

Iowa

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT
AND PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 09/01/2015 3:40:49 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 137348624

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Iowa Department of Human Services

Organizational Unit Division of Mental Health and Disability Services

Mailing Address 1305 E. Walnut

City Des Moines, IA

Zip Code 50319

II. Contact Person for the Grantee of the Block Grant

First Name Charles

Last Name Palmer

Agency Name Iowa Department of Human Services

Mailing Address 1305 E. Walnut

City Des Moines

Zip Code 50319

Telephone 515-281-5452

Fax

Email Address cpalmer1@dhs.state.ia.us

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/1/2015 3:39:50 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Laura

Last Name Larkin

Telephone 5152425880

Fax

Email Address llarkin@dhs.state.ia.us

Footnotes:



State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Charles M. Palmer

Signature of CEO or Designee¹: _____

Title: Director, Iowa Department of Human Services

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.



TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

May 17, 2011

Barbara Orlando
Grants Management Officer, Division of Grants Management
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

This letter designates Charles M. Palmer, Director of the Iowa Department of Human Services, to function as my designee for the following programs for as long as I remain Governor of the State of Iowa and Mr. Palmer remains Director of the Iowa Department of Human Services.

1. Charles M. Palmer is authorized to function as my designee for all activities related to the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Block Grant.
2. Charles M. Palmer is authorized to function as my designee for all activities related to the SAMHSA Projects for Assistance in Transition from Homelessness (PATH).

Please contact my office if you have any questions.

Sincerely,

Terry E. Branstad
Governor of Iowa

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Charles M. Palmer

Signature of CEO or Designee¹:

C. M. Palmer

Title: Director, Iowa Department of Human Services

Date Signed: 09-01-2015

09-01-2015

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

May 17, 2011

Barbara Orlando
Grants Management Officer, Division of Grants Management
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

This letter designates Charles M. Palmer, Director of the Iowa Department of Human Services, to function as my designee for the following programs for as long as I remain Governor of the State of Iowa and Mr. Palmer remains Director of the Iowa Department of Human Services.

1. Charles M. Palmer is authorized to function as my designee for all activities related to the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Block Grant.
2. Charles M. Palmer is authorized to function as my designee for all activities related to the SAMHSA Projects for Assistance in Transition from Homelessness (PATH).

Please contact my office if you have any questions.

Sincerely,

Terry E. Branstad
Governor of Iowa

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Charles M. Palmer

Signature of CEO or Designee¹:

C. M. Palmer

Title: Director, Iowa Department of Human Services

Date Signed: _____

09 - 01 - 2015

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

Step 1-Address the strengths and needs of the service system to address the specific populations

Overview of the State Mental Health System

Mental Health and Disability Service System Redesign and Legislative Updates

Iowa is in the midst of major changes to the publicly funded health system. These include the ongoing redesign of the mental health and disability services system and a move to managed care for Iowa's Medicaid system. During the last two years, Iowa has completed the move from county-based to regional mental health and disability service delivery. Iowans are now served by 15 regional entities in place of 99 separate county systems. The Mental Health and Disability Services (MHDS) redesign promotes statewide standards, regional management, and local access. The target population for the regional service system remains adults with a diagnosis of a mental illness or an intellectual disability whose incomes are at or below 150% of poverty level and who do not have other insurance coverage for mental health and disability services or who require services not covered by Medicaid or private insurance.

The Iowa Health and Wellness Plan (IHAWP), which is Iowa's Medicaid expansion program, began January 1, 2014 and has provided coverage for a significant number of individuals whose services were previously funded by the county/regional system.

Iowa has realigned institutional resources by closing two state mental health institutes located in Clarinda and Mt. Pleasant, effective July 1, 2015. Reasons for this realignment include difficulty recruiting clinical staff, low utilization of the adult psychiatric programs offered at the two facilities, and outdated facilities. Iowa is moving toward less reliance on facility-based care and more focus on community-based services and supports. The redesign referenced above has focused on development of local resources such as crisis intervention and stabilization services that will reduce the need for facility-based care.

Iowa has implemented an Inpatient Psychiatric Bed Tracking system effective August 1, 2015. This system was implemented due to concern expressed by stakeholders and advocates regarding difficulty in locating inpatient psychiatric beds, leading to persons having to travel long distances to receive inpatient care. The bed tracking system allows access to an online, searchable database of available psychiatric beds by authorized users, which includes hospitals, law enforcement, regional administrators, and judicial representatives.

Effective January 1, 2016, Iowa will move to managed care for most Medicaid physical and behavioral health services. The managed care program is referred to as IA Health Link. Eligible persons will choose between four managed care plans selected in August 2015 through a request for proposal process. Medicaid services currently available will continue under IA Health Link. Iowa has had a managed care program for behavioral health since 1994, but has not previously had management of physical and behavioral health by the same managed care organization. Stakeholders, advocates, and consumers are being engaged in the transition process and receive regular information updates on the move to managed care. Further information on IA Health Link can be found at this site:

<http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>

Legislative actions related to mental health include further legislation on subacute services. Senate File 401 allows subacute beds to be used for involuntary mental health commitments if the individual does not require acute care. The Department of Human Services (DHS) is required to develop an administrative rule process to determine where the seventy-five geographically dispersed subacute beds allowed by legislation will be located. This process is in the development phase at the time of this report.

Legislation was also passed regarding Mental Health Advocates. These advocates work with people subject to involuntary commitment for mental health treatment. This law makes advocates employees of the counties and gives DHS authority to develop rules on qualifications, reporting requirements, data and quality assurance, and job descriptions. DHS will be working with stakeholders including current advocates, county personnel, and judicial staff to develop administrative rules.

Olmstead Plan update

In 2010, the Iowa Department of Human Services, Division of MHDS worked with stakeholders to develop the framework for a five year Olmstead Plan to transform Iowa's mental health and disability service system. The plan established guiding principles and the vision of a "life in the community for everyone." The Department is currently reviewing the progress made toward the goals of that plan during the last five years and developing an updated plan to guide system improvement for the next five years.

Iowa has an active Olmstead Consumer Task Force. The Task Force has formed an ad hoc committee to provide input to the Department during the plan development process. The Department will also consult with the Mental Health and Disability Services Commission, the Mental Health Planning and Advisory Council, and the Iowa Developmental Disabilities Council, as well as other stakeholders, including individuals with mental illness or other disabilities and their families, advocates, service providers, and representatives of state agencies and county governments.

The 2016-2020 plan is intended to be flexible in responding to new challenges and opportunities, and build on recent systems and policy changes to promote community capacity, choice, and self-determination. The plan will focus on actions that are designed to achieve measurable progress toward target outcomes in nine domains: access to services, life in the community (integration), employment, housing, transportation, person-centeredness, health and wellness, quality of life and safety, and family and natural supports. The new plan is scheduled to be completed by January 2016.

The State Mental Health Authority

The Iowa Department of Human Services (DHS), Division of MHDS is the designated State Mental Health Authority (SMHA) for Iowa. Rick Shults is the Administrator for the Division of Mental Health and Disability Services.

MHDS includes:

- The two State Resource Centers for individuals with developmental and intellectual disabilities.
 - Woodward State Resource Center
 - Glenwood State Resource Center
- The two state Mental Health Institutes which provide inpatient mental health services to adults and children.
 - Cherokee Mental Health Institute
 - Independence Mental Health Institute
- The Civil Commitment Unit for Sexual Offenders (violent sexual predators)
- Eldora State Training School-for juvenile males adjudicated delinquent
- The Office of Facility Support
- The Bureau of Targeted Case Management
- The Bureau of Community Services and Planning (provides oversight of the MHBG)

The Current Iowa Mental Health System

The Iowa system of community based services for adults and children with mental illness is managed and funded in various ways depending on an individual's income, insurance coverage, and service needs. Services specifically for children will be identified throughout this section.

Currently, adults and children who are eligible for Medicaid receive mental health service funding and management through the Iowa Plan for Behavioral Health Services. Individuals eligible for the Iowa Health and Wellness Plan are covered through private insurance or the Wellness plan, administered by Medicaid. The Iowa Plan is the state's current managed care program for mental health and substance abuse services funded by Medicaid under the authority of the Department of Human Services, and for substance abuse services funded by the Substance Abuse Prevention and Treatment Block Grant and associated State appropriations under the authority of the Iowa Department of Public Health SSA. The current contractor for the Iowa Plan is Magellan Health Services. Magellan's contract ends December 31, 2015. Effective January 1, 2016, behavioral health services will be managed by the four managed care organizations that were selected in August 2015.

Mental health services through the Iowa Plan include a broad range of inpatient and outpatient mental health services and supports. Medicaid -eligible adults needing residential and/or vocational services are funded through 100% county funding, dependent on which specific services a county or region elects to fund. Some of those costs may be offset by the individual's ability to access Habilitation Services through Medicaid. Habilitation services are available to Medicaid-eligible individuals who meet the criteria for chronic mental illness and have income at or below 150% of poverty level.

Adults without Medicaid or other insurance coverage, or who need services not otherwise covered by Medicaid or other insurance may access mental health services through the regional system if eligible by residence and financial eligibility.

County /Regional Services and Funding

County governments historically managed many of the adult mental health and disability services available in the state. Iowa has transitioned from a county based system to a regional

system with expectations for provision of standardized core services, eligibility based on residency, and increased usage of functional assessments to determine need for services.

Iowa MHDS regions, through state payment program funds from the State and property tax dollars raised by the counties, fund outpatient mental health services, mental health hospitalizations (and those services associated with involuntary hospitalizations), community support services, facility based residential services, and work and/or day activity services, when no other funding is available through Medicaid or private insurance. Counties are not required to fund services for children but some fund outpatient mental health services and sometimes coordinate the involuntary commitment process for juveniles.

Previously each county was required to employ a Central Point of Coordination (CPC) Administrator who managed the funding and eligibility processes for individuals, primarily adults, seeking publicly-funded mental health and disability services. Under the regional MHDS system, regions provide services under a regional administrative entity with local access points available to individuals within the region. One county received a waiver to form a region of one county, one region of 2 counties received provisional status to develop as a region of less than 3 counties, while the remaining 13 regions are comprised of groups of 3 to 22 counties. With regionalization, counties are able to pool local tax dollars to implement new services such as crisis stabilization and response services and share administrative responsibilities.

Integrated Health Homes for Individuals with an SMI or SED

As of July 1, 2013, Iowa implemented integrated health homes (IHH) for Medicaid-eligible adults with a serious mental illness and children with a serious emotional disturbance. The health home program was created through Section 2703 of the Patient Protection and Affordable Care Act. Magellan Health Services, the contractor for the Iowa Plan, manages integrated health home development and implementation in close collaboration with Iowa Medicaid Enterprise and the SMHA. IHH services will continue under IA Health Link.

This program's goal is to provide care coordination and integrated services to populations at high risk of poor health outcomes. Development of health homes is part of Iowa's overall goal to increase availability of supports for individuals with serious mental health conditions that allow them to remain in their homes and communities and have improved health and wellness outcomes. Integrated health homes are available to residents statewide. In SFY 15, 12,868 adults with an SMI and 10,916 children with an SED were enrolled in IHH programs. There are 39 IHH programs across the state. 23 of the 39 IHH are CMHCs. 15 of the IHH are also licensed providers of substance use disorder services. 10 serve only adults, 13 serve only children, and 16 serve both children and adults. The role of Integrated Health Homes in delivery of services to individuals with an SMI or SED will be further explained in the sections on Children's Mental Health Services, Habilitation, and Case Management. An overview of the program can be found at this link: <http://www.magellanoofowa.com/for-providers-ia/integrated-health-home.aspx>

The Iowa Health and Wellness Plan

Beginning January 1, 2014, Iowa began to offer the Iowa Health and Wellness Plan for individuals, ages 19-64, with income at or below 133% of the Federal Poverty Level without

regard to categorical eligibility. The program served 133,056 Iowans as of June 30, 2015. The goals of the plan are focused on improvements in health and outcomes, incentives for healthy behavior, an emphasis on care coordination, and local access to care. The plan has two types of coverage, dependent on income. For individuals at 100% of FPL or below, the Wellness Plan, a Medicaid-administered plan offers coverage equal to that provided to state employees. Incentives for using preventative services are built into the program.

For individuals with incomes of 101-133% of FPL, the state has offered premium assistance for individuals to purchase a commercial health plan on the Health Insurance Marketplace. The Marketplace Choice plan offers coverage at least equivalent to that offered to state employees.

Individuals eligible for IHAWP coverage but deemed “medically exempt”, which includes individuals with chronic mental illness, chronic substance use disorders, and other serious medical conditions may choose between IHAWP or state plan Medicaid. Access to state plan Medicaid allows the individual to receive HCBS services and other community-based supports not available under the IHAWP plans.

For 2016, individuals on the Marketplace Choice plan will be moved to the Wellness plan due to no qualified health plans available to contract with Medicaid. IHAWP enrollees will transition to IA Health Link managed care on January 1, 2016.

STRENGTHS AND NEEDS OF IOWA’S MENTAL HEALTH SYSTEM

The strengths and needs of the mental health system will be described under the four primary headings of prevention, early intervention, treatment service, and recovery supports. Some organizations or services may be included in more than one category.

1. BEHAVIORAL HEALTH PREVENTION

Education for the general public and providers

Iowa offers a wide variety of training opportunities related to mental health. The focus on professional growth and development is a strength of the Iowa mental health and disability system. Individuals with lived experience and their families are integral participants of many of the training opportunities offered, either as attendees, planners, or presenters.

The Iowa Mental Health Conference is held annually in October. This conference is planned by consumer groups including NAMI and Iowa Advocates for Mental Health Recovery; state agencies including Iowa Department of Human Services-MHDS, Iowa Department of Public Health-SSA, and Iowa Department of Education; and private providers and individuals. This is an opportunity for professionals and experts to share the most recent trends and issues, treatment programs and research relating to mental health and mental illness. This conference traditionally brings mental health professionals, substance use disorder professionals and stakeholders, consumers, families, program funders, policy makers, and community partners together to learn and work toward establishing and improving the mental health system of Iowa. MHBG funds are used to support consumer stipends which promote conference participation by individuals served by the mental health system. In October 2014, 38 consumers of mental health services attended the conference with support from the Mental Health Block Grant. A similar amount is

expected to attend the 2015 conference. Presentations at the 2015 conference include several presentations on emerging crisis programs in Iowa, as well as national experts on crisis services.

The Iowa Empowerment Conference began in 1999 to provide an opportunity for mental health consumers to join with each other and share ideas, talents, and experiences. The goal of the annual conference is to provide individuals, families, and youth dealing with mental health issues to learn coping skills and to strive for recovery through education. This consumer-led conference includes state and nationally recognized keynote speakers, peer support, social functions and more. The most recent conference was held in August 2015. Many of the workshops each year are presented by consumers. MHBG funds are used to promote mental health consumer participation in the conference through providing stipends for consumers with insufficient financial means to attend.

Trauma-Informed Care Training-Orchard Place Child Guidance Center, a MHBG contractor in the Des Moines area, has organized multi-day trainings to improve understanding and knowledge of trauma-informed care, provides targeted trainings and technical assistance to providers and community stakeholders, and facilitates a local stakeholders group to promote trauma-informed awareness and practices.

NAMI Signature Programs – These programs are free and available to the public.

NAMI Basics is a class for parents and other family caregivers of children and adolescents who have either been diagnosed with a mental health condition or who are experiencing symptoms but have not yet been diagnosed.

NAMI Family-to-Family is a class for families, partners and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills and empower participants to become advocates for their family members. This program was designated as an evidence-based program by SAMHSA.

NAMI Peer-to-Peer is a recovery education course open to anyone experiencing a mental health challenge. The course is designed to encourage growth, healing and recovery among participants.

NAMI Provider Education is a class for line staff at facilities providing mental health treatment services. The NAMI Provider Education class is designed to expand the participants' compassion for the individuals and their families and to promote a collaborative model of care.

NAMI Homefront is a class for families, partners and friends of military service members and veterans experiencing a mental health challenge. The course is designed specifically to help these families understand those challenges and improve the ability of participants to support their service member or veteran. -

NAMI Ending the Silence is an in-school presentation designed to teach middle and high school students about the signs and symptoms of mental illness, how to recognize

the early warning signs and the importance of acknowledging those warning signs.

NAMI In Our Own Voice is a presentation for the general public to promote awareness of mental illness and the possibility of recovery.

NAMI Parents & Teachers as Allies is a presentation for teachers and other school personnel to raise their awareness about mental illness and help them recognize the early warning signs and the importance of early intervention.

NAMI Connection is a weekly or monthly support group for people living with a mental health condition. Find the NAMI Connection support group nearest to you.

NAMI Family Support Group is a weekly or monthly support group for family members, partners and friends of individuals living with a mental illness.

NAMI Smarts for Advocacy is a hands on advocacy training program that helps people living with mental illness, friends and family to transform their passion and lived experience into skillful grassroots advocacy.

NAMI Say It Out Loud is a program to raise mental health awareness with youth. It provides videos and a facilitator guide to help community facilitators (faith, civic, others) start a discussion about the basics of mental illness.

NAMI on Campus is a peer led campus organization. NAMI on Campus clubs provide students with what they have repeatedly said they want: peer-run mental health organizations on campus. These student-led clubs help:

- Support fellow students
- Raise mental health awareness
- Educate the campus community
- Promote and advocate for services and supports

NAMI on Campus clubs address mental health issues so that all students have a positive, successful and fun college experience.

Prior to 2015, a number of these programs were funded by a community re-investment grant through Magellan Behavioral Health. Future programming is subject to funding.

Each NAMI affiliate may offer all or part of the Signature Programs listed above and may have additional classes advertised on their website. Classes can be through webinars, on-line trainings, and in-person training, for example:

- 30 Pearls of Wisdom in Treating a Person with Mental Illness (an hour in-service)
- Hearing Voices That Are Distressing (a training and simulation experience)
- Wellness Recovery Action Planning (WRAP)
- NAMI Hearts and Minds (on-line) – wellness education
- Mental Health First Aid
- Crisis Intervention Team training (NAMI is part of a community effort to present this training)
- Online support group for parents and caregivers of children with mental illness
- Support group for teens and college students

Mental Health First Aid

Mental Health First Aid (MHFA) is an eight hour certification course available to the general public. Mental Health First Aid is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. The main goals are:

- Preserve life when a person may be a danger to self or others
- Provide help to prevent the problem from becoming more serious
- Promote and enhance recovery
- Provide comfort and support

Iowa has also added capacity to provide the 8-hour Youth MHFA training. In October 2014, the SMHA sponsored a train the instructor training using MHBG funds to increase community capacity of Youth MHFA instructors. The state, through the Iowa Department of Education and local education agencies, also received several federal Project AWARE grants which have added significant capacity for Youth MHFA instruction across the state.

