Substance Abuse and Mental Health Services Administration
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Behavioral Health is Essential To Health • Prevention Works • Treatment is Effective • People Recover

FY 2012–2013 Block Grant Application

Community Mental Health Plan and Report

Substance Abuse Prevention and Treatment Plan and Report

Reducing the impact of substance abuse and mental illness on America's communities.

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Table of Contents

6. SYNAR Reporting

7. Required Forms
    a. Face Page—Community Mental Health Services Block Grant
    b. Face Page—Substance Abuse Prevention and Treatment Block Grant
    c. Funding Agreements/Certifications—Mental Health Services Block Grant
    d. Funding Agreements/Certifications—Substance Abuse Prevention and Treatment Block Grant

8. Appendix

1. INTRODUCTION

a. Background

In 1981, President Reagan sought and received from Congress a new way of providing assistance to States[1] for an assortment of services including substance abuse and mental health. Termed Block Grants, these grants were originally designed to give States 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 given 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. Today, SAMHSA observes a more complex interplay between the Block Grants and other funding streams such as Medicaid, and an increasing knowledge in the behavioral health field about evidence-based practices, self-direction, and peer services require more consistency and direction to ensure that the Nation's behavioral health system is providing the best and most cost effective care possible, based on the best possible evidence, and tracking the quality and outcome of services so impacts can be reported and improvements 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 these funds in a generally unrestricted, flexible manner – without strong accountability measures. In the meantime, 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 behavioral health care is essential to the nation's health so it 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 OMB, as to the effectiveness and accountability achieved through the two Block Grants administered by SAMHSA.

The Substance Abuse Block Grant (SABG) and the Community Mental Health Block Grant (MHBG) differ on a number of their practices (e.g., data collection at individual or aggregate levels) and statutory authorities (e.g., method of calculating 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

[1] References to States in this document include the 50 States, 9 Territories and for the SABG, the Red Lake Band of the Chippewa.

dollars are spent and what is known about the services and clients that receive these funds varies by Block Grant and by State.

b. Current Environmental Factors

Health Reform

National economic conditions, a growing prevention science, and recent laws create a dynamic critical for SAMHSA to address. The Mental Health Parity and Addictions Equity Act (MHPAEA) significantly enhances access to behavioral health services for millions of Americans. The Affordable Care Act will also enhance access to the prevention, treatment and recovery support services for persons with or at risk of mental and substance use disorders. These laws will improve the nation's ability to close service gaps that have existed for decades for far too many individuals and their families.

In addition to these laws, recent and proposed changes in the Medicaid program will have a significant impact on how State Mental Health Authorities (SMHAs) and State Substance Abuse Authorities (SSAs) use their limited resources. In 2009, more than 39 percent of individuals with serious mental illnesses or serious emotional disturbances and 60 percent of individuals with substance use disorders were poor and uninsured. Their treatment and recovery support services were supported wholly or in part by SAMHSA Block Grant funds. A substantial proportion of this population (maybe as many as six million people) will gain health insurance coverage in 2014 and will have some but not all preventive, treatment and support services covered either through Medicaid, Medicare, or private insurance. However, these plans will not provide access to the full range of support services necessary to achieve and maintain recovery for most of these individuals and their families.

The two Block Grants have never been able to fund all the populations or all the services needed by persons not otherwise eligible for Medicaid or private insurance. Given that many individuals whose services are funded (in whole or in part) by Block Grants will likely be covered in the future by Medicaid or private insurance, SAMHSA envisions a new generation of Block Grants. States will use the Block Grant program for prevention, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance. SAMHSA Block Grant funds will 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. SAMHSA needs to begin planning now for the FY 2014 when more individuals who are uninsured will

have the option to become insured. This will require that SAMHSA use FY 2011, 2012 and 2013 to work with States to plan for and transition the Block Grants to these four purposes. This transition includes fully exercising SAMHSA's existing authority regarding States' use of Block Grant funds, and a shift in SAMHSA staff functions to support and provide technical assistance for States receiving Block Grant funds, as they move through these changes.

Coordination with Primary Care

Coordination between primary care and specialty care- including behavioral health- is a necessity. Nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved individuals with a mental disorder, substance abuse problem, or both, according to *News and Numbers*[2], Agency for Healthcare Research and Quality (AHRQ). These visits account for one in eight of the 95 million visits to emergency departments by adults that year. Of these, two-thirds involved those with a mental disorder, one quarter was for those with a substance abuse problem, and the rest involved those dealing with both a mental disorder and substance abuse. Almost a quarter of hospital admissions are associated with a mental or substance use disorder.

People with serious mental illness (SMI) have elevated rates of hypertension, diabetes, obesity and cardiovascular disease, leading to morbidity and mortality disparities where those with SMI die on average at 53 years of age. 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. Many of these health 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[3]. 70 percent of Maine's population living with serious mental illnesses has at least one of these chronic health conditions, 45 percent have two, and almost 30 percent have three or more.[4] 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.[5,6] The needs of children and youth with serious emotional disturbances (SED) are best addressed when coordinated within a coordinated System of Care that involves, but extends beyond the primary care setting. A similar

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[2] Owens P.L., Mutter R., Stocks C. *Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007*. HCUP Statistical Brief #92. July 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf

[3]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

[4] 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.

[5] 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 practices.* Pediatrics, 89, 480–485.

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

coordinated approach should be used to address the needs of youth with substance use problems.

