STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH
CORDELL HULL BUILDING, 3RD FLOOR
425 FIFTH AVENUE, NORTH
NASHVILLE, TENNESSEE 37243-0675

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

July 14, 2011

SAMHSA
Desk Officer
Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

Sent via facsimile to: 202–395–7285

RE: Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2012-2013 Application Guidance and Instructions (OMB No. 0930-0168) Revision

Dear SAMHSA Desk Officer:

The purpose of this letter is to provide comment on the ***Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2102 – 2013 Application Guidance and Instructions Revision*** ("*Unified Application Revision*"), posted in the *Federal Register / Vol. 76, No. 117 / Friday, June 17, 2011 / Notices* in response to comment received during the prior public comment period that closed on June 9, 2011.

The Tennessee Department of Mental Health (TDMH) is the state's mental health and substance abuse authority. Its mission is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports based on the needs and choices of individuals and families served. The department is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocating for persons of all ages who have mental illness, serious emotional disturbance, or substance abuse disorders. The department is privileged to

provide oversight and administration of four SAMHSA Children's Mental Health Initiative (CMHI) Grants ("System of Care Grants"). TDMH also annually assesses the public's needs for mental health, substance abuse, and recovery service supports. Title 33 of the Tennessee Code Annotated requires that functions of TDMH be carried out in consultation and collaboration with current or former service recipients; their families, guardians, or conservators; advocates; providers; agencies; and other affected persons and organizations.

SAMHSA is to be commended for posting the *Unified Application Revision* for further public comment. The additional guidance and clarification included in the updated instructions, as highlighted in the below comments, are appreciated. However, we would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults. The *Unified Application Revision* cites the Institute of Medicine's (IOM) 2009 Report, *Preventing Mental, Emotional, Behavioral Disorders Among Young People: Progress and Possibilities.*[1] This publication's *Report Brief for Policy Makers* includes the following call to action:

> ***National leadership is necessary to make systematic prevention efforts a high priority in the health care system as well as an integral aspect of the network of local, state, and federal programs and systems that serve young people and families***[2] (p. 3).

The *Unified Application Revision* is the opportunity for SAMHSA to assume this national leadership role and assist local, state, and federal programs in better understanding and utilizing a System of Care (SOC) framework to improve outcomes for children and youth with behavioral health needs and their families.

TDMH has outlined the following recommendations to be included in the *Unified Application Revision:*

Recommendation 1: Provide additional language highlighting the SOC approach as a best practice in serving children and youth with MH and/or SA needs and their families.

The *Unified Application Revision* does add language under *Section 3d* on page 38 that custodial parents should be involved in the planning, monitoring and delivery of services to their children. However, reference to SOC as a best practice remains buried in the document within a bullet about thinking more broadly than historically served populations on page 11, and within a bulleted list as an example of a service-specific

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change on page 23. **Given SAMSHA's recognition of the success of the CMHI program and the SOC framework, the lack of emphasis on children, youth and families and SOC within SAMHSA's Strategic Initiatives, and the requirement in the *SOC Expansion RFA* for grantees to explore the use SABG and MHBG dollars to fund SOC expansion, the reference to SOC as a best practice approach for children, youth and families should be highlighted within the *Unified Application Revision* instead of hidden within the lengthy text of the instructions.**

Recommendation 2: Ensure that a certain minimum percentage of MHSBG and SAPTBG dollars be allocated to serve children and youth with MH and/or SA needs and their families. The minimum percentage should be based on a state's population of children with social, emotional, or behavioral needs and diagnosable mental health disorders.

The *Unified Application Revision* does add language under *Section 3a* on page 19 requiring that children with SED and their families be included in the MHBG and SABG. needs assessments; adding that the description of the behavioral health resources and systems should include "youth who are often underserved" as part of the planning steps in *Section 3b* on page 21; including reference to "age-appropriate interventions and providers" on p. 24; and adding the "State Child Serving Agency" as a suggested partner on page 12 and suggested member of the Advisory Council in Table 11 on page 48. While these additions are appreciated, **it is critical that SAMHSA ensures that states allocate a minimum percentage of their Block Grant funding to support initiatives for children and youth and their families.**

In federal fiscal year 2007, 20.4% of Medicaid spending was on children (17 and younger), with an additional 42.4% of spending on "disabled" population, which includes children[3]. Without this mandate and in the current fiscal climate, there is a risk that states will use this formula funding to cover historic adult system deficits, thereby limiting, rather than expanding, improving, and sustaining SOC for children and youth with behavioral health needs and their families.

Recommendation 3: Include specific requirements on service provision for children and youth with MH and/or SA needs and their families within the *Unified Application*, and develop a technical assistance unit with expertise on the needs of and best practice approaches to serving children and youth with behavioral health needs and their families to ensure compliance and share expertise at both state- and federal-level planning efforts.

Section 3k on page 43 requires states to describe their technical assistance needs. The *Unified Application Revision* does add instruction to take into account cultural and linguistic competency needs, but **falls short of requiring that states explore technical assistance needs to effectively serve the populations required to be**

[3] Kaiser Family Foundation. (2010). State Health Facts: **Distribution of Medicaid Payments by Enrollment Group (in millions), FY2007. Retrieved from the State Health Facts website on 7/14/11:** http://www.statehealthfacts.org/.

included in the needs assessment, including children with SED and their families (*Section 3a,* p. 19). System planners at both the federal and state levels need to understand and appreciate the data that demands our focus on children and youth with behavioral health needs and their families, and have expertise to ensure that health reform and Block Grant planning include best practice approaches that will improve outcomes for children, youth and families with MH and SA needs. For each grant that is issued, different technical assistance providers and/or evaluators are selected, without a requirement that those providers coordinate with one another. States such as Maryland and Georgia currently have CMHI grants, CMS PRTF Demonstration Waiver Grants, CHIPRA Quality Demonstration Grants, and Healthy Transitions Initiative grants, all of which have their own data collection and reporting requirements and technical assistance providers. **Through all of these grants and, in particular, the *Unified Application*, SAMHSA has an opportunity to model SOC for the States, through coordinated and targeted technical assistance and support that would ensure that the behavioral health needs of children, youth and families are met.** As noted above, without dedicated requirements and a focus on compliance, the progress that has been made to grow and sustain SOC for children, youth and families could be lost.