In Iowa there are 70 Mental Health First Aid instructors certified to train the adult MHFA course and 116 instructors certified to train the Youth MHFA course. The instructors are located across the state in a variety of settings which include state staff from the Department of Human Services, Division of Mental Health and Disability Services, Department of Public Health, Division of Behavioral Health Services, Department of Education, Iowa Law Enforcement Academy and the Iowa National Guard.

Currently there are four community mental health centers using Mental Health Block Grant funds to support their provision of Mental Health First Aid training.

Project AWARE Iowa

The Iowa Department of Education was awarded the Now Is the Time State Education Agency (SEA) Project AWARE Iowa Grant in October 2014, as well as the SEA School Climate Transformation Grant from the US Department of Education. The two grants are designed to be complimentary, increasing awareness of mental health issues impacting children and youth and building a multi-tiered system of behavioral health support to identify and respond to a youth who may be experiencing a mental health crisis. Both grants are partnering with three local education agencies (LEAs) in Iowa, Davenport CSD; Sioux City CSD; and Waterloo CSD. DHS is an important partner on both of the state grants.

Through the SEA Project AWARE Iowa grant, 45 adults have been certified as Youth MHFA Instructors and 493 school and community adults have been trained as “First Aiders.” The Department of Education will be hosting another Youth MHFA Instructor training in April 2016.

In September and November 2015, a behavioral health data base will be piloted at the three LEA grant partner schools. The behavioral health database will exist alongside the LEAs existing student information system and allow for a complete picture of a youth’s lived experience to be viewed in one place. This comprehensive database will make possible an early warning system for a student, as well as making possible effective progress monitoring and support for transitions.

In addition to the SEA Project AWARE and SEA School Climate Transformation grant, Iowa was also awarded 4 additional LEA Project AWARE grants and 6 LEA School Climate Transformation grants.

Disaster Behavioral Health Response Training and Team Deployment

The State Mental Health Authority is responsible for administering the disaster behavioral health plan for Iowa. The State Mental Health Authority Administrator assigns a position to serve as the liaison between the federal government disaster programs and the state of Iowa. In addition to this function, the position provides oversight and management of the Iowa Disaster Behavioral Health Response Team.

In Iowa, the team responds when local resources have been depleted or are insufficient to respond to the mental health needs of Iowans during all phases of disaster including preparedness through long term recovery. The team is also trained to assist with crisis and critical incident efforts. The team is comprised of trained volunteers who can be deployed within the United States through the Emergency Management Assistance Compact.

Disaster Behavioral Health Response Team members are trained in a wide range of response skills including but not limited to: Psychological First Aid, Critical Incident Stress Management, Mental Health First Aid and Basic Disaster Training.

2. EARLY INTERVENTION

Early ACCESS

Early ACCESS is a partnership between families with young children, birth to age three, and the Departments of Education (lead agency), Public Health, Human Services, and the University of Iowa Child Health Specialty Clinics. The purpose of Iowa's Early ACCESS system is to enhance the development of infants and toddlers with or at-risk for developmental delays, and increase the capacity of families to meet their child's needs. Early ACCESS focuses on helping the caregivers of eligible infants and toddlers learn how to support their child learn the basic and brand new skills that typically develop during the first three years of life.

Services: The family and providers work together to identify and address specific family concerns and priorities as they relate to the child's overall growth and development. In addition, broader family needs and concerns can be addressed by locating other supportive resources and services in the local community for the family and/or child. All services are provided in the child's natural environment including the home and other community settings where children of the same age without disabilities participate. Early ACCESS services are voluntary.

Specific services are recommended based on each child's development. Services listed here are provided through the Area Education Agency:

- Service Coordination
- Screenings, evaluation and assessments
- Assistive Technology
- Audiology
- Family Training/Counseling

- Health Services
- Medical evaluations to determine eligibility
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Psychology
- Social Work
- Special Instruction
- Speech Language Therapy
- Vision
- Transportation

Age Requirements and Eligibility:

An infant or toddler under the age of three (birth to age three) who:

- Has a known condition or disability that has a high probability of later delays if early intervention services are not provided, OR
- Has a 25% or more delay in one or more areas of the following developmental areas: cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development.

Costs: There is no cost to families for service coordination activities, evaluation and developmental assessment, identifying the priorities, concerns and resources of the family, and development and reviews of the Individualized Family Service Plan. Most Early ACCESS services and therapy are provided at no cost to the family. In some situations, a service may be recommended that may have a fee. In those situations, the service coordinator works with the family to determine costs and payment arrangements of any other needed service. Costs are determined by a variety of factors that are individualized to each child and family.

Adverse Childhood Experiences (ACEs)

The Central Iowa Adverse Childhood Experience (ACEs) 360 Steering Committee makes online training available regarding the impact of adverse childhood experiences and trauma on children’s current and future development, behaviors, and long-term health outcomes. Also available through the website is Iowa-specific data regarding ACEs, information on statewide activities related to awareness of the effects of ACEs on children and adults. The website is: <http://www.iowaaces360.org/>

1st Five Healthy Mental Development

Iowa’s 1st Five Initiative builds partnerships between physician practices and public service providers to enhance high quality well-child care. 1st Five promotes the use of standardized developmental tools that support healthy mental development for young children in the first five years. The tools include questions on social/emotional development and family risk factors, such as depression and stress. When a medical provider discovers a concern, the provider makes a referral to a 1st Five coordinator. Shortly after receiving the referral, the coordinator then contacts the family to discuss available resources that will meet the family’s needs. For every one medical

referral to 1st Five, there are an additional 2-3 referrals identified when the care coordinator contacts the family. Often these intervention services are related to the behavioral health needs of the child and/or family. In this respect, 1st Five supports a community-based systems approach to building a bridge between primary care and mental health professionals. From 2007-2014, there were 11 Coordinating sites in 49 Iowa counties, serving 7,588 families referred by health providers into 1st Five.

Parent Child Interaction Therapy (PCIT)

Iowa is continuing the focus on increasing provider's abilities to provide evidence based practices with young children. Provider trainings on the EBP of Parent-Child Interaction Therapy (PCIT) have occurred across the state. This is an evidenced based practice for parents of children ages 2 to 7, consisting of 40 hours of intensive training followed by 16 hours of advanced training in the small group setting. MHBG funding has helped support provider training and implementation of this practice and will continue to be used to assist mental health providers increase their knowledge and skills in delivering this EBP.

Iowa Association for Infant and Early Childhood Mental Health

In 2013, a group of public and private stakeholders formed the Iowa Association for Infant and Early Childhood Mental Health. This association is a collaboration among many public and private partners, including Early Childhood Iowa, Iowa Department of Public Health, and the Iowa Chapter of the American Academy of Pediatrics. A focus of this organization is to develop professional competency standards for providers of early childhood services and supports. The organization has developed a strategic plan that includes implementation of the Michigan Infant Mental Health Competencies and other workforce development strategies. A kickoff event to introduce the Michigan competencies to Iowa stakeholders was held in March 2015. The organization also offers webinars to the public on topics such as young children and autism, and provides resources to providers and the public on infant and early childhood mental health. Organization leaders have participated in the Children's Disability Services workgroups as part of the larger system redesign and will continue to advocate for inclusion of promotion and prevention activities focused on young children and their families as part of the statewide mental health and disability services system.

Suicide Prevention Efforts

In 2013, 445 Iowans lost their lives to suicide; 26 of those deaths were teens. Suicide was the second leading cause of death for Iowans ages 15 to 24 and ages 25 to 44 in 2012, the third leading cause of death for ages 5 to 14, and the fifth leading cause of death for ages 45 to 54.

The Iowa Department of Public Health (IDPH) is the lead agency for suicide prevention efforts in Iowa. IDPH received a Garrett Lee Smith State Youth Suicide Prevention (GLS) Grant from SAMHSA in 2007 for the project period of 2007-2011.

IDPH received its second GLS grant in 2013. Iowa's project is entitled the Youth and Young Adult Suicide Prevention Program (Y-YASP), with \$1.3 million total for the three-year project period (2013-2016.) Through the grant, IDPH is implementing strategies to reduce suicides, suicidal behavior, and suicide risk among Iowa's youth and young adults aged 10 to 24 years.

Specific Y-YASP project goals:

Ensure suicide prevention best practices are integrated into Iowa's youth- and young adult-serving programs;

- Screen all youth and young adults seeking substance use disorder treatment for suicide risk;
- Implement an evidence-based gatekeeper program for middle and high school educators in all Iowa's middle/junior high and high schools;
- Provide trauma-informed care and other evidence-based practice trainings for providers who work with those at risk of suicide and with co-occurring substance use and mental health disorders; and
- Promote suicide prevention resources through a social media campaign that targets youth and young adults.

Other project activities:

- IDPH coordinates Y-YASP activities with IDPH's Your Life Iowa program. Your Life Iowa was established by a 2012 State appropriation as a resource for Iowans seeking help and information about bullying and youth suicide prevention. Your Life Iowa services are provided via website (<http://www.yourlifeiowa.org>), a toll free telephone hotline, and texting. Your Life Iowa is funded at \$50,000 each year. Promotional materials have been widely distributed and communicated.
- IDPH coordinates Y-YASP activities with implementation of its 2012 SBIRT award. SBIRT-Iowa uses the Patient Health Questionnaire-9 and other nationally accepted screening tools to screen for substance use and mental health issues, including suicide. Screenings are conducted at seven project sites, involving SAPT Block Grant-funded substance use disorder treatment providers, Federally Qualified Health Centers, and the Iowa National Guard.
- Iowa's Department of Education received two grants in October 2014 that are expected to support suicide prevention efforts. The grants are Now is the Time (NITT)-Project AWARE, from SAMHSA, and the School Climate Transformation (SCT) grant, from the U.S. Department of Education. Iowa's grants are complementary, with aligned goals.
- IDPH was awarded Partnerships for Success grant in October 2014 to address underage alcohol use, including binge drinking. In implementing the grant, IDPH is developing collaboration between substance use and suicide prevention efforts at both the state and community levels through public presentations, cross-training, and expanding access to national resources.
- The Y-YASP project supports local suicide prevention coalitions through meetings, by providing resources, and by fostering connections across coalitions and groups with related interests.
- The Y-YASP Iowa Suicide Prevention Planning Group meets quarterly and provides recommendations to improve suicide prevention efforts across Iowa and across the lifespan.
- IDPH has provided training on the Patient Healthcare Questionnaire-9 (PHQ-9); a screening tool for depression. The PHQ-9 is implemented in 19 IDPH substance abuse treatment provider agencies statewide. Through May 31, 2015, more than 900 youth ages 10-24 years

old have provided consent and been screened; with almost 350 of these referred for additional mental health services as a result.

Iowa Suicide Prevention Planning Group and Plan

The Iowa Suicide Prevention Planning Group was convened in August 2014 and is comprised of about 25 members representing diverse suicide prevention organizations and experiences. The SMHA is represented on the planning group by the MHBG State Planner. The Planning Group has met monthly since, focusing primarily on drafting the Iowa Suicide Prevention Plan 2015-2017, which is expected to be released by October 2015. The Plan is based on Iowa's previous plan and the 2012 National Strategy for Suicide Prevention. Drug use is one risk factor for suicide; the Plan recognizes this connection and provides guidance to improve overall prevention services that span suicide, bullying, and substance abuse. The Plan does not specifically address IV drug users, pregnant and parenting women, or people living with HIV outside of their inclusion in Iowa's general population and therefore inclusion in the Plan.

“Your Life Iowa”

- Your Life Iowa has three components: 1) 24/7 telephone hotline; 2) texting services from 2 p.m. to 10 p.m. seven nights a week; and 3) the Your Life Iowa website: <http://www.yourlifeiowa.org/>.
- The hotline and website became operational on November 26, 2012. The texting service went live on December 17, 2012.
- Your Life Iowa offers a range of services including:
 - 24/7/365 crisis call intervention and support;
 - Screening for immediate safety needs; connecting with first-responders;
 - Identification of and referrals to local resources;
 - Development of strategies with youth/parents/educators;
 - Collaborative problem solving;
 - Empowerment of youth and families; and
 - Helping youth and families make informed decisions.
- The first half of 2015 had 158 engaged calls, 364 engaged chats, more than 4,200 site visits, and 71 engaged text conversations. (“Engaged” means these were legitimate contacts and not hang-ups or solicitations.)
- Nearly 2/3 of people utilizing Your Life Iowa resources were female during the first quarter of 2015.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR):

In 2011, Iowa implemented a multitude of positive changes resulting in a fully federally compliant Preadmission Screening and Resident Review (PASRR) process in Iowa. PASRR in Iowa made these broad and sweeping changes to the process as a result of a commitment by the Iowa Medicaid Enterprise (Medicaid Authority, known as IME) and the SMHA to move forward together in the implementation of the dramatically improved process. Preadmission Screening is required for all applicants to any Medicaid-certified nursing facility in the state, which includes all but four of over 450 such facilities in Iowa. An RFP was released in 2011 and an award for a PASRR contract was made to Ascend Management Innovations of Nashville, TN. A full-time program manager for PASRR has been designated within MHDS to represent the SMHA in PASRR and to manage the contract with Ascend. She collaborates actively with a

nursing facility and long term care expert in IME has also been designated to lead Iowa's new PASRR process. The new procedures for the Level II part of PASRR screening went into effect Sept. 1, 2011. Many training opportunities were undertaken in person, by webinar, and by phone, with hospitals and nursing facility staff, during 2011, and were well attended by the provider community. In January of 2012, the next phase of implementation began, when Ascend launched "WebSTARS," a web-based data entry and application system which can accept and process Level I referrals for PASRR on a 24/7/365 basis. This quick, efficient, and effective system has been well embraced by the provider community. LI PASRR screens that determine whether a person may need additional screening for the possibility of a mental illness, intellectual disability, or related condition, are completed within one business day. The vast majority of LI screens offer a nearly instantaneous outcome to the submitter within moments. LII evaluations, which require face to face contact with the individual by an Iowa based independent contractor/assessor and a detailed review of records as well as interviews with caregivers and family members are completed within five business days.

Iowa's PASRR process helps assure that individuals with an identified mental health, intellectual disability, or related conditions are not placed in nursing facilities unless such placement is necessary and appropriate. LII evaluations determine whether the person does indeed have a PASRR related disability and if so, what services and supports they may need to be successfully placed in a nursing facility for the best possible outcomes related to their disability, and it looks at what services and supports they may need in order to return home or to another lower level of care in the community. In 2014, Iowa PASRR began rendering short term approvals for individuals who appear to need a brief rehabilitative stay and should be able to successfully return to a lower level of care within six months or less. Also in 2014, Iowa PASRR began an intensive new training and technical assistance effort which includes detailed reviews of nursing facility care plans to determine whether they are implementing all of the services identified by PASRR.

3. TREATMENT SERVICES

The Iowa Plan for Behavioral Health Care

The Iowa Plan for Behavioral Health is the State's managed care plan for mental health and substance use services funded by Medicaid, under the authority of the Department of Human Services Iowa Medicaid Enterprise (DHS/IME), and substance use treatment funded by the SAPT block grant and State appropriations, under the authority of the IDPH Division of Behavioral Health/SSA. The Iowa Plan contractor is Magellan Health Services (Magellan). The state's contract with Magellan ends on December 31, 2015.

In SFY15, 684,339 Iowans were eligible for mental health and substance abuse services through The Iowa Plan. In SFY 15, Magellan provided mental health services to 42,868 children ages 0-17, and 60,771 adult clients 18 or older. Magellan maintains a network of appropriately credentialed mental health service/substance abuse providers to assure availability of the following services to meet the behavioral needs of eligible enrollees. Covered services are those included in the Iowa Medicaid Program and are reimbursed for all non-Iowa Plan beneficiaries through the Iowa Medicaid Enterprise (IME). The Contractor maintains a network of appropriately credentialed mental health service providers to assure availability of the following

services to meet the mental health needs of eligible enrollees. In SFY15, 684,339 Iowans were eligible for mental health and substance abuse services through The Iowa Plan. In SFY 15, Magellan provided mental health services to 42,868 children ages 0-17, and 60,771 adult clients 18 or older.

The *Iowa Plan* continues to be jointly administered by the Department of Human Services and the Department of Public Health to best coordinate services and funding so Iowans with mental health and/or substance abuse concerns can live, recreate, and work in the communities of their choice with minimum disruption. The *Iowa Plan* promotes and implements an integrated managed care program for both mental health and substance abuse services through a single contractor.

The *Iowa Plan* contractor, Magellan Health Services is at full risk for all Medicaid-funded services and provides specified administrative support for the IDPH-funded substance abuse treatment service system. The contractor is required to:

- Implement a quality assurance process to monitor consistency of access and quality of care
- Focus on best practices within and across the systems
- Support local planning and decision-making through existing de-categorization boards, county and regional administrative entities, and provider consortiums
- Allow flexible and cost-effective use of resources by blending various funding streams
- Individualize services by requiring the consideration of environmental factors in the authorization of services and supports
- Promote an on-going dialogue between the state agencies, consumers, and providers through roundtables for a variety of constituencies
- Eliminate duplication and gaps through a coordinated, consumer-centered treatment planning and administration of services
- Improve consistency through centralized utilization management, quality assurance, provider profiling, statistical reporting, and analysis

The *Iowa Plan* covers both categorically and medically needy individuals eligible through the Iowa Medicaid program. Enrollment in the *Iowa Plan* is mandatory and automatic for all Medicaid beneficiaries. The state Medicaid agency oversees this contract.

Mental health and substance abuse services available through the *Iowa Plan* to Medicaid-eligible Iowans-children and adult unless designated otherwise

Services are provided by appropriately credentialed mental health service providers to assure availability of the following services to address the mental health and substance abuse needs of both adults and children:

Medicaid Mental Health and Substance Abuse Services

- 24-hour crisis and emergency services (for a serious illness or problem).
- 24-hour mental health and substance abuse services in a hospital.
- Residential (live-in) substance abuse services by a licensed (approved) program.*

- Psychiatric Medical Institutes for Children (PMIC)*
- Outpatient services (not in a hospital or facility). These include some mental health services provided by non-psychiatric doctors.
- Intensive outpatient services. (There are more hours of service provided than regular outpatient care.)
- Consumer-run services, warm line and peer support (clients run these).*
- Mental health services through a community mental health center.
- Substance abuse services provided by a licensed substance abuse program.
- In-home mental health services.
- Targeted case management (setting up special care plans). This is for individuals with a chronic mental illness.
- Integrated (combined) mental health services and supports.*
- Assessment and evaluation. (This means finding out exactly what a client needs.)
- Behavioral Health Intervention Services (BHIS).*
- Habilitation services. *
- Assertive Community Treatment*

Some of the services above have an asterisk (). These are not covered services under the Iowa Wellness Plan through the Iowa Plan for Behavioral Health.