According to SAMHSA's National Survey on Drug Use and Health (NSDUH)[7], about 9.3 percent of the general population (about 24 million Americans over the age of 12 or older) needed treatment for a substance abuse problem in 2009. Yet only about 11 percent of those identified had been treated in the specialty treatment system within the past year and over 40 percent of those not treated who try to get help say they cannot access treatment because of cost or insurance barriers. Those with substance use conditions are therefore more reliant on public funding sources for treatment. About 22 percent of general health care patients report having a co-morbid substance use disorder of some severity, which is likely related to the myriad physical consequences resulting from untreated substance misuse and dependency. Additionally, the presence of substance use and mental health conditions often complicate the treatment of a variety of common medical disorders.

Individuals with mental or substance use disorders have much higher rates of smoking relative to the general population. In particular, individuals with schizophrenia have one of the highest rates of smoking (58–88 percent).[8] Persons with mental illness or substance abuse disorder represent 25 percent of the population, but they account for 44 percent of the cigarettes consumed in the U.S. SAMHSA has developed several national initiatives regarding primary care and behavioral health coordination. Information regarding these initiatives can be found at: http://www.samhsa.gov/healthReform/healthHomes/index.aspx.

Consultation with Tribes

President Obama signed a Memorandum on Tribal Consultation in November 2009[9] that directed all agencies to submit plans on how they will engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications. The President reaffirmed the unique legal and political relationship with Tribes that has been established through and confirmed by the Constitution, treaties, statutes, executive orders and judicial decisions. States with Federally recognized tribal governments or tribal lands within their borders will be expected to show evidence of tribal consultation as part of their Block Grant planning processes. Tribal governments shall not be required to waive sovereign immunity as a condition of receiving Block Grant funds or services. SAMHSA will work with States to develop appropriate consultation policies.

Prevention

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[7] Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD.

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

[9] Federal Register: November 9, 2009 (Volume 74, Number 215

The 2009 Institute of Medicine (IOM) report entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*[10] articulates the current scientific understanding of the prevention of mental and substance use disorders. This report summarizes those programs and interventions with the strongest scientific evidence of effectiveness in preventing substance use and mental disorders and promoting positive emotional/behavioral health. These programs prevent alcohol and drug abuse, depression, conduct disorder, and other behavioral health problems and build resilience by addressing common risk and protective factors.

Implementing these evidenced-based practices will require cooperation across a number of community settings and service systems, including medical settings, homes, childcare, child welfare, schools, juvenile and criminal justice systems. In addition to program improvements, policy changes and environmental strategies such as social marketing are a key part of a comprehensive prevention strategy. Coordinated and targeted prevention programs in a range of settings together with research-supported environmental strategies can and will reduce the incidence of substance use and mental disorders.

In addition to a broad approach that addresses a range of behavioral issues and settings it is also important to target specific problems such as underage drinking. Underage drinking is a serious health and safety issue. Many adults, including some parents, mistakenly think that underage drinking is a part of growing up and a harmless rite of passage. Nearly 5,000 deaths are attributable to underage drinking each year, and many more young people fail to reach their full potential because of alcohol.

In addition to targeting specific problems such as underage drinking, States must also focus efforts on communities at highest risk. SAMHSA encourages States to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs. MH and SABG funds have the flexibility to support this targeted approach.

SAMHSA requires that States spend at least 20 percent of their SABG allotment on primary prevention programs for persons who do not require treatment. Some States spend more. In addition, 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. 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.

[10] 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

States should make prevention a top priority, taking advantage of recent science, best practices in community coordination, proven planning processes such as the Strategic Prevention Framework, and the science articulated by the IOM report on *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*. States will be allowed to use some of their current MHBG to support these activities. In the meantime, SAMHSA will work with States to increase their accountability systems for prevention and to develop necessary reporting capacities.

The President's budget for FY 2012 includes several new SAMHSA programs that may affect the MHBG and SABG. Specifically, the President proposes three new formula grant programs: 1) the Substance Abuse-State Prevention Grant (SA-SPG) focusing exclusively on the primary prevention of substance abuse, 2) the Mental Health-State Prevention Grant (MH-SPG) focusing on building positive emotional health and addressing risk and protective factors to help prevent mental, emotional, and behavioral disorders, including substance abuse, among youth, and 3) the Behavioral Health - Tribal Prevention Grant (BH-TPG) to prevent substance abuse and suicide in Tribal communities. In anticipation of this enhanced emphasis on prevention in States, Territories, Tribes and communities, SAMHSA requests that States 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. If the President's FY 2012 budget is adopted, applications for the new formula grants will be separate from the SAPT and MHS Block Grant process. SAMHSA will work with States to develop and/or amend their FY 2012 Block Grant State Plan(s) once a budget for FY 2012 is finalized. Additionally, SAMHSA will conduct formal tribal consultation on development of specifications for the BH-TPG prior to appropriation of the 2012 Budget.

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 services to advance and protect the Nation's health. These initiatives will focus SAMHSA's work on improving lives and capitalizing on emerging opportunities. 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 application(s) 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 will focus especially on the Nation's high risk youth, youth in Tribal communities, and 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 and 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, peer and prevention specialists, fully participates with the general healthcare delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).

