FY 2016-17 DRAFT Block Grant Application

Community Mental Health Services Plan and Report
Substance Abuse Prevention and Treatment Plan and Report

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

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FY2016-2017 Block Grant Application

I. INTRODUCTION

This block grant application includes four major parts: introduction, submission of application and plan timeframes, planning materials and reporting requirements. These sections include discussion and planning around the following policy topics: health care systems and integration; health disparities; use of evidence in purchasing decisions; prevention of substance abuse; evidence-based practices for early intervention (e.g., serious mental illness (SMI)); participant-directed care; program integrity; tribal affairs; primary prevention for substance abuse, quality, data, and technology; quality improvement; trauma; criminal and juvenile justice; state parity efforts; medication-assisted treatment; crisis services; recovery; community living and Olmstead; children and adolescents behavioral health services; pregnant women and women with dependent children; suicide prevention; behavioral health planning council; and delegation of authority letter.

A. Background

Block grants were developed to give states maximum flexibility in the use of funds to address the behavioral health[1] needs of their populations. Currently, significant flexibility is provided to allow states to address their unique issues. However, health care systems, laws, knowledge, and conditions have changed, with the enactment of the Patient Protection and Affordable Care Act serving as one recent example. Therefore, states'[2] use of block grant funds must take into account this changing environment as well as Congressional requirements.

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). 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. Both the MHBG and SABG are governed by statute and the SABG by detailed and comprehensive regulations.[3] In addition, the centers within SAMHSA that administer these block grants historically have had different approaches to reviewing application requirements and their reporting. As a result, how these dollars were spent and what is known about the services and clients that receive these 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 best and most cost effective treatment and other services. Though there is principled scientific and policy debate about many aspects of behavioral

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[1] 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.

[2] References to states in this document include the 50 states and 9 Territories. The SABG also includes the Red Lake Band of the Chippewa. Each State designates a Single State Authority responsible for the MHBG and for the SABG.

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

health, block grant expenditures should be based on the best possible evidence while program quality and outcomes should be carefully tracked. Ultimately, such data will lead to improvements as science and circumstances change.

Since their inception, some assumptions about the nature and use of block grants have evolved. Over time, block grants have become equated with the practice of allowing states to use funds in a generally unrestricted and flexible manner. Sometimes, newer, innovative, and evidence-based services have gone unfunded or without widespread adoption. The nation's health care system is focusing increasingly on quality and accountability; because behavioral health is essential to the nation's health, the behavioral health system must focus on quality and accountability as well.

Better alignment of the MHBG and SABG applications will help block grant recipients improve data collection and coordination between programs. In fiscal year (FY) 2011, SAMHSA redesigned the FY 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 health and substance abuse services, submit a biennial versus an annual plan[4],[5] 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 abuse prevention, and treatment administration.

Almost half of the states took advantage of this streamlined application during FY 2014-2015 and submitted combined plans for mental health and substance abuse 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 promotion of emotional health.

The FY 2016-2017 Block Grant Application builds upon the FY 2014-2015 applications and furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. In addition, the FY 2016-2017 Block Grant Application continues to allow states to submit an application for both mental health and substance abuse services as well as a biennial plan. This application also reflects the Affordable Care Act's strong emphasis on coordinated and integrated care along with the need to improve services for persons facing behavioral health crises.

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

As the driving force for its direction, 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. *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015 – 2018*, issued in late FY 2014, reflects SAMHSA's programmatic priorities and policy drivers including the new HHS strategic plan and the transition to full implementation of the Affordable Care Act.

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[4] 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)

[5] State Plan (Sec. 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x- 32(b))

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 to focus its work on improving lives and capitalizing on emerging opportunities. These include:

1. *Prevention of Substance Abuse and Mental Illness:* Focuses on the prevention of substance abuse, SMI and severe emotional disturbance (SED)[6] 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 will include 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 abuse; American Indian/Alaska Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and lesbian, gay, bisexual, and transgender (LGBT) individuals.

2. *Health Care and Health Systems Integration:* Focuses on health care and integration across systems 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 will 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/SEDs) 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. This SI also will support the use of innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

4. *Recovery Support:* Emphasizing person-centered planning, this Strategic Initiative promotes partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system 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.

[6] 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; (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.

5. *Health Information Technology:* Ensures that the behavioral health system – including states, 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 (EHRs) 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 the behavioral health workforce. Through technical assistance, training, and focused programs, the initiative will promote an integrated, aligned, competent workforce that enhances the availability of prevention and treatment for substance abuse and mental illness; 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. These environmental factors are key drivers that will enhance the ability of SMHAs and SSAs to take advantage of many changes that will decrease the prevalence of 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. Changes to the block grant application(s) incorporate several key assumptions:

States should be strategic in their efforts to purchase services.
The availability of new evidenced-based approaches and funding will require states to rethink what services they purchase as well as how those services are purchased. Although access to Medicaid and private insurance will continue to increase over the next few years as the Affordable Care Act is fully implemented, gaps in coverage will remain for specific populations and services. SMHAs and SSAs need to continue to identify those gaps by first mapping out which populations and services will be covered by various coverage options available through the Marketplaces. Secondly, within the different insurance packages, states have to consider the extent to which specific mental illness 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 being covered by insurers and other payers. States will need to become more diligent in their efforts to identify individuals in their systems that may currently qualify, but are not 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. States are encouraged to expand Medicaid where possible for persons and services not otherwise covered.