Additional Required Services in the Iowa Plan

Although not covered in the fee-for-service Iowa Medicaid Program, the following services are required of the *Iowa Plan* Contractor as appropriate ways to address the mental health needs of enrollees. The Contractor must expand availability of all required services assuring system capacity to meet the needs of *Iowa Plan* enrollees. These additional required services are:

- Services for those diagnosed with both chronic substance abuse and chronic mental illness (services for the dually diagnosed)
- Level I Sub-acute Facilities delivering 24-hour stabilization services;
- 23-hour observation in a 24-hour treatment facility;
- Case consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated mental health services and supports;
- Intensive psychiatric rehabilitation services;
- Peer support services for persons with chronic mental illness;
- Community support services; Community support services include:
 - monitoring of mental health symptoms and functioning/reality orientation
 - transportation
 - supportive relationship
 - communication with other providers
 - ensuring Enrollee attends appointments and obtains medications
 - crisis intervention and developing of a crisis plan

- coordination and development of natural support systems for mental health support;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family;
- Family therapy to family members of a child in order to address the mental health needs of that child;
- Specified services to adults admitted to a state mental health institute
- Court-ordered mental health services if clinically appropriate or up to 5 days for a mental health assessment
- Services to address the mental health needs of children in the adoption subsidy program

Iowa Department of Public Health Substance Use Treatment

The IDPH Single State Authority (SSA) leads, funds, monitors, supports and regulates statewide substance use treatment through the programs and efforts described below. Overall, the SSA is responsible for comprehensive statewide planning, coordination, delivery, monitoring and evaluation of substance use treatment services including: 24-hour information and referral at 1-866-242-4111; collaboration at local, state and national levels on treatment initiatives and policy; program licensure; counselor and practitioner training and workforce development; data management and reporting; evidence-based curricula and models; and public and professional information and education through the Iowa Substance Abuse Information Center at www.drugfreeinfo.org.

Iowa Plan for Behavioral Health - IDPH/SSA Substance Use Services

Substance use disorder treatment is provided to residents of all 99 Iowa counties by treatment programs licensed and funded by the SSA.

For IDPH/SSA-funded services, Magellan provides certain administrative services and contracts with providers for at-risk, provider-managed services, with providers required to serve a minimum number of IDPH/SSA-funded clients. Authorization is not required at any level of service for the IDPH population. Magellan analyzes data and conducts retrospective review of provider services and records to assure clinical and contractual compliance.

For Iowa Plan Medicaid Enrollees, authorization by Magellan is required for ASAM Level IV Inpatient and Level III Residential and for PMIC (Psychiatric Medical Institutions for Children) services. Authorization may also be required by Magellan for the other services or levels of care for quality improvement or contract compliance purposes, as approved by DHS/IME and IDPH/SSA.

Iowa Plan substance use covered services are as follows:

- IDPH/SSA-Funded Substance Abuse Services
 - Assessment (except related to drinking and driving)
 - Outpatient Treatment, including continuing care
 - Intensive Outpatient
 - Residential Treatment
 - Halfway House services
- Medicaid-Funded Substance Abuse Services:

- Ambulance Services for substance abuse conditions
- Ambulatory Detoxification
- Emergency services for substance abuse conditions available 24 hours a day, seven days a week
- Evaluation, treatment planning, and service coordination
- Inpatient Hospitalization
- Intake, Assessment and Diagnosis services
- Intensive Outpatient
- Outpatient Treatment
- Partial Hospitalization
- PMIC substance abuse services for individuals up to age 21
- Residential Treatment, including Halfway House services

IDPH/SSA-funded providers form a limited provider panel, selected through a competitive request for proposals process that assures access through outpatient geographic services areas and statewide residential services. Providers must be not-for-profit, licensed substance abuse treatment programs. Magellan generally maintains an open provider panel for Medicaid mental health and substance abuse services.

A limited number of Iowa hospitals have inpatient substance abuse treatment units and/or outpatient treatment programs. The majority of these hospitals participate in the Iowa Plan, providing Medicaid-funded services. Hospitals may provide inpatient medical detoxification services. Any licensed prescriber can provide outpatient/ambulatory detox.

IDPH/SSA-funded substance abuse treatment services follow SABG requirements:

- Meeting required set asides
- Services for women and pregnant women
 - time frames for individuals requesting and in need of treatment
 - interim services if program at capacity
 - Services to injecting drug users, including: time frames for individuals requesting and in need of treatment and interim services if program at capacity
- Use of outreach services
- Tuberculosis services
- HIV services

Key Elements of IDPH-Funded System of Care

Core Set of Services: IDPH-funded substance use disorder treatment encompasses a core set of services statewide including:

- 24-hour helpline and treatment locator at 1-866-242-4111 or www.drugfreeinfo.org
- Assessment, evaluation and referral
- Outpatient and Intensive Outpatient treatment
- Two levels of short-term subacute residential treatment, plus halfway house services

Provider Network: IDPH has 23 funded, experienced, not-for-profit, licensed programs in 20 geographic service areas that together form a safety-net provider network serving residents of all 99 Iowa counties. All 23 programs provide assessment and outpatient treatment services. Eleven of the 23 programs also provide statewide residential treatment for adults or juveniles and 11 programs provide IDPH-funded women and children services. 18 contractors provide IDPH-funded substance use prevention services statewide, with a focus on young people.

Client Eligibility and Performance Measures: Un- and under-insured Iowa residents up to 200% of the Federal Poverty Level are eligible for IDPH-funded treatment with client co-pays determined by a sliding scale fee scale that considers family income and size. Provider contracts have been tied to performance measures intended to 1) decrease wait times for services, 2) expand client engagement in services over time, 3) expand provider eligibility for insurance reimbursement, 4) support workforce development, and 5) increase provider capacity to serve clients with complex co-occurring mental and physical health problems.

Co-Occurring System Initiatives and Services

For the past several years, the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) have led state efforts to understand and develop services for Iowans with co-occurring mental health and substance abuse problems. These efforts have involved consumers, clients, family members, providers, consultants, Departments staff, and other stakeholders in forums, planning groups, and trainings. As a result, Iowa has a strong base of educated and committed individuals who are contributing in ways specific to their individual advocacy organization, or agency mission, to a statewide comprehensive system of care that supports people working toward personal recovery. Information on available resources and known activities and events statewide are posted on DHS and IDPH websites including: DHS and IDPH activities, meetings, resources and training opportunities.

IDPH has implemented a transition to a comprehensive and integrated resiliency- and recovery-oriented system of care (ROSC) for addictive disorders, built on coordination and collaboration across problem gambling and substance abuse prevention, treatment, and recovery support services. IDPH-funded treatment provider contracts include financial incentives for documented co-occurring capability.

DHS and IDPH continue to develop services for co-occurring disorders with the goal of assuring a strong base of educated and committed individuals who contribute in ways specific to their individual, advocacy organization, or agency mission to a statewide comprehensive system of care that supports people working toward personal recovery.

The State has contracted with ZIA Partners (Dr. Ken Minkoff and Dr. Chris Kline) to provide training for mental health, substance abuse, disability service and brain injury service providers as well as community stakeholders and administrative level personnel to understand, develop and integrate multi-occurring capabilities throughout the general systems of service in Iowa. ZIA Partners also provided technical assistance in addressing some of the barriers for individuals with multi-occurring service needs to receive effective treatment. This contract ended in 2015. The SMHA is currently developing a request for proposals for technical assistance to continue building provider capacity to serve individuals with complex needs, including co-occurring mental health and substance use disorders.

Mental Health providers have worked to certify some of their therapists in both substance abuse and mental health issues. Training has been conducted in recovery principles related to other complex needs including individuals who have co-occurring mental illness, substance abuse, intellectual or developmental disability, brain injury or other health conditions.

Services for individuals with co-occurring issues

IDPH administers Access to Recovery (ATR), a three year grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment. ATR is a presidential initiative which provides vouchers to clients for purchase of ATR covered services including mental health services. The goals of the program are to support client choice and increase the array of faith-based and community based providers. ATR - Iowa focuses on serving individuals in recovery from substance abuse.

There are 425 adult residential treatment beds identified as dual substance abuse treatment beds. and two PMIC's licensed to provide substance abuse treatment and mental health services to individuals up to age 21. Both are in western Iowa, with a combined capacity of 56 beds. Other providers of mental health services are increasing their co-occurring capability through training in motivational interviewing, the co-occurring capability training referenced above, and cross-training between mental health and substance abuse providers. Of the 27 accredited Iowa CMHCs, 11 are also licensed substance use disorder services providers and 12 of the 65 accredited Mental Health Service providers are also licensed SUD service providers.

Children's Health Insurance Program (CHIP)- Healthy and Well Kids in Iowa (hawk-I)

The Children's Health Insurance Program (CHIP) was created by Title XXI of the Social Security Act. The purpose of the Children's Health Insurance Program (CHIP) program is to increase the number of children with health and dental coverage, thereby improving their health outcomes. The CHIP program includes both a Medicaid expansion and a separate program called the Healthy and Well Kids in Iowa (*hawk-i*) program.

Children covered by *hawk-i* receive a comprehensive package of health and dental benefits that includes coverage for physician services, hospitalization, prescription drugs, immunizations, dental, chiropractic, vision care and mental health services. The *hawk-i* program provides health and dental coverage to eligible children whose families have too much income to qualify for Medicaid but who do not have health care coverage. Eligibility requirements:

- Under age 19.
- Uninsured and do not qualify for Medicaid.
- U.S. citizens or lawfully residing children
- Live in a family whose countable income is between 133 - 300% of the Federal poverty guidelines.
- *hawk-I* is included in the IA Health Link managed care program effective Jan. 1, 2016

Inpatient Psychiatric Care and Residential Care

Mental Health Institutes (MHI)

The Iowa Department of Human Services oversees two MHIs, located in Cherokee and Independence. The MHIs provide critical access to quality acute psychiatric care for Iowa's adults and children needing mental health treatment.

The MHIs are licensed as hospitals and provide inpatient mental health services via a total of:

- 64 beds of inpatient psychiatric services to adults
- 32 beds of inpatient psychiatric services to children and adolescents
- 15 beds of PMIC services

Specialized Psychiatric Units in General Hospitals

There are twenty seven hospitals in Iowa which have licensed inpatient psychiatric units serving children and adults with a total capacity of 656 beds. While inpatient psychiatric care is concentrated in metropolitan areas, Iowans can generally access inpatient care within a two-hour drive of their residence. As part of the formation of mental health and disability service regions, inpatient psychiatric care is required to be available within the region or within reasonably close proximity (defined in administrative rule as 100 miles or a drive of two hours or less from the county or region). Iowa has recently implemented a web-based inpatient psychiatric bed tracking system to be used by all inpatient psychiatric facilities as well as those seeking to locate beds for people in need of inpatient psychiatric services. This system will streamline the process of finding available inpatient psychiatric services. While assisting the courts and law enforcement systems to locate available beds, the transportation of individuals may continue to be difficult to coordinate. The bed tracking system has been in use for approximately one month and is already providing useful data on availability of inpatient beds in the state.

Residential Care Facilities for Persons with a Mental Illness

The Iowa Department of Inspections and Appeals (DIA) licenses Residential Care Facilities for Persons with a Mental Illness (RCF/PMI). Eleven programs with 186 beds are currently licensed. These programs provide care in residential facilities to persons with severe psychiatric disabilities who require specialized psychiatric care. While they are scattered around the state, these programs are not readily available in every locale. Iowa is moving toward less dependency on institutional care, leading to some RCF-PMI providers reviewing their business models and seeking ways to provide care in more community-based settings.

Intermediate Care Facilities for Person with Mental Illness:

The Department of Inspections and Appeals also licenses Intermediate Care Facilities for person with mental illness (ICF/PMI). These programs provide care at the intermediate nursing level to persons who also have specialized psychiatric care needs. They may participate in Medicaid, if they wish, as a Nursing Facility for Persons with Mental Illness (NF/PMI). Medicaid will only fund persons 65 and over in this setting. Currently there are three Iowa facilities that hold this licensure with a capacity of 109. MHDS regions may pay for this level of care for individuals who are not eligible for Medicaid funding.

Psychiatric Medical Institutions for Children (PMIC)

These facilities are a treatment option for children and adolescents with an SED who have behaviors and treatment needs that exceed those that can be met in the home and community. There are 10 private facilities with 430 Medicaid-funded beds and one public facility with 15

beds that deliver these services to children in Iowa. 56 of the private facility beds are designated for children ages 12 to 18 with substance use treatment needs. Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa.

In July 2012, Iowa moved management of PMIC services to the Iowa Plan contractor, Magellan as part of the effort to improve coordination of mental health services for Medicaid-eligible individuals. Magellan was tasked with providing intensive review and oversight of children in, or at risk of, out of state placements. Magellan has provided additional funding and training to providers willing to work with high-needs children and youth, and has facilitated conference calls among the PMIC providers to identify providers willing to serve high-needs children who otherwise might be referred out of state. Magellan has regular meetings with the PMIC provider community. Topics include improvement of coordination between the educational system and the PMIC providers, improvement of family involvement in their child's care in the PMIC to help ensure that children placed out of the home have a successful transition back to their home, school, and community, patient and family satisfaction with services, and integration of IHH care coordination into the PMIC service.

Services provided in PMICs include diagnostic, psychiatric, nursing care, behavioral health, and services to families, including family therapy and other services aimed toward reunification or aftercare. Children served are those with psychiatric disorders that need 24-hour services and supervision. Children may be admitted voluntarily by parental consent or through a court order if the child is under the custody of the Department of Human Services. 1,010 children with a primary mental health diagnosis received PMIC services in SFY 14.

Case Management Services

Targeted Case Management (TCM) is a Medicaid service that assists persons with Intellectual Disabilities and Developmental Disabilities in gaining access to appropriate living environments, needed medical services, and interrelated social, vocational, and educational services. Persons on the brain injury waiver and the elderly waiver do not receive TCM but do receive case management .

The goal of case management is to enhance the member's ability to exercise choices, make decisions, and take risks that are typical of life, and fully participate in the community. Case management activities include the following:

- A comprehensive diagnosis and evaluation
- Assistance in obtaining appropriate services and living arrangements
- Coordination of service delivery
- Ongoing monitoring of the appropriateness of services and living arrangements
- Crisis assistance to facilitate referral to the appropriate providers

In Iowa, case management services are used to link consumers to service agencies and community supports, and to coordinate and monitor those services. Case managers are not responsible for providing direct care. Each county is responsible for accepting the responsibility of TCM by either providing the service or contracting with an accredited agency or the Target Case Management Unit affiliated with the Department of Human Services. Persons who are not

eligible for Medicaid but would benefit from case management or care coordination services are funded by the region if eligible.

Clients are linked with appropriate resources to receive direct services and supports and participate in developing an individualized plan. Clients are encouraged to exercise choice, make decisions, and take risks that are a typical part of life, and to fully participate as members of the community. Family members and significant others may be involved in the planning and provision of services as appropriate and as desired by the client.

Through the Integrated Health Home program, Medicaid-eligible individuals who qualify for TCM due to a chronic mental illness or a serious emotional disturbance receive care coordination through an Integrated Health Home (IHH) in place of traditional TCM. The goal is for the individual to receive coordination of services through a team that includes a care coordinator, nurse care manager, and family or peer support specialist. This promotes greater integration of the coordination/case management functions with the actual services and supports provided to the individual.

Habilitation Services

Habilitation Services is a Medicaid program operated through a 1915-I waiver. The Habilitation program provides services similar to HCBS waiver services to individuals meeting the criteria of chronic mental illness. The goal is to separate rehabilitative and non-rehabilitative services into distinct programs in order to continue the services needed by Iowans, while at the same time assuring that the state remains in compliance with federal regulations. Individuals receiving Habilitation also qualify to receive targeted case management.

As part of the Integrated Health Home program, individuals receiving Habilitation services receive care coordination through an Integrated Health Home in lieu of case management. This aligns the community supports offered through Habilitation with the mental health and physical health care needs of the individual and provides additional coordination services to those with intensive health needs.

Habilitation services include the following:

- Home-based Habilitation which is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision.
- Day Habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly

scheduled basis for 1 or more days per week or as specified in the participant's service plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan.

- Vocational (pre-employment) Habilitation includes services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are directed to habilitative rather than explicit employment objectives.
- Supported Employment Habilitation are services that consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training.

Educational System Services and Supports

For children in primary and secondary schools, Area Education Agencies are significant providers of services to children under IDEA. Iowa Area Education Agencies are regional service agencies which provide school improvement services for students, families, teachers, administrators and their communities.

Area Education Agencies (AEAs) work as educational partners with public and accredited, private schools to help students, school staff, parents and communities meet these challenges. AEAs provide special education support services, media and technology services, a variety of instructional services, professional development and leadership to help improve student achievement.

AEAs were established by the 1974 Iowa Legislature to provide equitable, efficient and economical educational opportunities for all Iowa children. AEAs serve as intermediate units that provide educational services to local schools and are widely regarded as one of the foremost regional service systems in the country.

AEA budgets include a combination of direct state aid, local property taxes and federal funds. AEAs have no taxing authority. Funding appears in each local school district's budget and "flows through" the school budgets

Local School Systems also provide early education, intervention, evaluation, special education services, and other services identified in Individual Education Plans and 504 plans for children identified as eligible individuals.

The Iowa Department of Education, in collaboration with area and local education agencies, has implemented the Learning Supports Initiative.

Learning Supports are the wide range of strategies, programs, services, and practices that are implemented to create conditions that enhance student learning. Learning supports:

- promote core learning and healthy development for all students,
- are proactive to prevent problems for students at-risk and serve as early interventions and supplemental support for students that have barriers to learning, and
- address the complex, intensive needs of some students.

SERVICES TO VETERANS

Iowa has two Veterans Administration (VA) health centers located in Iowa City and Des Moines that provide comprehensive mental health care for veterans. The VA facilities work to connect with community providers to ensure that veterans, service personnel and their families have access to appropriate care and services.

Advocates for veterans continue to identify lack of providers and services, both outpatient and residential, as a gap in the system.

Veterans are also represented on the Mental Health Planning Council and the Mental Health and Disability Services Commission. The veterans' representatives offer information and insight into the unique mental health needs of veterans.

SERVICES TO HOMELESS INDIVIDUALS

DHS- Division of MHDS (the State Mental Health Authority) administers the federal Projects for Assistance in Transition from Homelessness (PATH) program. It is a formula grant program administered by SAMHSA. Iowa will receive a \$334,000 for state fiscal year 7/1/2015-6/30/2016.

PATH funds are used for community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illnesses—including those with co-occurring substance use disorders—who are experiencing homelessness or are at risk of becoming homeless. DHS-MHDS administers contracts with seven provider agencies located in Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City and Waterloo. Provider allocations range from \$36,558 to \$53,550 for SFY 2016. In recent years each provider agency exceeded goals for numbers of individuals who were contacted, engaged and enrolled in the program; the percent of individuals enrolled that are literally homeless; and percent of enrollees that receive community mental health services. The agencies predict that this state fiscal year they will contact and engage 1,162 individuals, enrolling 789 of them in PATH services.