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 State Mental Health Authorities (SMHAs) and Substance Abuse Authorities (SSAs) are prepared and ready to address the priorities described above. These environmental factors are key drivers that will enhance the SMHAs and SSAs ability to take advantage of many changes that will improve the health of individuals with mental and substance use disorders, improve how they experience care and reduce costs. While certain changes will not occur until 2014, State authorities should begin to consider the possible changes in what services they purchase, the system improvements necessary to operate in a new healthcare environment and how they will prepare their providers to offer effective care. Changes to the new application allow for this range of differences and the goals that each State has for health reform. SAMHSA believes the application will enhance the ability of States to use resources to assist them

in making the transitions that are unique to their own State decisions and strategies. The changes to the Block Grant application(s) incorporate several key assumptions:

- *States will play an important role in the design and implementation of the national health reform strategy*. At the national level, Federal agencies are developing opportunities for States to successfully implement health reform. However, these efforts rely heavily on States to take advantage of these new opportunities and to begin to develop the system improvements needed to achieve the promise of the Affordable Care Act. Federal funding has already been made available to States and communities to enhance the home and community based services, increase prevention activities, expand the use of primary care and to begin planning for many State health insurance exchanges that will be operational in FY 2014.

- *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 MH/SUD services will remain uncovered. In order to identify gaps in the continuum of services, State Mental Health and Substance Abuse Authorities will need to determine what specific MH/SUD services they should cover in addition or over and above to 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[11] when they consider service issues. In addition, States will need to become more diligent in their efforts to identify individuals in their systems that may currently qualify, but are not enrolled in the Children's Health Insurance Program Reauthorization Act (CHIPRA), Medicaid and Medicare programs.

  When developing strategies for purchasing services, SMHAs and SSAs must identify other State and Federal sources that can be used to purchase services. Funding available from the Center for Medicare and Medicaid Services (CMS), such as Medicaid, CHIPRA, 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 funding for behavioral health services. In addition, funding from the Health Resources Services and Administration (HRSA) must be considered as States develop these strategies. HRSA has significantly expanded access to health and behavioral health services offered through its Federally

[11] 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

Qualified Health Centers (FQHCs). 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 and additional potential partners at the State and community levels.

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. 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 to 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 substance use disorder services, individuals who experience trauma, increased numbers of individuals released from correctional facilities, and lesbian, gay, bi-sexual and transgendered and questioning (LGBTQ) individuals. In addition, the context of service delivery has significantly changed. SAMHSA's Childrens Mental Health Initiative, which serves children and youth with serious emotional disturbances and their families has shown that services and supports to this population should be delivered within a System of Care approach that is strengths-based, linguistically and culturally-competent, provided in the least restrictive, community-based settings and coordinates care across families, schools, and other community agencies. Systems of Care are family driven and youth guided. This means that the family is the primary driver of the single care plan, which should be coordinated across agencies such as the education system, child welfare and juvenile justice. Single care plans are largely influenced by the youth as well. Systems of care generally employ a Wraparound approach to service delivery. Family members and youth should be included in meaningful ways in all aspects of system development, implementation and evaluation. This Systems of Care approach should be used to meet the needs of children and youth with serious emotional disorders. Similar steps should be taken to ensure that the unique needs of children and youth with substance use problems are met, recognizing that this group's service needs are often distinct from adults with substance use problems.

  Services must be delivered in a manner that promotes recovery and resiliency. Individuals that have personal experiences from mental or substance abuse disorders are playing an increasingly important role in the delivery of recovery-

oriented systems of care. Services must also take into account ethnic-specific/culture-specific services for racial and ethnic minorities. Services must address the unique needs of tribal populations and the unique role of tribal governments in planning and delivering services. In addition, advances in technology have changed significantly since 1991. 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. ICTS are also being used by individuals to report health information and outcomes. 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 seeks 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 collect information on provider characteristics, client enrollment, demographics, and characteristics. Current laws will require these systems to comply with national standards (national provider numbers, ICD-10, CPT/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 to continue to collaborate and discuss mutual issues concerning system interoperability, electronic health records, Federal information technology requirements and other related issues.

- *States may form strategic partnerships in order for individuals to have access to a good and modern services system.* SAMHSA is seeking to enhance SMHAs and SSAs ability to be full partners in developing and implementing MHPAEA, health reform strategies in their State. In many respects, successful implementation will be dependent on leadership and collaboration among multiple stakeholders. The relationships among the State Mental Health and Substance Abuse Authorities and the State Medicaid Director, the State Insurance Commissioner, State prevention agencies, the State child serving agency, the public health authorities and the health information technology authorities are of paramount importance 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 success, collaboration must foster a long-range view, open communication, encourage knowledge-sharing and consider all stakeholder concerns and priorities. SMHAs and SSAs should consider developing strategic partnerships with TRICARE, primary care, public health, criminal and juvenile justice, education, child welfare, Veterans Affairs, National Guard Bureaus,

insurers and employers. State authorities should also have meaningful and timely tribal consultation 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. 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 redesign their systems to be more accountable for improving the experience of care and for the health of the population.* SAMHSA is committed to engaging in a meaningful, structured process, in consultation with States, other stakeholders and policymakers, including HHS and OMB, to develop accountability measures for the Block Grants. Through the Block Grant application and planning process and in conversation with States, providers, service recipients, 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 the science evolves. As the quality and outcome measures for the Block Grants develop through SAMHSA's Strategic Initiative on Data, Outcomes, and Quality, the described approach to accountability will allow those measures to drive the application(s), review, approval, and monitoring processes.