The Unified Application should be an opportunity for collaboration, coordination, and leveraging. Without implementation of the recommendations outlined in this letter, the *Unified Application* may result in the pitting of the "adult system" against the "child system," and the wasted effort of individuals trying to identify "what works" when we know that an SOC framework is intuitive, tested, and accessible for families, providers and communities.

We cannot afford to lose the momentum that has been building for almost two decades. We thank you for the opportunity to provide comment on this important topic and look forward to partnering with SAMHSA to ensure that the SOC framework is used for children and youth with intensive needs and their families to ensure individualized, home- and community-based, data- and outcomes-driven, and culturally- and linguistically-competent services and supports.

Sincerely,

E. Douglas Varney
Commissioner
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July 13, 2011

SAMHSA Desk Officer
Human Resources and Housing Branch
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New Executive Office Building
Room 10235
Washington, DC 20503

Via FAX: (202)395-7285

Comment on SAMHSA Agency Information Collection, Submission for OMB
(Federal Register 76:117)

Goal #9 of the SAPT Block Grant application must be revised to include an agreement to publicize the availability of treatment and admission priority for pregnant women at all treatment entities funded under the Grant. At present, Goal #9, which addresses the requirements of 96.131 relating to treatment of pregnant women, fails to address the requirement of 96.131(b) that the State publicize the availability of treatment and admission priority for pregnant women.

States acting in reliance upon the application do not complete the requirement of 96.122(g)(11) that the State Plan submitted in the application includes "A detailed description of State procedures implementing 96.131 relating to treatment services for pregnant women." because Goal #9 omits the publicity requirement of 96.131(b). States acting in reliance upon Goal #9 do not report on State goals, objectives, and activities relating to the requirement of 96.131(b) to publicize the availability of treatment and admission priority for pregnant women, and thus do not complete the reporting requirements of 96.122(f)(1) and (5) , because Goal #9 omits the publicity requirement of 96.131(b). Finally, the SAPT Block Grant application itself fails to meet the requirement of 96.122(c) that "The application will require the State to submit the assurances listed under 96.123, *the report as provided 96.122(f), and the State Plan as provided in 96.122(g).*" [emphasis added] because Goal #9 omits the publicity requirement of 96.131(b).

96.131(b) states:

/

"The State will, in carrying out this provision [of 96.131(a), requiring that treatment entities funded under the SAPT Block Grant provide treatment and admission priority to pregnant women], publicize the availability to such women of services from the facilities and the fact that pregnant women receive such preference. This may be done by means of street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers, and social services agencies."

The requirement of 96.122(g)(11) that the State Plan of the application includes "A detailed description of State procedures implementing 96.131 relating to treatment services for pregnant women." is met by the "Intended Use" response of the State to Goal #9, which appears in the application as:

"An agreement to ensure that each pregnant women be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant women be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman; or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. Section 300x-27 and 45 C.F.R. Section 96.131.)

"*Note:* In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*"

Note that Goal #9 is silent with regard to the requirement of 96.131(b) that the State publicize the availability of treatment and admission priority for pregnant women.

This creates the problems described in the second paragraph of this letter – i.e. State Plans that fail to meet the requirements of 96.122(g)(11), failure of the States to report progress on State goals, objectives, and activities relative to the publicity requirement of 96.131(b) as required by 96.122(f), and failure of the application itself to meet the requirements of 96.122(c).

A State that fails to address the publicity requirement of 96.131(b) in its State Plan and in its reporting of State goals, objectives, and activities, is likely to also ignore that requirement in its operations. It does little good to offer treatment and admission priority for pregnant women if nobody knows about it: Nobody knows how many children have been born with substance-related birth defects or perinatally-transmitted communicable diseases because it wasn't known that the mother could have obtained treatment and admission priority.

The Secretary of Health and Human Services identified the importance of the publicity requirement in the explanatory comments that preface the regulations specified in the Interim Final Rule for 45 CFR, Part 96:

> "The Secretary believes it is critical that pregnant women who are addicts be provided substance abuse and other treatment as early as possible both because of the health of the mother and the effects of the addiction on the fetus...
> "In carrying out this provision [requiring that treatment entities funded under the Grant provide treatment and admission priority to pregnant women] the Secretary requires the State to ensure that the availability of treatment to pregnant women is publicized by public service announcements (radio/television) or street outreach programs."

Goal #9 must be revised to address all requirements of 96.131 relating to treatment of pregnant women, and to address the intent of the Secretary of Health and Human Services stated in the introduction to the Interim Final Rule at the time the regulations were adopted: Goal #9 must be revised to address an agreement that the State will publicize the availability of treatment and admission priority for pregnant women as required by 96.131(b).

The SAPT Block Grant application should also be revised to require performance objectives specific to the two priority treatment populations specified in statute: Injection Drug Users (IVDU's) and pregnant substance abusers.

Performance objectives should be the number of IVDU's receiving treatment, and the number of pregnant women receiving treatment. These figures must be placed in the context of the State's best estimate of the number of IVDU's and substance-abusing pregnant women in the State, based upon the best available epidemiological and demographic data.

It is exceptionally odd that SAMHSA does not already require performance objectives relating to treatment of the two priority populations specified in statute. Without such objectives, it is impossible to determine if a State is adequately serving these populations. It is even more odd that the States would be allowed to specify additional "priorities" in the absence of evidence that the two priority populations specified in statute are receiving adequate treatment. "Priorities" is put into quotes because SAMHSA or the States establishing additional "priorities" in the absence of evidence that IVDU's and pregnant women receive adequate treatment services makes IVDU's and pregnant women not priorities at all, but instead populations for whom efforts to provide treatment services are diluted by efforts to address other "priorities". This is an example of the "flavor of the month" prioritization that so plagues the helping professions. Thankfully, some stability in establishing priorities is maintained by IVDU's and pregnant women being specified as priorities in statute, which is relatively difficult to change. SAMHSA should comply with the intent of the statute.