The Iowa Council on Homelessness (ICA) staffed by the Iowa Finance Authority is committed to ensuring that all Iowans have access to safe, decent and affordable housing. The ICH and its 38 members work to identify issues, raise awareness and secure resources that will allow all homeless Iowans to become self-sufficient. The SMHA has a voting member appointed to serve

on the council. The SMHA does not directly fund or manage any programs providing services to individuals in emergency shelter, temporary housing, or permanent supportive housing, but it does work closely with and collaborate with the Iowa Finance Authority, the Iowa Council on Homelessness, the three Iowa continuums of care, and local public housing authorities in providing services to Iowans with a mental illness who are homeless.

DHS-MHDS does not directly fund or manage services targeted specifically to homeless youth, but it does collaborate with the Department of Human Services, - Division of Adult, Children, and Family Services, the Iowa Department of Education, and with the organizations listed in the above paragraph to assure that homeless or at-risk youth with behavioral health illnesses have access to all the mainstream services that other youth have.

S.O.A.R- SSI/SSDI Outreach, Access, and Recovery

SSI/SSDI Outreach, Access, and Recovery (S.O.A.R.) is a national project to provide intensive assistance in applying for Social Security disability benefits for adults who are (a) homeless or at risk of homelessness and (b) meet Social Security criteria for not being able to work due to the disability. SMHA staff make the recommendation for people to attend the SOAR Leadership Academy paid for by SAMHSA. Currently there are three Leadership positions and 6 Trainers across the state to assist the 67 individuals trained to assist people in the application process for disability benefits. These benefits help individuals with serious mental illness and other disabilities obtain access to stable housing and health care.

The national SSI/SSDI approval rate for homeless individuals with serious mental illness without S.O.A.R. assistance is less than 15%. National S.O.A.R.-assisted averages are 70% of applications approved and an average of 90 days to approval. In FY 15, 30% of Iowa's S.O.A.R assisted applications were approved with an average length of 82 days to approval. FY 16 data is expected to show improvement in these statistics.

Housing Supports

Many adults with serious mental illness utilize take advantage of the "HUD Section 8 Rental Voucher Program". This program increases affordable housing choices for very low-income households by allowing families to choose privately owned rental housing. The public housing authority (PHA) generally pays the landlord the difference between 30 percent of household income and the PHA-determined payment standard, - about 80 to 100 percent of the fair market rent (FMR). The rent must be reasonable. The household may choose a unit with a higher rent than the FMR and pay the landlord the difference or choose a lower cost unit and keep the difference.

Home and Community Based Services Waiver Rent Subsidy Program

Rental subsidies are available to various disability populations in the state through the home and community-based waiver programs including: Health and Disability; Elderly; AIDS/HIV; Intellectual Disability ; Brain Injury and, Physical Disabilities Waivers. The overall purpose of this program is to encourage and assist persons who currently reside in a medical institution to move to and live in community housing. Iowa like most other states, does not have a waiver specifically targeted to individuals with mental illness; consequently, it is difficult if not impossible for individuals with mental illness to take advantage of this potentially important opportunity. As of July 2015, there is no waiting list for the HCBS Rent Subsidy program.

SUPPORTED EMPLOYMENT/EMPLOYMENT SERVICES

The MHDS system redesign legislation and stakeholder input process has had an important impact on DHS' work to improve employment services and supports. The core services required in Iowa's redesigned regional structure has a strong emphasis on community inclusion and employment grounded in Olmstead principles.

DHS continues to work on a Medicaid employment service redesign model to tip the balance toward integrated community employment. The model incorporates retooling service definitions and reimbursement rates, and increases collaboration with Iowa's Vocational Rehabilitation Services, Department for the Blind, and others. Community conversations were held in five locations throughout the state to gather input about employment for people with disabilities. From those participants, an informal workgroup was formed which met eight times with subject matter experts affiliated with the U.S. Department of Labor Office of Disability Employment Policy (ODEP) and the State Employment Leadership Network (SELN). Participants made recommendations for service definitions for prevocational and supported employment, service provider standards and staff qualifications for these services, and changes to the Medicaid rates to support quality staff and quality services. These changes go into effect at the end of calendar 2015.

The State of Iowa has developed an effective, collaborative working relationship with eight state partner agencies to identify and resolve barriers related to employment services for individuals with disabilities. These State partners, who meet on an annual basis, include the Department of Education, Iowa Vocational Rehabilitation Services (IVRS), Department of Human Rights, Department for the Blind, Department of Human Services, Iowa Department of Workforce Development, Iowa Department of Aging, and the Iowa Developmental Disabilities Council. A Memorandum of Understanding (MOU) states the common goal of improving integrated employment for Iowans with disabilities through the commitment of staff and resources to a statewide Operations Team to maintain communication and feedback from the field offices.

Iowa Vocational Rehabilitation Services (IVRS) works closely with students and their families to help the students develop career goals and a plan of action to assist the student in achieving their employment goal. Students can begin working with a trained Vocational Counselor during their sophomore year of high school. Services provided are specific to the students' needs to achieve their employment goal, but may include: assessments activities, career exploration, work experiences, college preparation, support services, financial assistance and job placement. IVRS has implemented funding for Customized Employment, and a focus on serving all customers under age 24.

While MHDS and IME do not directly provide training related to employment services, the companion projects of The Iowa Coalition for Integrated Employment (ICIE) and Employment First State Leadership Mentoring Program (EFSLMP) have worked with the Iowa Association of Community Providers (IACP) to offer direct service workforce trainings in Customized Employment, as well as an intensive leadership series for providers, and technical assistance related to agency transformation. The number of providers engaged in transforming their business models away from facility based services has doubled from last year. ICIE continues to offer training through a monthly community of practice webinar which is open to the entire provider community and other stakeholders.

Iowa is piloting a methodology for individual employment outcomes data collection, and gathering baseline data from 20 employment service providers representing each of the 15 Regions. The project is a collaboration among stakeholders including the Center for Disabilities and Development (CDD), the ICIE, the Governance Group, and the MHDS Regions. Data elements being collected are employment setting, hours worked, and gross earnings for each individual who had Medicaid-funded employment services in a given time-frame. Technical assistance will be available to providers, whose participation is voluntary. After data collection there will be a focus group to learn from and refine the process, and later in the year Iowa will release an aggregate baseline outcomes report.

PROVIDERS OF MENTAL HEALTH SERVICES

Community Mental Health Centers and other Mental Health Service Providers

Community mental health centers and other mental health service providers who act in lieu of a community mental health center are available to provide services across the state for those who are unable to afford services, as well as for those who do not have access to private providers due to income or location. There are 27 CMHC's in Iowa which provide mental health services to adults and children, with the exception of two CMHC's in Polk County, one of which serves only children and one which serves adults. Approximately 65 other agencies are accredited as Mental Health Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. For CMHC's receiving MHBG funding, Iowa law mandates that CMHCs receiving MHBG funds use them for the development and implementation of evidence based practices and direct services to individuals. The CMHC identifies through their contract with the state how the organization will serve adults with an SMI and children with an SED.

EBP's and best practices supported in SFY15 through MHBG funding to CMHCs include:

- Peer support services
- Trauma-informed care
- Co-occurring/multi-occurring capability
- Mental Health First Aid (MHFA)
- Parent Child Interaction Therapy (PCIT)
- WRAP services
- Motivational Interviewing
- Cognitive Behavioral Therapy (CBT)

- School-Based Mental Health
- Eye Movement Desensitization and Reprocessing (EMDR)
- Suicide Prevention
- Supported Employment
- Dialectical Behavior Therapy (DBT)
- Illness Management and Recovery (IMR)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Seeking Safety
- Trauma Incident Reduction (TIR)

CMHCs serve a defined catchment area, ranging from one county to seven counties. Other Mental Health Service Providers generally serve a specific geographic area. These agencies may be accredited to provide any of the following services: partial hospitalization, day treatment/intensive outpatient, psychiatric rehabilitation, supported community living, outpatient, emergency, and evaluation. Rules for the accreditations are found in Iowa Administrative Code 441--Chapter 24. Community mental health centers, targeted case managers, and certain mental health providers are accredited by the SMHA.

Federally Qualified Health Centers

Iowa presently has 44 Federally Qualified Health Centers (FQHC's) sites. FQHC's receive an actual cost reimbursement for Medicaid patients rather than the established rate of reimbursement. To qualify to be an FQHC, the clinic agrees to treat all that present, regardless of insurance or method to pay for services. This has become a valuable resource for adults and families that may not have any insurance coverage and do not qualify for any of the Medicaid programs. FQHC's also provide screening and referral to behavioral health services and in some instances, provide direct behavioral health services. Iowa has one agency that is qualified as both an FQHC and a CMHC, encouraging coordinated care for individuals with co-occurring health and mental health needs.

Mental Health Professionals Statewide

There are approximately 237 psychiatrists, in the State of Iowa, with 35 identified as child psychiatrists. The majority of psychiatrists practice in metropolitan or urban counties. A secondary concentration is found in or near those counties with a psychiatric institution, an MHI or a VA Hospital. There are, according to the AMOS Mental Health and Disabilities Workforce Report (December 2014): 564 licensed psychologists; approximately 170 Nurse Practitioners and Physicians Assistants with a Mental Health Specialty; 4,150 social workers which includes those at the independent (requires a master's in social work and additional experience), bachelor, and master's levels. There are 186 licensed marital and family therapists and 831 licensed mental health counselors, including temporary and fully licensed counselors and therapists.

The Iowa Department of Public Health /Board of Medical Examiners is responsible for regulating medical and osteopathic doctors. The Iowa Department of Public Health, Bureau of Professional Licensure licenses mental health professionals such as social workers, mental health counselors, and psychologists.

Mental Health Shortage Area Designation

As of August 2015, the Health Resources and Services Administration listed 96 Iowa counties as having a Health Professional Shortage Area designation for Mental Health. Lack of access to qualified mental health professionals at all levels is an identified gap in the service system.

CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

The Iowa Department of Human Services is designated by Iowa Code 225C.52 as the lead agency responsible for the development, implementation, oversight, and management of the mental health services system for children and youth with those responsibilities to be carried out by the Division of Mental Health and Disability Services, the State Mental Health Authority. The SMHA also oversees four Systems of Care in Iowa which serve 14 of Iowa's 99 counties. Other regions and counties in Iowa are at differing stages of development regarding Systems of Care for children. Several counties and mental health centers are attempting to build community support and blend available funds in order to support System of Care development.

The Iowa system for children's mental health services also includes multiple agencies, within and outside of the Department of Human Services, each with their own eligibility, funding, and limitations for provision of mental health services. Available services are dependent on type of insurance and locality, as some areas may have a larger service array and more financial investment in children's mental health services.

The Iowa Department of Human Services includes the following divisions which have some responsibility for meeting the mental health needs of children for whom the agency is responsible:

- The State Mental Health Authority (the Division of Mental Health and Disability Services)
- The State Child Welfare Authority (the Division of Adult, Children, and Family Services)
- The Division of Field Operations which oversees local service areas and De-categorization boards, and
- The State Medicaid authority (Iowa Medicaid Enterprise).

Additional state and local agencies which have funding, service, or regulatory responsibility within the children's mental health system include:

- The Juvenile Court System,
- Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
- Department of Public Health which includes Title V agencies such as the Child Health Specialty Clinics
- Department of Human Rights
- Department of Inspections and Appeals,

Children in need of mental health services have multiple access points by which they may enter the service system. While this is a strength of the system, it can also make it difficult for families to navigate the system. Families are not always aware of the array of services and may choose higher-end, more restrictive types of care because that is what they are aware of, or that is what is most readily available. Private mental health providers of psychiatric and clinical

services are available to individuals with Medicaid, as well as those with private insurance. Behavioral health intervention services –BHIS- are available to children who are Medicaid eligible. BHIS provides skill building services to children with a mental health diagnosis who are in need of additional services beyond traditional clinic-based therapy and/or medication management.

Iowa has a shortage of child psychiatrists with only 35 child psychiatrists in the state. Most of these are located in urban areas or close to the University of Iowa. Telemedicine is offered through Child Health Specialty Clinics and other mental health providers in order to increase access to specialty mental health services for children with SED and other mental health needs.

Private clinics and individual providers are not required to be accredited by the SMHA. There is no Central Point of Coordination for children at the local level to provide coordination of children's services; therefore, coordination and case management of children with mental health needs is fragmented. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children's system.

During the last two years, Iowa consolidated management of Medicaid mental health services under the managed mental health care organization. Previously certain children's mental health services including PMIC, the Children's Mental Health Waiver, and BHIS were managed directly by Medicaid, while other outpatient and inpatient mental health services were managed through Magellan. The goal for this change is to improve quality of services, coordination of clinical and other services, and to improve outcomes for those clients who receive this service. These services will be managed through IA Health Link as well as physical health care for increased opportunities for integration of physical and mental health care.

A legislatively mandated children's mental health and wellbeing workgroup will convene in the fall of 2015 to address coordination of children's mental health services across state systems as well as to address development of a children's mental health crisis response system. Parents of children with mental health needs, state department representatives, advocates and other stakeholders will be represented on this group. The workgroup is to provide recommendations to the Governor and general assembly by December 15, 2015.

Behavioral Health Intervention Services-

Behavioral health intervention services –BHIS- (formerly remedial services) are available to children who are Medicaid eligible. BHIS are supportive, directive, and teach interventions provided in a community-based or residential group care environment designed to improve the individual's level of functioning (child and adult) as it relates to a mental health diagnosis, with a primary goal of assisting the individual and his or her family to learn age-appropriate skills to manage their behavior, and regain, or retain self-control. This service is managed through the Iowa Plan, allowing for coordination between the clinical services managed by the *Iowa Plan* and the primarily community-based skill building and crisis intervention service provided through BHIS.

BHIS enables Medicaid eligible children and their families to access in-home or community-based services in addition to traditional outpatient mental health care without having to enter the

child welfare and/or juvenile justice system. BHIS services are also available to children in the custody of the Department of Human Services due to their eligibility for Medicaid. Through eligibility for the *Iowa Plan* as part of the Children's Mental Health Waiver, BHIS services are also available to children with an SED served by the waiver.

Specific services available through the BHIS include individual, group, and family skill building services, crisis intervention services, and services to children in residential settings. BHIS services are typically provided in the home, school, and community, as well as foster family and group care settings.

Children's Mental Health Waiver

When the Children's Mental Health (CMH) waiver program began in October 1, 2005, it had a capacity of serving 300 children. The current capacity of the waiver is 1,237. As of August 2015, 736 individuals are currently receiving services with 540 applications in process. The waiver has a waiting list of 2,298 with the next child to be served having an application date of November 28, 2012. This effectively means that the time from application to an open funding slot is approximately 3 years even though slot capacity has greatly increased since the implementation of the waiver.

Services included in the CMH waiver are respite, Family and community supports, in-home family therapy, environmental modifications and adaptive devices, and care coordination through the Integrated Health Homes. In addition, every child receiving services through the CMH waiver is also enrolled in the *Iowa Plan*; thus, services are combined through the two programs to meet the child's and family's needs. Children approved for the CMH waiver will also receive their care coordination through Integrated Health Homes as previously described in this document. The goal is to better coordinate the services children with an SED and their families receive and to ensure that children with an SED are accessing all appropriate services that will enable them to remain in their homes and communities.

Iowa continues to annually in July make available 10 reserved slots on the CMH waiver for children being discharged from PMIC's, MHI's, or out of state placements. These reserved slots are usually used within the first few months of release. This fact, as well as the large waiting list for the CMH waiver demonstrates the need for coordinated, supportive services in order to divert children from more intensive services, and aftercare services for children returning to their communities from PMIC and out of state treatment and placements. Children leaving high-end, restrictive types of treatments and placements need immediate access to services to support a successful transition back to their homes and communities.

Systems of Care

Central Iowa System of Care, Community Circle of Care, Four Oaks System of Care, Tanager Place

The Central Iowa System of Care (CISOC), Community Circle of Care (CCC), Four Oaks System of Care, and Tanager Place serve children and youth ages 0-21 who are diagnosed with a mental health disorder and meet the criteria for Serious Emotional Disturbance. The four

programs serve non-Medicaid eligible children and youth and provide access to community-based services and supports. The children and youth served by these programs are assessed to be at risk of involvement with more intensive and restrictive levels of treatment due to their serious behavioral and mental health challenges. All programs provide the following services:

- Care Coordination
- Parent Support Services
- Wraparound Family Team Meeting
- Flexible Funding for BHIS or other in-home services, respite or other mental health services and supports

The purpose of the SOC program is to help the identified child remain successfully in, or return to, their home, school, and community unless safety or clinical reasons require more intensive services. Families referred to an SOC are often at the point of requesting assistance from the court or child welfare system or are seeking PMIC placement. SOC services offer a community-based alternative to children who are at risk of out of home treatment and their families. If out of home services are recommended, the program can remain involved with the family to support the child's return to the family home by providing ongoing coordination and parent support. In some cases, this ongoing support can help shorten the length of stay in out of home treatment. Services provided include care coordination, access to clinical mental health services, wraparound and family team facilitation, family peer support, and funding for flexible services that strengthen the child's ability to function in the home, school, and community.

Referral sources for SOC programs include parents, schools, DHS Child Welfare, Juvenile Court Services, PMIC's, therapists, and other mental health service providers.

CCC directly served approximately 700 children and youth in SFY 15 in a ten county area. CISOC directly served 67 children and youth in a two county area. Four Oaks served 43 children in SFY 13. Tanager Place began its SOC program in SFY15 and served 23 children. Outcomes for the Systems of Care programs demonstrate improved stability of living situation, improved school attendance and performance, and diversion from involuntary mental health commitment.

The SOC programs are all Integrated Health Homes for Medicaid-eligible children with an SED. IHH care coordination is reimbursed by Medicaid allowing the state SOC funds to be dedicated to providing similar services to non-Medicaid eligible children and families.

Services to youth aging out of foster care/transition age youth Independent Living/Aftercare/PALS

On or before the date a child in foster care reaches the age of sixteen, the Iowa Department of Human Services engages the Independent Living Program, which is intended to help the child transition successfully from the foster care system to adulthood. Children in foster care often do not have sufficient support from parental figures and frequent change impedes the development of skills to live successfully in adulthood. Compounding their challenges, over 50% of children who "age out" of foster care have a diagnosed mental health condition.