SAMHSA wants to ensure the health and viability of State mental health and substance abuse systems which will require that SAMHSA and the States have strong quality improvement plans. A critical component of these plans will be the development and use of the quality and outcome measures. SAMHSA will work with States to identify those quality and outcome measures that can be used to develop a "dashboard" of key indicators that will measure a State's progress in key programmatic and operational areas. This dashboard will be able to determine if differences are being made to the State mental health and substance abuse system. SAMHSA is considering developing an incentive program for States that may include financial and administrative incentives based on their performance on this dashboard.

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 in the community for everyone in America. This life in the community includes:

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 overall mission and values, specifically:

- To promote participation by people with mental and substance use disorders in shared decision making person-centered planning, and self direction of their services and supports.

- To ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LGBTQ individuals.

- To promote recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.

- To increase accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.

- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.

- To conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.

- To provide HIV prevention as an early intervention services at the sites at which individuals receive substance use disorder treatment services.

- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.

- To increase accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.

- To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.

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 minority 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 TIMEFRAMES

As referenced in the *Introduction*, changes to the SAPT and CMHS Block Grant applications are, in part, being driven by MHPAEA and other legislation. SAMHSA wants to ensure that SMHAs/SSAs are well into strategic planning and implementation phases before 2014 approaches. In addition there are a number of standardizations between applications that are also necessary. While the statutory deadlines 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 State's fiscal year calendars, which are from July 1 through June 30th the following year. In addition, both the MHBG and the SABG application will be due on the same date. Previously, the MHBG and the SABG applications were due on different months. The dates for providing reports and assurances and the reporting periods for both Block Grants were also different. SAMHSA has also changed the report date and report periods to be consistent across both Block Grants.

The FFY 2012 MHBG and SABG Block Grant application(s) should be submitted to SAMHSA on 9/1/2011 and will consist of an application and plan for a twenty-one month period (10/1/11-6/30/13) to align with most States' fiscal year budget cycle[12]. The subsequent Block Grant application(s) should be submitted to SAMHSA on 4/1/13 for a two year period (July1, 2013 through June 30, 2015). There are no changes to the Block Grant award periods.

SAMHSA cannot waive the statutory deadlines for submission of applications. However, SAMHSA is proposing a phased submission process that will allow States to submit the parts of the plan that are completed on or before the deadline. For those States that do not have their whole plan complete, the State in their submission should identify those sections of the plan that require additional time. For those sections of the plan that will require more time, the State should provide a description of the work that will be done before the final submission, the timeframe for completing this work and submission date for the final plan. States that will be submitting additional information after the statutory deadline should work closely with their state project officer regarding the due dates for the final plan.

States should submit their Block Grant application(s) for 2012 and 2103 based on the guidance provided in this document. The Behavioral Health Systems Assessment and Plan provides a consistent framework for State Mental Health and Substance Abuse Authorities to assess the strengths and needs of their systems and to plan for system improvement. This framework 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 Planning Section in the FY 2012-2013 Block

[12] Reporting timeframes for SYNAR will remain on the current schedule.

Table 1

Application(s) for FFY	Plan and Assurances Due	Planning Period	Reports Due	Reporting Period
2012	9/1/2011	10/1/11 – 6/30/13	12/1/11	
2013	*	*	12/1/12	7/1/11 – 6/30/12
2014	4/1/13	7/1/13 – 6/30/15	12/1/13	7/1/12 – 6/30/13
2015	*	*	12/1/14	7/1/13 – 6/30/14
2016	4/1/15	7/1/15 – 6/30/17	12/1/15	7/1/14 - 6/30/15
2017	*	*	12/1/16	7/1/15 – 6/30/16

Grant Application is comprised of a needs assessment and 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 2012-2013 Block Grant Application has sections that are required and other sections where additional information is requested but not required. Section 3.b 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 3c, Tables 6 and 7 are required.
Sections 3.c-n 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 3.p is required for both the SABG and MHBG. Section 3.o 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 change SAMHSA's approval of their Plan or payment, 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 the U.S. Department of Health and Human Services, acting through the Administrator of SAMHSA, to make an award under the programs involved, States must submit an application(s) prepared in accordance with the authorizing legislation, and implementation regulations. The funds awarded will be available for obligation and expenditure[13] to plan, carry out, and evaluate activities and services

[13] Title XIX, Part B of the Public Health Service Act

designed to prevent serious emotional disturbances (SED) among children and serious mental illness (SMI) among adults and their consequences; to prevent substance abuse; to treat children with SED, adults with SMI, and individuals (youth and adults) with a substance use disorder (SUD); adolescents and adults with co-occurring disorders and to promote recovery among persons with SED, SMI, or SUD.

A grant may be awarded only if an application(s) submitted by a State includes a State Plan[14] [15] in such form and containing such 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 Public Health Service (PHS) Act or section 1921 of Title XIX, Part B, Subpart II of the PHS Act that is applicable to a State. This State Plan should include a description of the manner in which the State intends to obligate the grant. The State Plan must include a report[16] in such form and containing such information as the Secretary determines to be necessary for securing a record and a description of the purposes for which the grant was expended. The State Plan should also describe the activities and services purchased by the States under the program involved and a description of the recipients and amounts provided in the grant. 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 (i.e. mental health or substance abuse prevention and treatment).