In Nevada, failure of SAMHSA and the State to address IVDU's and pregnant women as true priorities resulted in performance measures being established for neither in the SAPT Block Grant application, the requirement of 96.131(b) to publicize the availability of treatment and admission priority for pregnant women largely being ignored in the State Plan for Goal #9 (which, as described in the first portion of this letter, itself ignores 96.131(b)) in the application, 96.131(b) largely being ignored in State reporting on Goal #9 (again, largely because Goal #9 itself ignores 96.131(b)), and subsequently State procedures to publicize the availablity of treatment and admission priority for pregnant women being so astonishingly inadequate that treatment of this population has *decreased* by over 50% since 2007.

The legislative intent of Public Law 102-321, which established both SAMHSA and the requirement that the State publicize the availability of treatment an admission priority for pregnant women, was to *increase* the access of pregnant women to treatment, not decrease it. This would not have happened had publicizing the availability of treatment and admission priority for pregnant women, as required by 96.131(b), been addressed in Goal #9 and had there been a performance objective of the number of substance-abusing pregnant women obtaining treatment.

Only when it is demonstrated that the State has adequately served these two populations should its efforts be directed towards addressing other priority populations. Even if establishment of performance objectives for other populations is to take place, it still is inexcusable to not establish performance objectives for the two priority populations established by statute to determine the extent to which the State has addressed their treatment needs.

A bit of a cautionary note: The requirements of 96.134 for programs receiving funding set aside for specialty treatment of pregnant women and women with dependent children are often confused with the requirements of 96.131 regarding treatment of pregnant women at *all* treatment programs receiving SAPT Block Grant funding. This letter is with regard to the latter, and only the latter.

Sincerely

Barry W. Lovgren

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Fair Lawn, NJ 07410
201-796-6209
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Family Support Organization
of Bergen County

Fax

To: SAMHSA Desk Officer **From:** Rosemarie Loretto

Fax: 202-395-7285 **Pages:** 6 w/cover

Phone: **Date:** 7/14/11

Re: application **cc:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

July 14, 2011

SAMHSA
Desk Officer
Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

Sent via facsimile to: 202–395–7285

RE: Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2012-2013 Application Guidance and Instructions (OMB No. 0930-0168) Revision

Dear SAMHSA Desk Officer:

The purpose of this letter is to provide comment on the ***Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2102 – 2013 Application Guidance and Instructions Revision*** ("*Unified Application Revision*"), posted in the *Federal Register / Vol. 76, No. 117 / Friday, June 17, 2011 / Notices* in response to comment received during the prior public comment period that closed on June 9, 2011.

The Family Support Organization of Bergen County (FSOBC) is a 501 (c) (3) incorporated in the State of New Jersey. FSOBC is a component of the NJ Children's Mental Heath System of Care. The FSOBC is a family- run, county based organization that provides direct family to family peer support, education and advocacy to family members of children with emotional and behavioral challenges. As such, it is from this perspective that we submit the following comments to you regarding the *Unified Application Revision.*

SAMHSA is to be commended for posting the *Unified Application Revision* for further public comment. The additional guidance and clarification included in the updated instructions, as highlighted in the below comments, are appreciated. However, we would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults. The *Unified Application Revision* cites the Institute of Medicine's (IOM) 2009 Report, *Preventing Mental, Emotional, Behavioral Disorders Among Young People: Progress*

and Possibilities.[1] This publication's *Report Brief for Policy Makers* includes the following call to action:

> ***National leadership is necessary to make systematic prevention efforts a high priority in the health care system as well as an integral aspect of the network of local, state, and federal programs and systems that serve young people and families***[2] (p. 3).

The *Unified Application Revision* is the opportunity for SAMHSA to assume this national leadership role and assist local, state, and federal programs better understand and utilize a System of Care (SOC) framework to improve outcomes for children and youth with behavioral health needs and their families.

In SAMHSA's *Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and their Families (Short Title: System of Care Expansion Planning Grants)* Request for Applications ("*SOC Expansion RFA*"), there is a recognition that the accumulating research and evaluation results from the Children's Mental Health Initiative (CMHI) program over the last 15 years have demonstrated the success of an SOC approach. Children and youth with intensive needs and their families are not served by a single provider or a single agency. As SAMHSA has demonstrated for over 15 years through its CMHI grants, an SOC approach recognizes the importance of multiple community-based services and supports working together in partnership with youth and families to design the services and supports that will be most effective for that particular youth and family. In fact, SAMHSA noted that youth in SOC tend to improve in attendance, performance, and progress in school, attend school more regularly, and have emotional and behavioral gains[3].

It appears that the intent of the *SOC Expansion RFA* is to build and expand upon the progress achieved in the CMHI program. There are also indications that the *SOC Expansion RFA* is SAMHSA's first step towards elimination of the CMHI program and merger with the Substance Abuse Block Grant (SABG) and Community Mental Health Block Grant (MHBG) programs. Elimination of the CMHI program would require a change in legislation and will invite the opportunity for further comment. While we feel that elimination of the CMHI program, especially during the current fiscal climate, would counter efforts to expand SOC, we will reserve comment until SAMHSA is clear on the direction it intends to take with the CMHI program. However, as the target population per the authorizing legislation for the CMHI program targets children and youth with serious emotional disturbance (SED), the *Unified Application Revision* provides states and tribes with the opportunity to respond to IOM's call to action and fill out their SOC continuum with focus on prevention and early intervention as well as their SED populations.

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[1] Available at: http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx.

[2] Available at: http://www.iom.edu/~/media/Files/Report%20Files/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People/Preventing%20Mental%20Emotional%20and%20Behavioral%20Disorders%202009%20%20Report%20Brief%20for%20Policymakers.pdf.