The block grant laws and 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.[7] Several states have indicated an interest in using block grant funds to cover client co-pays and insurance premiums, which is allowed as long as states that choose to do so develop specific policies and procedures for assuring compliance with the funding requirements.

States should 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 that can be used to purchase services. States should also consider promoting and supporting the revenue diversification efforts of funded providers to develop a provider pool that is more adept at navigating the new environment. States should assist providers to develop better financial strategies that will allow them to be less dependent on SMHA and SSA funding. Funding available from the Center for Medicare and Medicaid Services (CMS), such as Medicaid, CHIP, and Medicare may play an important role in the state's financial strategy. There are also national demonstration projects and programs (e.g., Health Homes, Clinical Practice Transformation, Innovation Accelerator Program, State Innovation Models, Medicaid Emergency Psychiatric Demonstration, Financial Alignment Initiative for Medicare-Medicaid Enrollees) that support efforts to provide behavioral health services. In addition, funding from the Health Resources and Services Administration (HRSA) must be considered as states develop these strategies. HRSA has significantly expanded access to health and behavioral health services offered through its Federally Qualified Health Center (FQHC) 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.). This means that SMHAs and SSAs (as well as public health authorities responsible for prevention) will need to engage and collaborate with different partners at the state, federal, and community levels. Both TRICARE and the Department of Veterans' Affairs (VA) provide behavioral health services as well. Persons eligible for such services should be assisted in accessing these services as appropriate.

States should think more broadly than the populations they have historically served through federal block grants and other funding.
While many of these populations originally targeted for the block grants remain a priority, other populations have evolving needs that must 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, and lesbian, gay, bisexual, transgender and questioning (LGBTQ) 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 personal experiences with mental or substance use disorders 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.

Advances in technology have changed significantly since SAMHSA's inception in 1991. Technology is playing a growing role in how individuals learn about, receive, and experience their health care services.

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

Interactive Communication Technologies (ICTs) 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. The use of these technologies may support access to services by new groups or populations, especially those more likely to be comfortable with these new technologies.

States should design and develop collaborative plans for health information systems. Health care payers will seek to promote EHR and interoperable information technology systems that allow for the effective exchange and use of health data.
Providers of behavioral health services should adopt health information technology 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)[8]. 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 (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 other payers (e.g., Medicaid, Medicare, and private insurance plans). SAMHSA believes it is important for public behavioral health purchasers to begin or continue to collaborate and discuss system interoperability, electronic health records, federal information technology requirements, and other related matters. Additional information from ONC is available at http://www.healthit.gov/.

States may form strategic partnerships to provide individuals with access to effective and efficient services systems.
SAMHSA seeks to enhance SMHAs and SSAs abilities to be full partners in developing and implementing MHPAEA and health reform strategies in their states. In many respects, successful implementation will be 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 health information technology authorities are integral. 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.

To increase the likelihood of cooperative success, there must be a long-range view, open communication, knowledge sharing, and a consideration of all stakeholder concerns and priorities. SMHAs and SSAs should develop strategic partnerships with TRICARE, primary care, public health, criminal and juvenile justice, education, child welfare, VA, National Guard Bureaus, insurers, and employers. State authorities should also engage in tribal consultation as an effective means to learn of needs, resources, and services not previously considered as they undertake their block grant planning process.

State authorities should focus on recovery from mental health and substance use problems.

8 http://healthit.gov/policy-researchers-implementers/standards-interoperability

People can and do recover from behavioral health problems, 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 mental and substance use disorders, families, and others in promoting recovery.

State authorities should 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 (MCOs) or Administrative Services Organizations (ASOs) 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 mental health and substance abuse services are appropriately included in plans, and that mental health and substance abuse providers are included in networks. Given the high proportion of mental health and substance use consumers who will be insured through Marketplaces and who may be eligible for Medicaid, significant consideration should be given to the inclusion of necessary services and providers.

States should make primary substance abuse 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 should be strategic in leveraging scarce resources to fund prevention services.
In times of declining federal, state, and local resources, states need to make the most efficient use of substance abuse prevention funds 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 abuse 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 abuse 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 should monitor the Marketplace to ensure that individuals with behavioral health conditions are aware of their eligibility, able to enroll, and able to remain enrolled.
Now that the Marketplace is in effect, state legislatures, state Marketplace entities, and state insurance commissioners are developing 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 mental and substance use disorders 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 should make every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time.
Block grant funds should be directed toward four purposes: (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 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 treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

States may have to make changes to their information systems and compliance review processes to assure better program integrity. This may include working closely with Medicaid and the Marketplace to review information and determine whether individuals and providers in their systems are enrolled. It also may include implementing strategies to assist their providers with the necessary infrastructures to operate in commercial and public (Medicaid and Medicare) systems. States are encouraged to consider developing metrics or targets to measure increases in the number of individuals who become enrolled or providers that join commercial or publicly funded managed care networks.

State authorities should 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 a critical input for making purchasing decisions and influencing coverage offered in their state through commercial insurers and Medicare/Medicaid. 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 show promising outcomes.

State authorities should 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.