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[14] Section 1912 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.C. § 300x-2)
[15] Section 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-32(b))
[16] Section 1942(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a))

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 environment and priorities described in this document and with the environment and 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 Public Health Services Act for the MHBG must be included in the application that addresses MHBG funds. States are encouraged, as State laws and regulations allow, to expand this Planning Council to include prevention and substance abuse stakeholders and utilize this mechanism to advise on the formation of the SABG application as well. Absent that approach, the State must describe the stakeholder input process for the SABG application and any additional input processes utilized for the MHBG process in furtherance of the statutory requirement to make the State plan available to the public in such a manner as to facilitate comment from any person. This description should show involvement of persons who are service recipients and/or in recovery, families of individuals with substance use and mental disorders (including parents and caregivers of children or youth with behavioral health problems), providers of services and supports, representatives from racial and ethnic minorities, LGBTQ populations, persons with co-existing disabilities and other key stakeholders. Evidence of meaningful consultation with Federally recognized Tribes where tribal governments or lands are located within the boundaries of the State must be provided in the application(s) for both Block Grants.

The assessment and planning activities are different from previous years. Under the previous SABG application, States were requested to address the seventeen national goals. Some of the goals were population specific, others were service specific. The MHBG application required States to address a set of criteria for children with serious emotional disturbances and adults with serious mental illness. While both Block Grants required States to do an assessment and plan, it did not always allow the State or SAMHSA to obtain an overall picture of the State's behavioral health needs and to incorporate consistent priorities and planning activities especially for individuals with a co-occurring mental and substance use disorder. SAMHSA has designed the current assessment and planning activities to be consistent with the criteria established in authorizing legislation and regulation as well as with the national goals and priorities described in this document. SAMHSA has identified other populations and activities beyond those that are statutorily required, that States may want to consider in their needs assessment and State Plan activities. SAMHSA continues to encourage States to identify other populations beyond those required in the statute and identified in the list of populations and strategies in the following section. In addition, SAMHSA is encouraging States to use data in their planning effort that will address services and prevention activities that address the cultural and linguistic needs of the individuals in their State.

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 consideration specific populations that are the current focus of the Block Grants, the changing health care environment and SAMHSA's strategic initiatives. 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 serious emotional disturbances (SED) and their families*
- Adults with serious mental illness (SMI)*

Services for persons with or at risk of having substance use and/or mental health disorders:

- Persons who are intravenous drug users (IDU)*
- Adolescents with substance abuse and/or a 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 *
- Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse*

Targeted 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 low-incomes who currently are uninsured but will be covered by Medicaid or private insurance in FY 2014 and 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[17].

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 State substance abuse and mental health authorities. SAMHSA is encouraging SMHAs and SSAs to develop and submit a combined plan to address the common areas below:

- Bi-directional integration of behavioral health and primary care services;
- Provision of recovery support services for individuals with mental or substance use disorders.

In addition, SAMHSA is also requesting a combined plan for any expenditure of funds for the provision of services for individuals with co-occurring mental and substance use disorders. For States that have separate mental health and substance abuse agencies, the combined plan for these activities should be included in both the State MHBG and SABG applications. These combined plans should be included in a State's application (for those states submitting one Block Grant application). For States that submit separate Block Grant applications, the combined plan for these activities should be included in both the State MHBG and SABG applications.

In addition, states should also consider linking their Olmstead planning work in the Block Grant application, identifying individuals who are needlessly institutionalized or at risk of institutionalization.

SAMHSA is encouraging states to undertake each of the following planning steps in a timely manner. The FY 2011 Block Grant application and Addendum indicated that some States have already undertaken a needs assessment of the populations identified in the FY 2012/2103 Block Grant application. Other States are designing needs assessment

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

processes that will be completed after the 9/1/2011 submission date. In the Block Grant application, States should either provide information on the unmet need or the critical gaps within the service system or provide the timeframe within FY 2012 that the assessment and analysis will be completed.

b. Planning Steps

For each of the populations and common areas, States should follow the following planning steps:

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, intermediate 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, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

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, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, 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.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Step 3: Prioritize State planning activities
Using the information in Step 2, States should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the ***target populations*** (as appropriate for each Block Grant) that are the Federal goals and aims of the Block Grant programs (those that are required in legislation and regulation) and should include ***other priority populations*** as identified by the State and as described in this document. Please list the priorities for the plan in the chart below.

Table 2 Plan Year_____

	State Priorities
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	Add more priority areas as needed

Step 4: Develop objectives, strategies and performance indicators.

For each of the priorities identified in Step Three, identify the relevant goals, strategies and performance indicators over the next two years. For each priority area, States should identify at least one goal. Each stated objective must be measurable.

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, 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[18]. 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 cite 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 serious emotional disturbances or substance use disorders should utilize a System of Care approach (Described below) that has been well-established for children with serious emotional disorders 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-supported treatments and supports through a family-driven, youth-guided, culturally competent, individualized treatment plan. For adolescents with substance use disorders, this approach should be used in conjunction with evidence-based interventions for substance abuse or dependence.

  A System of Care is a coordinated network of community-based services and supports that is organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations so services and supports are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. A System of Care helps children, youth, and families function better at home, in school, in the community, and throughout life.

  Children and youth with serious mental health conditions and their families need supports and services from many different child- and family-serving agencies and organizations. Often, these agencies and organizations are serving the same children, youth, and families. By creating partnerships among these groups, Systems of Care are able to coordinate services and supports that meet the ever-changing needs of each child, youth, and family. Coordinated services and

[18] http://www.samhsa.gov/Healthreform/docs/AddictionMHSystemBrief.pdf

supports lead to improved outcomes for children, youth, and families, and help prevent the duplication of services for authorized care among government agencies.

SAMHSA expects that these grants will help facilitate wide scale adoption of the System of Care framework and to create comprehensive and sustainable plans for infrastructure, services, and supports that are consistent with the values and principles of a System of Care approach that are articulated in Section 561 of the Public Health Service Act, as amended. SAMHSA also expects that grantees demonstrate how parents, caregivers and youth will be integrally involved in decision making related to the planning, monitoring and delivering of services for themselves as well as the development of policy and procedures governing care for all children and youth.

- Strategies targeted for adults with mental or substance use disorders 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 Interactive Communications Technologies (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 (e.g. web or texting) as a mode of communication.[19]
- Strategies that result in developing recovery support services, including permanent housing and supportive employment or education for persons with mental and substance use disorders. This includes how local authorities will be engaged to increase the availability of housing, employment and educational opportunities, and how the State will develop services that will wrap around these individuals to obtain and maintain safe and affordable housing, employment and/or education.
- Strategies that will enable the State to document the diversity of their service population and providers and specify the development of an array of culturally-specific and age-appropriate 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 recent IOM (2009) report on "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement"[20] in developing this strategy.

[19] Center of Budget and Policy Priorities

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

- 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 the use of 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 or exacerbate trauma.
- Strategies that increase the use of person-centered planning and 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 Institute of Medicine (IOM) report entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*[21] articulates the current scientific understanding of the prevention of mental and substance use disorders. This report describes a set of interventions that have shown effectiveness in preventing substance abuse and mental illness and promoting positive emotional health. These programs prevent substance abuse, depression, conduct disorder, and other behavioral health problems and promote 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:

- 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 specifically target the prevention of substance abuse and its consequences should be community based, developed using the strategic planning framework, and data driven.
- 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 National Registry of Evidence-based

[21] 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

Programs and Practices (NREPP) or other materials documenting their effectiveness.

- Strategies that engage schools, workplaces, and communities to establish programs and policies to improve knowledge about alcohol and other drug problem, effective ways to address them and enhance resilience.
- Strategies that address underage drinking which are 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, faith-based institutions, consistent with the current science.
- Strategies that address harder-to-reach racial/ethnic minority and LGBTQ communities who experience a cluster of risk factors that makes them especially vulnerable to substance use and related problems.

States should identify strategies for the MHBG that reflect the priorities identified from the needs assessment process. Goals that are focused on emotional health and the prevention of mental illnesses should be consistent with the IOM Report on Preventing Mental, Emotional, and Behavioral Disorders 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, or other trauma, including youth from racial/ethnic minority and LGBTQ communities.
- Strategies to support the use of a System of Care approach to meet the needs of children and youth with serious emotional disturbances.

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 and retention, adoption or adaptation of electronic health records (EHRs) or develop strategies to develop or increase workforce especially as many more individuals will be covered in FY 2014. These system improvement activities should make use of Federal and State resources that are available now and proposed for the planning period to expand

and enhance the competency of the behavioral health workforce. System improvements that seek to expand the workforce should also build upon current 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 accountable care organizations). This support may include assistance to develop the necessary infrastructure (e.g., electronic billing and health records) and reporting requirements to effectively participate in these networks.
- Support the use of peer specialists or recovery coaches to provide needed recovery support services. Some of these services are delivered by volunteers and paid staff. In all cases, peers are trained, supervised, regarded as staff and are operating out of a community-based or recovery community 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 support the use of volunteer-delivered or –run services should also be supported.
- Increase linkages between primary care and behavioral health providers, including supporting primary care provider efforts to screen patients for mental and substance use disorders, working with behavioral health provider organizations for expertise, collaboration and referral arrangements. Activities should also include developing model contract templates for bi-directional primary care and behavioral health integration and identifying State policies that present barriers to reimbursement.
- Develop support systems to provide communities with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other supports to foster the development of comprehensive community plans to improve mental, emotional and behavioral health outcomes in communities.
- 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 accessing these services.
- Develop benefit management strategies for high cost services (e.g. youth out of home services, adult residential services). SAMHSA believes that States should enhance their efforts to align how they manage care to ensure 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.
- Develop linkages and coordination to enable a Systems of Care approach to services and supports for children and youth with serious emotional disturbances.

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 describe the data and data source the State will use to develop the baseline for FY 2012 and how the State proposes to measure the change in FY 2013. Use the template below.

Table 3 Plan Year_____

Priority Area#
Goal:
Strategy (use as many lines needed for each strategy)
Performance Indicator:
Description of Collecting and Measuring Changes in Performance Indicator

States should be accountable for meeting the goals and performance indicators established in their plan. SAMHSA staff will work closely with States during the year to discuss progress, identify barriers and develop solutions to address these barriers.

However, if a State fails to demonstrate that it has taken reasonable steps to achieve its goals as stipulated in its application(s) and approved by SAMHSA, the State will provide a description of corrective actions to be taken. If further steps are not taken, SAMHSA may direct the State authority responsible for the program to change the State plan to ensure goals are met. States that do not choose to apply for the MHBG or SABG will have their funds redirected to other States as provided in statute.

c. Use Of Block Grant Dollars For Block Grant Activities

SAMHSA requests that SMHAs and SSAs consider using Block Grant funds and develop reimbursement strategies that are used in other areas of healthcare. Reimbursement strategies may include risk-based payments, payments for episodes of care, and payment for outcomes. SAMHSA understands that services for most individuals are not purchased with SABG or MHBG but through a variety of funding sources (e.g. Medicaid, Medicare, private insurance, other Federal funds, State, local and private sources). However, SAMHSA encourages States to use MHBG and SABG funds to support their or other agencies' efforts to develop reimbursement strategies that support innovation. This innovation could include using Block Grant funds to complement various demonstration projects including Money Follows the Person, Health Homes for Individuals with Chronic Conditions, Community First Choice Option and prevention initiatives funded through the Prevention and Public Health Trust Fund.

In the chart below, please describe your State's SMHA and/or SSAs overall reimbursement approach for services purchased with MHBG and SABG funds. SAMHSA understands that States may take different approaches based on strategies identified in the plan. States should identify the reimbursement methodology proposed for each service, prevention and emotional health development strategy, and system improvement. States should use the following reimbursement methodology categories for MHBG and SABG funds:

- *Encounter-based reimbursement*—includes fee-for-service and other strategies that pay individuals or organizations a specific amount for a unit of service.

States that have a specific reimbursement methodology or fee schedule for services purchased with Block Grant funds should provide that information as part of their application(s).

- *Grant/Contract reimbursement*—includes annual or periodic payments to individuals or organizations that provide services or system improvements.
- *Risk-based reimbursement*—includes but is not limited to capitated (per member per month) or case rate payment (monthly or other timeframe).
- *Innovative financing strategies*—This includes, but is not limited to pay-for-outcomes or payment for an episode of care.
- *Other reimbursement strategies*—States using other reimbursement strategies for services and activities should describe the methodology and the services and activities that are purchased using this methodology.

Table 4 Plan Year_____

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	
Grant/contract reimbursement	
Risk based reimbursement	
Innovative Financing Strategy	
Other reimbursement strategy (please describe)	

States and the service providers funded utilizing Block Grant funds should be able to account for unique individuals served and track the services provided to each individual. Please complete the following charts.

States should project how Block Grant funds will be used to provide services for the target populations or areas identified in their plans for States that have a combined MHBG and SABG application. Please complete Table 5, *Projected Expenditures for Treatment and Recovery Supports*, which requests that States project their expenditures under the MHBG and the SABG for treatment and support services. If the State purchases services or activities that are not included in the *Projected Expenditures for Treatment and Recovery Supports*, include this in the last row of the chart in the "Other" category. Please use a separate row for each services or activity funded with SABG or MHBG funds. Please complete a separate table for the MHBG and SABG. Also complete a separate table for FY 2012 and 2013.

Please complete the following tables for FY 2012 and FY 2013 regarding projected expenditures:

Table 6, the *Primary Prevention Checklist* for projecting expenditures for substance abuse prevention activities.

Table 7 requests information regarding projected total expenditure for 2012 under the SABG. Table 8 requests information regarding the SABG Projected Resource Development Expenditures.

Table 5 Plan Year_____

Projected Expenditures for Treatment and Recovery Supports

Category	Service/Activity Example	Estimated Percent of Funds Distributed				
		< 10%	10-25%	26-50%	51-75%	Over 75%
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services					
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach					
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers					

Category	Service/Activity Example	Estimated Percent of Funds Distributed				
		< 10%	10-25%	26-50%	51-75%	Over 75%
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**					

Category	Service/Activity Example	Estimated Percent of Funds Distributed				
		< 10%	10-25%	26-50%	51-75%	Over 75%
Other Supports (Habilitative)	• **Personal care** • **Homemaker** • **Respite** • **Supported Education** • **Transportation** • **Assisted living services** • **Recreational services** • **Interactive Communication Technology Devices** • **Trained behavioral health interpreters**					
Intensive Support Services	• **Substance abuse intensive outpatient services** • **Partial hospitalization** • **Assertive community treatment** • **Intensive home based treatment** • **Multi-systemic therapy** • **Intensive case management**					
Out-of-Home Residential Services	• **Crisis residential/stabilization** • **Clinically Managed 24-Hour Care** • **Clinically Managed Medium Intensity Care** • **Adult Mental Health Residential** • **Adult Substance Abuse Residential** • **Children's Mental Health Residential Services** • **Youth Substance Abuse Residential Services** • **Therapeutic Foster Care**					
Acute Intensive Services	• **Mobile crisis services** • **Medically Monitored Intensive Inpatient** • **Peer based crisis services** • **Urgent care services** • **23 hour crisis stabilization services**					

Category	Service/Activity Example	Estimated Percent of Funds Distributed				
		< 10%	10-25%	26-50%	51-75%	Over 75%
	• **24/7 crisis hotline 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**					
System improvement activities						
Other						

Table 6 Plan Year_____

Primary Prevention Planned Expenditures Checklist

Strategy	IOM Target	SABG MHBG Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$
	Unspecified	$	$	$	$	$
Education	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$
	Unspecified	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$
	Unspecified	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$
	Unspecified	$	$	$	$	$
Community-Based Process	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$
	Unspecified	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$

	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicated	$	$	$	$	$
	Unspecified	$	$	$	$	$
Other	Universal	$	$	$	$	$
	Selective	$	$	$	$	$
	Indicted	$	$	$	$	$
	Unspecified	$	$	$	$	$

*Please list all sources, if possible (e.g., Centers for Disease Control and Prevention Block Grant, foundations).