[3] SAMHSA. (2010). Working Together to Help Youth Thrive in Schools and Communities: Systems of Care. National Children's Mental Health Awareness Day - May 7, 2009. Retrieved from the SAMHSA website on 6/1/11: http://store.samhsa.gov. (Pub Id SMA10-4546)

SAMHSA is strongly urged to further strengthen the *Unified Application Revision* to emphasize 1) improving outcomes for children and youth with mental health (MH) and/or substance abuse (SA) needs and their families and 2) the importance of using SOC approaches to serve them in their homes and communities.

Without a clear directive from SAMHSA to continue the work of SOC for children, youth and families, there is a risk that states and communities will not invest the necessary resources to continue to grow and sustain their SOC, ultimately undermining almost two decades of hard work and accomplishments. SAMHSA needs to seize this opportunity to improve outcomes for children and youth with behavioral health needs and their families, especially given the lack of emphasis on children, youth and families in SAMHSA's strategic plan, *Leading Change: A Plan for SAMHSA's Role and Actions 2011-2014,* as set forth in the below Strategic Initiative (SI) examples.

- **SI #4 – Recovery Support** cites data that show **more than half of the adolescents in the United States who fail to complete high school have a diagnosable psychiatric disorder.** Within this SI, there is further discussion about how mental illness often begins when young adults are completing high school and are looking at future opportunities and career plans. **Despite stating that this SI emphasizes collaborative relationships with children, youth and families that involve shared decision making (found in the Behavioral Health Workforce discussion), there is little to no focus on children, youth and families.** The only references are in Objective 4.3.3 and 4.4.1 which seek to improve employment and educational outcomes for individuals served by SAMHSA grantees and reference the Family-Centered Substance Abuse Treatment Grants for Adolescents and their Families and the Statewide Family (and Consumer) Network Grants to provide training and technical assistance to promote peer-to-peer support.

- **SI #5 – Health Reform** is particularly relevant since **the majority of the Goals, Objectives and Action Steps in this SI focus on the *Unified Application* and the relationship of the Block Grant programs to health reform.** However, the only children, youth and family-specific Action Step is found in Objective 5.2.3, which seeks to develop a joint CMS/SAMSHA technical assistance (TA) effort for Olmstead and EPSDT issues. **This lack of recognition of the needs of children, youth and families is especially concerning given that SAMHSA expects that the SOC Expansion Grants will help facilitate statewide adoption of the SOC framework by requiring grantees to address financing strategies, including the use of Medicaid, the development of core services within health insurance benefit packages, and establishing linkages with Block Grants, and other health reform activities to develop and expand their SOCs.**

- **SI #8 – Public Awareness and Support** cites data that **only about half of American children and teenagers with common mental disorders receive professional services.** The overview further recognizes that half of all mental illnesses begin by age 14, and three-fourths begin by age 24, with initial symptoms preceding a disorder by 2 to 4 years. **Yet there are no children, youth and family-specific Goals, Objectives or Action Steps in this SI.**

Recommendation 1: Provide additional language highlighting the SOC approach as a best practice in serving children and youth with MH and/or SA needs and their families.

The *Unified Application Revision* does add language under *Section 3d* on page 38 that custodial parents should be involved in the planning, monitoring and delivery of services to their children. However, reference to SOC as a best practice remains buried in the document within a bullet about thinking more broadly than historically served populations on page 11, and within a bulleted list as an example of a service-specific change on page 23. **Given SAMSHA's recognition of the success of the CMHI program and the SOC framework, the lack of emphasis on children, youth and families and SOC within SAMHSA's Strategic Initiatives, and the requirement in the *SOC Expansion RFA* for grantees to explore the use SABG and MHBG dollars to fund SOC expansion, the reference to SOC as a best practice approach for children, youth and families should be highlighted within the *Unified Application Revision* instead of hidden within the lengthy text of the instructions.**

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CHILDREN'S MENTAL HEALTH COLLABORATIVE OF HENNEPIN COUNTY

Fax Transmittal Form

Date **07/14/2011**

To Name: Desk Officer
Organization Name/Dept: SAMHSA
CC:
Phone number:
Fax number: 202-395-7285

From Sarah Cheesman
CMHC
Phone:612-634-6782
Fax: 952-934-7178

Number of pages including cover sheet: 7

Message:
This fax is being sent on behalf of the Children's Mental Health Collaborative of Hennepin County

CHILDREN'S MENTAL HEALTH COLLABORATIVE OF HENNEPIN COUNTY

Sent via facsimile to: 202–395–7285

July 21, 2011

SAMHSA
Desk Officer
Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

RE: Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2012-2013 Application Guidance and Instructions (OMB No. 0930-0168) Revision

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Our collaborative, which is called The Hennepin County Children's Mental Health Collaborative (CMHC), began in 1993. The original focus was on 'service integration and collaboration' and establishing 'wrap-around services' and attempts were made to develop a managed care model to administer a newly created integrated fund.

The CMHC Mission Statement is to serve as the catalyst for improving children's lives by serving as convener, coordinator, advisor and advocate for community efforts to increase access to and resources for high quality mental health services for children and families. The CMHC does not provide any direct services to children or families, but provides financial support to agencies that do. The target population is children up to age 18 with an emotional or behavioral disturbance or who are at risk of suffering an emotional or behavioral disturbance.

The CMHC guiding principles include accessible services for clients; flexibility; individualized responses within an appropriate cultural and social context; accountability for client outcomes and system-wide goals; incorporation of evidence-based practices and "promising" practices; and embracing system based sustainable funding; not grant-making in the traditional sense.

The 2011 CMHC budget is used to promote the creation of integrated services, using the principles of System of Care, through out our county, including school-based mental health services, public health/mental health integration, and mental health services for youth in corrections. Our resources are also used to promote parent leadership in our children's mental health system.

Our collaborative is comprised of representatives of local governments (county, school districts, mental health, health plans), provider organizations, parent and advocacy organizations. We operate under a memorandum of understanding, and a set of interagency agreements to govern our work.