States authorities should monitor compliance with 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 that offer mental health and substance abuse 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 a M/SUD benefit do so at the same level of benefit as for physical conditions, it does not require a plan to offer a M/SUD benefit. With the enactment of the Affordable Care Act, M/SUD disorder services are among the ten categories of service elements that serve as components of the essential health benefits package that are be 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 to improve their implementation processes. States can work with their constituents and advocacy groups to develop resources and toolkits to address barriers to limited awareness. This active involvement to increase awareness helps to ensure that consumers receive quality behavioral health prevention, care, 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 should be 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 (such as the SAMHSA Physical and Behavioral Health Care Integration (PBHCI) grantees) 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. States are beginning to develop client-level and systemic strategies (e.g., moving to Accountable Care Organizations (ACOs) and carve-in managed care arrangements) that are aimed at enhancing integration between primary care and specialty care. 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 room care will see numerous behavioral health issues among the person served. SMHAs and SSAs should be collaborating to educate, consult and serve patients, practitioners and families seen in these systems. Integration in community prevention activities is equally important. Other public health issues are impacted by substance use and/or mental health 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 behavioral health 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 behavioral health prevention, care, and recovery for diverse racial, ethnic, and LGBT 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 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. 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 behavioral health 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, 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 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 attaining and maintain recovery. Recovery support services include efforts such as self-directed care, shared decision-making, peer-operated services, peer specialists and recovery coaches, wellness activities, supported housing, recovery housing, self-care, supported employment, supported education, warm lines, person-centered planning, peer and family support, social inclusion activities, and rights protection.

- *State authorities should ensure that their states have a system of care approach to children's and adolescents' behavioral health 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 developing or amending 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.

  States should also consider their existing administrative and programmatic infrastructures as they work to support local systems of care. Existing councils, such as children's cabinets, can be used to avoid duplication of effort when working towards better interagency coordination. Children and youth served through systems of care are likely to be involved in multiple systems and are probably already the focus of state-level programs and partnerships (e.g., in

education, juvenile justice, or child welfare), so such efforts may also be part of the foundation for a statewide systems of care approach. States are encouraged to look at the impact of adopting this approach across different agencies, addressing issues like access to care, no wrong door, and the best place(s) to house care coordination or case management resources; how to handle information sharing; and which components of a local system of care the agencies are best situated to provide the necessary funding.

C. Block Grant Programs' Goals

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

The components of a healthy life are the dimensions of recovery: health, home, purpose, and community. Additional aims of the block grant program reflect SAMHSA's role as a public health agency:

1. The focus is about everyone, not just those with an illness or disease, but families, communities, and the whole population, with an emphasis on prevention and wellness activities.
2. To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, medical and dental services, as well as behavioral health services and supports, to include services to the rural and homeless populations, and provider training activities.
3. The activities are data driven: a public health agency uses surveillance data as well as an analysis of other public health drivers/levers to identify targets of opportunity.
4. There is an emphasis on access to services and availability.
5. There is an emphasis on policy impact and support: an analysis of the laws, rules, and infrastructure that inform and support the work.

These goals are significant drivers in the block grant application. SAMHSA's and other federal agencies' focus on accountability, person-directed care, family-driven care for children and youth, underserved populations, tribal sovereignty, and comprehensive planning across health and specialty care services are reflected in these goals. States should use these aims as drivers in developing their application(s).

II. SUBMISSION OF APPLICATION AND PLAN TIMEFRAMES

Changes to the SABG and MHBG applications are, in part, being driven by MHPAEA and related laws, which require standardization among applications. SAMHSA wants to ensure that SMHAs and SSAs are well positioned during FYs 2016 and 2017. 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-only is due no later than September 1, 2015. The application for SABG-only is due no later than October 1, 2015. A single application for MHBG and SABG is due no later than September 1, 2015.

The FY 2016/2017 MHBG and SABG application(s) include(s) a two-year Block Grant Behavioral Health Systems Assessment and Plan (Plan) as well as projected expenditure tables, certifications and assurances. The Plan will cover a two-year period (7/1/15- 6/30/17) to align with most states' FY budget cycle.[9] States will have the option, but will not be required, to amend their Plans when they submit their FY 2017 application.

States should submit their block grant application(s) for FYs 2016 and 2017 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 requirements of the specific block grants and the three areas requiring or requesting a combined plan are described in the State Plan section.

The FY 2016-2017 Plan seeks to collect information from states regarding their activities in response to new federal legislation, initiatives, changes in technology, and advances in research and knowledge. The FY 2016-2017 Block Grant Application and Plan have sections that are required and other sections where additional information is requested but not required. States are strongly encouraged to answer each section thoroughly so that SAMHSA understands the totality of a state's 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 achieve their goals. Section IIIB, Planning Steps, requires states to undertake a needs assessment as part of their plan submission. This section identifies four key steps: assess the strengths and needs of the service system; identify unmet service needs and critical gaps; prioritize state planning activities to include the required target populations and other priority populations (e.g. youth with a substance use disorders); and develop objectives, strategies, and performance indicators. Section IIIB, Plan Tables 2 (State Agency Planned Expenditure) is required for both MHBG and SABG. For the SABG, Plan Tables 4 (SABG Planned Expenditures), 5a and b (SABG Primary Prevention Planned Expenditures) and 6a and b (SABG Resource Development Activities Planned Expenditures) are also required.

The application requests information on state efforts on certain policy, program, and technology advancements in physical and behavioral health prevention, care, 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 a changing environment. 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 requirement of law and sufficient enough for SAMHSA to assist and monitor the states' efforts using these funds. The funds awarded will be available for obligation and expenditure[10] to plan, carry out, and evaluate activities and services for children with SED and adults with SMI; substance abuse prevention; youth and adults with a substance use disorder; adolescents and adults with co-occurring disorders; and the promotion of

[9] Reporting timeframes for Synar will remain on the current schedule. Annual Synar Reports (ASRs) are due on December 31. The data reported in the FFY 2017 ASR, which is due on December 31, 2016, will be from inspections completed in FFY 2016 (October 1, 2015, through September 30, 2016). http://www.samhsa.gov/synar

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

recovery among persons with SED, SMI, or substance use disorder.

