CLERMONT COUNTY
MENTAL HEALTH
& RECOVERY
BOARD

The Wasserman Building
2337 Clermont Center Drive • Batavia, Ohio 45103
TELEPHONE: (513) 732-5400 FAX: (513) 732-5414 TTY: 1-800-750-0750

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.

I am the Executive Director of the Clermont County Mental Health and Recovery Board in Batavia, Ohio, and the Board received a SAMHSA System of Care grant in September 2009. 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:

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> ***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 I believe the elimination of the CMHI program, especially during the current fiscal climate, would counter efforts to expand SOC, I 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

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(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

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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 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.

The Behavioral health system cannot afford to lose the momentum that has been building for almost two decades. I 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,

Karen J. Scherra

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Executive Director

Clermont FAST TRAC

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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:

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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.

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GBehimer

Gretchen Behimer
FAST TRAC Project Director

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FACSIMILE COVER SHEET

DEPARTMENT OF PUBLIC WELFARE
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2ND FLOOR, BEECHMONT BUILDING
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Facsimile Telephone Number (717) 772-7964
To talk to us, call: (717) 772-7900

TO SAMHSA Desk officer

LOCATION:

FROM: Jennifer Parker

LOCATION: OMHSAS Rm 240 Beechmont Bldg #32

NUMBER OF ACCOMPANYING PAGES = 1

SPECIAL INSTRUCTIONS/COMMENTS

Comments on OMB 0930-0168
Uniform Application for CMHSBG + SAPTBG
FY 2012-2013

Jennifer Parker
Human Services Program Specialist
Pennsylvania Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Bureau of Policy, Planning, & Program Development
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Fax: 717.772.7964

Uniform 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:

1. Is the MOE and Children's Set Aside still required? If so, where is that located in the new guidance and where do we document that on the new BGAS?

2. For states submitting separate applications, are tables 6, 7, and 8 required for mental health only? It seems as though information can be entered through BGAS for mental health only, however, on page 29 of the new guidance, it states tables 6, 7, and 8 are for SABG.

3. Where should the NOMS be included?

Children's Mental Health Network
sharing the story...

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I have had the great pleasure and honor to work with the system of care movement since the early 1980's, when federal government had the wisdom to establish the Child, Adolescent Service System Program (CASSP). Since that time, NIMH, and then SAMHSA, has provided much support and encouragement for community-based efforts to improve mental health services for children and families. Key to the support received from SAMHSA has been the continued drive to establish programs that are family-driven and youth guided. I am writing this letter as an individual but want to share with you that I am part of a growing alliance of professionals, families and youth who have been a part of system of care development efforts in tribes, states and communities over the past 25 + years. The organization I am involved with is the Children's Mental Health Network. We are newly organized, very passionate and focused about the importance of a family-driven, youth guided approach. It is within this context of respect that I submit the following comments to you regarding the *Unified Application Revision.*

Children's Mental Health Network
2201 Wilshire Drive • Durham, NC 27707
919-219-2342

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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 I feel that elimination of the CMHI program, especially during the current fiscal climate, would counter efforts to expand SOC, I 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.**

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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

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[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/.

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 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. I 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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