FY 2014-2015
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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1. INTRODUCTION

This Block Grant Application guidance document is laid out in three major sections: introduction, implication for states, and planning. Each of these sections includes subsections on the following policy topics: health reform, coverage of mental and substance use disorder (M/SUD) services, Affordable Insurance Exchanges, use of evidence in purchasing decisions, program integrity, tribes, quality, trauma, justice, parity education, primary and behavioral health[1] care integration activities, health disparities, recovery, prevention, and children and adolescents behavioral health services.

A. Background

In 1981, President Reagan sought and received from Congress a new way of providing assistance to states for an assortment of services including substance abuse and mental health. Termed "Block Grants", these grants were originally designed to give states[2] maximum flexibility in the use of the funds to address the multiple needs of their populations. This flexibility was given in exchange for reductions in the overall amount of funding available to any particular state. Over time, a few requirements were added by Congress directing the states' use of these funds in a variety of ways. Currently, flexibility is given to allow states to address their unique issues; however, health care systems, laws, knowledge, and conditions have changed. The Substance Abuse and Mental Health Services Administration (SAMHSA) now observes a more complex interplay between the Block Grants and other funding streams, such as Medicaid, and increasing knowledge in the behavioral health field about evidence-based practices, self-direction, and peer services that require more consistency and direction to ensure that the nation's behavioral health system is providing the best and most cost effective care possible. This care is based on the best possible evidence, and tracking the quality and outcome of services enables informative reporting. This leads to improvements, which can be made 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 common practice of allowing states to use funds in a generally unrestricted, flexible manner without strong accountability measures. Within behavioral health, newer, innovative, and evidence-based services have gone unfunded or without widespread adoption. The nation's health care system is focusing more and more on quality and accountability, and because behavioral health care is essential to the nation's health, the system must do so as well. The "science to service" lag and a lack of adequate and consistent person-level data have resulted in questions from stakeholders and policy makers, including Congress and the Office of Management and Budget (OMB), as to the effectiveness and accountability achieved through the two Block Grants administered by SAMHSA.

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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

[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.

The Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG) differ in a number of their practices (e.g., data collection at individual or aggregate levels) 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.). Historically, the Centers within SAMHSA that administer these Block Grants have had different approaches to application requirements and reporting. To compound this variation, states have different structures for accepting, planning, and accounting for the Block Grants and the prevention set aside within the SABG. As a result, how these dollars are spent and what is known about the services and clients that receive these funds varies by Block Grant and by state.

In 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 Patient Protection and Affordable Care Act (ACA), 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 bi-annual versus an annual plan,[3,4] and provide information regarding their efforts to respond to various federal and state initiatives. Almost one-half of the states took advantage of this streamlined application and submitted combined plans for mental health and substance abuse services. Over 95 percent of 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, prevention of substance use, and promotion of emotional health. States continued to provide information regarding the spending of their Block Grant funds to support services identified in SAMHSA's *Good and Modern Service System* brief.

The FY 2014/2015 Block Grant application upon the FY 2012/2013 application and furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. In addition, the FY 2014/2015 Block Grant continues to allow states to submit a combined application for mental health and substance abuse services as well as a bi-annual versus an annual plan.

[3] 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)
[4] State Plan (Sec. 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 USC § 300x-32(b))

B. Current Environmental Factors

Health Reform

The Affordable Care Act, the health reform law of 2010, enhances opportunities for individuals with behavioral health conditions to have continuous access to insurance and a benefit package that includes mental health and substance abuse services, as well as preventive, medical, and other health services. A series of provisions referred to as the *Patient's Bill of Rights* helps to give individuals the stability and flexibility they need to make informed choices about their health care. Under the *Patient's Bill of Rights*, individuals have a right to appeal health insurance plan decisions, including appeals to health plans when payment for a service or treatment is denied; already extends coverage to children with pre-existing conditions, and will extend this protection to adults starting in 2014; allows individuals to continue to choose their primary care provider; keeps certain young adults covered up to age 26 on their parents' health plans; ends lifetime limits on coverage; and provides for review of unreasonable increases in insurance premiums, helping to ensure that premium dollars be primarily spent on health care (including behavioral health care).

The Affordable Care Act also improves individuals' access to information regarding their health coverage and provides grants to states for Consumer Assistance Programs (CAPs), which provide residents direct help with problems or questions about health coverage. Over 30 states have taken advantage of the CAP grants. In addition, the Affordable Care Act increases access for some important preventive services (including screening for various behavioral health conditions) at no additional cost to the consumer. Finally, the Affordable Care Act stops health insurance issuers from retroactively canceling insurance coverage solely because an individual or their employer made an honest mistake on an insurance application.

Since 2010, the Centers for Medicare & Medicaid Services (CMS) have also made significant changes in the Medicare and Medicaid programs. These changes will continue to have a significant impact on how State Mental Health Authorities (SMHAs) and State Substance Abuse Authorities (SSAs) use their limited resources. These changes seek to improve the coordination of care for individuals with behavioral health needs and others in primary care settings or transitioning from inpatient hospital, nursing facilities, and other settings. Specifically, some states have submitted comprehensive 1115 waivers or other innovative demonstration projects for integrated care programs that may impact individuals with behavioral health needs, both under 65 with longer term disabilities and those over 65 with behavioral health needs.

Additionally, associated standards for stakeholder engagement have been issued that offer an opportunity for the development of robust stakeholder engagement processes without any conflicts of interest.

SAMHSA is working closely with CMS and other federal agencies to improve access to home and community-based services. The 1915(i) and Community First Choice State

Medicaid Plan benefits, the Balancing Incentive Program, and proposed changes to the 1915(c) waiver program provide states the opportunity to enhance the availability and quality of home and community based services. For more information regarding these programs, please visit http://www.cms.gov.

In 2011, the Department of Health and Human Services (HHS) provided information to states regarding Essential Health Benefits (EHBs) in the form of an Essential Health Benefits Bulletin. This Bulletin provided states with information on how to draft strategies to identify and develop commercial insurance products for individuals participating in the Health Insurance Exchange, as well as services offered under the Medicaid benchmark plans. These commercial and benchmark products, which will be required to comply with mental health parity rules, will offer various mental health and substance abuse services.

Affordable Insurance Exchanges are designed to make buying health coverage easier and more affordable. Starting in 2014, Exchanges will allow individuals and small businesses to compare health plans, get answers to questions, and enroll in a health plan that meets their needs. It will also allow individuals to find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP).

After the full implementation of the Affordable Care Act, SAMHSA strongly recommends that Block Grant funds 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) 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. 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.

States should determine if established systems and procedures are sufficient to ensure that Block Grant funds are expended in accordance with program requirements and directed to support, not supplant, health care reform activities. States may have to make changes to information systems and conduct more compliance reviews to assure better program integrity, which may include working closely with Medicaid and Health Insurance Exchanges to review information and determine whether individuals and providers in their systems are enrolled or implementing strategies to assist their providers to build the necessary infrastructures to operate in commercial and public (Medicaid and Medicare). States are encouraged to consider developing metrics or targets for their systems to measure increases in the number of individuals that become enrolled or providers that join commercial or publicly funded managed care networks.

Coverage of M/SUD Services

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover these EHBs beginning in 2014.[5] On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

At this critical point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by Qualified Health Plans (QHPs) and Medicaid programs. SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds for what is not covered. There are various activities that will ensure that individuals with behavioral health problems utilize covered services and that will support the State's Department of Insurance in ensuring that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (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 utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

Affordable Insurance Exchanges

Affordable Insurance Exchanges are a crucial feature of the Affordable Care Act. Starting with coverage availability in January of 2014, Exchanges will provide qualified individual consumers, their families, and small businesses the opportunity to shop among a variety of affordable health insurance options (the QHPs) in a transparent marketplace. QHPs must be certified by meeting certain minimum requirements before they will be made available through an Exchange. The federal government will also provide advance payments of premium tax credits and cost sharing reductions to eligible low-income individuals in order to make QHPs within the Exchange more affordable. Eligible individuals, with very few exceptions, will be anyone without access to affordable minimum essential coverage whose income is under 400 percent of the federal poverty

[5] Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, provides that certain plans or coverage existing as of March 23, 2010 (the date of enactment of the Affordable Care Act) are subject to only certain provisions of the Affordable Care Act. The statute and the interim final regulations refer to these plans or health insurance coverage as grandfathered health plans. For further information on grandfathered plans, please see the Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act available at: https://www.federalregister.gov/articles/2010/11/17/2010-28861/amendment-to-the-interim-final-rules-for-group-health-plans-and-health-insurance-coverage-relating#p-32

level (FPL).[6] Nationally, Exchanges will provide access to affordable coverage through advance payment of premium tax credits and cost sharing for more than 20 million Americans.[7]

The establishment of Exchanges also entails significant reforms to the Medicaid program. Exchanges are required to establish agreements with State Medicaid Agencies (SMAs) to streamline the eligibility determination and enrollment process for consumers applying for coverage in insurance affordability programs, which include QHP enrollment and the Medicaid program. Additional resources are also available for states to develop a significantly more streamlined, data-driven eligibility determination process for Medicaid and the Exchanges. The new systems, which states have been actively engaged in developing since 2010, will reduce the burden on applicants and state agencies, and it will help to maintain strong program integrity. In addition, The Affordable Care Act requires all Exchanges to develop outreach and enrollment assistance grant programs to provide additional help to applicants in the application and eligibility determination process, facilitate enrollment in the selected QHP, and provide information in a culturally and linguistically appropriate manner. These programs, called Navigators,[8] will be financed out of the operational funds of each Exchange and will play a crucial role in facilitating the enrollment process. Entities eligible to receive Navigator grants include: community- and consumer-focused nonprofit groups; trade, industry, and professional associations; commercial fishing industry, ranching, and farming organizations; chambers of commerce; unions; resource partners of the Small Business Administration; licensed agents and brokers; and other public or private entities or individuals that meet the requirements. Other entities may include, but are not limited to, Indian tribes, tribal organizations, urban Indian organizations, and state or local human service agencies. The Congressional Budget Office (CBO) estimates that by the year 2021, the Affordable Care Act will increase the number of non-elderly Americans who have health insurance by 30 million people in 2016 and by up to 33 million people by 2021 resulting in 93 percent of people having health insurance coverage.[9]

At this time, states have identified what format of Exchange they will use for at least the first year. SMHAs and SSAs should now be focused on four main questions related to Exchanges: (1)What are the state-specific Medicaid, CHIP, and Exchange eligibility determination and enrollment regulations, policies, and systems?; (2) Which QHPs are likely going to be operating in the state and what steps do behavioral health providers need to take in order to participate in the networks?; (3) What steps are the state (or federal) Exchange organizations taking in establishing a Navigator program and what are the standards for participating organizations?; and (4) How is the state (or federal)

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[6] Minimum Essential Coverage is defined in Section 5000A(f) of the Internal Revenue Code as added by section 1501 of the Affordable Care Act

[7] National Survey of Drug Use and Health, (2010); Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

[8] Section 1311(e)(3)(i) of the Act

[9] Congressional Budget Office. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010.* (March 20, 2011). Retrieved July 2, 2012 from <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf

Exchange determining if the QHP has a sufficient number of providers that specialize in mental health and substance abuse?