A grant may be awarded only if a state's application(s) include(s) a State BG Plan[11][12] 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 BG Plan should include a description of the manner in which the state intends to obligate the grant funds, and it must include a report[13] in the proper format containing information that the Secretary determines to be necessary for securing a record and description of the purposes for which the grant will be expended. States have the option of updating their plans during the two-year planning cycle.

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

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, strategies, and measurable targets. 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 abuse 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 substance use and mental disorders, providers of services and supports, representatives from racial and ethnic minorities, LGBT 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

[11] 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

[12] 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

[13] 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

the state must be provided in the application(s) for both MHBGs and SABGs.

A. Framework for Planning—Mental Health and Substance Abuse 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; (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 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.

The SABG block grant program provides substance abuse prevention and treatment services (and certain related activities) to at-risk individuals or persons in need of treatment. See 42 U.S.C. §§ 300x-300x-66.

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. 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*

2. Services for persons with or at risk of having substance use and/or SMI/SED:
   - Persons who are intravenous drug users (IVDA)*
   - Adolescents with substance abuse 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

- Unaccompanied minor children and youth[14]

3. Services for persons with or at risk of contracting communicable diseases:
   - Individuals with tuberculosis* and other communicable diseases
   - Persons living with or at risk for HIV/AIDS and who are in need of mental health or substance abuse early intervention, treatment, or prevention services*[15]
   - The National HIV/AIDS Strategy (NHAS) for the United States and NHAS Implementation Plan [16]
   - Prevention of HIV among substance users; substance use is associated with a greater likelihood of acquiring HIV infection. HIV screening and other comprehensive HIV prevention services should be coupled with substance treatment programs

4. Services for individuals in need of primary substance abuse 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

States should undertake a broader approach to their assessment and planning process and include other individuals who are in need of behavioral health services. In particular, states should be planning for individuals with incomes below 400 percent Federal Poverty Level (FPL) who are currently uninsured but may be eligible for coverage by Medicaid or private insurance and subsidies to help with the cost of such insurance. This planning will present new opportunities for public behavioral health systems to expand access and capacity. In addition, states should identify how to use federal funds to support the individuals and services that are not covered by insurance and need treatments and supports.[17]

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[14] Section XXX of the Public Health Service Act does not prohibit the provision of these services.

[15] 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 section 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 24, 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 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.

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

[17] SAMHSA will provide each state with information regarding the projected number and demographics of potentially uninsured individuals.

MHPAEA, other legislation that enhances access to Medicaid, and SAMHSA's Strategic Initiatives place an emphasis on identifying the health, behavioral health, and long-term care needs of individuals with mental and substance use disorders. These laws and initiatives also present significant opportunities for states to include in their benefit design recovery support services for adults, youth, and families who have behavioral health needs. In addition, policy drivers place a heavy emphasis on wellness and the prevention of mental, emotional, addiction, and other behavioral disorders. These major themes are relevant for SSAs and SMHAs.

In addition, states should consider linking their *Olmstead* planning work in the block grant application, identifying 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 application 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 needs of the service system to address the specific populations.
Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Step 2: Identify the unmet service needs and critical gaps within the current system.
This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the 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 these 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 set 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 abuse prevention, and substance abuse 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 behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the 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[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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 MH/SA Block Grant 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 abuse prevention (SAP), substance abuse treatment (SAT), or mental health services (MHS).

Step 4: Develop objectives, strategies, and performance indicators.
For each of the priorities identified in Step 3, states should identify the relevant goals, strategies, and performance indicators over the next two years. For each priority area, states should identify at least one measurable goal/objective.

For each goal, the state should describe the specific strategy that will be used to reach the goal. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, improving emotional health and

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

prevention of mental illness, and system improvements that will address the goal. 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 serious M/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 supported employment in the community, rather than segregated programs.

- Strategies on how technology, especially integrated co-occurring treatments (ICTs) 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 (internet or texting) 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 increase the availability of screening, brief intervention, referral and treatment (SBIRT). In 2013, SAMHSA brought SBIRT to scale under the SABG. States now have the opportunity to use block grant funds for SBIRT services. However, states should be aware that primary prevention set-aside funds cannot be used to fund SBIRT and should be encouraging the SMAs and Health Insurance Marketplace to include SBIRT as a covered prevention or service-delivery benefit.

- 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 2009 IOM

report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*[19] 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 identify, choose, and hire their providers.

- Strategies that are developed to prevent substance abuse and mental disorders and promote emotional health and prevention of mental illness should be consistent with the latest research, including the 2009 IOM report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.*[20] This report articulates the current scientific understanding of the prevention of mental and substance use disorders. It also describes a set of interventions that have proven effective in preventing substance abuse and mental illness, promoting positive emotional health by addressing risk factors, and promoting protective factors related to these problems. States should identify strategies for the SABG that reflect the priorities identified from the needs assessment process, including:

- As specified in 45 C.F.R. §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.

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[19] 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

[20] National Research Council and Institute of Medicine. (2009). Preventing *Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC

- 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*[21], the National Registry of Evidenced-based Programs and Practices (NREPP), and/or other materials documenting their effectiveness. These strategies include:
  - 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 address underage drinking based in science and encompass a range of connected activities including policy and regulation, enforcement, and normative/behavior change initiatives and programs.
  - Strategies that implement evidence-based and cost-effective models to prevent substance abuse 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), that focus on policy and environmental programming to change the community's norms around, and parental acceptance of, underage alcohol use.
  - 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.