As such, it is from this perspective that our Governance group submits the following comments to you regarding the *Unified Application Revision.*

SAMHSA is to be commended for posting the *Unified Application Revision* for further public comment. The additional guidance and clarification included in the updated instructions, as highlighted in the below comments, are appreciated. However, we would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults. The *Unified Application Revision* cites the Institute of Medicine's (IOM) 2009 Report, *Preventing Mental, Emotional, Behavioral Disorders Among Young People: Progress and Possibilities.*[1] This publication's *Report Brief for Policy Makers* includes the following call to action:

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In SAMHSA's *Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and their Families (Short Title: System of Care Expansion Planning Grants)* Request for Applications ("*SOC Expansion RFA*"), there is a recognition that the accumulating research and evaluation results from the Children's Mental Health Initiative (CMHI) program over the last 15 years have demonstrated the success of an SOC approach. Children and youth with intensive needs and their families are not served by a single provider or a single agency. As SAMHSA has demonstrated for over 15 years through its CMHI grants, an SOC approach recognizes the importance of multiple community-based services and supports working together in partnership with youth and families to design the services and supports that will be most effective for that particular youth and family. In fact, SAMHSA noted that youth in SOC tend to improve in attendance, performance, and progress in school, attend school more regularly, and have emotional and behavioral gains[3].

It appears that the intent of the *SOC Expansion RFA* is to build and expand upon the progress achieved in the CMHI program. There are also indications that the *SOC Expansion RFA* is SAMHSA's first step towards elimination of the CMHI program and merger with the Substance Abuse Block Grant (SABG) and Community Mental Health Block Grant (MHBG) programs. Elimination of the CMHI program would require a change in legislation and will invite the opportunity for further comment. While we feel that elimination of the CMHI program, especially during the current fiscal climate, would counter efforts to expand SOC, we will reserve comment until SAMHSA is clear on the direction it intends to take with the CMHI program. However, as the target population per the authorizing legislation for the CMHI program targets children and youth with serious emotional disturbance (SED), the *Unified Application Revision* provides states and tribes with the opportunity to respond to IOM's call to action and fill out their SOC continuum with focus on prevention and early intervention as well as their SED populations.

SAMHSA is strongly urged to further strengthen the *Unified Application Revision* to emphasize 1) improving outcomes for children and youth with mental health (MH) and/or substance abuse (SA) needs and their families and 2) the importance of using SOC approaches to serve them in their homes and communities.

Without a clear directive from SAMHSA to continue the work of SOC for children, youth and families, there is a risk that states and communities will not invest the necessary resources to continue to grow and sustain their SOC, ultimately undermining almost two decades of hard work and accomplishments. SAMHSA needs to seize this opportunity to

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Recommendation 1: Provide additional language highlighting the SOC approach as a best practice in serving children and youth with MH and/or SA needs and their families.

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bulleted list as an example of a service-specific change on page 23. **Given SAMSHA's recognition of the success of the CMHI program and the SOC framework, the lack of emphasis on children, youth and families and SOC within SAMHSA's Strategic Initiatives, and the requirement in the *SOC Expansion RFA* for grantees to explore the use SABG and MHBG dollars to fund SOC expansion, the reference to SOC as a best practice approach for children, youth and families should be highlighted within the *Unified Application Revision* instead of hidden within the lengthy text of the instructions.**

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In federal fiscal year 2007, 20.4% of Medicaid spending was on children (17 and younger), with an additional 42.4% of spending on "disabled" population, which includes children[4]. Without this mandate and in the current fiscal climate, there is a risk that states will use this formula funding to cover historic adult system deficits, thereby limiting, rather than expanding, improving, and sustaining SOC for children and youth with behavioral health needs and their families.

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The Unified Application should be an opportunity for collaboration, coordination, and leveraging. Without implementation of the recommendations outlined in this letter, the *Unified Application* may result in the pitting of the "adult system" against the "child system," and the wasted effort of individuals trying to identify "what works" when we know that an SOC framework is intuitive, tested, and accessible for families, providers and communities.

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Sincerely,

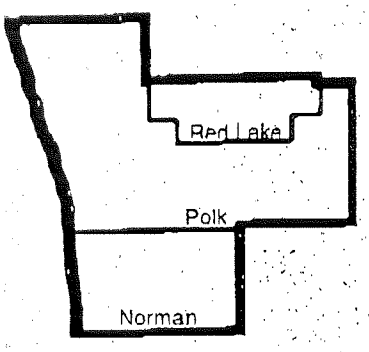
Pat Dale

Pat Dale
CMHC Governance Chair
CEO, Headway Emotional Health Services

Jamie Halpern

Jamie Halpern, Area Manager
Hennepin County Human Services and
Public Health Department

Tri-County Community Corrections



816 MARIN AVENUE, SUITE 110
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FAX 218-470-8135

July 13, 2011

SAMHSA Desk Officer
Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

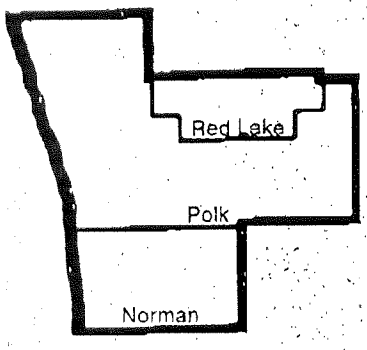
Sent via Facsimile to: 202-395-7285

RE: Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2012-2013 Application Guidance and Instructions (OMB No. 0930-0168) Revision

Dear SAMHSA Desk Officer:

The purpose of this letter is to provide comment on the ***Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2102 – 2013 Application Guidance and Instructions Revision*** ("*Unified Application Revision*"), posted in the *Federal Register / Vol. 76, No. 117 / Friday, June 17, 2011 / Notices* in response to comment received during the prior public comment period that closed on June 9, 2011.

Tri-County Community Corrections



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07/13/2011 17:03

=== COVER PAGE ===

TO: _____

FROM: NBC INC _____

FAX: 6103281153

TEL: 6103281139

COMMENT:

www.ibc-pa.org

848 West King's Hwy. Coatesville, PA 19320-1714 Secure phone/fax: 610-524-8701

SAMHSA
Desk Officer, Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

Via fax: 202–395–7285

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I am a licensed psychologist and a certified school psychologist with more than 30 years' experience in the field of children's mental health. I received a commendation from the Director of CMS recently for my work with the EPSDT system for the delivery of Behavioral Health Rehabilitation Services (BHRS) to provide cost-effective mental health treatment and behavioral support to children over the past 18 years and have been invited to provide testimony to a Congressional workgroup studying EPSDT and BHRS. I am submitting the following comments to you regarding the *Unified Application Revision.*

I deeply appreciate the effort that SAMHSA has made over the years to recognize and support the need for children's mental health treatment as a special branch of the mental health system. Your posting of the *Unified Application Revision* for further public comment is noteworthy in that regard. The additional guidance and clarification included in the updated instructions, as highlighted in the below comments, are specifically appreciated. However, I would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults as a separate

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The Family Involvement Center's Mission is to assist and support families/caregivers of children/youth with emotional, behavioral and mental health needs; and Assist policymakers, agencies and providers to transform systems; to ensure that these children/youth will succeed in school, live with families in their communities, avoid delinquency, and become productive adults."As such, it is from this perspective that we submit the following comments to you regarding the *Unified Application Revision*.

SAMHSA is to be commended for posting the *Unified Application Revision* for further public comment. The additional guidance and clarification included in the updated instructions, as highlighted in the below comments, are appreciated. However, we would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults. The *Unified Application Revision* cites the Institute of Medicine's (IOM) 2009 Report, *Preventing Mental, Emotional, Behavioral Disorders Among Young People: Progress and*

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For each grant that is issued, different technical assistance providers and/or evaluators are selected, without a requirement that those providers coordinate with one another. States such as Maryland and Georgia currently have CMHI grants, CMS Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver Grants, CHIPRA Quality Demonstration Grants, and Healthy Transitions Initiative grants, all of which have their own data collection and reporting requirements and technical assistance providers. **Through all of these grants and, in particular, the *Unified Application*, SAMHSA has an opportunity to model SOC for the States, through coordinated and targeted technical assistance and support that would ensure that the behavioral health needs of children, youth and families are met.** As noted above, without dedicated requirements and a focus on compliance, the progress that has been made to grow and sustain SOC for children, youth and families could be lost.

The Unified Application should be an opportunity for collaboration, coordination, and leveraging. Without implementation of the recommendations outlined in this letter, the *Unified Application* may result in the pitting of the "adult system" against the "child system," and the wasted effort of individuals trying to identify "what works" when we know that an SOC framework is intuitive, tested, and accessible for families, providers and communities.

We cannot afford to lose the momentum that has been building for almost two decades we thank you for the opportunity to provide comment on this important topic and look forward to partnering with SAMHSA to ensure that the SOC framework is utilized for children and youth with intensive needs and their families to ensure individualized, home- and community-based, data- and outcomes-driven, and culturally- and linguistically-competent services and supports.

Sincerely,

Michael Donnelly

FAX

CAROLINE COUNTY DEPARTMENT OF SOCIAL SERVICES
207 S. THIRD STREET
PO BOX 400
DENTON, MD 21629
Phone: 410-819-4500
Fax: 410-819-4501

DATE: 7/13/11

FROM: Ardeen Copeland-Lupton, LCSW-C
Child Protective Services Supervisor
PHONE: 410-819-4507

TO: SAMHSA Desk Officer

PHONE:

FAX: 202-395-7285

Number of pages, including cover sheet: 7

Comments:

SAMHSA
Desk Officer
Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

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I am currently employed with the State of Maryland, Caroline County Department of Social Services as the Child Protective Services Supervisor. As such, it is from this perspective that I submit the following comments to you regarding the *Unified Application Revision.*

SAMHSA is to be commended for posting the *Unified Application Revision* for further public comment. The additional guidance and clarification included in the updated instructions, as highlighted in the below comments, are appreciated. However, I would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults. The *Unified Application Revision* cites the Institute of Medicine's (IOM) 2009 Report, *Preventing Mental, Emotional, Behavioral Disorders Among Young People: Progress and Possibilities.*[1] This publication's *Report Brief for Policy Makers* includes the following call to action:

> ***National leadership is necessary to make systematic prevention efforts a high priority in the health care system as well as an integral***

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aspect of the network of local, state, and federal programs and systems that serve young people and families [2] (p. 3).

The *Unified Application Revision* is the opportunity for SAMHSA to assume this national leadership role and assist local, state, and federal programs better understand and utilize a System of Care (SOC) framework to improve outcomes for children and youth with behavioral health needs and their families.

In SAMHSA's *Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and their Families (Short Title: System of Care Expansion Planning Grants)* Request for Applications ("*SOC Expansion RFA*"), there is a recognition that the accumulating research and evaluation results from the Children's Mental Health Initiative (CMHI) program over the last 15 years have demonstrated the success of an SOC approach. Children and youth with intensive needs and their families are not served by a single provider or a single agency. As SAMHSA has demonstrated for over 15 years through its CMHI grants, an SOC approach recognizes the importance of multiple community-based services and supports working together in partnership with youth and families to design the services and supports that will be most effective for that particular youth and family. In fact, SAMHSA noted that youth in SOC tend to improve in attendance, performance, and progress in school, attend school more regularly, and have emotional and behavioral gains[3].

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Sincerely,

Ardeen Copeland-Lupton, LCSW-C
Child Protective Services Supervisor
Caroline County Department of Social Services
PO Box 400
Denton, Maryland 21629

University of Maryland
Child & Adolescent Psychiatry
Innovations Institute & Child and Adolescent Mental Health Institute
Research Evaluation Core

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Phone: 410-706-0961 Fax: 410-706-0998

FAX COVER

To: SAMHSA Desk Officer

Organization: _____

Fax Number: 808-395-7285

From: Tracey Cotton (for Michelle Zabel)

Date: 7.13.11 Time: 1:17

Number of Pages (*including cover*): 7

Comments: _____

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

SAMHSA
Desk Officer
Human Resources and Housing Branch
Office of Management and Budget
New Executive Office Building, Room 10235
Washington, DC 20503

Sent via facsimile to: 202–395–7285

July 14, 2011

RE: Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2012-2013 Application Guidance and Instructions (OMB No. 0930-0168) Revision

Dear SAMHSA Desk Officer:

The purpose of this letter is to provide comment on the ***Unified Application for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant FY 2102 – 2013 Application Guidance and Instructions Revision*** ("*Unified Application Revision*"), posted in the *Federal Register / Vol. 76, No. 117 / Friday, June 17, 2011 / Notices* in response to comment received during the prior public comment period that closed on June 9, 2011.

Innovations Institute is a training, technical assistance, research, evaluation, policy, and finance center at the University of Maryland School of Medicine, Department of Psychiatry. We are privileged to provide project management and evaluation for the State of Maryland on two SAMHSA Children's Mental Health Initiative (CMHI) Grants ("System of Care Grants"), a Centers for Medicare & Medicaid Services (CMS) Psychiatric Residential Treatment Facilities (PRTF) Demonstration Waiver, and a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant. Innovations also provides training and technical assistance to the State of Maryland and other states and communities on Wraparound, Systems of Care, and Care Management Entities, including under a contract supported by CMS to provide technical assistance to all nine PRTF Demonstration states, and serves as an intermediate purveyor of evidence-based practices for the Maryland Children's Cabinet. As such, it is from this perspective that we submit the following comments to you regarding the *Unified Application Revision*.

SAMHSA is to be commended for posting the *Unified Application Revision* for further public comment. The additional guidance and clarification included in the

updated instructions, as highlighted in the below comments, are appreciated. However, we would like to take this opportunity to again underscore the critical importance of focusing on the behavioral health needs of children, adolescents, and young adults. The *Unified Application Revision* cites the Institute of Medicine's (IOM) 2009 Report, *Preventing Mental, Emotional, Behavioral Disorders Among Young People: Progress and Possibilities.*[1] This publication's *Report Brief for Policy Makers* includes the following call to action:

> ***National leadership is necessary to make systematic prevention efforts a high priority in the health care system as well as an integral aspect of the network of local, state, and federal programs and systems that serve young people and families***[2] (p. 3).

The *Unified Application Revision* is the opportunity for SAMHSA to assume this national leadership role and assist local, state, and federal programs better understand and utilize a System of Care (SOC) framework to improve outcomes for children and youth with behavioral health needs and their families.

In SAMHSA's *Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and their Families (Short Title: System of Care Expansion Planning Grants)* Request for Applications ("*SOC Expansion RFA*"), there is a recognition that the accumulating research and evaluation results from the CMHI program over the last 15 years have demonstrated the success of an SOC approach. Children and youth with intensive needs and their families are not served by a single provider or a single agency. As SAMHSA has demonstrated for over 15 years through its CMHI grants, an SOC approach recognizes the importance of multiple community-based services and supports working together in partnership with youth and families to design the services and supports that will be most effective for that particular youth and family. In fact, SAMHSA noted that youth in SOC tend to improve in attendance, performance, and progress in school, attend school more regularly, and have emotional and behavioral gains[3].

It appears that the intent of the *SOC Expansion RFA* is to build and expand upon the progress achieved in the CMHI program. There are also indications that the *SOC Expansion RFA* is SAMHSA's first step towards elimination of the CMHI program and merger with the Substance Abuse Block Grant (SABG) and

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[1] Available at: http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx.

[2] Available at: http://www.iom.edu/~/media/Files/Report%20Files/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People/Preventing%20Mental%20Emotional%20and%20Behavioral%20Disorders%202009%20%20Report%20Brief%20for%20Policymakers.pdf.

[3] SAMHSA. (2010). Working Together to Help Youth Thrive in Schools and Communities: Systems of Care. National Children's Mental Health Awareness Day - May 7, 2009. Retrieved from the SAMHSA website on 6/1/11: http://store.samhsa.gov. (Pub Id SMA10-4546)

Community Mental Health Block Grant (MHBG) programs. Elimination of the CMHI program would require a change in legislation and will invite the opportunity for further comment. While we feel that elimination of the CMHI program, especially during the current fiscal climate, would counter efforts to expand SOC, we will reserve comment until SAMHSA is clear on the direction it intends to take with the CMHI program. However, as the target population per the authorizing legislation for the CMHI program targets children and youth with serious emotional disturbance (SED), the *Unified Application Revision* provides states and tribes with the opportunity to respond to IOM's call to action and fill out their SOC continuum with focus on prevention and early intervention as well as their SED populations.

SAMHSA is strongly urged to further strengthen the *Unified Application Revision* to emphasize 1) improving outcomes for children and youth with mental health (MH) and/or substance abuse (SA) needs and their families and 2) the importance of using SOC approaches to serve them in their homes and communities.

Without a clear directive from SAMHSA to continue the work of SOC for children, youth and families, there is a risk that states and communities will not invest the necessary resources to continue to grow and sustain their SOC, ultimately undermining almost two decades of hard work and accomplishments. SAMHSA needs to seize this opportunity to improve outcomes for children and youth with behavioral health needs and their families, especially given the lack of emphasis on children, youth and families in SAMHSA's strategic plan, *Leading Change: A Plan for SAMHSA's Role and Actions 2011-2014,* as set forth in the below Strategic Initiative (SI) examples.