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the final rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers,"[10] to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

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, Health Resources and Services Administration (HRSA), state Medicaid agencies, state behavioral health authorities, legislators, and others regarding the evidence of various mental health 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. Increasingly, evidence finds that even some of the most popular and widely disseminated programs are not evidence-based and can, in fact, be counterproductive (Goldman, et al., 2001). SAMHSA also acknowledges that evidence-based practices have not been tested in all population groups and that there is a possible impact of cultural factors in implementation of evidence-based services. In addition, the National Quality Forum and the Institute of Medicine (IOM) have recommended 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 is a searchable online registry of more than 220 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. In 2010, SAMHSA began a process to review the strength of the evidence of many services that were identified in SAMHSA's *Good and Modern Mental Health and Substance Abuse Services* brief. SAMHSA reviewed and summarized the current evidence for a wide range of interventions for individuals with mental and substance use disorders, including youth and adults with chronic addiction disorders, adults with serious mental illness, and children and youth with serious emotional disturbances. It 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 (National

[10] 77 Fed. Reg. 18,310, at 18470 (Mar. 27, 2012) (to be codified at 45 C.F.R. § 156.230(a)).

Institute of Mental Health (NIMH), 1999),[11] The New Freedom Commission on Mental Health (Department of Health and Human Services, 2003),[12] the Institute of Medicine (IOM) (National Academies Press, 2006),[13] and the National Quality Forum (National Quality Forum, 2007).[14] The review was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. SAMHSA provided SMHAs and SSAs with information they could use to educate policymakers and purchasers about the evidence base for many mental health and substance abuse interventions. SAMHSA and other federal partners (CMS, Administration for Children and Families (ACF), and Office of Civil Rights (OCR)) 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 promising practices. These are services that have not yet had the opportunity to be studied and become evidence-based practices, but anecdotal data and early studies indicate that they are effective.

SAMHSA's Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment's (CSAT) Division of Services Improvement 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 (KITs) were 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 the KITs to design and implement behavioral health practices that work. The KITs, part of SAMHSA's priority initiative on Behavioral Health Workforce–In Primary and Specialty Care Settings, cover 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.

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[11] 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.

[12] 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.

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

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

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 have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to (1) promote the proper expenditure of Block Grant funds, (2) improve Block Grant program compliance nationally, and (3) demonstrate the effective use of Block Grant funds. The Affordable Care Act will have an impact on federal Block Grants and discretionary funds and therefore will also impact SAMHSA's (and the states') program integrity efforts. As indicated earlier in the document, SAMHSA is strongly recommending that states use the MHBG and SABG resources to support, not supplant, individuals and services that will be covered through QHPs and Medicaid. This will require that SAMHSA change the lens through which it views its program integrity activities. Specifically, SAMHSA will provide additional guidance to the states to assist them in complying with SAMHSA's Block Grant recommendation, 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 and information to assist our program integrity efforts.

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.

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 which results in effective collaboration and informed decision-making.

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 Indian tribal governments located within or governing tribal lands within their borders to solicit their input during the Block Grant planning process. Evidence 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.

Prevention

One of SAMHSA's eight strategic initiatives articulated in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* is the Prevention of Substance Abuse and Mental Illness: "Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This initiative will include a focus on the nation's high-risk youth, youth in tribal communities, and military families."

To support that initiative, SAMHSA promotes the use of its Strategic Prevention Framework (SPF), which uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be adapted and utilized at the federal, state/tribal, and community levels. The idea behind SPF is to use the findings from public health research along with evidence-based prevention programs to build capacity within states, territories, tribes, and the prevention field. For SABG purposes, the term "state" includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Palau, Micronesia and the Marshall Islands, and the Red Lake Band of Chippewa Indians. This framework will promote resilience and decrease risk factors in individuals, families, and communities.

Implementing evidence-based practices requires cooperation across a variety of community settings and service systems for all segments of the population, especially those who are at high risk for mental and substance use disorders. These settings include, but are not limited to, health care, homes, childcare, child welfare, schools, juvenile and criminal justice systems, substance abuse treatment, and mental health services. In addition to program and practice improvements, a key part of a comprehensive prevention strategy is policy changes and environmental strategies, such as promoting the establishment or review of alcohol, tobacco, and drug use policies in schools; technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco, and other drugs; modifying alcohol and tobacco advertising practices; product pricing strategies; social marketing; bullying policies and practices; laws regarding violence in or around schools; and child welfare laws and systems. Coordinated and targeted prevention programs in a range of settings together with research-supported environmental strategies can and will reduce the incidence of mental and substance use disorders.

In implementing the primary prevention comprehensive program, states should use a variety of programs, policies, practices, and strategies that target populations with different levels of risk. Prevention can be classified according to the traditional public

health definitions of primary, secondary, and tertiary prevention, as well as the more recent classification advanced by the IOM. In the IOM model, the prevention category is divided into three classifications that are directed at whole populations and subsets of populations as follows: universal, selective, and indicated. The primary prevention of the onset of mental, emotional, behavioral, and substance use related problems may be best achieved by using a combination of universal and selective approaches.

An earlier IOM[15] report proposed a framework for classifying preventive interventions by the population targeted. Under this classification, universal interventions target the entire population, selective interventions target specific sub-populations whose risk of a disorder is significantly higher than average, and indicated interventions target individuals or communities who are exhibiting indicators that are at higher risk of developing a substance abuse disorder or an environment which supports risk behavior.

–Universal strategies, whether implemented through the mass media, legislation, community-wide interventions, change in cultural norms, or other types of efforts, can reach broad segments of the population. Selective procedures can target classes of individuals who have a high probability of developing a problem outcome with interventions of greater scope and intensity than would be necessary, practical, or affordable in a universal approach."[16]

While the federal statute requires states to spend a portion of the SABG on primary substance abuse prevention services, the scientific understanding of mental health promotion and mental illness prevention (or mitigation) was not well-known or developed when the MHBG was first authorized in the 1980s. Thus, states and communities should take scientific developments of the last 25 years into account as they develop plans to prevent substance use and mental disorders and promote emotional health. States should make general prevention and primary prevention top priorities, taking advantage of research findings, best practices in community coordination, proven planning processes such as the Strategic Prevention Framework, and the science articulated by the IOM's 2009 report, *Preventing, Mental, Emotional, and Behavioral Disorders Among Young People*, and the *Clinical Manual of Prevention in Mental Health* (Michael Compton, MD, ed.). States should use data collected and analyzed by their SAMHSA-supported State Epidemiological Outcomes Workgroups (SEOW) to help make funding decisions.

MHBG and SABG funds have the flexibility to support this targeted approach. States may use some of their current MHBG to support services that are preventative in nature for adults with serious mental illness (SMI) and children with serious emotional disorders

[15] Institute of Medicine (1994). Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. P.J. Mrazek & R.J. Haggerty, Editors. Committee on Prevention of Mental Disorders, Division of Biobehavioral Sciences and Mental Disorders. Washington, DC: National Academies Press.

[16] 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: The National Academies Press.

(SED) and their families. Such services (e.g., Screening, Brief Intervention, and Referral to Treatment (SBIRT)) can help promote early intervention and prevent future worsening of mental disorders. In the meantime, SAMHSA is working with states to increase their accountability systems for prevention and to develop necessary reporting capacities. For example, in the FY 2012/2013 uniform block grant application, SAMHSA requested states to provide the most recent copy of the state's suicide prevention plan or describe when the state would create or update the state's suicide prevention plan. States are then to report any updates on the plans' progress since that time and to attach a new or updated suicide prevention plan to the FY 2014/2015 Uniform Block Grant Application.

The President's budget for FY 2013 included several proposed SAMHSA programs that reflected a focus on the collaborative process for the planning and implementation of prevention activities and SAMHSA's emphasis on prevention as one of its Strategic Initiatives. Specifically, the President proposes three new formula grant programs: (1) the Substance Abuse-State Prevention Grant (SA-SPG) ensures funding availability and decision-making authority for substance abuse prevention at the state level, (2) the Mental Health-State Prevention Grant (MH-SPG) supports the development of a mental health promotion/mental illness prevention infrastructure in every state and territory, and (3) the Behavioral Health-Tribal Prevention Grant (BH-TPG) to prevent substance abuse and suicide in tribal communities. Consistent with this enhanced emphasis on prevention in states, territories, tribes, and communities, SAMHSA in encouraging states to provide a coordinated and combined plan addressing services and activities for the primary prevention of mental and substance use disorders (including the use of universal, selective, and indicated strategies) in the planning section of the current Block Grant application. SAMHSA will work with states to develop and/or amend their FY 2013 Block Grant State Plan(s) once a budget for FY 2013 is finalized.