Table 7

Plan Year:
State Identifier:

Projected State Agency Expenditure Report						
	Source of Funds					
ACTIVITY (See instructions for using Row 1.)	A. Block Grant	B. Medicaid (Federal, State, and local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State funds	E. Local funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention** and Treatment						
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						

Table 8

Plan Year:
State Identifier:

Resource Development Planned Expenditures Checklist						
Activity		**B. Prevention-SA**	**C. Treatment-MH**	**D. Treatment-SA**	**E. Combined**	**F. 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						

d. Activities that Support Individuals in Directing the Services

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their families/support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their family / supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. Families, other caregivers, and youth should be full partners in all aspects of the planning and delivery of their own services, including policies and procedures that govern care for children and youth.

In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s). States can describe how they define self-directed care in accordance with their own policies and structures.
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

e. Data and Information Technology

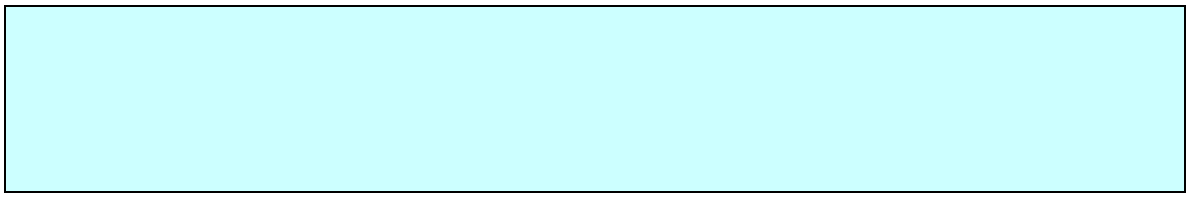
Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should be able to provide the service utilization (as reported inTable 5 in the Reporting Section of the Application). States should provide information on the number of unduplicated individuals provided each service purchased with Block Grant Funds. In addition, States should provide expenditures for each service identified in Table 5. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
    - Provider characteristics
    - Client enrollment, demographics, and characteristics
    - Admission, assessment, and discharge
    - Services provided, including type, amount, and individual service provider
    - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
    - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
    - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
    - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
    - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
    - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
    - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
    - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?

- Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
- Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
- Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please:

- Provide information regarding your State's current efforts to assist providers with developing and using Electronic Health Records;
- Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs your State may have regarding data and information technology specifically in Section 3.k.



f. Quality Improvement Reporting

SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their 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 critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

g. Consultation with Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to 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 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 with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description 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, please provide a description of these activities 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.

h. Service Management Strategies

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe: 1) the processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services; 2) the strategies that your State will deploy to address these utilization issues; 3) the intended results of your State's utilization management strategies; 4) the resources needed to implement utilization management strategies; and 5) the proposed timeframes for implementing these strategies.

i. State Dashboards

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X percent. The state could use this indicator for their dashboard. SAMHSA expects that States will provide a minimum of 2 State specific performance indicators for their Dashboard for both the SABG and MHBG.

In addition, SAMHSA will identify several national indicators to supplement the state-specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

In the space below please identify the state-specific performance measures.

Table 10 Plan Year_____

Priority Area	Performance Indicator

In the following section describe the rationale why these state-specific measures were selected.

j. Suicide Prevention

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

k. Technical Assistance Needs

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. Please also take into account cultural and linguistic needs. 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.

l. Involvement of Individuals and Families

The State must 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-oriented services. There are many activities that State 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:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists, recovery community centers, consumer drop-in centers and recovery housing)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment and recovery planning, shared decision making, and the behavioral health service delivery system and direct their ongoing care and support?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

m. Use of Technology

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care and recovery support services. ICTS are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific application of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support system does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan 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?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

n. 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, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide either a letter of support or memoranda of understanding indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(is); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters of support or memoranda of understanding should provide

specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan[22]. 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 Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into 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.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local 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 child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.
- The State Bureau of Primary Care that works directly with a variety of primary care and other health organizations including FQHCs, school based health centers, community health centers and rural health programs.

o. State Behavioral Health Advisory Council

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring,

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

reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State. For States that choose not to have a behavioral health advisory council please respond to the following questions:

- What planning mechanism does your State use to plan and implement substance abuse services?
- How do these efforts coordinate with the State mental health agency and its advisory body for substance abuse prevention and treatment services?

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

p. Comment on the State Plan

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

LIST OF ADVISORY COUNCIL MEMBERS

Table 11 Plan Year_____

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 Serving Agency		

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

BEHAVIORAL HEALTH ADVISORY COUNCIL COMPOSITION BY TYPE OF MEMBER

Table 12 Plan Year_____

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP		
Individuals in Recovery (from mental illness and addictions)		
Family Members of Individuals in Recovery		
Parents or Caregivers of Children or Youth with Behavioral Health Problems		
Vacancies (individual & family members)		
Others (Not State employees or providers)		
TOTAL Individuals in Recovery, Family Members & Others		
State Employees		
Providers		
Leading State Experts		
Federally Recognized Tribe Representatives		
Vacancies		
TOTAL State Employees & Providers		