- **SI #4 – Recovery Support** cites data that show **more than half of the adolescents in the United States who fail to complete high school have a diagnosable psychiatric disorder.** Within this SI, there is further discussion about how mental illness often begins when young adults are completing high school and are looking at future opportunities and career plans. **Despite stating that this SI emphasizes collaborative relationships with children, youth and families that involve shared decision making (found in the Behavioral Health Workforce discussion), there is little to no focus on children, youth and families.** The only references are in Objective 4.3.3 and 4.4.1 which seek to improve employment and educational outcomes for individuals served by SAMHSA grantees and reference the Family-Centered Substance Abuse Treatment Grants for Adolescents and their Families and the Statewide Family (and Consumer) Network Grants to provide training and technical assistance to promote peer-to-peer support.

- **SI #5 – Health Reform** is particularly relevant since **the majority of the Goals, Objectives and Action Steps in this SI focus on the *Unified***

***Application* and the relationship of the Block Grant programs to health reform.** However, the only children, youth and family-specific Action Step is found in Objective 5.2.3, which seeks to develop a joint CMS/SAMSHA technical assistance (TA) effort for Olmstead and EPSDT issues. **This lack of recognition of the needs of children, youth and families is especially concerning given that SAMHSA expects that the SOC Expansion Grants will help facilitate statewide adoption of the SOC framework by requiring grantees to address financing strategies, including the use of Medicaid, the development of core services within health insurance benefit packages, and establishing linkages with Block Grants, and other health reform activities to develop and expand their SOCs.**

- **SI #8 – Public Awareness and Support** cites data that **only about half of American children and teenagers with common mental disorders receive professional services.** The overview further recognizes that half of all mental illnesses begin by age 14, and three-fourths begin by age 24, with initial symptoms preceding a disorder by 2 to 4 years. **Yet there are no children, youth and family-specific Goals, Objectives or Action Steps in this SI.**

Recommendation 1: Provide additional language highlighting the SOC approach as a best practice in serving children and youth with MH and/or SA needs and their families.

The *Unified Application Revision* does add language under *Section 3d* on page 38 that custodial parents should be involved in the planning, monitoring and delivery of services to their children. However, reference to SOC as a best practice remains buried in the document within a bullet about thinking more broadly than historically served populations on page 11, and within a bulleted list as an example of a service-specific change on page 23. **Given SAMSHA's recognition of the success of the CMHI program and the SOC framework, the lack of emphasis on children, youth and families and SOC within SAMHSA's Strategic Initiatives, and the requirement in the *SOC Expansion RFA* for grantees to explore the use SABG and MHBG dollars to fund SOC expansion, the reference to SOC as a best practice approach for children, youth and families should be highlighted within the *Unified Application Revision* instead of hidden within the lengthy text of the instructions.**

Recommendation 2: Ensure that a certain minimum percentage of MHSBG and SAPTBG dollars be allocated to children and youth with MH and/or SA needs and their families.

The *Unified Application Revision* does add language under *Section 3a* on page 19 requiring that children with SED and their families be included in the MHBG and SABG needs assessments; adding that the description of the behavioral

health resources and systems should include "youth who are often underserved" as part of the planning steps in *Section 3b* on page 21; including reference to "age-appropriate interventions and providers" on p. 24; and adding the "State Child Serving Agency" as a suggested partner on page 12 and suggested member of the Advisory Council in Table 11 on page 48. While these additions are appreciated, **it is critical that SAMHSA ensures that states allocate a minimum percentage of their Block Grant funding to support initiatives for children and youth and their families.**

In federal fiscal year 2007, 20.4% of Medicaid spending was on children (17 and younger), with an additional 42.4% of spending on "disabled" population, which includes children[4]. Without this mandate and in the current fiscal climate, there is a risk that states will use this formula funding to cover historic adult system deficits, thereby limiting, rather than expanding, improving, and sustaining SOC for children and youth with behavioral health needs and their families.

Recommendation 3: Include specific requirements on service provision for children and youth with MH and/or SA needs and their families within the *Unified Application*, and develop a technical assistance unit with expertise on the needs of and best practice approaches to serving children and youth with behavioral health needs and their families to ensure compliance and share expertise at both state- and federal-level planning efforts.

Section 3k on page 43 requires states to describe their technical assistance needs. The *Unified Application Revision* does add instruction to take into account cultural and linguistic competency needs, but **falls short of requiring that states explore technical assistance needs to effectively serve the populations required to be included in the needs assessment, including children with SED and their families** (*Section 3a*, p. 19). System planners at both the federal and state levels need to understand and appreciate the data that demands our focus on children and youth with behavioral health needs and their families, and have expertise to ensure that health reform and Block Grant planning include best practice approaches that will improve outcomes for children, youth and families with MH and SA needs. For each grant that is issued, different technical assistance providers and/or evaluators are selected, without a requirement that those providers coordinate with one another. States such as Maryland and Georgia currently have CMHI grants, CMS PRTF Demonstration Waiver Grants, CHIPRA Quality Demonstration Grants, and Healthy Transitions Initiative grants, all of which have their own data collection and reporting requirements and technical assistance providers. **Through all of these grants and, in particular, the *Unified Application*, SAMHSA has an opportunity to model SOC for the States, through coordinated and targeted technical assistance and support that would ensure that the behavioral**

[4] Kaiser Family Foundation. (2010). State Health Facts: **Distribution of Medicaid Payments by Enrollment Group (in millions), FY2007. Retrieved from the State Health Facts website on 6/1/11:** http://www.statehealthfacts.org/.

health needs of children, youth and families are met. As noted above, without dedicated requirements and a focus on compliance, the progress that has been made to grow and sustain SOC for children, youth and families could be lost.

The Unified Application should be an opportunity for collaboration, coordination, and leveraging. Without implementation of the recommendations outlined in this letter, the *Unified Application* may result in the pitting of the "adult system" against the "child system," and the wasted effort of individuals trying to identify "what works" when we know that an SOC framework is intuitive, tested, and accessible for families, providers and communities.

We cannot afford to lose the momentum that has been building for almost two decades. We thank you for the opportunity to provide comment on this important topic and look forward to partnering with SAMHSA to ensure that the SOC framework is utilized for children and youth with intensive needs and their families to ensure individualized, home- and community-based, data- and outcomes-driven, and culturally- and linguistically-competent services and supports.

Sincerely,

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