The information requested here will help states in developing their responses to that application. Some of the information provided in response to this Block Grant Application will apply to the prevention grants. Recent data on youth drug use from the Monitoring the Future Survey highlights both the success of prevention and the need for additional prevention efforts. Specifically, data from the 2011 survey show that both alcohol and tobacco use among youth are at historically low rates: these are prevention success stories. However, marijuana use has increased, youths' perception that marijuana use is harmful has decreased, and prescription drug abuse continues to be a problem, highlighting the need for continued prevention efforts aimed at these substances, as well as continued vigilance on keeping tobacco and alcohol use rates low.

In times of declining federal, state, and local resources, states need to make the most efficient use of substance abuse prevention funds, which should be used to support evidence-based substance abuse programs and practices. Many evidence-based substance abuse prevention programs have a positive impact on the prevention of substance use and abuse as well as other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. States must be prepared to report the outcomes of their efforts on substance abuse-related attitudes and behaviors. This means that state-funded prevention providers will need 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. Thus, states must describe how all substance abuse prevention dollars in the state are planned and coordinated for a comprehensive, evidence-based, and effective substance abuse prevention system. States should include the SABG 20 percent set-aside for substance abuse primary prevention, the Strategic Prevention Framework State Incentive Grant (SPF-SIG), the Partnerships for Success (PFS) grant and other federal, state, and local dollars.

Current Environmental Factors regarding Substance Abuse Primary Prevention and Mental Health Promotion and Mental Illness Primary Prevention

SAMHSA requires that States spend no less than 20 percent of their SABG allotment on substance abuse primary prevention programs, and many states elect to spend a higher percentage. The Interim Final Rule for substance abuse primary prevention, §96.125 (a), and for purposes of §96.124, states that ―each State/Territory shall develop and implement a comprehensive substance abuse primary prevention program which includes a broad array of substance abuse primary prevention strategies directed at individuals not identified to be in need of treatment. The 20% set aside funds of the Substance Abuse Block Grant must be used only for substance abuse primary prevention activities by the State. The comprehensive substance abuse primary prevention program shall include activities and services provided in a variety of settings for both the general population as well as targeting subgroups who are at high risk for substance abuse."

At this critical point in time, Single State Authorities should be focused on following the SPF Logic Model to develop a comprehensive plan for substance abuse primary prevention programming that includes the following main areas:

(1) Ensuring data on substance use consumption and consequences are collected and analyzed to identify the substances of abuse and populations that should be targeted with prevention set-aside funds;
(2) Ensuring prevention activities and services purchased with SABG funds are both consistent with this needs assessment data and are not being funded through other public or private sources, including private commercial health insurance or Medicaid;
(3) Developing capacity throughout the state to implement a comprehensive approach to substance abuse issues identified by their SEOW or other statewide epidemiological work group;
(4) Collaborating with natural partners within the communities and state to focus on health and wellness to assist in the implementation of the newly revised Comprehensive Prevention Plan for their state;
(5) Including the use of environmental strategies to assist with the goal of behavior change, e.g., parental/community attitudes on underage drinking; and,
(6) Collecting and analyzing outcome data to ensure the most cost-efficient use of substance abuse primary prevention funds.

As specified in 45 C.F.R. 96.125(b), states shall use a variety of evidence-based programs, policies, and practices that include information dissemination, education, alternatives, problem identification and referral, community-based processes, and environmental strategies. It is important to note that classification of preventive interventions by strategy and by IOM category is not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the population served by the activity. It is SAMHSA's expectation that prevention set-aside funding be used to fund substance abuse prevention interventions in all six strategies that target universal, indicated, and selective populations.

Quality

SAMHSA will implement a comprehensive and practical approach to improving the quality and outcomes of behavioral health services. To meet this challenge, SAMHSA will focus on improvement in access to and utilization of services, service quality, and outcomes of prevention, treatment, and recovery support services. This requires addressing a number of systems and measurement issues, including the development of consistent definitions and formulae for the calculation of measures. Additionally, SAMHSA will work closely with those in the field to advance the adoption of Electronic Health Record (EHR) systems, particularly among behavioral health providers, and the promotion of greater systems interoperability between behavioral health care, primary care, and general medicine.

In conjunction with HHS's National Quality Strategy, SAMHSA has created the National Behavioral Health Quality Framework (NBHQF). The NBHQF complements the broader National Quality Strategy (NQS) being advanced by the federal government. Both the NQS and the NBHQF will pursue three broad aims to improve the quality of health and behavioral health care nationally and within states, communities, territories, and tribes:

- **Better Care:** Improve the overall quality, by making behavioral health care more person-, family-, and community-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the behavioral health of the U.S. population by supporting proven interventions to address behavioral, social, cultural, and environmental determinants of positive behavioral health in addition to delivering higher-quality behavioral health care.
- **Affordable Care:** Increase the value of behavioral health care for individuals, families, employers, and governments.

To advance these aims, SAMHSA will initially focus on six priorities that generally parallel those within the NQS. They are:

- Promote the most effective prevention, treatment, and recovery practices for behavioral health disorders;

- Assure behavioral health care is person-, family-, and community-centered;
- Encourage effective coordination within the behavioral health care field and between behavioral health care providers and other health care, recovery, and social support services;
- Assist communities to utilize best practices to enable healthy living;
- Make behavioral health care safer by reducing harm caused in the delivery of care; and
- Foster affordable, high-quality behavioral health care for individuals, families, employers, and governments by developing and advancing new—and recovery-oriented—delivery models.

SAMHSA recently made a policy decision to provide a coordinated approach to collecting facility and client-level data from states to reduce redundancy among SAMHSA's data collection efforts and data systems, thereby reducing the reporting burden on state agencies. In the FY13, under the direction of the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA will engage stakeholders in a comprehensive review of measures to support both discretionary and Block Grant data reporting. The state and national Behavioral Health Barometer, currently in development, will be published and can be used by states for problem identification and planning activities.

SAMHSA is committed to engaging in a meaningful, structured process in consultation with states, other stakeholders, and policymakers, including HHS and OMB, to build on current accountability measures for the Block Grants. Through the Block Grant Application and planning process and in conversation with states, providers, service recipients, individuals in recovery, families, and other stakeholders, SAMHSA will create a flexible, deliberate, and careful method of identifying meaningful and appropriate measures which may be modified as needs change and new science evolves. As the quality and outcome measures for the Block Grants develop through SAMHSA's Strategic Initiative on Data, Outcomes, and Quality, SAMHSA's approach to accountability will allow those measures to drive the application(s), review, approval, and monitoring processes.

Consistent with SAMHSA's focus on implementing a coordinated approach to the collection and application of data to inform policy and programmatic decisions, the Block Grant planning and reporting will be focused initially on a small, defined set of nationally collected data elements derived from the four major recovery domains: health, home, community, and purpose. These will provide a set of benchmarks for states and communities to assess the impact of resource decisions on the health and wellness of those involved in programs supported by the Block Grants. States will be provided with data that shows state, regional, and national data on the four core national measures, as well as other significant data of interest to SAMHSA and the states. For this two-year period, states should identify up to three additional measures to focus on in developing their state plan, which may be drawn from the state's behavioral health barometer or submitted in the application with information about the definition, source, periodicity, and calculation. These four to seven measures would serve as the basis for state planning for at least two years of the planning period.

Trauma

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse and maltreatment, 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. Traumatic exposures may have only transient effects or result in no apparent harm; however, traumatic exposures often result in psychological harm, increased rates of mental and substance use disorders, suicide, risk-taking behaviors, and chronic physical disorders. Exposure to trauma may increase the likelihood of substance abuse and lead to disruptions in daily functioning in educational and employment settings. Trauma is an almost universal shared experience of people receiving treatment for mental and substance use disorders, including those served through public systems.

Trauma is especially prevalent among populations who have been involved with the child welfare and criminal/juvenile justice systems, or who reside in communities with high rates of violence. Given the relatively high rates of exposure to traumatic events and the potential for long-term consequences when unrecognized and untreated, it is critical that public health systems screen for and intervene early with evidence-supported trauma interventions. Trauma-specific interventions have been developed for use across the life-span; however, practitioners are often unaware of or may not use interventions based on the best evidence. With the increased recognition of the centrality of trauma in mental and substance use disorders, public systems embrace the need to create trauma-informed service delivery systems that support behavioral health consumers and survivors of trauma. A trauma-informed approach to care is based on consumer choice and decision-making, prohibition of coercive or forced treatment, and promotion of safety and strengths-based practice.

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 both a substance abuse and mental health problem. The coverage expansions included in the Affordable Care Act will mean that individuals reentering communities from jails and prisons, who generally have not had health coverage in the past, will soon be eligible for coverage for some services for mental and substance use disorders. 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 around enrollment, workforce and service development, and coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs. Enrollment efforts will begin in 2013 and expanded eligibility for coverage will begin in January of 2014.

Parity Education

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires that group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applicable to mental or substance use disorder (M/SUD) benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both insured and ~~"l~~large group plans" sponsored by either private or public sector employers. This generally means that it applies when employers have more than 50 employees, including both self-insured and fully-insured arrangements. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group issuers participating in the State Insurance Exchanges (as well as most small group and individual issuers outside the Exchanges) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment.

Since its enactment, public awareness about MHPAEA has been limited. Some recent research suggests that the public does not fully understand mental health benefits, services covered, and to whom the law applies.[17] Increasing the public's awareness about MHPAEA could increase access and use of behavioral health services, provide financial benefits (e.g., reduced deductibles and co-payments) to individuals and families, and lead to reduced confusion and discrimination associated with M/SUDs. SAMHSA will be developing and implementing a parity communications plan.