Aftercare is a statewide program which includes pre-exit planning (up to 6 months prior to youth “aging out” of foster care) and case management services for youth ages 18 through 20 who have “aged out” of foster care or a PMIC. Aftercare also includes an assessment for independent living skills, life skills training, and referrals to appropriate community resources. Financial Assistance may be available to assist with one time or crisis needs for help purchasing housing, clothing, transportation, medical needs, food, day care, etc. Regular payments are provided to aftercare participants who attend work or school and meet certain program requirements. These funds are referred to as Preparation for Adult Living, or PAL, and help with rent, transportation, or other needs determined by the youth to move them closer to self sufficiency. Aftercare program eligibility requires that the young adult meet regularly with a case manager, participate in a self-sufficiency plan, develop goals, and participate in an education or training program or employment. The program is voluntary.

Iowa’s regional mental health and disability services systems are also involved in ensuring smooth transitions from child to adult services systems. In the regional MHDS system, individuals can receive services in the MHDS system three months before the age of 18 to allow them to move into the adult system in a planned manner. The Integrated Health Home program also assists with transitions for Medicaid-eligible children and youth with an SED or an SMI.

4. RECOVERY SUPPORT SERVICES

Peer Support Services have grown tremendously in Iowa and across the nation. Peer Support is an evidence-based practice which has been widely recognized by the Substance Abuse and Mental Health Services Agency (SAMHSA) and the Centers for Medicaid and Medicare Services (CMS). Peer Support Services are Medicaid billable in Iowa. In Iowa, Peer Support services are authorized through the managed care entity, Magellan Health Services.

In February 2015, the Division of MHDS contracted with the University of Iowa Center for Child Health Improvement and Innovation to provide training for core and continued education, technical assistance, oversight, and recommendation for a certification process for family peer support and adult peer support. Peer Support Services are required in the Mental Health and Disability Service Regions. Iowa is experiencing increased demand for certified peer support specialists for employment within the Integrated Health Home, crisis services and peer services. In SFY15 two trainings were held with a total of 24 individuals trained as peer support and 25 as family peer support specialists. In SFY16 additional trainings will be held, including training for supervisors of both family and peer support specialists.

In the substance use disorders system, Recovery Peer Coaching is a key service in IDPH’s Access to Recovery program. ATR Recovery Peer Coaching funds individual face-to-face meetings between clients and trained Recovery Peer Coaches to discuss routine recovery issues from a peer perspective. CSAT provided Iowa’s ATR program with technical assistance funding that brought trainers from the Connecticut Community for Addiction Recovery (CCAR) to Iowa in November 2009. CCAR training and curricula were provided to more than 30 coaches, representing 20 agencies, and provided “Train the Trainer” training for 10 individuals. Since 2010, Iowa has held trainings for coaches and trainers. As a result, Iowa has more than 110 trained Recovery Peer Coaches and 16 qualified trainers. Two IDPH staff were selected by

CCAR to become “Core” trainers, allowing them to train new trainers as well as new coaches, assuring sustainability of this service in Iowa.

While mental health peer support had been a Medicaid reimbursable service for several years under the Iowa Plan for Behavioral Health managed care plan, individuals with a primary diagnosis of substance use disorder were not eligible to receive such services outside of ATR. Further, Medicaid-funded mental health peer support was based in the Georgia Model and required that peer support specialists be supervised by licensed mental health professionals. Through lengthy negotiations over a three-year period, SSA staff obtained Medicaid approval to begin a pilot project for reimbursement of Recovery Peer Coaching using the CCAR curriculum.

At the end of the planned six-month pilot with three pilot sites, a determination will be made whether substance use disorder Recovery Peer Coaching will become a Medicaid covered service, available statewide.

Supported Community Living Programs

Supported Community Living Programs are accredited by the Department of Human Services, Division of MHDS, to provide supervised supported living to persons with disabilities. There are 90 accredited programs which currently provide services to persons with various disabilities.

These programs may be provided in residential institutions but most provide in-home services and supports to persons with a mental illness and other disabilities living in their own homes. Supported Community Living programs operate in every county of Iowa.

Illness Management Recovery (IMR)

Another program targeted at reducing hospitalization is Illness Management Recovery (IMR). This program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personalized strategies for managing mental illness and achieving personal goals. The program can be provided in an individual or group format, and generally lasts between three to six months. It is designed for people who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression. Some of the components of IMR are:

- Recovery strategies
- Practical facts about schizophrenia, bipolar disorder and major depression
- The stress-vulnerability model and treatment strategies
- Building social support
- Using medication effectively
- Reducing relapses
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

As part of Iowa’s redesign of the mental health and disability service system, IMR was identified as an EBP that must be available in each MHDS region or county approved to operate as a region.

Intensive Psychiatric Rehabilitation

Intensive Psychiatric Rehabilitation program incorporates recovery-oriented principles as part of a public sector managed care carve-out. IPR is guided by the values of consumer involvement, empowerment, and self-determination. Its mission is to provide enhanced role functioning accomplished through strategies for readiness, skill, and support development.

IPR provides services to adults with a serious and persistent mental illness who are interested in making a community ‘role recovery’ within the next six months to two years. The concept of role recovery is to engage or re-engage individuals in personally meaningful community roles. The purpose of intensive psychiatric rehabilitation services is to assist the person to choose, obtain get and keep valued roles and environments. The four specific environments and roles in which psychiatric rehabilitation will assist the individual are living, working, learning, and social interpersonal relationships.

Respite

Children and adults who access respite services typically do this through one of the HCBS waiver programs, including the Children’s Mental Health Waiver for children identified with an SED. Respite providers must be approved to be a Medicaid provider. For children served by Systems of Care, respite is also a key service requested by families. The Systems of Care have provided funding for families of children with SED in need of this service who are not receiving waiver services.

Wellness Recovery Action Plan

The Wellness Recovery Action Plan (WRAP) model is a person-driven program, which educates clients to manage illness and become active partners in their recovery. WRAP training has been funded by the MHBG in Iowa CMHCs for several years.

Consumer Organizations

The **Office of Consumer Affairs** is supported by the Mental Health Block Grant and offers a variety of services and supports to persons and families with behavioral health recovery and disabilities challenges, other state agencies, providers. The Office of Consumer Affairs:

- Serves as a statewide resource for information, referrals, community education, individual education, one-on-one problem solving, and system navigation.
- Provides input on the development and implementation of policies and programs impacting behavioral health services and systems in Iowa.
- Provides an advocacy voice to stakeholder groups throughout the state with the goal of promoting awareness of the concerns, perspectives and vision of persons and families with behavioral health recovery and disabilities challenges.
- Assists DHS staff and contractors with disseminating information and gathering feedback from end users of behavioral health services and systems in Iowa.

Each of the five DHS service areas is served by a Regional Coordinator with further support offered by regional Advisory Committees comprised of persons and families with behavioral

health recovery and/or disability experience. The Office Director and a statewide Advisory Committee function to consolidate the activities of regional committees and coordinators.

Iowa Advocates for Mental Health Recovery (IAMHR) is a statewide consumer advocacy network founded by and for adults with serious mental illness and other life challenges. Iowa Advocates for Mental Health Recovery is also the contractor for the Office of Consumer Affairs through the SMHA. IAMHR is a member of the National Coalition for Mental Health Recovery, committed to working for all persons “seeking to regain something lost” and/or “working toward a positive future.” It is the mission of IAMHR to “create opportunities for advancing hope and recovery for all by transforming our community, and the mental health system it reflects, to one of respect and trust by educating, advocating and empowering.” IAMHR was founded in April of 2007. Currently IAMHR serves people in recovery through direct membership and through indirect service such as education, advocacy and social inclusion efforts.

The **Depression and Bipolar Support Alliance (DBSA)** is the leading patient directed national organization focusing on the most prevalent mental illnesses. Since 1985, DBSA has worked to provide hope, help, and support to improve the lives of people living with depression, bipolar disorder, and other mental illnesses with common symptoms. DBSA pursues and accomplishes this mission through peer-based, recovery oriented, empowering services and resources when people want them, where they want them, and how they want them.

DBSA in Iowa has three local chapters and an incorporated statewide organization. There is no such thing as official membership, although each chapter has elected officers and facilitators to run the group. Each chapter chooses how it would like to operate within the DBSA guidelines, but each chapter does have a mental health professional advisor who may or may not attend meetings. There is no charge to attend meetings, and attendance is completely voluntary. Meetings vary in size, from as few as three to as many as forty. Most of the people who attend on a regular basis show improvement in their ability to cope with their illness.

National Alliance on Mental Illness (NAMI) is a 501c3 non-profit organization offering support, education, and advocacy to persons, families, and communities affected by mental illness. The NAMI organization operates at the local, state and national levels and is the largest grassroots organization of its kind working on mental illness issues.

Local and state affiliates work with the following centers at the National Office:

- Policy and Research Institute,
- Crisis Intervention Team (CIT) Technical Assistance Resource Center,
- Child and Adolescent Action Center,
- Multi-Cultural Action Center, and the
- Education, Training and Peer Support Center - NAMI offers 11 educational and support programs and offers these programs at no cost to families, consumers, and mental health and school professionals.

Besides the state office, Iowa has 12 local affiliates and 6 support group organizations. Each local affiliate offers a variety of educational activities and support groups for consumers, family members, and parents/caregivers of children and adolescents with severe emotional disorder. Local affiliates and the state organization identify and work

on issues most important to their community and state. The goal is to free people with mental illnesses and their families from stigma and discrimination, and to assure their access to a world-class mental health treatment system to speed their recovery.

NAMI Iowa Children's Mental Health Committee (NCMHC) was established as a formal committee under the auspices of the NAMI Iowa Board of Directors in 2014. The CMHC advocates on behalf of children with behavioral, emotional, developmental, neurological, or mental health needs; offers parents and family members support; and strives to raise awareness of children's mental health issues and the acceptance of neurodiversity.

NAMI Iowa Casserole Club (NICC) is a statewide online support group for parents and caregivers of children with severe emotional disorder. It was founded by the NCMHC in October 2014 and presently has over 115 members.

The Coalition for a Children's Mental Health Redesign was formed and is led by the CMHC. The coalition formed in January 2015 and will produce a strategic plan for implementing a comprehensive mental health redesign at the state, regional, county, and city level. The coalition consists of over 100 stakeholders and family members and represents 50 non-profit and professional organizations dedicated to the wellness of children. The plan will be shared with elected officials and community leaders beginning in the summer of 2015.

The Iowa Federation of Families for Children's Mental Health (IFFCMH) is a statewide network of families of children and youth who have serious emotional disturbances and behavioral disorders. The mission of IFFCMH is to ensure families have access to a comprehensive, coordinated, individualized, strength-based system of care in which they are seen as partners in determining the nature and volume of care provided, and that communities are supportive of families with children who have emotional/behavioral challenges. The IFFCMH Director is a member of several statewide boards, councils, and committees addressing state system level change.

Access for Special Kids (ASK) Family Resource Center is a "one-stop-shop" for children and adults with disabilities and their families. Through its partner organizations, ASK Resource Center provides a broad range of information, advocacy, support, training, and direct services. These services are all accessible in one building or from one phone call. A single contact can direct individuals or families to the most appropriate services and supports to meet their needs. Access for Special Kids identifies its primary focus as offering information and resources for the benefit of children with disabilities and their families throughout the state of Iowa.

Parent Training and Information Center of Iowa (PTI) is a federally funded grant project from the U.S. Department of Education that focuses on the educational needs of children with disabilities in Iowa, particularly those who are underserved or may be inappropriately identified.

In addition to technical assistance to families, PTI also provides training on the Individuals with

Disabilities Education Act (IDEA). The goal is to help parents better understand the Individual Education Program (IEP) and Individual Family Support Program (IFSP) process and become better advocates for their children.

There is no cost for information and training provided to families. Shared costs may be requested for services to professionals and others. Services provided include information and training on IDEA, skills to effectively participate in the IEP process, communication strategies to help improve family/ school relationships, information on family support, disability types and rights.

The Iowa Department on Aging (IDA) has a significant collaborative and policy relationship with Iowa's Area Agencies on Aging (AAA), covering all 99 counties. The AAA's have a strong statewide membership organization, the Iowa Association of Area Agencies on Aging (IAA). There are six AAA's in Iowa. The leadership of the IDA has been solid and active participants in the MHDS redesign efforts and as a result of these many new changes, new and stronger partnerships have been formed between the DHS and the IDA. IDA is partnering with DHS and AAA's in the development of the Aging and Disability Resource Centers (ADRC).

Aging and Disability Resource Centers (ADRC)

Iowa's ADRC system has been branded with the name Lifelong Links, and can be found on the web at: <http://www.lifelonglinks.org/> and via phone through a statewide toll free phone number: 1-866-468-7887. The ADRC model was initially funded by grants Administration on Aging (AoA) and Centers for Medicaid and Medicare (CMS) to develop pilot programs in two locations within the State. Over the next several years, the program expanded throughout the rest of the state based upon lessons learned in the two pilot efforts. The statewide telephone operation rings into the ADRC side in Waterloo, IA, and can be linked immediately to the appropriate AAA/ADRC location elsewhere in the state without asking the individual to hang up or dial another number. An ADRC is meant to serve as a single point of entry with a "no wrong door," for access to long term services and supports throughout the State. July of 2014 was the official launch of the statewide ADRC system. The ADRC process has caused the Area Agencies on Aging to expand their expertise beyond their historical service to Iowans over 60 without regard to disability and to also begin serving Iowans 18+ with disabilities. Lifelong Links includes four pillar programs including: 1) Information, Referral, and Access, 2) Eligibility Assistance – Navigation, 3) Options Counseling, and 4) Care Transition Support. Options Counseling is closely linked to the long term care system and the Minimum Data Set (MDS 3.0) survey, which collects information about individuals in nursing facilities on a quarterly or semi-annual basis. Options Counseling is also closely linked to Iowa's PASRR program. If any individual indicates an interest, during an MDS interview, in placement outside of the nursing facility, or if an individual receives a short term nursing facility approval from the Preadmission Screening and Resident Review program (PASRR), or if an individual expresses an interest in information and services that may lead to a return to home or lower level of care, then Options Counselors from ADRCs will be contacted in order to help the individual and their family explore community placement options and services, including any services that have been identified by PASRR. Options counseling is intended to be a person centered short-term intervention for individuals with immediate or emerging service needs and can involve support that is more intensive and hands on than standard information and referral, but is also less than what a case management provider would offer.

Planning Steps

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

Narrative Question:

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

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

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

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

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

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.

Identified needs and gaps within the current system

Children with Serious Emotional Disturbance-Identified Needs

According to the most recent prevalence estimate provided by SAMSHA in URS Table 1, Number of Children with Serious Emotional Disturbance, ages 9-17, 2013, it is estimated that approximately 40,138 children in Iowa meet the criteria of serious emotional disturbance. Of that amount, in FY 15 approximately 2% were served by the Children's Mental Health Waiver and 3% were served by Systems of Care. The SAMHSA Behavioral Health Barometer identifies that approximately 8.3% of Iowa adolescents had at least one major depressive episode per year from 2009-2013. Medicaid data for SFY15 identifies that in SFY15, 2,038 children (or 4.7% of those receiving a Medicaid-funded mental health services) had an emergency department (ED) visit due to mental health reasons with 523 having more than one ED visit during the same time period.

Increasing numbers of families are on the waiting list for the Children's Mental Health Waiver. The waiting list has increased over the last two years by approximately 880 children. (Iowa Medicaid Slot Waiting List July 2015).

The combination of factors including limited waiver slots, limited access to community-based services if not Medicaid-eligible, and lack of providers available to treat children with an SED, places children with an SED at risk of higher-intensity, out of home treatment and placement.

Iowa has implemented Integrated Health Homes (IHH) for Medicaid-eligible children with a Serious Emotional Disturbance to address the lack of coordinated care for children with an SED. In SFY15, 10,916 children were enrolled in IHH out of the total 42,868 who received a Medicaid mental health service during the state fiscal year. Iowa continues to promote System of Care (SOC) principles and practices to address the need for coordinated services and supports for Iowa's children with serious mental health issues. It is a priority for Iowa that the IHH operate using the principles of family driven, youth guided care with the goal of helping children remain in their homes, schools, and communities, and families remain together.

Families of children with mental health issues identify lack of trained providers, lack of recreational activities for children with disabilities, a need for therapeutic school settings, lack of services for children with multi-occurring conditions such as mental illness and autism as barriers to children with an SED being able to live successfully in the community.

Iowa continues to work collaboratively with stakeholders to improve the children's mental health system. A legislatively mandated children's mental health and wellbeing workgroup will convene in the fall of 2015 to address coordination of children's mental health services across state systems as well as to address development of a children's mental health crisis response system.

Adults with SMI/Older Adults with Serious Mental Illness/Children with an SED Crisis Mental Health Services

The need for a crisis service system has long been an identified priority of Iowa stakeholders. Multiple workgroups, stakeholders, and advocates have identified lack of crisis service as a gap across most of Iowa and a reason that Iowans seek inpatient psychiatric care, sometimes for lack of any other option when experiencing a crisis.

	Available prior to July 1, 2014	Available as of July 1, 2015	In Development
Jail Diversion (# of counties)	14	27	28
Mobile Crisis Response # of counties)	5	16	11
Residential Crisis Beds	30	57	40
24 Hour Crisis Line	0	6	1

As evidenced by the chart above, Iowa has made significant progress toward improving access to locally-accessible crisis mental health services, however, more work is needed to expand access statewide.

The following prevalences were found:

According to the SAMHSA 2014 Behavioral Health Barometer, in the years 2009-2013, 4.2% of all adults in the years within the year prior to the survey had serious thoughts of suicide, 4.7% had an SMI, and 49.3% of those identified as having any mental illness (AMI) received treatment. SAMHSA URS Table 1 2013 identifies a prevalence rate for Iowa of adults with SMI of 5.4% or 127,707.

Iowa has also identified that of the 60,771 adults receiving mental health services funded by Medicaid in SFY15, 4,693 adults (or 7.7%) had an emergency department (ED) visit related to mental health. 1,452 adults had more than one ED visit during the same time period. For children during the same time period, 2,038 (or 4.7%) of children had an ED visit due to mental health reasons with 523 having more than one ED visit during the same time period. Iowa proposes that expansion of community-based crisis services will reduce reliance on ED services for mental health crisis intervention.

**Adults/Older Adults with Serious Mental Illness, Children with an SED and their families
Adult Peer Support Services, Family Peer Support Services**

Iowa has increased the availability of peer support and family peer support through the inclusion of peer support and family peer support specialists in the care coordination teams offered through Integrated Health Homes. Peer support and family peer support is a Medicaid-funded service. Peer support and family peer support is also a required service to be offered through Mental Health and Disability Regional Service systems. Use of peer support and family peer support services funded by Medicaid has increased steadily. Training of peer support and family peer support specialists continues to be a priority in the mental health system in order to meet increased demand for services provided by peers. The SMHA has contracted for development and provision of a standardized training curriculum and has set specific goals for numbers of peer support and family peer support specialists to be trained and able to work in integrated health home settings and mental health provider organizations.

