the use of evidence-based interventions for individuals with a FEP?

3. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a FEP?
   ☐ Yes ☐ No

4. Does the state collect data specifically related to FEP?
   ☐ Yes ☐ No
5. Does the state provide trainings to increase capacity of providers to deliver interventions related to FEP?
   ☐ Yes ☐ No
6. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for FEP.

7. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's FEP

programs?

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

9. Please list the diagnostic categories identified for your state's FEP programs

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

5. Person Centered Planning (PCP) and Self-Direction - Requested

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

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following:

1. Does your state have policies related to person centered planning? ☐Yes ☐ No
2. Does your state have policies related to self-direction?
   ☐ Yes ☐ No
3. Are there any concretely planned initiatives in your state specific to person centered planning and/or self-direction? ☐Yes ☐ No
   If yes, describe the current or planned initiative. In particular, please answer the following questions:
   a) How is the initiative financed?

   b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) Describe the person-centered planning process.

e) What role, if any, do peers with lived experience of the mental health system play in the initiative?

f) What, if any, research and evaluation activities are connected to the initiative?

g) If no, describe any action steps planned by the state in developing PCP and self-direction initiatives in the future.

6. Program Integrity - Required

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

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

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

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

Please respond to the following:

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?

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

7. Tribes - Requested

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[60] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a

[60] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?.

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

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

8. Primary Prevention-required (SABG only)

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance misuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

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

Please respond to the following questions:

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   a) ☐ 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 assessment 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) ☐ Cultural/ethnic minorities
   g) ☐ Sexual/gender minorities
   h) ☐ Rural communities
   i) ☐ Other (please list:)

4. Does your state use data from the following sources in its primary prevention needs assessment? (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 Behavior 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 SABG primary prevention funds?
   a) ☐ Yes ☐ No
      i) If yes, (if yes, please explain

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

Capacity Building

6. Does your state have a statewide licensing or certification program for the substance misuse prevention workforce?

a) ☐ Yes (if yes, please describe)

b) ☐ No

7. Does your state have a formal mechanism to provide training and technical assistance to the substance misuse prevention workforce?
   a) ☐ Yes (if yes, please describe mechanism used)

   b) ☐ No

8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?
   a) ☐ Yes (if yes, please describe mechanism used:)

   b) ☐ No

Planning

9. Does your state have a strategic plan that addresses substance misuse prevention that was developed within the last five years?
   a) ☐ Yes (If yes, please attach the plan in BGAS)

b) ☐ No

10. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?
    a) ☐ Yes
    b) ☐ No
    c) ☐ Not applicable (no prevention strategic plan)
11. Does your state's prevention strategic plan include the following components? (check all that apply):
    a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
    b) ☐ Timelines
    c) ☐ Roles and responsibilities
    d) ☐ Process indicators
    e) ☐ Outcome indicators
    f) ☐ Cultural competence component
    g) ☐ Sustainability component
    h) ☐ Other (please list:)
    i) ☐ Not applicable/no prevention strategic plan

12. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
    a) ☐ Yes ☐ No
13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
    a) ☐ Yes ☐ No
    b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Implementation

14. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
    a) ☐ SSA staff directly implements primary prevention programs and strategies.

b) ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

b) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
c) ☐ The SSA funds regional entities that provide training and technical assistance.
d) ☐ The SSA funds regional entities to provide prevention services.
e) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
f) ☐ The SSA funds community coalitions to provide prevention services.
g) ☐ The SSA funds individual programs that are not part of a larger community effort.
h) ☐ The SSA directly funds other state agency prevention programs.

i) ☐ Other (please describe)

15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
    a) ☐ Information Dissemination:
    b) ☐ Education:
    c) ☐ Alternatives:
    d) ☐ Problem Identification and Referral:
    e) ☐ Community-Based Processes:
    f) ☐ Environmental:

16. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?
    a) ☐ Yes (if so, please describe:)

    b) ☐ No

Evaluation

17. Does your state have an evaluation plan for substance misuse prevention that was developed within the last five years?
    a) ☐ Yes (If yes, please attach the plan in BGAS)
    b) ☐ No