Primary and Behavioral Health Care Integration Activities

People with SMI have elevated rates of hypertension, diabetes, obesity, and cardiovascular disease, leading to morbidity and mortality disparities. These health conditions are exacerbated by unhealthy lifestyle practices such as lack of physical activity, poor nutrition, smoking, substance abuse and side effects of necessary medication. As a result, those with SMI die on average at 53 years of age. Many of these conditions are preventable through routine primary care screening, monitoring, treatment, and care management/coordination strategies. The Massachusetts Department of Mental Health (DMH) found that for adults ages 25 to 44, cardiovascular mortality was 6.6 times higher among DMH clients than the general population.[18] Seventy percent of Maine's population living with SMI has at least one of these chronic health conditions, 45 percent have two, and almost 30 percent have three or more.[19] Integration of behavioral health and primary care is just as important for children and youth: studies suggest that approximately a quarter of pediatric primary care visits are related to behavioral health issues.[20,21] The needs of children and youth with SED are best addressed when

[17] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589 – 1594.
[13] NASMHPD (2006), NASMHPD Medical Directors Council Technical Report: Morbidity and Mortality in People with Serious Mental Illness (Editors: Parks, J.; Svendsen, D.; Singer, P.; Foti, M.) Alexandria, VA
[14] Freeman, E., Yoe, J.T. The Poor Health Status of Consumers of Mental Healthcare: Behavioral Disorders and Chronic Disease, Presentation to NASMHPD Medical Directors Work Group, May 2006.
[15] Horwitz, S. M., Leaf, P. J., Leventhal, J. M., Forsyth, B., & Speechley, K. N. (1992). *Identification and management of psychosocial and developmental problems in community-based primary care pediatric*

coordinated within a System of Care approach that coordinates cross-sector services, including primary care, and a similar coordinated approach should be used to address the needs of youth with substance use problems.

Pursuant to the Affordable Care Act, HHS is undertaking several coordinated care initiatives. The purpose of these projects is to coordinate and integrate services through the co-location of primary and specialty care services in community-based behavioral health and primary care settings, all with the goal to improve the physical health status of individuals with various behavioral health conditions or at risk of these conditions.

The passage of the Affordable Care Act has ensured many opportunities to improve health care quality through integration of primary and behavioral health care. SAMHSA has taken a leading role in the promotion and adoption of primary and behavioral health care integration nationwide through a number of different initiatives, including section 520K of the Public Health Services Act (PHS Act), which authorizes the Primary and Behavioral Health Care Integration grants, and Section 2703 of the Affordable Care Act, which allows states to establish health homes through their Medicaid program, in addition to our ongoing work with the CMS Federal Coordinated Health Care Office. This work includes several very important initiatives:

- **Primary and Behavioral Health Care Integration (PBHCI):** This program supports community-based behavioral health agencies‘ efforts to build the partnerships and infrastructures needed to initiate or expand the provision of primary healthcare services for people in treatment for SMI and co-occurring SMI and substance use disorders. The purpose of this program is to improve the physical health status of people with SMI and co-occurring SMI and substance use disorders by supporting community-based efforts to coordinate and integrate primary health care with mental health services in community-based behavioral health care settings. The anticipated outcomes are improved access to primary care services; improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses, including chronic disease; increased availability of integrated, holistic care for physical and behavioral disorders; and better overall health status of clients.

  The types of services provided include: facilitated screening and referral for primary care prevention and treatment needs; assurances that primary care screening, assessment, treatment and referral be provided in a community-based behavioral health agency; the development and implementation of a registry or tracking system to follow primary health care needs and outcomes; prevention and wellness support services (utilizing no less than10% of grant funding); and the establishment of referral and follow-up processes for specialized services beyond the primary care setting. Since 2009, SAMHSA has made grant awards to 64 organizations at up to $500,000 per year for four years. In 2011, SAMHSA

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practices. Pediatrics, 89, 480–485.[16] Cooper, S., et al. (2006). Running out of time: Physician management of behavioral health concerns in rural pediatric primary care. *Pediatrics,* 118, 132–138.

awarded a one-year health information technology supplement of $200,000 to 47 grantees.

For more information please visit the website at http://www.integration.samhsa.gov

- **HRSA Health Center Grants:** The Mental and Behavioral Health Education and Training Grants Program (MBHETG) is authorized through Title VII, Section 756 of the PHS Act (U.S.C. 294e-1), as amended by Sec. 5306(a) of the Affordable Care Act, Public Law 111-148, to support eligible institutions of higher education with accredited health professions training programs in social work and psychology to recruit students and provide education and clinical experience in mental and behavioral health. Section 750 (a) of the PHS Act requires that academic institutions receiving assistance under Title VII, Part D of the PHS Act, Interdisciplinary Community-Based Linkages, must use the funds in collaboration with two or more disciplines. The program aims to increase the number of social workers and psychologists who pursue clinical work with high need and high demand populations. In this context, "high need and high demand" refers to rural, vulnerable, and/or underserved populations, and veterans, military personnel and their families. The funding for this announcement is provided through the Affordable Care Act's Prevention and Public Health Fund (Section 4002 (42 U.S.C. 300 u-11)).

- **Dual Eligibles:** Dual eligibles refers to individuals who participate in and receive benefits from both the Medicare and Medicaid programs. The Federal Coordinated Health Care Office within CMS will bring together officials of the Medicare and Medicaid programs to more effectively integrate benefits under those programs and improve the coordination between the federal and state governments for dual eligibles. During FY 2011 and 2012, this Office launched two demonstration projects for states to plan and implement coordinated care initiatives for dual eligibles.

  Specifically, some states have submitted comprehensive 1115 waivers or other innovative demonstration projects for integrated care programs that may impact individuals with behavioral health needs, both under 65 with longer term disabilities and those over 65 with behavioral health needs. Additionally, associated standards for stakeholder engagement have been issued that offer an opportunity for the development of robust stakeholder engagement processes without any conflicts of interest.

- **Accountable Care Organizations:** HHS has implemented several initiatives involving Accountable Care Organizations (ACOs). ACOs help doctors, hospitals, and other health care providers better coordinate care for Medicare beneficiaries. The opportunity for ACOs to share in the savings with the Medicare program creates an incentive for health care providers to work together to treat an individual patient across care settings, including doctors offices,

hospitals, and long-term care facilities. The final rule establishing the Medicare Shared Savings Program and the Agreements with the Pioneer ACOs, initiated over the past year, provides for monitoring to ensure that ACOs do not discriminate against certain populations (e.g., individuals with a substance use disorder) and require that all data sharing with ACOs complies with the protections under 42 CFR Part 2 for information regarding substance abuse treatment, education, etc.

- **Health Homes; Patient-Centered Medical Home**: Numerous provisions in the Affordable Care Act contain funding or initiatives to improve the coordination of care for patients. One of these is through the promotion of health homes, where providers will be rewarded to coordinate care for patients with chronic conditions. SAMHSA has consulted with more than fifteen states in their efforts to take advantage of the Medicaid Health Home provisions (Section 2703) of the Affordable Care Act

- **Million Hearts Campaign:** The CDC's Million Hearts Campaign is an unprecedented national initiative that was launched by HHS in September 2011 to prevent 1 million heart attacks and strokes over five years. The Million Hearts initiative has and will continue to focus, coordinate, and enhance cardiovascular disease prevention activities across the public and private sectors while demonstrating to the American people that improving the health system can save lives. Million Hearts will scale-up proven clinical and community strategies to prevent heart disease and stroke across the nation. http://millionhearts.hhs.gov/index.html

- **Wellness Initiative:** The SAMHSA Wellness Initiative in an ongoing effort to educate the general public, providers, and individuals about the early mortality of individuals with mental and substance use disorders that co-occur with preventable medical conditions, such as cardiovascular disease, diabetes, and respiratory illnesses. The program seeks to reduce the rate of early mortality of through a state and community level approach.

Another concern of SAMHSA and its HHS partners is that individuals with mental or substance use disorders have much higher rates of smoking tobacco relative to the general population. In particular, individuals with schizophrenia have one of the highest rates of smoking (58-88 percent).[22] In a population-based study of smoking prevalence in the U.S., Lasser and colleagues found that smoking prevalence among persons with and without a psychiatric disorder were 41 percent and 22.5 percent, respectively.[23] The highest prevalence (67.9 percent) was found among persons with drug abuse.[24] SAMHSA has developed several national initiatives regarding primary care and behavioral health coordination to combat this additional risk factor and lower these

[22] Kalman D, Morrisette SB, George TP. Co-morbidity of smoking with psychiatric and substance use disorders. Am J Addict. 2005;14:106–23.
[23] Ibid.
[24] Ibid.

disconcerting statistics. Information regarding these initiatives can be found at: http://www.samhsa.gov/healthReform/healthHomes/index.aspx

Health Disparities

In accordance with the disparity-focused provisions of the Affordable Care Act, SAMHSA expects Block Grant dollars to support the reduction of disparities in access, services provided, and behavioral health outcomes among its diverse subpopulations. Grantees should collect and utilize 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. A strategy for addressing health disparities is use of the recently revised national Culturally and Linguistically Appropriate Services (CLAS) standards: http://www.ThinkCulturalHealth.hhs.gov

The Affordable Care Act directed the Secretary of HHS to develop a plan to address health disparities and to develop standard guidelines for the collection of data to assess these disparities. In April 2011, the Secretary released the *Action Plan to Reduce Racial and Ethnic Health Disparities*.[25] This plan outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to continuously 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." In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[26] This guidance conforms to the existing OMB directive on racial/ethnic categories with the expansion of intra-group, granular data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies are in the process of updating their limited English proficiency plans and, in accordance with current and updated planning, 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 disparities within and special service needs of tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. Additionally, 67% of

[25] http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
[26] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

American Indian and Alaska Natives live off-reservation.[27] States provide behavioral health services to these individuals with state Block Grant dollars. While the Block Grant generally requires the use of evidence-based practices, consideration is given to the fact that many of these practices have not been normed on various diverse racial and ethnic populations. Therefore flexibility in the use of evidence-based practices, adaptation, and alternative practices may be allowed in special circumstances.