- States should identify strategies for the MHBG that reflect the priorities identified from the needs assessment process. Goals that are focused on emotional health and the prevention of mental illnesses should be consistent with the IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* and should include:
  - Strategies that work with schools, workplaces, and communities to deliver programs to improve mental health literacy and enhance resilience.
  - Strategies that target prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools, and other related organizations, and to include evidence-based and cost-effective models of intervention for early psychosis in young people.
  - Strategies that implement suicide prevention activities to identify youth at risk of suicide and improve the effectiveness of services and support available to them, including educating frontline workers in health, and other social services settings about mental health and suicide prevention.
  - Strategies that implement evidenced-based interventions and trauma- specific treatments for highly vulnerable children and young people who have experienced physical, sexual, or emotional abuse, bullying, and/or other trauma, with a separate focus on youth from tribal, racial/ethnic minority, and LGBT communities.

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

- Strategies that follow the Surgeon General's *National Strategy for Suicide Prevention*, including promoting the awareness that suicide is a public health problem that is preventable and implementing community-based suicide prevention programs.
- Strategies that identify evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.[22] [23]

- 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 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 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 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), 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 mental health and substance use 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

[22] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

[23] www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

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. SAMHSA will expect states to develop spending targets for certain services and manage within those targets.

1. Quality and Data Collection Readiness

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. 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 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 National Quality Strategy (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 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.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, 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 this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

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 FY 2016 and how the state proposes to measure the change in FY 2017. 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 Abuse Prevention and Treatment and 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:

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 abuse prevention, **SAT –** substance abuse 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*. From the drop-down menu select:
SMI–Adults with SMI,
SED–Children with an SED,
PWWDC–Pregnant women and women with dependent children,
IVDUs–Intravenous drug users,
HIV EIS–Persons with or at risk of HIV/AIDS, who are in treatment for substance abuse,
TB–Persons with or at risk of TB who are in treatment for substance abuse, and/or
Other: Specify (Refer to section IIIA of the Assessment and Plan).

4) *Goal of the priority area*. Provide a general description of what the state hopes to accomplish.

5) *Strategies to attain the goal*. Indicate state program strategies or means to reach the stated goal.

6) *Annual Performance Indicators* to measure success on a yearly basis. For the SABG, each indicator must reflect progress on a measure that is impacted by the block grant. After this 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;
   (b) First-year target/outcome measurement (Progress to end of State FY (SFY) 2016);
   (c) Second-year target/outcome measurement (Final to end of SFY 2017),
   (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:	2. Priority Type (SAP, SAT, MHS):
3. Population(s) (SMI, SED, PWWDC, IVDUs, HIV EIS, TB, OTHER):	
4. Goal of the priority area:	
5. Strategies to attain the goal:	
6. Annual Performance Indicators to measure goal success: Indicator #1:	
a) Baseline measurement (Initial data collected prior to and during SFY 2016):	
b) First-year target/outcome measurement (Progress to end of SFY 2016):	
c) Second-year target/outcome measurement (Final to end of SFY 2017):	
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 and performance targets established in their plans, and to provide technical assistance as needed. 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 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, that SAMHSA will assist in developing, to achieve its goals. 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]

[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. All expenditures should be documented for activities, services, and or persons not otherwise able to be funded by Medicaid, Medicare, other government programs (e.g., VA or TriCare) or private insurance.

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 (5% of total award MHBG)		$					
4. Tuberculosis Services	$		$	$	$	$	$
5. HIV Early Intervention Services	$		$	$	$	$	$
6. State Hospital	$	$	$	$	$	$	$
7. Other 24-Hour Care	$	$	$	$	$	$	$
8. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$	$
9. Administration (excluding program / provider level	$	$	$	$	$	$	$
10. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$	$

11. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$	$
12. Total	$	$	$	$	$	$	$

* Prevention other than primary prevention.
**The 20% set aside funds in the SABG must be used for activities designed to prevent substance abuse.

Plan Table 3: State Agency Planned Block Grant Expenditures by Service

States should project how SABG and MHBG funds will be used to provide services for the target populations or areas identified in their plans. Plan Table 3 must be completed by overall category for the planning period. If the state purchases services or activities that are not included in the listed categories, please report and describe them in the last row of the table in the "Other" category and in the summary.

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and Specialized Outpatient Medical Services		
Acute Primary Care		
General Health Screens, Tests and Immunizations		
Comprehensive Care Management		
Care Coordination and Health Promotion		
Comprehensive Transitional Care		
Individual and Family Support		
Referral to Community Services		
Prevention examples of approaches include:	$	$
a. Prevention including Promotion		
Screening, Brief Intervention and Referral to Treatment		
Brief Motivational Interviews		
Screening and Brief Intervention for Tobacco Cessation		
Parent Training		
Facilitated Referrals		
Relapse Prevention/Wellness Recovery Support		
Warm Line		
b. Substance Abuse Primary Prevention		
Classroom and/or small group sessions (Education)		