Other needs identified by Planning Council members include:

- Housing supports for persons with mental illness-especially for people who cannot qualify for public housing subsidies due to criminal history
- Mental health workforce shortage-especially psychiatrists as well as other prescribers, and licensed mental health professionals.
- Increased mental health training for law enforcement professionals and first responders
- Increase access to Youth Mental Health First Aid training in schools and to law enforcement personnel who interact with youth as well as youth themselves
- Increase mental health training for offenders involved in domestic violence and sexual abuse cases
- Strengthen opportunities for early intervention by offering training through a variety of formats to pediatricians and family practitioners to promote early identification and intervention of mental health issues in children
- Strengthen role of Office of Consumer Affairs
- Increase capacity of the system to provide mental health services for Veterans

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

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

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

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

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Planning Steps-Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels)

The Iowa Department of Human Services (DHS) Division of Data Management (DDM) has built an extensive data warehouse to provide decision support and reporting. Data included in DHS Data Warehouse include:

- Client-level and program-level data through annual payment submissions from regions
- Client-level data for persons served through claims submissions from state Mental Health Institutes and resource centers
- Client-level, program and provider level data through Medicaid claims

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Mental health data are reported into a larger system for the Iowa Department of Human Services that includes Medicaid, MHI and Non-Medicaid populations. Substance abuse data for non-Medicaid populations are reported into a separate system to the Iowa Department of Public Health.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Iowa is currently collecting limited client-level measures; however is not collecting the SAMHSA proposed client-level measures. Iowa currently reports a select number of client-level measures through the CLD system to the NRI.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Iowa is not in the position to report all of the proposed client-level measures in the TEDS format. Iowa will continue to report select measures in the CLD format to the NRI. However, the state is working to expand the capacity to report on client-level measures for the purpose of monitoring the performance of the redesign of the Mental Health and Disability Services system and to reflect the needs of our state and our new regional system for continuous quality improvement. Iowa is also in the process of moving most Medicaid services to managed care which may improve availability of client-level data.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Children's Mental Health Services and Supports
Priority Type: MHS
Population(s): SED (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Improve the system of care for children with mental health needs and their families by improving interdepartmental coordination of children's mental health services and creation of a plan for children's mental health crisis services.

Objective:

Develop recommendations for interdepartmental coordination of children's mental health services, strategies to promote community partnerships to address children's mental health, and develop recommendations for development of a children's mental health crisis response system.

Strategies to attain the objective:

Engage with multiple stakeholders, including family members of children with an SED, in a legislatively mandated workgroup to address the goals listed in Senate File 505, Division XXIII, Section 102. The workgroup is scheduled to meet during fall 2015 to complete the identified tasks and shall submit a report to the Governor and general assembly on or before December 15, 2015.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Submit a legislatively mandated workgroup report to the Governor and legislators by December 15, 2015
Baseline Measurement: none
First-year target/outcome measurement: Report is delivered to appropriate entities by December 15, 2015
Second-year target/outcome measurement: Recommendations of the report will be considered for legislative action in the 2016 legislative session but additional targets cannot be determined until legislative action is determined.

Data Source:

DHS is the convener and submitter of the workgroup report.

Description of Data:

Workgroup report

Data issues/caveats that affect outcome measures::

Priority #: 2
Priority Area: Peer Support Services
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:

To increase access to quality peer support services through increased training opportunities for persons wishing to become certified peer support and family peer support specialists.

Objective:

In the FY14-15 MHBG plan, Iowa set the goal of contracting for technical assistance and oversight of the peer support training system. That goal was achieved, a contract is in place, and training of peer and family support specialists has begun. The next objective related to peer support is to increase numbers of individuals who have completed the standardized training and are employed in either health home or provider settings.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase numbers of peer support specialists trained in the standardized curriculum implemented in SFY15

Baseline Measurement:

First-year target/outcome measurement: In SFY 2016, the Contractor shall train a minimum of 60 individuals to provide Peer Support Specialist services as part of an IHH care coordination team, and a minimum of 50 individuals to provide Peer Support Specialist services within a Provider agency.

Second-year target/outcome measurement: In SFY 17, the Contractor shall train a minimum of 25 individuals to provide peer support as part of an IHH care coordination team and a minimum of 50 individuals to provide peer support services within Provider agency.

Data Source:

The Peer Support Training Contractor shall provide data on numbers of persons trained and their roles following training.

Description of Data:

Numbers of persons trained and employment status of person trained.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase number of family peer support specialists trained in the standardized curriculum implemented in SFY15

Baseline Measurement:

First-year target/outcome measurement: In SFY 2016, the Contractor shall train a minimum of 50 individuals to provide Family Support Peer Services as a part of an IHH care coordination team, and a minimum of 40 individuals to provide Family Support Peer Services.

Second-year target/outcome measurement: In SFY 2017, the Contractor shall train a minimum of 25 individuals to provide Family Support Peer Services as part of an IHH care coordination team and a minimum of 50 individuals to provide Family Support services within other agencies

Data Source:

The Peer Support Training Contractor shall report data to the state on numbers of persons trained and employment roles of those persons.

Description of Data:

Numbers of persons trained and employment roles of those persons.

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Development of crisis services

Priority Type: MHS

Population(s): SMI, SED (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Increase access to regional crisis services for Iowans experiencing a mental health-related crisis

Objective:

Iowans will have access to community-based crisis services focused on diversion from restrictive settings such as jail and inpatient psychiatric settings unless clinically necessary.

Strategies to attain the objective:

Each of the mental health and disability service regions is required to provide a basic level of crisis response services as part of MHDS redesign legislation core service requirements. The regions are in the process of developing basic crisis services as well as developing core-plus services that include mobile crisis response services and jail diversion.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of MHDS regions that have a functioning mobile crisis response system.
Baseline Measurement:	As of 7/1/2015, 3 of 15 MHDS regions have functioning mobile crisis response services.
First-year target/outcome measurement:	In SFY16, 2 additional MHDS regions will implement mobile crisis response services
Second-year target/outcome measurement:	In SFY17, 1 additional MHDS will implement mobile crisis response services
Data Source:	The MHDS regions report regularly to MHDS staff on program development and compliance with core service requirements.
Description of Data:	Program descriptions and supporting documentation.
Data issues/caveats that affect outcome measures::	

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$6,635,298	\$0	\$0	\$0	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$368,628	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$368,628	\$0	\$0	\$0	\$0	\$0
13. Total	\$0	\$7,372,554	\$0	\$0	\$0	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$0

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$0
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

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

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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

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

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

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

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

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

²⁷ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

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

²⁹ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>: <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

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

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

<http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

⁴¹ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

⁴³ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴⁷ <http://www.nrepp.samhsa.gov/>

⁴⁸ Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

⁴⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁵⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

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

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

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

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

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

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Iowa has two teams which are using the NAVIGATE model of delivering services for First Episode Psychosis. Each team is located in an urban county but serve several surrounding rural counties. Each team is located within a Community Mental Health Center(CMHC's). Prior to these teams, both CMHC's have dedicated significant resources to developing and implementing several specific evidence based interventions such as Cognitive Behavior Therapy, EMDR, motivational interviewing, and peer support services. One of the CMHC's have trained Mental Health First Aid instructors on staff. Lastly, prior to development of the NAVIGATE teams, both CMHC's have worked to transform their agency cultures to address individuals' complex needs and provide trauma informed care.

Iowa has contracted with an individual who has substantial experience with this model as he was involved with the original RAISE research to provide training, technical assistance, and clinical discussion for each team. In addition, the TA person hosts calls for both team directors and other staff from the two sites. By doing this, Iowa has created a "learning community" in which the teams can support each other and learn from one another.

The two teams were selected in March 2015. Training for both teams was completed in late April 2015. A specific webinar training was provided for the two medication providers in June 2015.

After some discussion with national experts, Iowa has modified the range of diagnosis accepted into the service. The acceptance criteria now include affective disorders with psychotic symptoms. Individuals with such diagnosis are carefully reviewed with the teams to determine how well the NAVIGATE model could meet the individual's needs.

The teams began to serve individuals in August 2015. It is hoped to gradually enroll individuals to assure each team's capacity is built gradually and allow sufficient time to implement the model.

Going forward, Iowa is planning to continue the calls and providing the technical assistance to the teams. As this is a fairly new service, it is expected that modifications, etc. may be necessary to not only ensure sufficient numbers of individuals enrolled now but to consider specific changes that may be needed to deliver the service in rural areas. For the coming year, there is an ongoing emphasis on recruiting and marketing the service and "coaching" the CMHC's how to do that work.

In SFY16, Iowa plans to use the 5% to support the two teams for ongoing training, technical assistance, and to fund recruiting/marketing efforts for which there is no other funding source. In addition, the CMHC's have included budget items such as transportation for individuals being served, services which may be needed but for which there is no other funding. Examples of such costs may be staff time to work with individuals to secure insurance, work with the individual to secure housing, and other unmet needs. Budgets and workplans for the fiscal year beginning Oct. 1, 2015 are in the process of being developed

Iowa has not firmly established what data will be collected or how. Initially, Iowa is looking at each element of the overall service. For example, the teams are collecting data on their

recruiting/marketing work to analyze the best methods. Such data will be valuable if the service is to be replicated in another site within the state.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

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

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

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

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

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

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

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

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

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

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

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

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

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

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

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

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

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

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

Footnotes:

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

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

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach".⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

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

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

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

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

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

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

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

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

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

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

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

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

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

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

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

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

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

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

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

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

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

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

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

Crisis Prevention and Early Intervention:

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

Crisis Intervention/Stabilization:

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

Post Crisis Intervention/Support:

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

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

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

16. Recovery

Narrative Question:

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

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

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

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

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

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

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

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

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

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

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

use, and co-occurring disorders?

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

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

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

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

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

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

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

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

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

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Iowa Plan for Suicide Prevention: 2011 to 2014

The Iowa Department of Public Health (IDPH) and Iowa's Suicide Prevention Strategy Steering Committee, hereinafter referred to as the Committee, has guided the development of the Iowa Plan for Suicide Prevention: 2011 to 2014. The committee reviewed the most recent Iowa Plan for Suicide Prevention 2005-2009 and the *Surgeon General's Call to Action to Prevent Suicide* and the *National Strategy for Suicide Prevention*, which highlights the need to increase awareness of suicide as a public health issue and calls for a public health approach toward suicide prevention. This approach calls for five basic steps: clearly define the problem; identify risk and protective factors; develop and test interventions; implement interventions; and evaluate effectiveness.

Problem: IDPH reports that from 2002-2007, a total of 1,998 suicide attempts resulted in death and 332 of these completions were children and young adults from 10 to 24 years of age. In Iowa, suicide is the second leading cause of death for all Iowans 15-40 years of age.

Suicide affects Iowa's families, friends, schools, businesses and communities. Although the number of Iowans impacted by suicide is difficult to calculate, conservative estimates indicate that there are at least six family members and friends intimately affected for every person who has attempted or completed suicide. This equates to about 12,000 Iowans affected by a person's death from suicide from 2002-2007. The IDPH reports that over this same time period, 2,656 Iowa youth were hospitalized for attempted suicide, tragically impacting an estimated 15,936 family members and friends.¹ A successful reduction in the number of people who attempt or complete suicide will require a reduction in the number of people who are at risk.

Risk and Protective Factors: Risk factors are conditions or circumstances that increase a person's vulnerability or potential for suicidal behavior. Protective factors reduce one's potential for suicidal behavior or reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biopsychosocial, environmental, or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives.² The following risk and protective factors were developed as part of the national strategy.

RISK FACTORS

Biopsychosocial

- Mental disorders
- Alcohol and substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Suicide contagion

¹ Calculated using data provided by the American Association of Suicidology – www.suicidology.org - 1,998 and 2,656 multiplied by 6 respectively.

² National Strategy for Suicide Prevention: Goals and Objectives for Action United States Department of Health and Human Services, 2001.

Social Cultural

- Lack of social support and perceived sense of isolation
- Stigma associated with help seeking behavior and mental illness
- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation

Interventions and Evaluation: This plan is designed to increase awareness of suicide as a public health issue in Iowa and calls for a public health approach focused on suicide prevention across the life span. The purpose is to build on the foundation of prior suicide prevention efforts in order to develop and implement statewide suicide prevention and early intervention strategies, grounded in public/private collaboration. The plan seeks to specify a targeted number of goals and objectives, focused on implementing initiatives with a focus on evidence-based programs. The goals and objectives are flexible with specific objectives or dates changing based on emerging opportunities and available financial resources.

The committee acknowledges the need to develop the plan over a long time period, but agreed on a draft plan that includes broad goals and objectives. As more stakeholders are identified, workgroups will be established to focus on each goal to ensure it is being addressed. Each workgroup will reassess objectives within the goal, and determine the activities, timelines and specific agencies or individuals responsible for carrying out the activities.

Goal 1: Develop and implement a public education and information campaign focused on recognition of suicide as a public health problem that is preventable.

- Objective 1.1: The Committee and the IDPH will select data-driven, promising practices focused on promoting suicide prevention services.
- Objective 1.2: The Committee will include the promotion of the importance of positive mental health and its impact on the whole person.
- Objective 1.3: The Committee will expand collaborative partnerships to develop an implementation plan for a social marketing campaign.
- Objective 1.4: The Committee, the IDPH and collaborative stakeholders will utilize a logic model to develop an implementation plan for a social marketing campaign, to include identification of measurable outcomes.
- Objective 1.5: The committee will promote the Suicide Prevention Lifeline number and website through their networks.
- Objective 1.6: The Committee, the IDPH and collaborative stakeholders will implement the planned social marketing campaign.
- Objective 1.7: On an annual basis, the Committee will review, update and distribute media guidelines for reporting about suicide to schools as well as all media.

Goal 2: Implement training across multiple disciplines for the recognition of at-risk behavior and referral to appropriate service providers.

- Objective 2.1 The Committee and the IDPH will identify specific populations (substance abuse treatment centers, mental health providers, LGBT, etc.) needing training.
- Objective 2.2: The Committee and the IDPH will identify promising practices in suicide prevention training focused for each of the identified populations.
- Objective 2.3: The Committee and IDPH will develop plans to train volunteers who work with at-risk older adults, and those who work with families facing mental health challenges.
- Objective 2.4 The Committee and IDPH will work with aging networks, youth workers (such as counselors, coaches, child care providers, and college resident hall advisors), and with Family-to-Family education programs of the Iowa Alliance for the Mentally Ill.
- Objective 2.5: The Committee and the IDPH will identify and promote suicide awareness and prevention training programs for a variety of professions.

Goal 3: Expand evidence based, community screening, early identification and intervention programs.

- Objective 3.1: The Department of Education, through its Learning Supports Initiative will encourage Area Education Agencies and local schools to collaborate with community service providers to implement research-based early identification and intervention programs (e.g. Columbia University Depression TeenScreen® Program, Signs of Suicide, etc.).
- Objective 3.2: The Committee and the IDPH will promote mental health screening programs to primary care providers, pediatricians, and other healthcare providers.
- Objective 3.3: The Committee will collaborate with the Iowa Department of Elder Affairs and its Area Agencies on Aging to enhance its screening and suicide prevention efforts.
- Objective 3.4: The Committee will collaborate with the Iowa National Guard, the Veteran's Administration Central Iowa Healthcare System and Vet Center Programs to enhance screening and suicide prevention efforts for Iowa veterans.
- Objective 3.5: The Committee will promote development of statewide suicide survivor programs and a statewide survivor network to address the needs of relatives and friends of those who have died by suicide.

Goal 4: Promote evidence-based gatekeeper training programs in schools, colleges, and in the general population.

- Objective 4.1: The committee will identify current suicide prevention gatekeeper programs conducted in schools and colleges and determine the most effective method to promote them.
- Objective 4.2: The committee will identify gatekeeper programs for other populations (elderly, veterans, etc.) and assist appropriate agencies in implementing them.

Goal 5: Improve and expand surveillance and evaluation systems and develop methods for systematically disseminating knowledge obtained about effective practices and programs for suicide prevention.

- Objective 5.1: The IDPH epidemiologist will collect suicide death and injury data and provide a summary report, using hospital data and tracking demographic data and rates at the county, state, and regional levels.
- Objective 5.2: The IDPH, in consultation with the Committee, will complete the development of a database to track statewide suicide prevention activities and evaluation results and will begin distribution of a quarterly e-mail newsletter about suicide prevention research, potential funding sources, and updates on the state suicide plan to identified stakeholders.
- Objective 5.3: The Committee will identify additional data sources and indicators to expand understanding of those at risk for suicide.

Goal 6: Develop a policy agenda for suicide prevention.

- Objective 6.1: The Committee will develop a policy agenda to educate legislators and policy makers on the importance of mental health, and affordable/accessible substance abuse and mental illness treatment for all Iowans.
- Objective 6.2: The Committee will develop a policy agenda to educate legislators and policy makers on the importance of expanding and replicating the concept and principles of mobile crisis response teams.
- Objective 6.3: The Committee will distribute its policy agenda to legislators and policy makers.

Partners:

The following organizations participated in the development of the Iowa Plan for Suicide Prevention:

- Community School Representatives
- Foundation 2 Crisis Center
- Iowa Department of Education
- Iowa Department of Human Services
- Iowa Department of Public Health
 - Bureau of Substance Abuse Treatment and Prevention
 - Bureau of Family Health
- Iowa School Nurse Organization
- Veteran’s Administration Medical Center – Des Moines
 - Iowa National Guard
 - Employee and Family Resources
 - NAMI of Greater Des Moines
 - Iowa Pride Network
 - NASW – Iowa Chapter
 - Orchard Place – Child Guidance Center
 - University of Iowa Carver College of Medicine
 - Polk County Health Services
 - Juvenile Court Services – Sioux Cit

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

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

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

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

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

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

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

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

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors -Item 22

Behavioral Health Advisory Council narrative:

States must consider the following questions:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.). The Mental Health Planning Council met with SMHA staff on four separate occasions to review the previous Block Grant application and discuss priorities for the new application. Planning Council members provided information for the Behavioral Health Assessment and reviewed the application prior to submission. Notes from meetings are attached.