Recovery

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. SAMHSA has identified recovery support services as one of its strategic initiatives. The urgency of health reform compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. In addition, 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 promote a high-quality and satisfying life in the community for all Americans.

Recently, SAMHSA released the following working definition of recovery from mental and substance use disorders: ~~–~~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 individual, family, community strengths, and responsibility;***
> ***Recovery is based on respect.***

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders, which can be found online at http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

Community Living and the Implementation of Olmstead

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

[27] Norris, T., Vines, P.L., and Hoeffel, E.M. The American Indian and Alaska Native Population: 2010. U.S. Census Bureau, January 2012.

needless institutionalization and segregation in work, living, and other settings. In response to the tenth anniversary of the Supreme Court's *Olmstead* decision, Secretary Sebelius directed the creation of the Coordinating Council on Community Living at the HHS. SAMHSA has been a key member of the Coordinating Council on Community Living 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). There is a focus on collaboration between HUD and HHS to fund supportive housing opportunities for persons with disabilities, which encompasses those with behavioral health needs. In addition, there has been increased enforcement by the Department of Justice (DOJ) and the OCR at HHS, including a number of actions involving state mental health systems: traditional institutions and other residences that have institutional characteristics. Very recently, there has been litigation regarding supported employment services and challenging sheltered workshops.

Children and Adolescents Behavioral Health Services

Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and about one in ten suffers from a serious mental disorder that contributes to substantial impairment in functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting disorders by age 14 and 75 percent by age 24. Eleven percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or other drugs. Nine out of ten 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 develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple problems, diagnoses, and co-occurring disorders. These children and youth are frequently involved in more than one specialized system, whether it is mental health, substance abuse, primary health, education, child care, child welfare, juvenile justice, or developmental disabilities. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children and youth with mental, and/or substance use disorders and co-occurring disorders. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. The system of care helps to build meaningful partnerships with families and youth, and addresses cultural and linguistic needs, which improves the child's functioning in home, school and community and promotes recovery and resilience. The system of care approach provides individualized services, builds on the strengths of the child/youth and family, is delivered in the least restrictive environment,

incorporates evidence-based practices, and provides effective cross-system collaboration including integrated management of service delivery and costs.

This approach has guided system reform in many states, communities, tribes, and territories. Extensive research and evaluation have documented the effectiveness of this approach in improving clinical and functional outcomes for children, including increases in behavioral and emotional strengths, reductions in suicide attempts, improvements in school performance and attendance, fewer contacts with law enforcement, reductions in inpatient care, and more stable living situations. Outcomes have also been documented at the family-level, including reduced caregiver strain, more adequate array of resources, fewer missed days of work due to behavioral health needs and crises of the child, and improvement in overall family unit functioning.

SAMHSA's Strategic Initiatives

In addition to health reform, SAMHSA has established eight Strategic Initiatives to improve the delivery and financing of prevention, treatment, and recovery support activities and services to advance and protect the nation's health. These initiatives will allow SAMHSA's to capitalize on emerging opportunities to focus on improving lives. As each initiative is developed and integrated throughout SAMHSA activities, information will be disseminated to states, stakeholder groups, national organizations, and policy makers. With this guidance, states should develop plans and applications with a focus on SAMHSA's Strategic Initiatives. The areas and goals that comprise the strategic initiatives include:

1. *Prevention of Substance Abuse and Mental Illness*: Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide. This initiative focuses especially on the nation's high risk youth, youth in tribal communities, and mental illness and substance abuse among military families.

2. *Trauma and Justice*: Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems; as well as addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.

3. *Military Families*: Supporting America's service men and women–Active Duty, National Guard, Reserve, and Veterans–together with their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

4. *Recovery Support*: Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing,

employment, education, and other necessary supports; and reduce barriers to social inclusion.

5. *Health Reform*: Broadening health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions.

6. *Health Information Technology*: Ensuring the behavioral health system, including states, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of Health Information Technology (HIT) and interoperable EHRs.

7. *Data, Outcomes, and Quality*: Realizing an integrated data strategy that informs policy and measures program impact leading to improved quality of services and outcomes for individuals, families, and communities.

8. *Public Awareness and Support*: Increasing understanding of mental and substance use disorders to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

C. Impact on State Authorities and Systems

SAMHSA seeks to ensure that SMHAs and SSAs are prepared and ready to address the priorities described above. 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. With all of the recent changes that will take effect on January 1, 2014, state authorities must be mindful of what services they buy, how they adapt to operate in a new health care environment, and how to best help their providers to offer effective care. The changes to the Block Grant application(s) incorporate several key assumptions:

- *States should be more 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 increase over the next few years, gaps in coverage will remain for specific populations and services. SMHAs and SSAs need to begin to identify those gaps by first mapping out which populations will be covered by various coverage options available under health reform. Secondly, within the different insurance packages, states have to consider the extent to which specific M/SUD services will remain uncovered. In order 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 should use SAMHSA‘s description of a Good and Modern Mental Health and

Addiction Service System[28] when they consider service issues. 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 CHIP, Medicaid, and Medicare programs. Accordingly, states may want to look at outreach opportunities in order enroll those qualified for these programs, as well as QHPs offered through Health Insurance Exchanges or other commercial insurance plans.

When developing strategies for purchasing services, SMHAs and SSAs must 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 in order to develop a provider pool that is more adept at navigating the new environment. Providers need to develop better financial strategies that will allow them to be less dependent on SMHA and SSA funding. Funding available from CMS, such as Medicaid, CHIP, Medicare, and national demonstration projects (e.g., Money Follows the Person, Rebalancing Initiatives, Health Homes, IMD Demonstration), will play a more important role to states given the recent reductions in state, local, and federal funding for behavioral health services. In addition, funding from 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.

The new environment may create new ways to purchase services: reimbursement for episodes of care and pay-for-outcomes are just two strategies that payers may use in the future, though these strategies have not been widely deployed by public behavioral health payers. SAMHSA suggests that SMHAs and SSAs consider using their Block Grant funds and develop reimbursement strategies that are consistent with the intent of health reform and pay for better services, not just more services.

- *States should think more broadly than the populations they have historically served through Federal Block Grants and other funding*.
  The focus of SAMHSA's Block Grant programs has not changed significantly over the past 20 years. While many of these populations originally targeted for the Block Grants are still a priority, certain populations have evolving needs that must be addressed. These populations include military families, youth who need

[28] Substance Abuse and Mental Health Services Administration. (2010), *Description of a Modern Addictions and Mental Health Delivery System,* Office of Policy, Planning, and Innovation, Rockville, MD http://www.samhsa.gov/healthreform/docs/AddictionMHSystemBrief.pdf

substance use disorder services, individuals who experience trauma, increased numbers of individuals released from correctional facilities, and lesbian, gay, bisexual and transgendered 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 that have personal experiences with mental or substance abuse disorders are playing an increasingly important role in the delivery of recovery-oriented systems of care. Services should also take into account ethnic- and culture-specific services for racial and ethnic minorities. For example, services should address the unique needs of tribal populations and the unique role of tribal governments in planning and delivering services. Advances in technology have changed significantly since 1991, SAMHSA's inception. Technology is playing a growing role in how individuals learn about, receive, and experience their health care services. Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care and recovery support services by providers and to report health information and outcomes by individuals. A more detailed discussion regarding ICTs is provided later in this document in Section 3m.

- *States should design and develop collaborative plans for health information systems. Health care payers seek to promote EHR and interoperable information technology systems that allow for the effective exchange and utilization of health data.* Purchasers of behavioral health services should acquire information technology systems that are Office of the National Coordinator for Health Information Technology (ONC) Meaningful Use certified EHR applications which 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 in a state (or region) to begin or continue to collaborate and discuss system interoperability, electronic health records, federal information technology requirements, and other related matters.

- *States may form strategic partnerships in order for individuals to have access to a good and modern services system.*

  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 Director, Insurance Commissioner, prevention agencies, child serving agency, education authority,

justice authorities, public health authorities, and health information technology authorities are of integral during this time of transition. 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 consider the practice of tribal consultation as an effective means to learn of resources and services not previously considered as they undertake their Block Grant planning process(es).

- *State authorities should focus more on recovery from mental health and substance use problems.*
  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, as well as 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 qualified health plans and Medicaid to ensure that individuals with behavioral health conditions have adequate coverage and access to services.*
  Some states are currently putting out requests for proposals (RFPs) for managed care organizations (MCOs). State legislatures, state Exchange entities, and state insurance commissioners are developing policies and regulations related to the EHBs. 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 that will be insured through Affordable Insurance Exchanges and expanded Medicaid eligibility, significant consideration should be given to the inclusion of necessary services and providers.

- *States should make primary substance abuse prevention a priority.*
  In order to respond to the primary prevention set-aside requirement of the SABG, states should keep in mind that the backbone of a Good and Modern 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 which will aid the state in developing and maintaining a comprehensive substance abuse prevention system.

- *State authorities should monitor Exchanges to ensure that individuals with behavioral health conditions are aware of their eligibility, able to get enrolled, and able to stay enrolled.*
  Now that Exchanges are going into effect, state legislatures, state Exchange entities, and state insurance commissioners are developing policies and regulations related to the coordination between the Exchanges, 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 the organizations performing the outreach and enrollment assistance are prepared to help individuals with mental and substance use disorders. Historically, the individuals who have the most difficulty navigating public health insurance eligibility determination and enrollment process have disproportionately high rates of behavioral health conditions. In order to avoid a similarly disproportionate representation among the uninsured after 2014, SMHAs and SSAs need be proactive in ensuring that their state‘s efforts do not overlook individuals with 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.*
  After the full implementation of the Affordable Care Act, SAMHSA strongly recommends that Block Grant funds 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) 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 should determine if established systems and procedures are sufficient to ensure that Block Grant funds are expended in accordance with program requirements and directed to support, not supplant, health care reform activities. States may have to make changes to information systems and conduct more compliance reviews to assure better program integrity, which may include working closely with Medicaid and Health Insurance Exchanges to review information and determine whether individuals and providers in their systems are enrolled or implementing strategies to assist their providers to build the necessary infrastructures to operate in commercial and public (Medicaid and Medicare). States are encouraged to consider developing metrics or targets for their systems to measure increases in the number of individuals that become enrolled or providers that join commercial or publicly funded managed care networks.

- *State authorities should use evidence to support their funding and purchasing decisions.*
  Information gathered from the FY 2011 Block Grant Addendum and the FY 2012/2013 Block Grant Application indicates that almost all states are using Block Grant funds to purchase services in all categories identified in SAMHSA's *Description of a Modern Addictions and Mental Health Service System*. In addition, state Medicaid programs purchase a subset of these services, some of which will be included in EHBs offered through commercial insurers participating in Health Insurance Exchanges and the Medicaid benchmark plans. SMHAs and SSAs will be 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 Medicaid. In addition, states may also be able to use this information to educate policymakers (including legislators) and to support 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. North Carolina's Practice Improvement Collaborative, is an excellent example of a state's effort to provide guidance in determining the future evidence based services and supports that will be provided through their public system.

- *State authorities should ensure that they comport with changes in quality reporting.*
  The NBHQF will provide a platform for the data SAMHSA requests from states through the Block Grant and receives from both its discretionary and formula grantees. SAMHSA has been working with states to identify and implement within the NBHQF a core set of quality and outcome measures. Once finalized, these measures will be used for SAMHSA's performance monitoring and quality improvement activities. This effort has sought both to 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 have a series of questions–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.

- *State authorities should pay particular attention to trauma.*
  Individuals who have been exposed to traumatic events are at increased risk for mental and substance use disorders. Many symptoms of trauma are similar to and may contribute to other behavioral health problems including depression, anxiety, disruptive behavioral disorders, personality disorders, and substance use disorders. Exposure to past trauma may also complicate treatment for mental and substance abuse disorders.

  The current behavioral health workforce needs training on the role of trauma in people's lives, the centrality of trauma to behavioral health disorders, trauma-specific interventions, and strategies to build trauma-informed systems that better identify and address trauma. Practitioners and policymakers also need to have a better understanding of how their policies, practices, and behaviors can promote healing and recovery or be secondarily traumatizing to people. There is a growing evidence base for the treatment of trauma and generic therapies have not been shown to be effective in addressing trauma. There are a number of evidence-based approaches that states should focus on adopting. States can better address this issue by screening for trauma, providing trauma-focused treatments, and offering trauma-informed care.

- *State authorities should collaborate closely with their counterparts in the criminal and juvenile justice systems.*
  Because individuals involved in the criminal and juvenile justice systems experience comparatively high rates of mental and substance use disorders, an opportunity exists to coordinate new health coverage with other efforts to facilitate improved functioning and health. The impending coverage expansion will have a large impact on funding sources for mental health and substance abuse services for individuals involved in the criminal and juvenile justice systems. A majority of these individuals are male adults below 133 percent of the FPL, placing them squarely within the Medicaid expansion population. Given that many of these individuals would not have had coverage for services before or would have relied on public systems and/or charity care, this change provides opportunities for increased levels of coverage as well as the opportunity to shift current coverage for individuals receiving services through the MHBG and SABG to new funding sources.

  Block Grant resources will be important in this new environment. Significant workforce needs are related to behavioral health in the criminal justice system. Police and other first responders need training and consultation to respond appropriately and safely to people with mental and substance use disorders in crisis. Judges and other court officials need education and support to develop

successful specialty court and other diversion programs for people with mental and substance use disorders. The behavioral health workforce also needs to develop a better understanding of issues that may come up when serving individuals who are involved in the justice system. States should place an emphasis on screening and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. Secondarily, states should work with courts, correctional systems, and law enforcement personnel to help with enrollment and coverage during periods of lapsed coverage, and coordination with reentry programs to provide services to help prevent relapse and re-incarceration.

The Administration on Children, Youth, and Families (ACYF) and the broader child welfare system are placing an increased focus on the social and emotional well-being of children and youth in foster care. Congress passed the Child and Family Services Improvement and Innovation Act in 2011. This Act gives states the option of applying for waivers to focus state funding received through Titles IV-E and IV-B of the Social Security Act on improving wellness and outcomes for children and youth in the foster care system. In addition to focusing on behavioral health supports for children in foster care, this flexibility will allow states to place an increased emphasis on risk factors such as child trauma and parental substance abuse. Given that 63 percent of youth in the foster care system have met the criteria for at least one behavioral health diagnosis at some point in their lives and the recent developments in state and federal policy, states should consider coordinating MHBG and SABG funding with work in the child welfare system.

- *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 mental and substance use disorder benefits in relation to medical/surgical benefits. However, the law does not require insurance plans to provide mental or substance use disorder benefits. Whether it is federal- or state-level parity, continued efforts for education are key to increase 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 (e.g., California, Vermont, and Maryland) 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 assure that consumers receive quality behavioral health care services within their state and are aware of what protections, if any, that exist in their state should their claim be denied inappropriately by insurance companies.

- *State authorities should be key players in primary and behavioral health care 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 Agency 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 State Medicaid Agencies 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 PBCHI grantees) that have effective models, and assist with training or retraining staff to provide care coordination across primary care and behavioral health care.

  The SMHAs and SSAs can also assist the Medicaid agency in messaging the importance of the various coordinated care initiative 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 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 State Medicaid Agencies with identifying key principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction.

  In addition, states play a key role in developing strategies for reducing smoking among individuals with a behavioral health condition. States should consider several 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 care for diverse racial, ethnic, and LGBTQ populations with the goal of reducing disparities for these subpopulations.*
  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 in order 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 care services within their states as authorized under the SABG and MHBG.*
  Behavioral health care recovery-support services include the following four major dimensions that support a life in recovery (the 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 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.

  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. 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.

States should evaluate their services to ensure that they are provided in the most integrated setting appropriate and maximize the ability to interact with persons without disabilities. State mental health authorities should carefully review all settings where people with mental illness reside and should work with their housing development partners to develop additional capacity for supported housing in integrating settings. In addition, states should look closely at how persons with mental illness are spending their time during the day to ensure that individuals with behavioral health needs have opportunities for supported employment, leading to competitive employment in the community.

- *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 the child/youth and family is critical. Facilitating and sustaining this approach at the local level requires a parallel effort at the state level, and as states adopt a systems 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 these efforts may also be part of the foundation for a statewide systems of care approach. States must look at the impact of adopting this approach across different agencies, addressing issues like 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.

D. 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, substance use disorders, and associated problems. 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:

a. A physically and emotionally healthy lifestyle (***health***);
b. A stable, safe and supportive place to live (a ***home***);
c. Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a ***purpose***); and,
d. Relationships and social networks that provide support, friendship, love, and hope (a ***community***).

Additional aims of the Block Grant programs reflect SAMHSA's role as a public health agency:

1. The focus is about everyone, not just those with an illness or disease, but the whole population.
2. The focus is on prevention and wellness 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 inform 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 which informs and supports the work.

These goals are significant drivers in the revised Block Grant application(s). 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).

2. SUBMISSION OF APPLICATION AND PLAN TIMEFRAMES

As referenced in the *Introduction*, changes to the SABG and MH BG applications are, in part, being driven by MHPAEA and related laws, which require a number of standardizations amongst applications. SAMHSA wants to ensure that SMHAs and SSAs are well positioned during FYs 2014 and 2015. While the statutory deadlines and Block Grant award periods remain unchanged, SAMHSA has made changes to the timeframe in which states are asked to submit application(s) and report their progress towards implementing planned activities. These changes were made to better coincide with the majority of states' fiscal year calendars, which are from July 1st through June 30th of the following year. In addition, both the MHBG and the SABG applications will be due on the same date, whereas previously, they were due in different months. The dates for providing reports and assurances and the reporting periods for both Block Grants were also different and SAMHSA has aligned the annual report due dates and annual expenditure reporting periods to be consistent across both Block Grants.

The FY 2014/2015 MHBG and SABG application(s) includes 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 (7/1/13-6/30/15) to align with most states' fiscal year budget cycle.[29] States will have the option of amending their Plans when they submit their 2015 application. The following table identifies Application and Plan due dates.

Application(s) for FY	Application Due	Plan Due	Planning Period	Reports Due
2014	4/1/13	Yes	7/1/13 – 6/30/15	12/1/13
2015	4/1/14	No *		12/1/14
2016	4/1/15	Yes	7/1/15 – 6/30/17	12/1/15
2017	4/01/16	No *		12/1/16

*States may revise previously submitted plans

[29] Reporting timeframes for Synar will remain on the current schedule. Annual Synar Reports (ASR) are due on December 31. The data reported in the ASR due on December 31, 2012, will be from inspections completed in FFY 2012 (October 1, 2011, through September 30, 2012).

States should submit their Block Grant application(s) for 2014 and 2015 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 covered in the State Plan section.

The FY 2014/2015 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 2014/2015 Block Grant Application and Plan have sections that are required and other sections where additional information is requested but not required. Section 3b requires states to undertake a needs assessment as part of their plan submission. This section identifies the populations that states must include in their assessment but are encouraged to plan for other populations (e.g. youth with a substance use disorders). Section 3b, Plan Tables 2 and 5a are required.

Sections 3.c-v requests information on state efforts on certain policy, program, and technology advancements in health and behavioral health care. While this information is not required, it will help SAMHSA understand the whole of the applicant state‘s efforts and identify how it can assist the applicant state meet 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. Section 3x is required for both the SABG and MHBG. Section 3w is required for those states submitting a combined Block Grant application or states submitting just their MHBG application.

Some states may choose not to include other populations in their needs assessment or provide the requested information in other sections of the plan. While not submitting this information will not impact SAMHSA‘s approval of the Plan or award, states are strongly encouraged to submit as much as they can so the nation, as a whole, will have a complete picture of needs of individuals with behavioral health conditions, as well as the innovative approaches states are undertaking in these areas as well as the barriers they encounter designing and implementing important policies and programs.

In order 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). The funds awarded will be available for obligation and expenditure[30] to plan, carry out, and evaluate activities and services for children with SED and adults with SMI and their consequences; substance abuse prevention; youth and adults with a substance use disorder; adolescents and adults with co-occurring disorders; and the promotion of recovery among persons with SED, SMI, or substance use disorder.

[30] Title XIX, Part B of the PHS Act

A grant may be awarded only if an application(s) submitted by a state include(s) a State BG Plan[31, 32] 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[33] 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 shall 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).

3. 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 utilize this mechanism to assist in the development of the State BG 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 BG Plans be made available to the public in such a manner as to facilitate comment from any person 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, LGBTQ populations, persons with co-existing disabilities, and other key stakeholders. Evidence of meaningful consultation with federally recognized tribes where tribal governments or lands are

[31] Section 1912 of Title XIX, Part B, Subpart I of the PHS Act (42 U.S.C. § 300x-2)
[32] Section 1932(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-32(b))
[33] Section 1942(a) of Title XIX, Part B, Subpart III of the PHS Act (42 U.S.C. § 300x-52(a))

located within the boundaries of 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. At a minimum, the plan should address the following populations as appropriate for each Block Grant:

- Comprehensive community-based services for adults with SMI and children with SED:
  - Children with SED and their families*
  - Adults with SMI*
  - Older Adults with SMI*

- Services for persons with or at risk of having substance use and/or mental disorders:
  - Persons who are intravenous drug users (IDU)*
  - 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

- 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*
  - The National HIV/AIDS Strategy (NHAS) for the United States (p. 15) and NHAS Implementation Plan (p. 11)(.pdf documents attached)
    - 1.2.4 Prevent 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 (P. 15)

- Services for individuals in need of primary substance abuse prevention

- 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 LGBTQ 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

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.

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 begin planning now for individuals with incomes below 400% FPL who are currently uninsured but will be covered by Medicaid or private insurance in FY 2014. This planning will present new opportunities for public behavioral health systems to expand access and capacity. In addition, states should identify who will not be covered after FY 2014 and how federal funds will be used to support these individuals who may need treatment and supports.[34]

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, and behavioral disorders. These major themes are relevant for SSAs and SMHAs.

The planning steps established for the MHBG and SABG follow the process described in the SPF. The SPF encompasses the following five steps: (1) assess needs; (2) build

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

capacity to address 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, mental disorders, and their associated consequences; and (5) evaluate progress towards goals. SAMHSA is encouraging states to undertake each of the following planning steps in a timely manner.

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.

Step 2: Identify the unmet service needs and critical gaps within the current system.
This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the state's behavioral health care system, especially for those required populations described in this document and other populations identified by the state as a priority.

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, and the Uniform Reporting System (URS). Those states that have an SEOW should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the historically reported prevalence formulas for adults with SMI and children with SED, as well as the

prevalence estimates, epidemiological analyses, and profiles to establish substance abuse prevention, mental health treatment, 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 annual report will present 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). 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 Behavioral Health Barometer will assist the agency in furthering its mission of reducing the impact of substance abuse and mental illness on America's communities.

SAMHSA will provide each state with its state-specific outcome data for several indicators from the Behavioral Health Barometer. 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. The data sets that states could use for developing their needs assessment and plans are included in the attachment.

Through the Healthy People Initiative, 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[35], 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 two, 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 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 1and indicate the priority type (i.e., substance abuse prevention (SAP), substance abuse treatment (SAT), mental health prevention (MHP), or mental health services (MHS).

Step 4: Develop objectives, strategies, and performance indicators.
For each of the priorities identified in step three, 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.

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

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 prevention of mental illness, and system improvements that will address the goal.

Strategies that use ***service-specific changes*** to achieve a goal should be consistent with SAMHSA's continuum of services identified in the *Good and Modern System* brief.[36] If the state is recommending services that are not specifically referenced in this brief, please describe the population(s) that will receive these services, the rationale for this recommendation, and the evidence regarding the effectiveness of this service. In addition, the description of the strategy should provide the context for how the service-specific change will be implemented. Strategies that should be considered and addressed include:

- Strategies that are targeted for children and youth with SED or substance use disorders should utilize a system of care approach that has been well-established for children with SED and co-occurring substance use disorders. This approach should be utilized 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 abuse or dependence.
- Strategies targeted for adults with M/SUDs that will 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 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 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.[37]
- 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.

[36] Substance Abuse and Mental Health Services Administration. (2010), *Description of a Modern Addictions and Mental Health Delivery System,* Office of Policy, Planning, and Innovation, Rockville, MD http://www.samhsa.gov/healthreform/docs/AddictionMHSystemBrief.pdf

[37] Center of Budget and Policy Priorities

- Strategies that will increase the availability of 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 State Medicaid Agency and Health Insurance Exchange 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 cultural-specific interventions and providers to improve access, engagement, quality, and outcomes of services for diverse ethnic and racial minorities and LGBTQ populations. States will be encouraged to refer to the 2009 IOM report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*[38] 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 central 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.
- Strategies that increase the use of person-centered planning, self-direction, and participant-directed care. This includes measures to help an individual or their caregiver (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. The 2009 IOM report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.*[39] 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:

[38] 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

[39] 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: The National Academies Press

- 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.
- 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*[40], the NREPP, and/or other materials documenting their effectiveness. These strategies include:
    - Strategies that target tobacco use prevention, tobacco cessation, 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 *National Strategy to Prevent 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 LGBTQ communities that experience a cluster of risk factors that make them especially vulnerable to substance use and related problems.
    - 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.

[40] http://www.surgeongeneral.gov/library/calls/underagedrinking/calltoaction.pdf

- 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 emergency, 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 racial/ethnic minority and LGBTQ communities.
- System improvement activities may be included as strategies 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 as more individuals will be covered in FY 2014. 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 effectively 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 care and behavioral health providers working with behavioral health provider organizations for expertise, collaboration, and referral arrangements, including the support of primary care provider efforts to screen patients for mental and substance use disorders. Activities should also focus on developing model contract templates for reciprocal primary care 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 primary care 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 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.

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 2014 and how the state proposes to measure the change in FY 2015. States shall 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 (3A) and Planning Steps (3B) 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. The following information is required:

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 edited.

2) Priority Type. From the drop-down menu, select:
   SAP–substance abuse prevention,
   SAT–substance abuse treatment,
   MHP–mental health promotion, 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 3A *Framework for Planning—Mental Health and Substance Abuse Prevention and Treatment*. From the drop-down menu select:
   SMI–Adults with serious mental illness,
   SED–Children with a serious emotional disturbance,
   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 3a 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, 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 SFY 2014),
   (c) Second-year target/outcome measurement (Final to end of SFY 2015),
   (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, MHP, 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 2014):	
b) First-year target/outcome measurement (Progress to end of SFY 2014):	
c) Second-year target/outcome measurement (Final to end of SFY 2015):	
d) Data source:	
e) Description of data:	
f) Data issues/caveats that affect outcome measures:	

States are accountable for meeting the goals and performance targets established in their plans. 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 fails to achieve its goals as stated in its application(s) approved by SAMHSA, the state will 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.

Plan Table 2: State Agency Planned Expenditures

States should project how the SMHA and/or the SSA will use available funds to provide authorized services. Plan Table 2 must be completed for the planning period.

Plan Table 2: State Agency Planned Expenditures

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. Substance Abuse Block Grant	B. Mental Health Block Grant.	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*	$		$	$	$	$	$
b. All Other	$		$	$	$	$	$
2. Primary Prevention**	$	$	$	$	$	$	$
3. Tuberculosis Services	$		$	$	$	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital		$	$	$	$	$	$
6. Other 24 Hour Care		$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care		$	$	$	$	$	$
8. Administration (excluding program / provider level	$	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$	$
11. Total	$	$	$	$	$	$	$

* Prevention other than primary prevention.

** States may only use MH Block Grant funds to provide primary prevention services to the priority populations of adults with serious mental illness and children with serious emotional disturbance.

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 for the planning period. If the state purchases services or activities that are not included in the listed categories, please report them in the last row of the table in the "Other" category.

Plan Table 3	State Agency Planned Block Grant Expenditures by Service				
State Identifier:					
Planning Period – From: **To:**					
Service	**Unduplicated Individuals**	**Unit Type**	**Unit Quantity**	**MHBG Expenditures**	**SABG 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 (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				$	$
Engagement Services				$	$
Assessment				$	$
Specialized Evaluations (Psychological and Neurological)				$	$
Service Planning (including crisis planning)				$	$

Plan Table 3	State Agency Planned Block Grant Expenditures by Service				
State Identifier:					
Planning Period – From:	**To:**				
Service	**Unduplicated Individuals**	**Unit Type**	**Unit Quantity**	**MHBG Expenditures**	**SABG Expenditures**
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				$	$
Traditional Healing Services				$	$
Recovery Supports				$	$
Peer Support				$	$
Recovery Support Coaching				$	$
Recovery Support Center Services				$	$
Supports for Self-directed Care				$	$

Plan Table 3	State Agency Planned Block Grant Expenditures by Service				
State Identifier:					
Planning Period – From:	**To:**				
Service	**Unduplicated Individuals**	**Unit Type**	**Unit Quantity**	**MHBG Expenditures**	**SABG Expenditures**
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				$	$

Plan Table 3	State Agency Planned Block Grant Expenditures by Service				
State Identifier:					
Planning Period – From:	**To:**				
Service	**Unduplicated Individuals**	**Unit Type**	**Unit Quantity**	**MHBG Expenditures**	**SABG Expenditures**
Peer-based Crisis Services				$	$
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 should 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 2014 and FY 2015 SABG awards.