Service	SABG Expenditures	MHBG Expenditures
Media campaigns (Information Dissemination)		
Systematic Planning/Coalition and Community Team Building (Community-Based Process)		
Parenting and family management (Education)		
Education programs for youth groups (Education)		
Community Service Activities (Alternatives)		
Student Assistance Programs (Problem Identification and Referral)		
Employee Assistance Programs (Problem Identification and Referral)		
Community Team Building (Community-Based Process)		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)		
Engagement Services	$	$
Assessment		
Specialized Evaluations (Psychological and Neurological)		
Service Planning (including crisis planning)		
Consumer/Family Education		
Outreach		
Outpatient Services	$	$
Individual Evidenced-based Therapies		
Group Therapy		
Family Therapy		
Multi-family Therapy		
Consultation to Caregivers		
Medication Services	$	$
Medication Management		
Pharmacotherapy (including MAT)		
Laboratory Services		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support		
Skill Building (social, daily living, cognitive)		
Case Management		
Behavior Management		
Supported Employment		
Permanent Supported Housing		
Recovery Housing		
Therapeutic Mentoring		

Service	SABG Expenditures	MHBG Expenditures
Traditional Healing Services		
Recovery Supports	$	$
Peer Support		
Recovery Support Coaching		
Recovery Support Center Services		
Supports for Self-directed Care		
Other Supports (Habilitative)	$	$
Personal Care		
Homemaker		
Respite		
Supported Education		
Transportation		
Assisted Living Services		
Recreational Services		
Trained Behavioral Health Interpreters		
Interactive Communication Technology Devices		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP)		
Partial Hospital		
Assertive Community Treatment		
Intensive Home-based Services		
Multi-systemic Therapy		
Intensive Case Management		
Out of Home Residential Services	$	$
Crisis Residential/Stabilization		
Clinically Managed 24-hour Care (SA)		
Clinically Managed Medium Intensity Care (SA)		
Adult Mental Health Residential		
Youth Substance Abuse Residential Services		
Children's Residential Mental Health Services		
Therapeutic Foster Care		
Acute Intensive Services	$	$
Mobile Crisis		
Peer-based Crisis Services		

Service	SABG Expenditures	MHBG Expenditures
Urgent Care		
23-hour Observation Bed		
Medically Monitored Intensive Inpatient (SA)		
24/7 Crisis Hotline Services		
Other (please list)	$	$
Total	$	$

Plan Table 4: SABG Planned Expenditures.

States must project how they will use SABG funds to provide authorized services as required by the SABG regulations. Plan Table 4 must be completed for the FY 2016 and FY 2017 SABG awards.

Plan Table 4 SABG Planned Expenditures		
State Identifier:		
Expenditure Category	**FY 2016 SA Block Grant Award**	**FY 2017 SA Block Grant Award**
1. Substance Abuse Prevention* and Treatment	$	$
2. Primary Substance Abuse Prevention	$	$
3. HIV Early Intervention Services[25]	$	$
4. Tuberculosis Services	$	$
5. Administration (SSA level only)	$	$
6. Total	$	$

* Prevention other than Primary Prevention

[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 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 CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, 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 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 does not meet the AIDS case rate threshold for the fiscal year involved. 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 would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Plan Table 5a: SABG Primary Prevention Planned Expenditures

States must project how they will use SABG funds to conduct and/or fund primary prevention and §1926[26]-related activities. Primary prevention activities are those directed at individuals who do not require treatment for substance abuse. In implementing a comprehensive primary prevention program, the state shall use a variety of strategies including but not limited to the six strategies listed on Plan Table 5a. If a state employs strategies not covered by these six strategies, they should be reported under 'Other' in a separate row for each strategy; alternatively, the state may choose to report those activities using the IOM model of universal, selective, and indicated. Note that the row entitled 'Section 1926 Tobacco" on Plan Table 5a must be completed by states reporting expenditures by the six strategies and for those reporting by IOM category. Plan Table 5a must be completed for the FY 2016 and FY 2017 SABG awards. The total amounts should equal amount reported on Plan Table 4, Row 2, Primary Prevention.

Plan Table 5a: SABG Primary Prevention Planned Expenditures			
State Identifier:			
Report Period- From:		To:	
	A	B	C
Strategy	IOM Target	FY 2016 SA Block Grant Award	FY 2017 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	$	$

[26] Section 1926 of the PHS Act as added by the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321, section 202).

	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		%	%

Plan Table 5b: SABG Primary Prevention Planned ***Expenditures***

States must project how they will use SABG funds to conduct and/or fund primary prevention and §1926-related activities. Plan Table 5b must be completed for the FY 2016 and FY 2017 SABG awards. The total amounts for each award should equal amount reported on Plan Table 4, Row 2, Primary Prevention.

Plan Table 5b: SABG Primary Prevention Planned Expenditures by IOM Category		
State Identifier:		
Activity	FY 2016 SA Block Grant Award	FY 2017 SA Block Grant Award
Universal Direct	$	$
Universal Indirect	$	$
Selective	$	$
Indicated	$	$
Column Total	$	
Total SABG Award	$	$
Planned Primary Prevention Percentage	%	%

Plan Table 5c: 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 FY 2016 and FY 2017 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 6a: SABG Resource Development Activities Planned Expenditures

States must project how they will use SABG funds to conduct and/or fund resource development activities. Plan Table 6a should be completed for the FY 2016 and FY 2017 SABG awards.

Plan Table 6A	SABG Resource Development Activities Planned Expenditures							
State Identifier:								
	FY 2016 SA Block Grant Award				**FY 2017 SA Block Grant Award**			
	Prevention	**Treatment**	**Combined**	**Total**	**Prevention**	**Treatment**	**Combined**	**Total**
1. Planning, Coordination, and Needs Assessment	$	$	$	$	$	$	$	$
2. Quality Assurance	$	$	$	$	$	$	$	$
3. Training (post-employment)	$	$	$	$	$	$	$	$
4. Education (pre-employment)	$	$	$	$	$	$	$	$
5. Program Development	$	$	$	$	$	$	$	$
6. Research and Evaluation	$	$	$	$	$	$	$	$
7. Information Systems	$	$	$	$	$	$	$	$
8. Total	$	$	$	$	$	$	$	$

Plan Table 6b: MHBG Non-Direct Service Activities Planned Expenditures

States must project how they will use MHBG funds to conduct and/or fund non-direct service activities. Plan Table 6b must be completed for the planning period. States should only report the planned expenditures of the MHBG by the SMHA or programs with which they are in direct contract. States should not report on planned expenditures by programs more than one-level down from the state in funding. For example, if a state provides MHBG funds to county mental health authorities that in turn contract with private, not-for-profit mental health providers, only the planned expenditures by the SMHA and the county mental health authorities should be reported in this table.

Plan Table 6B MHBG Non-Direct Service Activities Planned Expenditures State Identifier: Planning Period - From: To:	
Service	**MH Block Grant**
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	
	Comments:

C. Environmental Factors and Plan

1. The Health Care System and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[27] 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.[28] It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[29] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The *Framingham Heart Study* produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[30] [31] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse 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

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[27] 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

[28] 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

[29] 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/

[30] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); JAMA. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

[31] A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk; http://circ.ahajournals.org/

persons with mental illness and substance use disorders.[32] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral and physical health. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[33] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[34] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[35] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[36] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[37]

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

[33] Depression and Diabetes, NIMH, http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5; Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

[34] J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, Journal of Clinical Psychology Practice, 2011 (2) 33-40

[35] C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, Diabetes Care, 2010; 33(5) 1061-1064

[36] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

[37] 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.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[38] 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 mental and substance abuse treatment 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 electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[39] 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, care, 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[40] and ACOs[41] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

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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

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

[39] 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

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

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

Implementation by SMHAs, SSAs and their partners of the Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. In a recent report, the Congressional Budget Office estimates that by 2018, 25 million persons will have enrolled in the Affordable Care Act Marketplace and 12 million in Medicaid and the Children's Health Insurance Program (CHIP).[42] The Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) estimates that more than 60 million individuals will have new or expanded access to coverage because of the Affordable Care Act, including both previously uninsured persons and those enrolled in plans that lacked adequate coverage.[43] In 2014, 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.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[44] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[45]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[46] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[47] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[48] 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 finding a provider.[49] SMHAs and SSAs should

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[42] Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act, http://www.cbo.gov/publication/45159

[43] http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf

[44] 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

[45] 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

[46] 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

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

[48] 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

[49] 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

remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[50] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[51]

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.[52] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices. The Affordable Care Act provides for workforce development and training grants that may be helpful in staff retention, recruitment, and training efforts.[53]

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 NQS, 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.[54]

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[50] http://www.nrepp.samhsa.gov/

[51] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[52] 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

[53] Mental and Behavioral Health Education and Training, http://bhpr.hrsa.gov/grants/mentalbehavioral/mbhet.html

[54] 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

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[55] 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 illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

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

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?
10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes

[55] 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/

- Quit Helplines/Peer supports
- Others_____

11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports.

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

2. Health Disparities

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[56], *Healthy People, 2020*[57], *National Stakeholder Strategy for Achieving Health Equity*[58], 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 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, and people living with HIV/AIDS or other chronic diseases/impairments) 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 standards).[59]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial 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."[60]

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

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[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
[57] http://www.healthypeople.gov/2020/default.aspx
[58] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf
[59] http://www.ThinkCulturalHealth.hhs.gov
[60] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

status.[61] 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.[62] 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 are routinely asked to define the population 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 being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

[61] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208
[62] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

3. Use of Evidence in Purchasing Decisions

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[63] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. 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[64], The New Freedom Commission on Mental Health[65], the IOM[66], and the NQF.[67] The activity included a

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[63] *Ibid, 47, p. 41*

[64] 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

[65] 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.

[66] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

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."[68] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), 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, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. 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)[69] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (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 substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[70] 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 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 mental health and substance abuse services.

(2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

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

[68] http://psychiatryonline.org/

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

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

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    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 incentives to drive quality.
    d. Provider involvement in planning value-based purchasing.
    e. Gained consensus on the use of accurate and reliable measures of quality.
    f. Quality measures focus on consumer outcomes rather than care processes.
    g. Development of strategies to educate consumers and empower them to select quality services.
    h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
    i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

4. Prevention for Serious Mental Illness

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[71] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

[71] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[72] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[73] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[74] [75] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

It is important to note that 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.

Please indicate areas of technical assistance needed related to this section

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[72] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[73] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[74] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[75] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

5. Evidence-Based Practices for Early Intervention (5 Percent)

In its FY 2014 appropriation, SAMHSA was directed to require that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[76] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded *Recovery After an Initial Schizophrenia Episode (RAISE)* initiative[77], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. States should be reviewing their data collection efforts related to demonstrating the effectiveness of the programs for the targeted population. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Describe the state's assessed need for the target population and proposed evidence-based programs; provide an explanation for why this population was chosen, a description of planned activities, and a budget showing how the set-aside will be spent.

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

1. Identify a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.).

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[76] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[77] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

2. Describe the evidence-based programs using the set-aside.
3. Are there alternative uses of the funds other than EBP's (i.e. staff development, regional plan, etc.) to support this required funding?
4. Describe the data collection efforts being used to demonstrate the effectiveness of the programs for this targeted population.

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

6. *Participant Directed Care*

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program.