2. What mechanism does the state use to plan and implement substance abuse services?

Answer-The SSA, which is in a separate department of Iowa state government has responsibility for planning and implementation of substance abuse services. The SMHA and SSA work together on issues of joint concern, and representatives of each agency participate on the other department's planning boards for grants and projects as appropriate.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Answer- The Council continues to integrate concerns related to mental health and substance use disorders (SUD) but there is still work to be done in this area. The continued participation of the representative from the Iowa Department of Public Health, who has expertise in and responsibility for overseeing the management of substance prevention and treatment services in Iowa, to the Council has enhanced the group's ability to share information about mental health concerns, learn more about substance abuse issues, and have meaningful discussion toward integrating SUD activities into the work of the Council.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Answer-The Council has a mix of rural, suburban, and urban representatives. The council has added representation of families with younger children compared to the last MHBG plan submitted in 2013, which identified the need to recruit parents of younger children with an SED. Several individuals on the MHPC are older adults and the MHPC does address the mental health needs of older persons. A representative from the Iowa Department on Aging is an active Council member. According to US Census information, Iowa's racial composition is 92.5% white, 3.3% Black, 2% Asian .5% American Indian/Alaska Native, Native Hawaiian and other Pacific Islander .1%, and two or more races 1.6%. 87.6% of Iowans are identified as white alone, not Hispanic or Latino, and 5.5% Hispanic or Latino. The Planning Council's current

composition is 100% white. The Planning Council is always seeking culturally diverse membership and is open to increasing diversity in all aspects of membership.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Answer- People in recovery and families are well represented in the membership of the Council. The current composition of the MHPC is 57.8% persons in recovery, family members, and others. Many of the members are active in groups and programs in their local communities that bring them into contact with other people in recovery and other family members who share issues and concerns with them to bring back to the Council. Various Council members are involved with community advocacy organizations such as NAMI, Iowa Advocates for Mental Health Recovery, Veterans groups, parent groups, and peer support groups, which help them connect with and gather input from others in their communities. Several members of the Council gather input through their experiences as Peer Support and Family Peer Support Specialists, and several also work, or have worked, with the Office of Consumer Affairs (OCA). Policymakers from within DHS and from other state and private entities are also regularly invited to Council meetings to provide information about current issues and initiatives, and to both provide input to and gather input from Council members.

These are the duties of the Planning Council as identified in the By-Laws

Section 1. Duties

- A. To participate in the development of and subsequently review mental health plans for Iowa provided to the Council pursuant to 42 USC 300X-4 (a) and to submit to the State of Iowa any recommendations of the Council for modifications to the plans;
- B. To serve as an advocate for adults with serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or emotional problems;
- C. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within Iowa; and
- D. To affiliate, join, and collaborate with groups, organizations, and professional associations that the Council may designate or choose to advance its stated purposes under these bylaws and federal law; and, specifically, to join the National Association of Mental Health Planning and Advisory Councils.

Section 2. Activities

- A. To organize as a proactive and effectively working Council;
- B. To actively participate in the development of the State's Center for Mental Health Services (CMHS) Community Mental Health Block Grant Application;

- C. To provide recommendations on State goals according to the criteria of the CMHS Community Mental Health Block Grant;
- D. To advise on the allocation of monies received by the State Mental Health Authority through CMHS Community Mental Health Block Grant funding;
- E. To advise the State Mental Health Authority on matters that may affect the stated purposes of this Council;
- F. To review the annual submission of the CMHS Community Mental Health Block Grant Application and comment on it to the Director of the Center for Mental Health Services;
- G. To review the annual submission of a copy of the CMHS Community Mental Health Block Grant Application and comment on it to the Governor of the State of Iowa; and
- H. To perform other duties as required by federal regulations.

FY16-17 Block Grant Committee Meeting #1
December 16, 2014
Hoover 5 SE, Side 2 and by telephone
11:00 am to 12:30 pm

Committee Members:

- Teresa Bomhoff
- Ken Briggs
- Tammy Nyden (phone)
- Anna Killpack (phone)
- Christina Scharck (phone)
- Brad Richardson (phone)
- Kim Wilson (phone)
- Jackie Dieckmann (phone)
- Michelle Tilotta (phone)

MHDS Staff:

- Laura Larkin
- Connie Fanselow

Michelle is the Substance Abuse Block Grant Manager for the Iowa Department of Public Health (IDPH). DHS and IDPH have been coordinating in the development of the two block grant applications.

Laura talked about plan and process and led the group in a review of the last two year plan that describes the status of the mental health system in Iowa and the other systems that interact with it, particularly with regard to the specific populations of adults with serious mental illness and children with serious emotional disturbance. The previous plan narrative will be the basis for developing the Fiscal Year 2016 & 2017 plan. The committee will discuss what has changed and how it should be updated. Laura noted that federal guidance for the FY 16-17 plan has not yet been issued.

- People who are content experts in specific areas will be asked to share updates and give their insight in those areas
- The committee will try to identify where needs exist and how they can be addressed
- Need attention to how the system addresses the needs of diverse minority populations; this has been a challenging area in previous plans
- The plan will describe adult and children's services in one narrative, with explanation in areas where they differ

Review and Discussion:

Overview of the State Mental Health System Updates:

- Regions began operation July 1, 2014; all references to counties will need to be changed to regions
- Integrated Health Homes have been implemented statewide
- Iowa Health and Wellness Plan began January 1, 2014
- IHAWP medically exempt process
- Toledo Juvenile home closed

Strengths and Needs:

- Need for more development of a comprehensive children's mental health system
- Need for more outreach and engagement to get people enrolled in IHAWP (Teresa Bomhoff will share a "Parity and Disparity" report from NAMI)
- Compare number of people enrolled in IHAWP to number of people potentially eligible to enroll

Prevention:

- NAMI training
- Mental Health First Aid training
- Youth MHFA instructor training
- Department of Education grants for MHFA and school districts participating

Early Intervention:

- Programs for young children – Early ACCESS
- Update ACEs activities
- Brain and Behavior Conference held - over 800 attendees
- Tammy Nyden will share updates on NAMI's Children's MH Committee
- Project LAUNCH
- New state suicide prevention plan
- Therapeutic school in southwest Iowa; Anna Killpack will share information
- The 5% set aside for the early intervention programs will be addressed in a whole new section
- Anything on early intervention for adults?
- Early intervention in terms of recognizing and addressing the onset of mental illness symptoms in youth

Treatment:

- Update on the Iowa Plan for Behavioral Health – numbers served, new services added
- Teresa suggested a chart comparing what MH services are covered by Medicaid, The Iowa Wellness Plan, and the Marketplace Choice plan
- Number of MHI and acute care beds available
- Availability of RCF beds – several RCF closures and movement of people into community settings
- Ken noted concerns about making sure needs are identified and people are able to connect with the services they need
- Teresa suggested using numbers and comparisons as much as possible

- PMICS
- Substance abuse assessment and treatment numbers
- Data on waiting times in emergency rooms? – could speak to the need for an acute bed tracking system
- Regions starting to provide core services, including crisis stabilization – new and interesting things regions are doing
- Programs to avoid hospitalizations
- Co-occurring capability, including SA providers
- Multi-dimensional family therapy
- Depression screening PHQ2 (of9)
- Case management
- CMH waiver
- Changes in the Habilitation program and IHAWP users
- Educational services and supports
- Project AWARE grant
- Educator MH training

Veterans Services:

- Ken said they are changing fast
- More need for PTSD services
- Closure of Knoxville campus – look at need for acute beds

Homeless Services:

- PATH program
- Housing supports
- IFA's new requirements for MH training for property managers connected to housing development tax credits

Supported Employment:

Providers of MH Services:

Children's MH System:

- Shortage of psychiatrists
- Teresa B. will share the workforce report from AMOS
- No regional entity or central point of coordination for children's services
- Youth and transition

Recovery Support Services:

- Talk about family support
- Peer and family support RFP
- Advocacy groups

STEP TWO – Identify the unmet service needs and critical gaps within the current system:

- Updates on mental health courts – Christina will share information from Wapello County; Pottawattamie is also starting one
- MH training for law enforcement and educators

Planning Steps/Setting Priorities:

- Laura will contact committee members to schedule meetings for January and February
- Will probably plan three meetings and do follow-up review by email
- Next meeting will review at a deeper level
- Committee members are asked to send any additional information they have to share prior to the next meeting if possible

Notes by Connie Fanselow

MHPC Block Grant Committee Meeting #2
January 20, 2015
10:00 am to Noon
Hoover 5 NE, Side 2
Notes by Connie Fanselow

Committee Members Present:

- Teresa Bomhoff
- Ken Briggs
- Jackie Dieckmann (phone)
- Anna Killpack (phone)
- Tammy Nyden (phone)

Staff:

- Laura Larkin
- Connie Fanselow
- Michelle Tilotta, IDPH

Introduction - Laura provided an update:

- The draft block grant application form is now on SAMHSA website
- It is about 87 pages and can be reviewed electronically
- SAMHSA is accepting public comment on the document for 60 days starting January 8
- SAMHSA is looking for information on how states are using their resources most effectively

Laura indicated the planning steps have not really changed from previous applications.

Page 15 - Planning Steps 1 & 2:

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

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

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

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

Laura noted that Iowa's application has often lacked information about tribal resources. Ken said he has some connections at Meskwaki and he will see if he can get any information about mental health resources available.

Michelle talked about the Substance Abuse application:

- It has had some more significant changes
- IDPH is in the process of reworking the state suicide plan
- Suicide prevention grant updates
- Opportunities for training for providers on medication assisted treatment
- Requiring narratives about pregnant women in SA treatment
- Analysis of guidance on use of SA block grant for housing; it must be for residential treatment services and not-for-profit – clarifying what that means

SAMHSA has removed the reference to submitting applications by April 1, but is recommending filing much earlier than Oct. 1 and would like submissions as soon as possible.

SAMHSA has moved to a new data reporting platform for all discretionary grants and want SA and MH data sources to stream together. They will be requiring the use of client interview tools at intake and after services delivered as performance measures.

Review & Discussion - Laura directed everyone's attention to page 25 of last year's application, where the committee's review left off at the last meeting.

Department of Education Suicide Prevention:

- New DoE and IDPH legislative report in 2014
- Include data on number of educators trained

Veterans:

- Ken will talk to VA providers
- Iowa Veterans Home has closed their psychiatric beds and eliminated psychiatrists and psychologists
- Services available at Des Moines VA and Iowa City VA
- Involvement with peer support
- Loan forgiveness program to attract workforce
- Governor's Home Base program to attract veterans to Iowa

Laura noted that SAMHSA considers veterans a population that may need special attention.

Tammy asked to go back and revisit the CMH Waiver:

- Need for step down programs; services in community not available for children leaving PMICS, including group homes, day programs, therapeutic schools
- Thinks this should be addressed as a gap

Homeless:

- PATH is a formula grant from SAMHSA; DHS RFPs the program to provider agencies, currently six in Iowa
- PATH provides outreach to help connect people to housing and services
- Add in numbers and locations of shelters and shelter beds
- Number of homeless in the state?
- Address homelessness and education?
- Prevalence rate of MI and SA in homeless population?

SOAR:

- Assists in making application for SSI/SSDI benefits
- Include number of people trained and number of people who were assisted

Housing Supports:

- Need to update
- Information from Community Integration Workgroup Report can be included
- Add number served with rental assistance and number on waiting list
- Michelle said Access to Recovery grant can no longer pay for housing supports
- Rural Development has project-based housing assistance
- IFA programs/HCBS Rent Subsidy Program – clarify IFA role and Medicaid HCBS funding restrictions for housing
- Gaps - criminal background disqualifies a person for housing programs

Supported Employment & Employment Services:

- Will work with MHDS employment specialist to update
- A lot of activities have been going on in this area

Providers of Mental Health Services:

- Community mental health centers and other providers accredited by DHS
- Providers who work with regions
- Will update EBPs and best practices

Tammy said EBPs and best practices are not available statewide and asked if there is a way to indicate where the gaps are. Laura said there is information about how CMHCs have used block grant funds for training and services in these areas, although most of the actual service delivery is paid for by Medicaid or private insurance. Laura said there is not definitive information on the services that all providers are delivering across the

state and there is not a way to track what EBPs are being used by what providers to pinpoint particular areas of gaps. She said she will provide more detail where it is available.

FQHCs:

- Will update

MH Professionals Statewide:

- Teresa B. has updated some information about mental health professionals
- Know we have shortages; the federal government has designated Iowa a MH shortage area

Children's MH system:

- Project LAUNCH is ending; a new RFP will be issued
- Additional information on the public health adolescent grant, which is providing multi-dimensional intensive family therapy in selected sites until September 30
- The grant will be re-released and IDPH can apply for another year
- Youth focused suicide prevention and screening

Systems of Care Programs:

- Address problem of getting services for children with co-occurring issues (example: MH behavioral and autism)
- Services are limited even though the child meets the criteria for SED because of co-morbid conditions

Youth Aging Out of Foster Care/Transition Age Youth:

- Services are coordinated through the Division of Children and Family Services at DHS; will work with them to update
- AMP – Achieving Maximum Potential

Next Meeting:

- Start on page 35 - Recovery Support Services

Laura will schedule another meeting for later in February to continue review of the application from last year. The committee should be able to finish the review next time. If anyone has thoughts or information they would like to share, please email to Laura or to the entire committee. Connie has been keeping notes and will send them out to everyone.

Ken will do some more work on veteran's resources.

Tammy suggested taking a look at the physical implications from medicines and the effects of psychiatric medication and finding an appropriate place to include that issue.

The meeting ended at 11:55 a.m.

MHPC Block Grant Committee Meeting Notes 3/17/15

Attending:

Tammy Nyden
Teresa Bomhoff
Kim Wilson
Laura Larkin
Jackie Dieckmann
Anna Killpack

Connie Fanselow
Peter Schumacher

There's a new Recovery Support Services Contract that was just awarded to Ulowa, they will be presenting at MHPC. This new program will be added to the recovery and support section. Question about whether it was paid for by regions or Medicaid. Peer support is an IHH core service, could be done by regions, but Medicaid is planning on it now.

Support and Community Living will be updated. Peer Support will be updated to reflect Ulowa Peer Support Specialist (PSS) and Family Peer Support Specialist (FPSS) contract.

WRAP will be updated to reflect new trainings. Kim asked for something on housing in recovery because there are so many services with WRAP. Laura would like to mention it in recovery for sure. It is mentioned elsewhere.

Jackie Dieckmann asked about sub-acute services, and Anna Killpack asked about crisis services. Laura says these will have sections to themselves.

Kim Wilson asked for clarification on the term "Medically frail". Laura answered that it is a federal term roughly equal to the state term "Medically exempt", the section on the Iowa Health and Wellness Plan will be redone to match and update progress.

Anna Killpack asked about therapeutic schools in Iowa. There is only one currently. Laura said she would ask the department of Ed about it, and see if they have more information about them.

Laura encouraged the committee members to let her know about other services she forgot to mention.

Consumer Organizations:

Jackie asked why the Olmstead Consumer Task Force was not included. Laura said she would add them. Jackie also asks for the addition of Disability Rights Iowa.

Laura will add the Ulowa Centers for Disabilities and Development, Parents Creating Change, and the Iowa Disability and Aging Advisory Network as well. Other groups mentioned were Life Long Links (formerly ADRC), Tourette's syndrome Association, and Autism groups. All groups currently in the application will be updated as appropriate.

If there are any we've missed, please let Laura know and she will include them.

Unmet Service Needs in Iowa:

Laura said she hesitates to have this discussion with a small group.

Jackie expressed concern with long term community support and the lack of sub-acute services right now. Jackie would also would like to look at court committals and people waiting for slots.

Anna would like to see more therapeutic schools throughout the state.

Laura needs to learn more about therapeutic schools and see if there's a distinct definition for a therapeutic school, or if some schools just have a different philosophy for how to educate children with special educational needs. Many schools refer to themselves as therapeutic and focus on behavior modification.

Next Meeting:

Will probably in late April or early May. Will probably be looking at Step 2, which is more focusing on the unmet needs in the system. Please be thinking about them for next meeting.

A word of caution from Laura that for the purposed of the block grant application, we need to find things that can be measured and show with data as unmet needs or things to improve upon.

Larkin, Laura L

From: Larkin, Laura L
Sent: Friday, August 07, 2015 3:35 PM
To: 'Teresa Bomhoff'; 'simhc@lisco.com'; 'brad-richardson@uiowa.edu'; 'kgraves@live.com'; ' (kebriggs@earthlink.net)'; 'Kim Wilson'; 'jackiead@cox.net'; 'annakillpack@yahoo.com'; 'Nyden@grinnell.edu'
Cc: Armstrong, Theresa; Tilotta, Michele [IDPH]; Schumacher, Peter J
Subject: RE: MHPC committee for MHBG Fy16-17 Plan - update
Attachments: FY14-15MHBG-Plan-p.11-63.pdf; MHPC Priority Doc. 2015.pdf

MHBG Committee Members:

We met today to review where we are and what will be happening in the next three weeks prior to the Sept. 1 submission of the FY16-17 MHBG application.

Present were Teresa Bomhoff, Kim Wilson, Brad Richardson, Laura Larkin, and Peter Schumacher. Brad requested the narrative document that we will be updating-it is attached. As you can see, some areas will only need updating, while others will have major revisions based on changes in the system since the 2013 application.

We discussed priority areas that MHDS will consider for the targeted priority items for FY16-17. The narrative document also has the three previous priority items included.

Priorities previously shared by committee members and added to today are:

- The MHPC priority document (attached)-includes MH training of law enforcement and first responders, development of therapeutic schools, development of MH workforce, increase access to MHFA in schools, increase access to MH training for persons involved in victim or offender programs for domestic or sexual abuse, strengthen opportunities for early intervention, strengthen capacity of Office of Consumer Affairs.
- Lack of long-term care options, including lack of RCF, subacute, and overall lack of adequate community supports for persons with an SMI. This is also related to persons under mental health commitment who might be unable to leave a hospital due to lack of appropriate community placement or services.
- Crisis services development
- Veterans MH services access
- Continued regional system of care for adults development
- Children's MH system development

We also discussed system elements that members think should be addressed in the system overview.

- Use of ADRC for information and referral
- Medicaid/IHAWP changes -Change to MCO for all Medicaid services, any changes anticipated for individuals' services
- IDPH Suicide prevention activities

- 5 Star Quality Initiative
- Integration of Primary Care and Behavioral Health grants/programs
- Overview of regional service development with possible charts and graphs to show each region's progress in implementing core and core plus services.
- New children's well-being workgroup

If there are other priority items or items you think should be mentioned in the system overview, please send them to me.

My plan is to work this next week on incorporating this information and have a draft out in the next week for your feedback. As stated before our timeframe is compressed, so due dates for comments will be brief to keep the work moving forward.

Thanks for all of your help,

Laura Larkin, Executive Officer 2
Iowa Department of Human Services
Division of Mental Health and Disability Services
1305 E. Walnut
Des Moines IA 50319
515-242-5880



Bridging the Gap for Iowans with Mental Health Issues

August 31, 2015

Virginia Simmons
Grants Management Office
Office of Financial Resources, Division of Grants Management
SAMHSA
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Laura Larkin
Iowa Department of Human Services
Division of Mental Health and Disability Services
1305 E. Walnut St.
Des Moines, IA 50319
515-242-5880

RE: Comments on FY 16-17 Mental Health and Substance Abuse Block Grant

Dear Virginia and Laura:

This letter is an acknowledgement of the completion of the FY 16-17 Mental Health and Block Grant application. The Iowa Mental Health Planning Council had several opportunities to provide input to its preparation as indicated by the minutes of our meetings included in the grant application.