18. Does your state's prevention evaluation plan include the following components? (check all that apply):
    a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
    b) ☐ Includes evaluation information from sub-recipients
    c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
    d) ☐ Establishes a process for providing timely evaluation information to stakeholders
    e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
    f) ☐ Other (please describe:)

    g) ☐ Not applicable/no prevention evaluation plan

19. Please check those process measures listed below that your state collects on its SABG funded prevention services:
    a) ☐ Numbers served
    b) ☐ Implementation fidelity
    c) ☐ Participant satisfaction
    d) ☐ Number of evidence based programs/practices/policies implemented
    e) ☐ Attendance
    f) ☐ Demographic information
    g) ☐ Other (please describe:)

20. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
    a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc…

b) ☐ Heavy use
☐ Binge use
☐ Perception of harm
c) ☐ Disapproval of use
d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
e) ☐ Other (please describe:)

9. Statutory Criterion for MHBG (Required MHBG)

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.

1. Does your state provide the following services under comprehensive community-based mental health service systems?
   a) Physical health
      ☐ Yes ☐ No
   b) Mental Health
      ☐ Yes ☐ No
   c) Rehabilitation services
      ☐ Yes ☐ No
   d) Employment services
      ☐ Yes ☐ No
   e) Housing services
      ☐ Yes ☐ No
   f) Educational services
      ☐ Yes ☐ No
   g) Substance misuse prevention and SUD treatment services
      ☐ Yes ☐ No
   h) Medical and dental services
      ☐ Yes ☐ No
   i) Support services
      ☐ Yes ☐ No

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
☐ Yes ☐ No

k) Services for persons with co-occurring M/SUDs
☐ Yes ☐ No

l)Describe your state's case management services and any other activities leading to reduction of hospitalization.

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.

Describe your state's mental health system data epidemiology.

Criterion 3: Children's Services

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

2. Does your state integrate the following services into a comprehensive system of care?
   a)Social Services
   ☐ Yes ☐ No
   b)Educational services, including services provided under IDE
   ☐ Yes ☐ No
   c)Juvenile justice services
   ☐ Yes ☐ No
   d)Substance misuse prevention and SUD treatment services
   ☐ Yes ☐ No
   e)Health and mental health services

☐ Yes ☐ No

f)Establishes defined geographic area for the provision of the services of such system

☐ Yes ☐ No

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.

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

Describe your state's management systems.

10. Substance Use Disorder Treatment - Required SABG

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

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services:

i) Screening

☐ **Yes** ☐ **No**

ii) Education

☐ **Yes** ☐ **No**

iii) Brief intervention

☐ **Yes** ☐ **No**

iv) Assessment

☐ **Yes** ☐ **No**

v) Detox (inpatient/social)

☐ **Yes** ☐ **No**

vi) Outpatient

☐ **Yes** ☐ **No**

vii) Intensive outpatient

☐ **Yes** ☐ **No**

viii) Inpatient/residential

☐ **Yes**☐ **No**

ix) Aftercare; recovery support

☐ **Yes** ☐ **No**

b)Are you considering any of the following:

Inclusion of recovery support services

☐ **Yes** ☐ **No**

Integration with primary healthcare

☐ **Yes** ☐ **No**

Targeted services for veterans

☐ **Yes** ☐ **No**

Expansion of services for:

(1) Adolescents
(a) ☐ **Yes** ☐ **No**

(2) Older adults
(a) ☐ **Yes** ☐ **No**

(3) Medication-Assisted Treatment (MAT)
(a) ☐ **Yes** ☐N**o**

<u>Criterion2: Improving Access and Addressing Primary Prevention – see Section 8</u>

<u>Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)</u>

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?