Plan Table 3: SABG Planned Expenditures

Plan Table 4 SABG Planned Expenditures		
State Identifier:		
Expenditure Category	**FY 2014 SA Block Grant Award**	**FY 2015 SA Block Grant Award**
1. Substance Abuse Prevention* and Treatment	$	$
2. Primary Prevention	$	$
3. HIV Early Intervention Services**	$	$
4. Tuberculosis Services	$	$
5. Administration (SSA level only)	$	$
6. Total	$	$

* Prevention other than Primary Prevention
** HIV Designated States Only

Plan Table 5a: SABG Primary Prevention Planned Expenditures

States should project how they will use SABG funds to conduct and/or fund primary prevention and §1926[41]-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 included 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; or, alternatively, the state may choose to report those activities utilizing 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 2014 and FY 2015 SABG awards. The total amounts should equal amount reported on Plan Table 4, Row 2, Primary Prevention.

Plan Table 4a: SABG Primary Prevention Planned Expenditures			
State Identifier:			
Report Period- From:		**To:**	
	A	**B**	**C**
Strategy	**IOM Target**	**FY 2014 SA Block Grant Award**	**FY 2015 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**	$	$

[41] 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).

	Selected	$	$
	Indicated	$	$
6. Environmental	**Universal**	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
7. Section 1926-Tobacco	**Universal**	$	$
	Selected	$	$
	Indicated	$	$
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 should 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 2014 and FY 2015 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

Plan Table 5b: SABG Primary Prevention Planned Expenditures by IOM Category		
State Identifier:		
Activity	**FY 2014 SA Block Grant Award**	**FY 2015 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 2014 and FY 2015 SABG awards.

Plan Table 5c: SABG Planned Primary Prevention Targeted Priorities

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	
LGBTQ	
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 should project how they will use SABG funds to conduct and/or fund resource development activities. Plan Table 6a must be completed for the FY 2014 and FY 2015 SABG awards.

Plan Table 5a: SABG Resource Development Activities Planned Expenditures

	Plan Table 6A	SABG Resource Development Activities Planned Expenditures						
State Identifier:								
	FY 2014 SA Block Grant Award				**FY 2015 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 should 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 that they directly contract with. 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

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 on Data:	

C. Coverage for M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their 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 what is bought given the coverage offered in the state‘s EHB package?

D. Affordable Insurance Exchange

Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state‘s new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who

will be participating in insurers‘ networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 –Statewide Entity Inventory” of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state‘s Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

E. Program Integrity

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (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 utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

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. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. 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.

States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Encounter/utilization/performance analysis; and
    f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

F. Use of Evidence in Purchasing Decisions

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. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
    a) What information did you use?

b) What information was most useful?

3) How have you used information regarding evidence-based practices?
   a) Educating State Medicaid agencies and other purchasers regarding this information?
   b) Making decisions about what you buy with funds that are under your control?

G. Quality

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use-Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections– Community Connections	Percent in TX employed, in school, etc. (TEDS)	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.
3) What are your states' specific priority areas to address the issues identified by the data?
4) What are the milestones and plans for addressing each of your priority areas?

H. Trauma

In order to better 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 care approach consistent with SAMHSA's trauma-informed care definition and principles. 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 more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

I. Justice

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 abuse 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.[42,43] 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 utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. 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 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 answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating 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. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

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[42] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.
[43] 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.
[44] 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

5. What cross-trainings do you provide 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?

J. Parity Education

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.
Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

K. Primary and Behavioral Health Care Integration Activities

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 rewarded to coordinate 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 answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
    a. heart disease,
    b. hypertension,
    c. high cholesterol, and/or
    d. diabetes.

L. Health Disparities

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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. In order 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).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

M. Recovery

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in *The Good and Modern Continuum of Care Service Definitions,* including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. 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?
6. 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?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must 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 actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

N. Prevention

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should 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*, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities

that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data 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?
5. How is the state‘s budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

O. Children and Adolescents Behavioral Health 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 over 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 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.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with 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.
Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with 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?

P. Consultation with Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or in order 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Q. Data and Information Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and

- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

R. Quality Improvement Plan

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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, states must submit a CQI plan for FY 2014/2015.

S. Suicide Prevention

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document *Guidance for State Suicide Prevention Leadership and Plans* available on the SAMHSA website at http://www.samhsa.gov/grants/blockGrant/docs/SAMHSA_State_Suicide_Prevention_Plans_Guide_Final.pdf.

T. Use of Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;

- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

U. Technical Assistance Needs

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

V. Support of State Partners

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information exchanges (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The state justice system authorities that will work 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. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.

[45] SAMHSA will inform the federal agencies that are responsible for other health, social services, and education programs of this requirement.

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

W. State Behavioral Health Advisory Council

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. SAMHSA encourages states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?

- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council.

Behavioral Health Advisory Council Members

Name	Type of Membership*	Agency or Organization Represented*	Address Phone & Fax	Email Address (If Available)
		State Education Agency		
		State Vocational Rehabilitation Agency		
		State Criminal Justice Agency		
		State Housing Agency		
		State Social Services Agency		
		State Medicaid Agency		
		State Exchange 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.

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 (Not State employees or providers)		
Total Individuals in Recovery, Family Members and Others		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies		
TOTAL State Employees & Providers		
Individuals/Family Members from Diverse Racial, Ethnic and LGBTQ Populations		
Providers from Diverse Racial, Ethnic and LGBTQ Populations		
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

*States are encouraged to select these representatives from state Family/Consumer organizations

X. Comment on the State BG Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) 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 BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

ACRONYMS

ACA: Patient Protection and Affordable Care Act

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

PPACA: Patient Protection and Affordable Care Act

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

ATTACHMENT

Substance Use and Mental Health Issues		
Source	**Link**	**Description of Data Source**
Substance Abuse Mental Health Services Administration	http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm	National Household Data Survey on Health, Drug Use and Mental Health Findings. 2010.
SAMHSA Data Archive	http://www.icpsr.umich.edu/icpsrweb/SAMHDA/	Can be sorted by issue, state, report including DAWN, N-SSATS, NSDUH, TEDS, Quick Tables and interactive maps. Can be queried by state.
Health Issues		
Source	**Link**	**Description of Data Source**
Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=bb-od-atlas_005	***Atlas*** is an interactive tool allowing access to the CDC's active data bases inclusive of HIV, AIDS, TB, Hepatitis and sexual transmitted disease conditions sortable by state. Can be queried by state.
U.S. Library of Medicine/National Institute of Health	http://www.nlm.nih.gov/hsrinfo/disparities.html#495Data,%20Tools,%20and%20Statistics	Variety of tools and publications covering a range of health disparities by demographic group/ethnicity/culture /age ranges in US.
U.S. Department of Health and Human Services/Health Resources and Services Administration	http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/index.html	Data by state summarizing patient counts, insurance status, health conditions, special population data including homeless, migrant populations, etc.
Youth and Adolescent Issues		
Source	**Link**	**Description of Data Source**

Substance Abuse Mental Health Data (SAMHDA) Archive/Inter-University Consortium for Political and Social Research (ICPSR)	http://www.monitoringthefuture.org/data/data.html	Sample of high school students on a variety of issues contains 2011 data tables; alcohol/drug use, tobacco use, adolescent health issues, parental influences etc.
Annie E. Casey Foundation Kids Count	http://datacenter.kidscount.org/	Data organized by state and includes data sets including over 100 measures of child well-being
National Center for Educational Statistics	http://nces.ed.gov/surveys/sdds/ed/index.asp	Data and mapping tools which allows for view maps of states and school districts, while overlaying statistics on population and housing, race and ethnicity, economics and social characteristics. Can be queried by state/regional or local area including information on American Indian/Alaska Natives.
	Criminal Justice- Adolescent and Adult	
Source	**Link**	**Description of Data Source**
U.S. Department of Justice/Bureau of Justice Statistics	http://www.bjs.gov/index.cfm?ty=dca	Data encompassing state and federal parole/probation, jails, inmates, arrest related deaths, emergency room data on intentional violence injuries, Tribal law enforcement, jails in Indian country.
	General Population Statistics	

Source	Link	Description of Data Source
U.S. Bureau of the Census	http://www.census.gov/	Data that can be sorted by state and location and includes the following: population, housing economic, household, ethic/race, age groups, government and other demographic features. Can be queried by state.
U.S. Bureau of Labor Statistics	http://www.bls.gov/data/	Data that can be sorted by state, local and regional areas and includes information on civilian employment and unemployment, wage information, farm and seasonal workforce. Can be tailored to answer queries by state.
U.S. Department of Housing and Urban Development	http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf	2010 Statistical report on Homeless in US.
National Alliance to End Homelessness	http://www.endhomelessness.org/content/article/detail/3759	2011 Media Map by state/location regarding the status of homelessness by location.
	Veterans Issues	
Source	**Link**	**Description of Data Source**
Department of Veteran's Affairs	http://www.va.gov/vetdata/veteran_population.asp	Data includes current veteran population by state and county with particular details by race, ethnicity, retired, active, gender.