Please indicate areas of technical assistance needed related to this section

7. Program Integrity

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 and premium payments, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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. If a state chooses to allow the use of block grant funds for these purposes, specific policies and procedures for assuring compliance with the funding requirements must be in place. Under 42 USC § 300x–55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible 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 abuse 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 SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

8. Tribes

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[78] 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.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a 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. In further recognition of strengthening state/tribal relations, tribal governments shall not be required to waive sovereign immunity as a condition of receiving block grant funds or services. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state.
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 consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

9. Primary Prevention for Substance Abuse

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** 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 information source to the audience, with limited contact between the two.

- **Education** 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 capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- **Alternatives** provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- **Problem Identification and Referral** aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does **not** include any activity designed to determine if a person is in need of treatment.
- **Community-based Process** 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 Strategies** establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- **Universal:** The general public or a whole population group that has not been identified based on individual risk.
- **Selective:** Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated:** Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice

involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states 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 communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse-related attitudes and behaviors. 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 abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and

- The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to college on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

11. Quality Improvement Plan

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.

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

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

12. Trauma

Trauma[79] 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 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, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems.[80] Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

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[79] 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.*

[80] http://www.samhsa.gov/trauma-violence/types

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.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach".[81] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[82] paper.

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

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

[81] http://store.samhsa.gov/product/SMA14-4884
[82] *Ibid*

13. Criminal and Juvenile Justice

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 substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[83]

The SABG and MHBG 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. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[84] [85] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths 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.[86]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment

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[83] http://csgjusticecenter.org/mental-health/

[84] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[85] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[86] 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.

and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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 mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility 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.

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided 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?

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

14. State Parity Efforts

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment – and to comply with MHPAEA. Guidance was released for states in January 2013.[87] Further guidance will be released in the winter of 2014-2015.

[87] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[88]

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. 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. SMHAs and SSAs should collaborate with their state's Medicaid authority in implementing Affordable Care Act provisions and 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.

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

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[88] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

15. Medication Assisted Treatment

There is a voluminous literature on the efficacy of FDA-approved medications for 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 medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[89], 43[90], 45[91], and 49[92]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have failed abstinence-based treatment in the past and who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

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

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[89] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[90] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[91] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[92] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

16. Crisis Services

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders 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 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*[93],

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

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

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

[93] 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

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

17. Recovery

The implementation of recovery-based approaches is 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. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist
- Promotoras
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Supported employment
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

11. Describe how the state is supporting the employment and educational needs of individuals served.

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

18. Community Living and the Implementation of Olmstead

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 substance abuse and mental illness 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 arrangement appropriate 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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain 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.

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

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
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?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

5. Is the state involved in a partnership with other state agencies to address community integration?

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

19. Children and Adolescents Behavioral Health Services

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[94] Most mental health 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.[95] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[96]

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.[97] 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 liaison 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 more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to

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[94] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).
[95] 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.
[96] 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.
[97] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[98]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[99]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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[98] 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.

[99] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

20. Pregnant Women and Women with Dependent Children

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States*; *Treatment Standards for Women with Substance Use Disorders*; *Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

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

1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

21. Suicide Prevention

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[100]

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

22. Support of State Partners

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 mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, 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 health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in

[100] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

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

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

23. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

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 mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, 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 abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[101]

If the state does not have an integrated BHPC, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG, requires that, 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.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

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

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council.

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.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. 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.[102]

[102] 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 *		
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 substance abuse 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 abuse expertise in their Councils.

Acronyms

ACF: Administration for Children and Families

ACL: Administration for Community Living

ACO: Accountable Care Organization

AHRQ: Agency for Healthcare Research and Quality

AI: American Indian

AIDS: Acquired Immune Deficiency Syndrome

AN: Alaska Native

BHSIS: Behavioral Health Services Information System

CAP: Consumer Assistance Programs

CBHSQ: Center for Behavioral Health Statistics and Quality

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 & Medicaid Services

CO: Carbon Monoxide

CPT: Current Procedural Terminology

CSAP: Center for Substance Abuse Prevention

CSAT: Center for Substance Abuse Treatment

EBP: Evidence-Based Practice

EHB: Essential Health Benefit

EHR: Electronic Health Record

FFY: Federal Fiscal Year

FMAP: Federal Medical Assistance Percentage

FPL: Federal Poverty Level

FQHC: Federally-Qualified Health Center

FY: Fiscal Year

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

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

LGBT: Lesbian, Gay, Bisexual, and Transgendered

LGBTQ: Lesbian, Gay, Bisexual, Transgendered, and Questioning

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

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

QHP: Qualified Health Plan

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

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 Authority

SUD: Substance Use Disorder

TIP: Treatment Improvement Protocol

TLOA: Tribal Law and Order Act

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 FY2010 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.

Early Intervention Set-Aside Guidance	http://www.samhsa.gov/grants/block-grants/resources	SAMHSA guidance regarding its Fiscal Year 2014 appropriation, in which SAMHSA has been directed to require that states set aside 5 percent of their Mental Health Block Grant (MHBG) allocation to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders."
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
Health People Initiative	http://www.healthypeople.gov/2020/default.aspx	Government website that reviews the goals of Health 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 mental health and substance abuse services at the same time and in one setting. Offers suggestions from successful programs.
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

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 disorder 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 more than 330 substance abuse and mental health 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

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 substance abuse treatment services for women, States and Territories 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 abuse prevention topics.
Synar Program	http://samhsa.gov/synar	Description and overview of the SYNAR program, which is a requirement of the Substance Abuse Prevention Block Grant
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