a) ☐ **Yes** ☐ **No**

2. Either directly or through an arrangement with public or private nonprofit entities make prenatal care available to PWWDC receiving services?
   a) ☐ **Yes** ☐ **No**
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
   a) ☐ **Yes** ☐ **No**
4. Does your state have an arrangement for ensuring the provision of required supportive services?
   a) ☐ **Yes** ☐ N**o**
5. Are you considering any of the following:
   a)Open assessment and intake scheduling
   ☐ **Yes** ☐ **No**
   b) Establishment of an electronic system to identify available treatment slots
   ☐ **Yes** ☐ **No**
   c)Expanded community network for supportive services and healthcare
   ☐ **Yes** ☐ **No**
   d)Inclusion of recovery support services
   ☐ **Yes** ☐ **No**
   e)Health navigators to assist clients with community linkages
   ☐ **Yes**☐ **No**
   f)Expanded capability for family services, relationship restoration, custody issue
   ☐ **Yes**☐ N**o**
   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.

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the
   a) 90 percent capacity reporting requirement
   ☐ **Yes** ☐ **No**
   b) 14-120 day performance requirement with provision of interim services
   ☐ **Yes** ☐ **No**
   c) Outreach activities
   ☐ **Yes** ☐ **No**
   d) Syringe services programs
   ☐ Y**es** ☐ **No**
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation
   ☐ **Yes** ☐ **No**

2. Are you considering any of the following:
   a) Electronic system with alert when 90 percent capacity is reached
   ☐ **Yes** ☐ **No**
   b) Automatic reminder system associated with 14-120 day performance requirement
   ☐ **Yes** ☐ **No**
   c) Use of peer recovery supports to maintain contact and support
   ☐ **Yes** ☐ **No**
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)
   ☐ **Yes** ☐ **No**

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

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?
   a) ☐ **Yes** ☐ **No**

2. Are you considering any of the following:
   a) Business agreement/MOU with primary healthcare providers
      ☐ **Yes** ☐ **No**
   b) Cooperative agreement/MOU with public health entity for testing and treatment
      ☐ **Yes** ☐ **No**
   c) Established co-located SUD professionals within FQHCs
      ☐ **Yes** ☐ **No**

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

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

1. Does your state current 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. Are you considering any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas
      ☐ **Yes** ☐ **No**
   b) Establishment or expansion of tele-health and social media support services
      ☐ **Yes** ☐ **No**
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS
      ☐ **Yes** ☐ **No**

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?
   ☐ **Yes** ☐ **No**

2) Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program

☐ **Yes** ☐ **No**

3) Do any of your programs use SABG funds to support elements of a Syringe Services Program

a) ☐**Yes** ☐ **No**

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

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

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. Are you considering any of the following:

   a) Workforce development efforts to expand service access

   ☐ **Yes** ☐ **No**

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services

   ☐ **Yes** ☐ **No**

   c) Establish a peer recovery support network to assist in filling the gaps

   ☐ **Yes** ☐ **No**

   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)

   ☐ **Yes** ☐ **No**

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations

   ☐ **Yes** ☐ **No**

   f) Explore expansion of services for:

   i) MAT

   (1) ☐ **Yes** ☐ **No**

   ii) Tele-health

(1) ☐ **Yes** ☐ **No**

iii) Social media outreach

(1) ☐ **Yes** ☐ **No**

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

☐ **Yes** ☐ **No**

2. Are you considering any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
      ☐ **Yes** ☐ **No**
   b) Establish a program to provide trauma-informed care
      ☐ **Yes** ☐ **No**
   c) Identify current and perspective partners to be included in building a system of care, e.g., FQHCs, primary healthcare, recovery community organizations, juvenile justice 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. Are you considering any of the following:
   a) Notice to Program Beneficiaries
      ☐ **Yes** ☐ **No**
   b) Develop an organized referral system to identify alternative providers
      ☐ **Yes** ☐ **No**
   c) Develop a system to maintain a list of referrals made by religious organizations
      ☐ **Yes** ☐ **No**

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs

☐ **Yes** ☐ **No**

2. Are you considering any of the following:
   a) Review and update of screening and assessment instruments
      ☐ **Yes** ☐ **No**
   b) Review of current levels of care to determine changes or additions
      ☐ **Yes** ☐ **No**
   c) Identify workforce needs to expand service capabilities
      ☐ **Yes** ☐ **No**
   d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background
      ☐ **Yes** ☐ **No**

Patient Records

1. Does your state have an agreement to ensure the protection of client records
   a) ☐ **Yes** ☐ **No**
2. Are you considering any of the following:
   a) Training staff and community partners on confidentiality requirements
      ☐ **Yes** ☐ **No**
   b) Training on responding to requests asking for acknowledgement of the presence of clients
      ☐ **Yes** ☐ **No**
   c) Updating written procedures which regulate and control access to records
      ☐ **Yes** ☐ **No**
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure
      ☐ **Yes** ☐ **No**

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers
   a) ☐ **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

3. Are you considering 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) Develop 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, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
   a) ☐ **Yes** ☐ **No**
   b) **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 and 11: Group Homes for Persons In Recovery and Continuing Education for 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. Are you considering any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service
      ☐ **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**

Continuing Education

1. Does your state have an agreement to provide continuing education to employees of facilities, which provide prevention activities and/or treatment services?
   ☐ **Yes** ☐ **No**

2. Are you considering 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**

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations Regarding Women
   ☐ Yes ☐ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus
   a) Tuberculosis
   ☐ Yes ☐ No
   b) Early Intervention Services Regarding HIV
   ☐ Yes ☐ No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment
   ☐ Yes ☐ No
   b) Continuing Education
   ☐ Yes ☐ No
   c) Coordination of Various Activities and Services

☐ Yes ☐ No

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

11.Quality Improvement Plan- requested

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

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?
   a) ☐ Yes ☐ No

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

12. Trauma -requested

Trauma[61] is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening

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

experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

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

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

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[62] paper.

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

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☐Yes ☐ No

[62] *Ibid*

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?
   ☐Yes ☐ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?
   ☐ Yes ☐ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   ☐ Yes ☐ No

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

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

13. Criminal and Juvenile Justice - Requested

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[63]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[64]

[63] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.
[64] http://csgjusticecenter.org/mental-health/

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

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

Please respond to the following items:

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?
   ☐ Yes ☐ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?
   ☐ Yes ☐ No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?
   ☐ Yes ☐ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?
   ☐ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

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

14. Medication Assisted Treatment - Requested

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

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

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

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

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

Please respond to the following:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?
   ☐ Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?
   ☐ Yes ☐ No

3. Does the state purchase any of the following medication with block grant funds?
   a) ☐ Methadone
   b) ☐ Buprenorphine; Buprenorphine/naloxone
   c) ☐ Disulfiram
   d) ☐ Acamprosate
   e) ☐ Naltrexone (oral, IM)
   f) ☐ Naloxone

4.Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance use disorders are used appropriately*?

☐ Yes ☐ No

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

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

15. Crisis Services - Requested

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[65] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, *Practice Guidelines: Core Elements for Responding to Mental Health Crises*[66],

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

[65] http://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

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

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

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

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

3. Post Crisis Intervention/Support:
   a) ☐ WRAP Post-Crisis
   b) ☐ Peer Support/Peer Bridgers
   c) ☐ Follow-Up Outreach and Support
   d) ☐ Family-to-Family engagement
   e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
   f) ☐ Follow-up crisis engagement with families and involved community members
   g) ☐ Recovery community coaches/peer recovery coaches
   h) ☐ Recovery community organization

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

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

16. Recovery - Requested

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

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

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing

Peer-run respite services

- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)

Whole Health Action Management (WHAM)

- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

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

Please respond to the following:

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

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

☐ Yes ☐ No

b) Required peer accreditation or certification?

☐ Yes ☐ No

c) Block grant funding of recovery support services.
☐Yes ☐ No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

☐ Yes ☐ No

2. Does the state measure the impact of your consumer and recovery community outreach activity?
☐ Yes ☐ No

3. Does the state have any activities that it would like to highlight?

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

17. Community Living and the Implementation of Olmstead- requested

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of

recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's *Olmstead* decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

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

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

1. Does the state's Olmstead plan include :
   housing services provided ☐ Yes ☐ No
   home and community based services ☐ Yes ☐ No
   peer support services ☐ Yes ☐ No
   employment services. ☐ Yes ☐ No

2. Does the state have a plan to transition individuals from hospital to community settings?
   ☐ Yes ☐ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

18. Children and Adolescents Behavioral Health Services –required MHBG, requested SABG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[67] 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.[68] For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[69]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[70] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a

[67] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).
[68] 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.
[69] 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.
[70] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[71]

According to data from the 2015 Report to Congress[72] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
      ☐ Yes ☐ No
   b) The recovery and resilience of children and youth with SUD?
      ☐ Yes ☐ No

[71] 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 http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

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

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs
   a) Child welfare?
      ☐ Yes ☐ No
   b) Juvenile justice?
      ☐ Yes☐ No
   c) 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 misuse 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 behavioral health system?
      ☐ Yes ☐ No
   b) for youth in foster care?
      ☐ Yes ☐ No

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

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

19. Suicide Prevention - Requested

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?
   ☐ Yes ☐ No

2. Have you incorporated any strategies supportive of Zero Suicide?
   ☐ Yes ☐ No

3. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?
   ☐ Yes ☐ No

4. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?
   ☐ Yes ☐ No
   If so, please describe the population targeted?

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

20. Support of State Partners - Required MHBG

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?
   ☐ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place?

   ☐ Yes ☐ No
   If yes, with whom?

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

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

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[73]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

    a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

[73] http://beta.samhsa.gov/grants/block-grants/resources

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
☐ Yes ☐ No

2. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
☐ Yes ☐ No
3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[74]

[74] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Behavioral Health Advisory Council Members

Name	**Type of Membership***	**Agency or Organization Represented***	Address Phone & Fax	Email Address (If Available)
		**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		
		***State Marketplace Agency		
		***State Child Welfare Agency		
		***State Health Agency		
		***State Agency on Aging		

*Council members should be listed *only once* by type of membership and Agency/organization represented.

** Required by Statute.

***Requested not required

Behavioral Health Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Total Membership		
Individuals in Recovery * (to include adults with SMI who are receiving, or have received, mental health services		
Family Members of Individuals in Recovery * (to include family members of adults with SMI)		
Parents of children with SED/SUD *		
Vacancies (individual & family members)		
Others (Advocates who are not State employees or providers)		
Total Individuals in Recovery, Family Members and Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations		
Providers from Diverse Racial, Ethnic, and LGBT Populations		
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations		
Persons in recovery from or providing treatment for or advocating for SUD services		
Federally Recognized Tribal Representatives		
Youth/adolescent representative (or member from an organization serving young people).		

*States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment and recovery expertise in their Councils.

22. Public Comment on the State Plan- required

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C.§ 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

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

      Other?
      f yes, provide URL

      ☐

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

Acronyms

ACA	Affordable Care Act
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
AI	American Indian
AIDS	Acquired Immune Deficiency Syndrome
AN	Alaskan Native
AOT	Assisted Outpatient Treatment
BHSIS	Behavioral Health Services Information System
CAP	Consumer Assistance Programs
CBHSQ	Center for Behavioral Health Statistics and Quality
CCBHC	Certified Community Behavioral Health Center
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSC	Coordinated Specialty Care
DSM V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association
EBP	Evidence-Based Practice
EHB	Essential Health Benefit

EHR	Electronic Health Record
EIS	Early Intervention Services (association with Human Immunodeficiency Virus (HIV)
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus (associated with Early Intervention Services)
HRSA	Health Resources and Services Administration
ICD-10	*The International Statistical Classification of Diseases and Related Health Problems*, 10th Revision
ICT	Interactive Communication Technology
IDU	Intravenous Drug User
IMD	Institutions for Mental Diseases
IOM	Institute of Medicine
KIT	Knowledge Information Transformation (associated with EBP implementation)
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Questioning
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MHBG	Community Mental Health Services Block Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
MOE	Maintenance of Effort
M/SUD	Mental and/or Substance Use Disorder
NBHQF	National Behavioral Health Quality Framework
NHAS	National HIV/AIDS Strategy
NIAAA	National Institute on Alcoholism and Alcohol Abuse

NIDA	National Institute on Drug Abuse
NIMH	National Institute on Mental Health
NOMS	National Outcome Measures
NQF	National Quality Forum
NQS	National Quality Strategy
NREPP	National Registry of Evidence-based Programs and Practices
OCR	Office of Civil Rights
OMB	Office of Management and Budget
PBHCI	Primary and Behavioral Health Care Integration
PBR	Patient Bill of Rights
PHS	Public Health Service
PPW	Pregnant and Parenting Women
PPWC	Pregnant and Postpartum Women and Children
PWWDC	Pregnant Women and Women with Dependent Children
PWID	Persons Who Inject Drugs
QHP	Qualified Health Plan
RAISE	Recovery After an Initial Schizophrenia Episode
RCO	Recovery Community Organization
RFP	Request for Proposal
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Serious Emotional Disturbance
SFY	State fiscal year
SEOW	State Epidemiological Outcome Workgroup
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SPA	State Plan Amendment
SPF	Strategic Prevention Framework
SSA	Single State Agency
SUD	Substance Use Disorder

TIP	Treatment Improvement Protocol
TLOA	Tribal Law and Order Act
U.S.C.	United States Code
VA	Veterans Administration

Resources

TOPIC	LINK	DESCRIPTION
SAMHSA Block Grants	http://samhsa.gov/grants/block-grants	Description of Block Grant, its purpose, deadlines, laws and regulations and resources
SAMHSA Topic Search	http://www.samhsa.gov/topics	Search SAMHSA's website for resources, information and updates by topic or program
SAMHSA Store	http://store.samhsa.gov/	Search SAMHSA's store to download or order publications and resources
RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE		
TOPIC	**LINK**	**DESCRIPTION**
Center for Integrated Health Solutions	http://www.integration.samhsa.gov/	HRSA-SAMHSA Center for Integrated Health Solutions offers resources, trainings, hot topics, and webinars on primary and behavioral health care integration
Characteristics of State Mental Health Agency Data Systems	http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361	Reviews current information technology (IT) systems and technology implementation efforts in state mental health agencies. Reports key findings on IT and structure, client-level and claims-level data, linking to other state data, and electronic health records. (Downloadable report)
Children Mental Health	http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010	Presents program evaluation findings of a federally funded initiative that supports systems of care for community-based mental health services for children, youth and their families. Reports on FFY2010 data that track service characteristics, use, and outcomes. (Downloadable report)
Co-Occurring Resources and Models	http://www.samhsa.gov/co-occurring/	SAMHSA's webpage dedicated to co-occurring models and practice. Includes: resources, webinars, public resource links and more.

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Health Care Integration	http://www.samhsa.gov/health-care-health-systems-integration	Overview of SAMHSA Health Care Integration initiatives and links to resources and information about health care integration
Health Homes	http://www.integration.samhsa.gov/integrated-care-models/health-homes	SAMHSA's description of Health Homes and resources around health homes
Healthy People Initiative	http://www.healthypeople.gov/2020/default.aspx	Government website that reviews the goals of Healthy People 2020 and provides resources to help meet the goals.
Health Financing	http://www.samhsa.gov/health-financing	SAMHSA guides, trainings and technical assistance resources around health reform implementation.
Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT	http://store.samhsa.gov/product/SMA08-4367	Provides practice principles about integrated treatment for co-occurring disorders, an approach that helps people recover by offering M/SUD services at the same time and in one setting. Offers suggestions from successful programs.
LGBT Populations	http://www.samhsa.gov/behavioral-health-equity/lgbt	Resources on the LGBT population include national survey reports, agency and federal initiatives, and related behavioral health resources.
Medicaid Policy Guidance	http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html	Searchable database of Medicaid Policy Guidance's; including: peer support services, affordable care act, health homes, prescription drugs, etc.
Medication Assisted Treatment	http://www.samhsa.gov/medication-assisted-treatment	SAMHSA's resources, guides and TIPs on MAT
Mental Health and Substance Abuse Block Grant Laws and Regulations	http://www.samhsa.gov/grants/block-grants/laws-regulations	Links to the laws and regulations that govern the Mental Health and Substance Abuse Block Grants

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Mental Health Crisis	http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427	Presents guidelines to improve services for people with serious mental illness or emotional disorders who are in mental health crises. Defines values, principles, and infrastructure to support appropriate responses to mental health crises in various situations.
National CLAS Standards	http://www.ThinkCulturalHealth.hhs.gov	The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.
National HIV/AIDS Strategy (NHAS) for the United States	http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf	July 2010 PDF of the National HIV/AIDS Strategy for the United States
National Partnership for Action to End Health Disparities	http://minorityhealth.hhs.gov/npa/	Offers an overview and resources to help end health disparities
National Registry of Evidenced-Based Programs and Practices	http://www.nrepp.samhsa.gov/	NREPP is a searchable online registry of M/SUD interventions. NREPP was developed to help the public learn more about evidence-based interventions that are available for implementation.
National Strategy for Suicide Prevention	http://store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-2012-Goals-and-Objectives-for-Action/PEP12-NSSPGOALS	Outlines a national strategy to guide suicide prevention actions. Includes 13 goals and 60 objectives across four strategic directions: wellness and empowerment; prevention services; treatment and support services; and surveillance, research, and evaluation. (Downloadable report)
Olmstead	http://www.samhsa.gov/laws-regulations-guidelines/civil-rights-protections	Links to the Olmstead decision document, as well as, a report that offers a basic primer on supportive housing, as well as a thorough review of states' current Olmstead planning efforts in this area
Parity	http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf	Letter from Medicaid on Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans

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Prevention of Underage Drinking	http://www.ncbi.nlm.nih.gov/books/NBK44360/	The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking seeks to engage all levels of government as well as individuals and private sector institutions and organizations in a coordinated, multifaceted effort to prevent and reduce underage drinking and its adverse consequences.
Recovery	http://www.samhsa.gov/recovery/	SAMHSA's resources, guides and technical assistance on recovery
SAMHSA.gov Data Resources	http://www.samhsa.gov/data/	Links to SAMHSA data sets including: NSDUH, DAWN, NSSATS/NMHSS, TEDS, Uniform Reporting System (URS), National and State Barometers, etc.
SAMHSA's Evidenced Based Practice Knowledge Information Transformation (KIT)	http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345	SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[1] were developed to help move the latest information available on effective behavioral health practices into community-based service delivery.
Substance Abuse for Women	http://www.samhsa.gov/women-children-families	Guidance on components of quality SUD treatment services for women, states can refer to the documents found at this link
Suicide Prevention	http://www.samhsa.gov/prevention/	Links to resources and guides around suicide prevention and other mental and substance misuse prevention topics.
Synar Program	http://samhsa.gov/synar	Description and overview of the SYNAR program, which is a requirement of the SABG.
Telehealth Policy Resource	http://telehealthpolicy.us/medicaid	Telehealth Medicaid Policy site that provides telehealth laws and reimbursement by state, telehealth policy PDF and a review of pending legislations
Trauma & Violence	http://www.samhsa.gov/trauma-violence	Includes information around violence and trauma, including the definition and review of trauma informed care.
Criminal & Juvenile Justice	http://www.samhsa.gov/criminal-juvenile-justice	Review of behavioral health services and resources in the criminal justice and juvenile justice systems.
Tribal Consultation	http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president	The White House memorandum regarding the requirements related to tribal consultation

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