The most recent communication to Laura on 8-9-2015 was as follows:

Thank you for the conversation via telephone this last week on completion of the Block Grant application. Since then, I've sent you the redesign history document for information on legislative actions this last year. Included in this email are more documents for your use.

One of the purposes of the IMHPC is to **monitor, review and evaluate**, not less than once each year, the **allocation and adequacy** of mental health services within the State.

Be sure to include the RESTORE program at Eyerly Ball.

Please note in the redesign history document sent to you

https://www.namigdm.org/en/resources/iowas_mental_health_system/

– it includes FY 16 legislative priorities – which are indicative of need. You also have the list of funding priorities from the IMHPC courtesy of the Monitoring and Oversight committee's work.

The following attachments or links are to documents indicating need, urgency, or both.

1. Attachment 1 - Report Card
2. Attachment 2 – Statistical charts
3. United Way report on mental health needs in central Iowa
The report - http://www.unitedwaydm.org/UserDocs/Pages/Behavioral_Health_Report_6_2_2015.pdf
The 2 page summary -
http://www.unitedwaydm.org/UserDocs/Pages/Behavioral_Health_Summary_Report_May_2015.pdf
The addendum http://www.unitedwaydm.org/UserDocs/Pages/TAC_Study_Addendum_5-26-2015.pdf
4. AMOS Mental Health and Disability Workforce Report
https://www.namigdm.org/documents/news/AMOS_MH_and_Disabilities_Workforce_63E73DDF8D9E2.pdf
For ex: We have 316 prescribers in the state and very few training locations within the state to reach more. There is no entity identified to have the responsibility of building an inadequate mental health workforce. An often mentioned incentive which the state does not have is a loan forgiveness program designated for all levels of mental health professionals.
5. The third attachment is a report on mental health compiled by Dr. Angela Franklin at DMU with the help of a mental health committee. It is part of a larger report on a community health assessment. Several mental health needs are noted in this report.

Hopefully, the regions can provide information on core and core plus services in operation, and those that are prioritized to be developed. We had talked about placing the information in a chart or charts. This information would be very useful for many organizations and purposes.

Thank you for your diligence and expertise in assembling the Block Grant application, Laura.

This letter will be sent to the IMHPC members. We will advise the Iowa Mental Health Planning Council to read through the grant application and view it as having 3 major parts to look at:

- I. Page 10 – 51 – the narrative describing the Iowa mental health system
- II. Page 55-56 – Priority Areas
 - 1) Children’s Mental Health Services and Supports
 - 2) Peer Support Services
 - 3) Development of crisis services
- III. Page 56-121 – Environmental Factors and Plan – *Read the SAMHSA directions for each factor. Some of the information can be found in the narrative pages 10-51 – but was directly addressed in information following each factor in 3 instances.*
 - 1) The Health Care system and Integration
 - 2) Health Disparities
 - 3) Use of Evidence in Purchasing Decisions
 - 4) Prevention for Serious Mental Illness
 - 5) EBP for Early Intervention (5% set aside) – *has a narrative from state of Iowa*
 - 6) Participant Directed Care
 - 7) Program Integrity
 - 8) Tribes
 - 9) Primary Prevention for Substance Abuse
 - 10) Quality Improvement Plan
 - 11) Trauma
 - 12) Criminal and Juvenile Justice
 - 13) State Parity Efforts
 - 14) Medication Assisted Treatment
 - 15) Crisis Services
 - 16) Recovery
 - 17) Community Living and the Implementation of Olmstead
 - 18) Children and Adolescents Behavioral Health Services
 - 19) Pregnant Women and Women with Dependent Children
 - 20) Suicide Prevention – *has a narrative from state of Iowa*
 - 21) Support of State Partners
 - 22) State Behavioral Health Planning/Advisory Council and input on the MH/SA Block Grant Application - *has the minutes of IMHPC meetings with MHDS staff on the Block Grant completion*

There have been many changes in the adult mental health system through the Adult Redesign effort which started in 2011. We are certainly pleased with the development of additional services through Regional planning. For the most part, changes have been positive.

However, the State of Iowa still has a long way to go to receive an evaluation from the Iowa Mental Health Planning Council that mental health resources are adequate or that funding is adequate. The two most puzzling and controversial decisions made in the last year were:

1. The closure of the two Mental Health Institutes without having sufficient community based services in place to replace the services they provided. There are still too many individuals who need a level of care that is simply non-existent or not available in Iowa.
2. The swift move to privatized managed care companies for the Medicaid program when our State Medicaid Agency has been touted as one of the top programs in the nation. We'll have more to say on this topic as events unfold in the coming year.

A glaring gap in Iowa is a children's mental health system. We have pockets of children's mental health services – but no "system" that can be easily accessed. We have great hopes that we will have movement toward a children's system through the legislative workgroup which is being assembled and will have a report by 12-15-15.

The monumental stumbling block will be money to finance a children's mental health system – the same reason services are not robust for the adult system. Regions are still dealing with a 20 year old funding level minus \$40 million. The other controlling factor will be the lack of an adequate mental health workforce.

The gaps are outlined in the attachments to this letter.

Thank you for allowing us to make comment to the FY 16-17 Block grant application. Thanks also to Laura Larkin, for her hard work and the immense amount of time it took to assemble the information in our grant application.

Teresa Bomhoff
Iowa Mental Health Planning Council Chairperson
tbomhoff@mchsi.com

Attachments: Report Card – A Public Health Crisis
Statistics

A Public Health Crisis

Iowa Ranks at the Bottom of the 50 states in Mental Health Care

Prevalence and Rate of Treatment

Lifetime prevalence - 1 of 2 people (1.5 M)
Annual prevalence - 1 of 4 experience a mental illness (mild, moderate, severe) - 750,000 people
4.1% severe mental illness - 123,000 people
Half of all lifetime cases begin by age 14
Three-quarters by age 25
13% of youth age 8-15 live with mental illness causing significant impairment in their day to day lives
This figure jumps to 21% in youth age 13-18.
Less than half get help.

Beds - Acute Care, Sub-Acute, Crisis

47th in the nation for hospital beds based on our population
726 Acute care beds statewide (96 at MHI's)
compared to 123,000 with severe mental illness
Beds are full every day, people are turned away for treatment, tragedies happen
No facility based subacute beds - only 5 ACT teams
5 crisis observation centers
No place outside of criminal justice system to place persons with challenging behaviors for which effective treatment has not been found
Southern half of state in extreme need given the closing of two MHI's at Mt. Pleasant and Clarinda

Suicide

445 in Iowa in 2013 (17% increase) compared to 50 homicides
40,000 nationally compared to 20,000 homicides
Suicide is now the first cause of injury deaths, followed by car crashes, poisoning, falls and murder
Many who complete suicide have visited their medical doctor within one month of their death
Males complete suicide 4X the rate of females
Completed suicides are more likely to be men over 45 who are depressed or alcoholic.
Over 4600 youth die from suicide each year
Over 90% of those who complete suicide have a mental disorder - 1/3 have alcohol or other drugs in their system
In recent wars, there have been more suicides than combat deaths
22 veterans complete suicide every day

Stigma - Lack of knowledge about MI

A mental illness is a medical illness - a disease - a neurodevelopmental disorder, not a criminal offense
Mental illness is an equal opportunity disease. It strikes families from all walks of life regardless of age, race, income, religion and education.
A flaw in brain chemistry, not character
An ambulance won't respond to a request for medical assistance, our help comes from law enforcement
Treatment is needed, not punishment
Those with severe mental illness die on average 25-30 years sooner than the general population

Workforce - Services

Without adequate workforce, there is no mental health system, there are no services or beds
Iowa is: 47th for # of psychiatrists,
46th for # of psychologists
44th for overall mental health workforce availability
316 prescribers in the state
(150 psychiatrists in private practice, 146 ARNP's and 20 PA's with psychiatric emphasis)
Problems with poor reimbursement, high caseloads, frequent burn-out, enough training locations and dollars, incentives, loan forgiveness programs
Nationally, only 55% of psychiatrists accept insurance - they want cash and no interference from insurance to treat individuals
Dire need for direct care professionals, peers, home aides

Criminalizing a Medical Illness

Iowa builds prisons instead of recovery centers
40%+ of male inmates have mental illness
60%+ of female inmates have mental illness
70% have a substance use disorder
Local jails have larger percentages.
Beds are increasing in prison, reducing in the public sector
Nationally, there are 10X more people with mental illness in jails and prison than hospital beds
We've come full circle from the 1840's - Dorothy Dix would find more persons with mental illness in jails and prisons than in hospital beds in 2015, just like she did in the 1840's
People with mental illness and substance abuse need treatment, not punishment
We need investment in the public sector.



Projected FY 16 Cash Reserve (rainy day fund): \$538.9 million
 Projected FY 16 Economic Emergency Fund: \$179.6 million
 FY 16 ends June 30, 2016
 These numbers provided by LSA Legislative Services Agency

PLEASE FIND YOUR VOICE! Please contact the Governor & your legislators, we need more beds, workforce & services, not less!

Mental Health Institutes (MHI)	Total # of Beds	# adult beds	# child & adolescent beds	# geriatric beds	PMIC Beds*	Dual Diagnosis Beds	Substance Abuse Beds	Some of the prison mental health bed numbers compared to bed numbers outside corrections system
Cherokee MHI	36	24	12					100 bed Civil Commitment Unit for Sexual Offenders at Cherokee MHI
Clarinda MHI <i>Governor closed</i>	350 <i>Loss of beds</i>	450 <i>Loss of beds</i>		200 <i>Loss of beds</i>				The entire Clarinda MHI campus is now controlled by Dept. of Corrections – they have a 795 bed prison and a 147 bed minimum security unit.
Independence MHI	60	40	20		15			
Mt. Pleasant MHI – <i>Governor closed</i>	9 <i>Loss of beds</i>	9 <i>Loss of beds</i>				49 <i>Loss of beds</i>	50 <i>Loss of beds</i>	The entire Mt. Pleasant MHI campus is now controlled by the Dept. of Corrections – they have a 914 bed prison at the Mt. Pleasant MHI.
Total MHI beds	140 – 44 = 96	88 – 24 = 64	32	20 – 20 = 0	15	19 – 19 = 0	50 – 50 = 0	Iowa is: <ul style="list-style-type: none"> • 47th in the nation for # of acute care beds based on our population. • 44th in the nation for mental health workforce availability • 47th in the nation for # of psychiatrists • 46th in the nation for # of psychologists
Staffed Hospital Beds Statewide	630	475	90	61				
Total Updated 3-7-15	770 – 44 = 726	563	122	81 – 20 = 61				

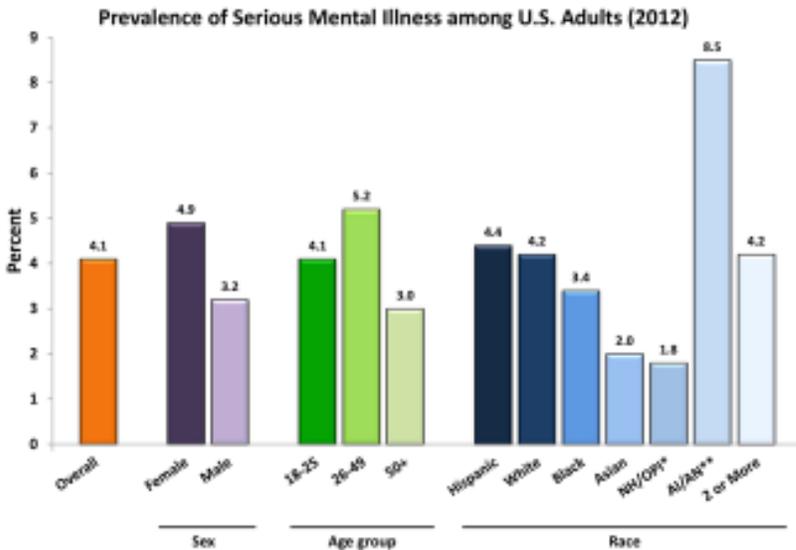
4.1% of Iowa's population has severe mental illness or approximately **123,000** people. Listed above are the beds available for acute care. Reduced to **726 vs. 123,000** if MHI's closed - beds are full every day, 365 days a year, access is difficult and will get worse – people are being turned away for treatment.

A critical need for Community based services.

These are Medicaid waiver programs Iowa offers eligible residents to allow persons to receive necessary services to remain in their home and community rather than an institutional setting.

Waiver Programs	# slots there are \$'s for	# on Waiting List May 2015	FY 2013 Ave. Cost per person
Health & Disability	2800	3585	\$10,356
AIDS/HIV	73	0	\$10,889
Elderly	9500	0	\$8824
Intellectual Disabilities	12912	944	\$36,021
Brain Injury	1400	1255	\$22,353
Physical Disability	1250	2707	\$5872
Children's Mental Health	1237	2148	\$11,617
	29172	10,639	

<https://dhs.iowa.gov/sites/default/files/5.7.15%20Monthly%20Slot%20and%20Waiting%20list%20%28public%29.pdf>



Check out www.infonetiowa.org/ for legislative information, too.

Legislative Branch www.legis.iowa.gov
 Iowa Senate: (515) 281-3271
 Iowa House: (515) 281-3221
Executive Branch www.governor.iowa.gov (515) 281-5211
MHDS Website <http://dhs.iowa.gov/>

More information at www.namigdm.org and www.nami.org

Data courtesy of SAMHSA.

*NI/OPI = Native Hawaiian/Other Pacific Islander
 **AI/AN = American Indian/Alaska Native

Comment on the MHBG

The FY16-17 MHBG Plan was sent to MHPC members on August 27, 2015 for review and comment. Attached is a letter from the MHPC chair, Teresa Bomhoff, indicating review of the MHBG plan. Ms. Bomhoff's letter also includes comments on the strengths and gaps of Iowa's mental health system but no specific comments on changes to the content of the MHBG plan. Another MHPC member also indicated receipt and review of the plan and offered positive feedback on the plan. The Plan will also be posted on the DHS website for public review and comment.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Teresa Bomhoff	Family Members of Individuals in Recovery (to include family members of adults with SMI)		200 S.W. 42nd Street Des Moines, IA 50312 PH: 515-274-6876	tbomhoff@mchsi.com
Kenneth Briggs, Jr.	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1701 Campus Drive, Apt. 3430 Clive, IA 50324 PH: 515-221-4560	kebriggs@earthlink.net
Jim Chesnik	State Employees	Iowa Department of Human Services	Hoover State Office Bldg., 5th Floor, 1305 E. Walnut Des Moines, IA 50319 PH: 515-281-9368	jchesni@dhs.state.ia.us
Jackie Dieckmann	Family Members of Individuals in Recovery (to include family members of adults with SMI)		620 Grace Street Council Bluffs, IA 51503 PH: 712-343-1647	jackiead@cox.net
Jim Donoghue	State Employees	Iowa Department of Education	Grimes Bldg, 400 E. 14th Street Des Moines, IA 50319 PH: 515-281-8505	Jim.donoghue@iowa.gov
Julie Kalambokidis	Parents of children with SED		6 North Hazel Glenwood , IA 51534 PH: 712-527-4188	Embracellc@yahoo.com
Sharon Lambert	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		719 13th Ave Coralville, IA 52441 PH: 563-499-3502	Lambertsha@gmail.com
Todd Lange	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		225 West 6th Street Dubuque, IA 52001 PH: 563-564-2933	tjlange1@yahoo.com
Amber Lewis	State Employees	Iowa Finance Authority	2015 Grand Ave. Des Moines, IA 50312 PH: 515-725-4900	Amber.lewis@iowa.gov
Lori Reynolds	Parents of children with SED		106 South Booth Anamosa, IA 52205 PH: 319-462-2187	lori@iffcmh.org
Donna Richard-Langer	Providers		4105 Bel Air Drive Urbandale, IA 50323 PH: 515-278-7010	drldkl@msn.com
Brad Richardson	State Employees	University of Iowa School of Social Work	Research Park, W206 Oakdale Hall Iowa City, IA 52242 PH: 515-953-1990	Brad-richardson@uiowa.edu
James W. Rixner	Family Members of Individuals in Recovery (to include family members of adults with SMI)		114 Midvale Avenue Sioux City, IA 51104 PH: 712-258-7855	jwrx@aol.com
Kris Graves	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2631 Lakeside Drive #1 Iowa City, IA 52404 PH: 319-354-3155	kgraves@live.com

D.J Swope	State Employees	Iowa Department on Aging	Des Moines, IA	djswope@iowa.gov
Kimberly Wilson	Others (Not State employees or providers)		2510 320th Street Spencer, IA 51301 PH: 712-262-9438	kwilson@co.clay.ia.us
Lee Ann Russo	State Employees	Iowa Vocational Rehabilitation Services		Leeann.russo@iowa.gov
Dennis Sharp	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1106 4th Street, Apt. 416 Sioux City, IA 51101 PH: 712-899-2809	Dennissharp2007@yahoo.com
Kathy Stone	State Employees	Iowa Department of Public Health, Division of Behavioral Health	PH: 515-281-4417	kathy.stone@idph.iowa.gov
Dr. Gary Keller	State Employees	Iowa Department of Corrections	Iowa Medical and Classification Center, Highway 965 Oakdale, IA 52319 PH: 319-626-4278	Gary.j.keller@iowa.gov
Christina Schark	Providers		110 East Main Street Ottumwa, IA 52501 PH: 641-682-8772	simhc@lisco.com
Craig Matzke	Providers	Iowa Law Enforcement Academy	3514 SW 34th St. Des Moines, IA 50321	
Anna Killpack	Parents of children with SED		32356 270th St. Neola, IA 51559	
Kathleen Goins	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		129 West High Street Villisca, IA 50864	Kathleen@waubonsiemhc.com
Julie Hartman	Others (Not State employees or providers)		207 3rd Ave. Box 285 Collins, IA 50055	julieabaird@gmail.com
Marlene Jessop	Parents of children with SED		513 Frank St. Ottumwa, IA 52501	simhcmarlene@lisco.com
Tammy Nyden	Parents of children with SED	NAMI	2512 Princeton Road Iowa City, IA 52245	namiowacmhc@mediacombb.net
Jennifer Vitko	Others (Not State employees or providers)	South Central Iowa Behavioral Health Region	Ottumwa, IA 52501	jvitko@wapellocounty.org
Rhonda Shouse	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		530 Bentley Drive. #2 Marion, IA 52302	Rhonda_shouse@yahoo.com
Lisa Wunn	Parents of children with SED		2105 Barr Drive Ames, IA 50010	Lisa1wunn@yahoo.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	33	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	6	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	19	57.58%
State Employees	8	
Providers	3	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="3"/>	
Total State Employees & Providers	14	42.42%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="1"/>	

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

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The planning council committee met with DHS staff on four separate occasions to provide input on the content of the MHBG. Information was also shared via email between planning council members and DHS staff. Meeting minutes are attached. The Planning Council did not make any recommendations to modify the application.

Footnotes: