Oklahoma
UNIFORM APPLICATION
FY 2022/2023 Combined MHBG Application
Behavioral Health Assessment and Plan
SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/27/2021 5.33.11 PM)
Center for Substance Abuse Prevention
Division of State Programs
Center for Substance Abuse Treatment
Division of State and Community Assistance
and
Center for Mental Health Services
Division of State and Community Systems Development
State Information

Plan Year
Start Year 2022
End Year 2023

State SAPT DUNS Number
Number 933662934
Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
 Agency Name Oklahoma Department of Mental Health and Substance Abuse Services
Organizational Unit Treatment and Recovery Services
Mailing Address 2000 N. Classen Blvd. Suite 600
City Oklahoma City
Zip Code 73106

II. Contact Person for the SAPT Grantee of the Block Grant
First Name Carrie
Last Name Slatton-Hodges
Agency Name Oklahoma Department of Mental Health and Substance Abuse Services
Mailing Address 2000 N. Classen Blvd. Suite 600
City Oklahoma City
Zip Code 73106
Telephone 405-248-9281
Fax
Email Address CHodges@odmhsas.org

State CMHS DUNS Number
Number 933662934
Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant
 Agency Name Oklahoma Department of Mental Health and Substance Abuse Services
Organizational Unit Treatment and Recovery Services
Mailing Address 2000 N. Classen Blvd. Suite 600
City Oklahoma City
Zip Code 73106

II. Contact Person for the CMHS Grantee of the Block Grant
First Name Carrie
Last Name Slatton-Hodges
Agency Name Oklahoma Department of Mental Health and Substance Abuse Services
III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  ☐ Yes  ☒ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name  Jacqueline

Last Name  Millspaugh

Telephone  405-248-9342

Fax

Email Address  jmillspaugh@odmhsas.org

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
# State Information

**Chief Executive Officer’s Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]**

## Fiscal Year 2022

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
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<tbody>
<tr>
<td>Section 1921</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x-21</td>
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<td>Section 1922</td>
<td>Certain Allocations</td>
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<td>Requirements Regarding Tuberculosis and Human Immunodeficiency Virus</td>
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<td>Section 1926</td>
<td>State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18</td>
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<td>Restrictions on Expenditure of Grant</td>
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<td>42 USC § 300x-35</td>
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Title XIX, Part B, Subpart III of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
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<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
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<td>Section 1946</td>
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<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
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</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

b. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that
1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall oblige the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall oblige the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

State: ________________________________

Name of Chief Executive Officer (CEO) or Designee: Carrie Slatton-Hodges

Signature of CEO or Designee: ________________________________

Title: Commissioner

Date Signed: ________________

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
QUESTIONS

SAMHSA requests that the following information is included when submitting the proposals:

1. Identify the needs and gaps of your state’s SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

While the framework for evidence-based approaches in prevention, intervention, treatment, and recovery support services have been developed and implemented in many areas of the state, the need for services in all levels of care in the SUD continuum outpaces resources. The spending plan detailed in this document addresses gaps in each of the continuum areas to increase access to those in need.

2. Describe how your state’s spending plan proposal will address the state’s substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

Budget

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<th>Total</th>
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<tr>
<td>Telehealth Expansion</td>
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<tr>
<td>Services</td>
<td>$6,000,000.00</td>
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<td>Education/Media</td>
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<td>Harm Reduction</td>
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<td>Housing and Recovery</td>
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<td>TOTAL</td>
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**Prevention:**

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<td>Adolescent Screening and Brief Intervention services</td>
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<td>School-based primary prevention services</td>
<td>$227,455</td>
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<td>Prevention needs assessment data visualization (Google)</td>
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<tr>
<td>Oklahoma Prevention Needs Assessment expansion</td>
<td>$0</td>
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Continuation of community, family, and school-based primary substance use prevention services. Community-based services will fund approximately six (6) high-need community coalitions to implement primary prevention services based on priority needs to include a focus on substances identified by epidemiological data. Funded Local education agencies (LEAs) will continue implementation of school-based, primary prevention services as defined in their MTSS plans. Families will be able to access Strengthening Families Program groups in a universal application of the service via a network of faith institutions trained to deliver the program. All services will align with the Center for Substance Abuse Prevention’s six primary prevention strategies and are allocated in high need communities and among universal populations of focus. The ODMHSAS will continue to partner with an array of community-based organizations (non-profits, tribes, universities), LEAs and the State Department of Education, and the Oklahoma Conference of Churches, among others to implement these services.

These one-time funds will be used to provide an increase of prevention evidence-based strategies to the most in need populations in the state.

**Telehealth Expansion:**
The ODMHSAS will expand access to telehealth services to support immediate access to higher levels of addiction services, including access to telehealth ASAM assessments by licensed clinicians for individuals anywhere in the state. ASAM PPC is the required method to identify eligibility for the most acute levels of addiction treatment services in Oklahoma. Improving access to these assessments through telehealth will increase access to care for individuals with addiction services who are most in need.

These one-time funds will support the initial expansion of telehealth which will be sustained through fee for service billing from the telehealth clinicians. This sustainability plan is supported through the July 1, 2021 expansion of Medicaid which dramatically increases the percentage of the population with a funding source for behavioral health services.

**Services:**
Expansion of addiction services throughout the continuum of care including the development of a drop in substance abuse treatment urgent recovery center, residential treatment services, and Medication Assisted Treatment. The urgent recovery center model is a 24/7 drop in facility which offers respite and immediate access to trained clinicians and peers. Individuals may be served in these facilities and then connected to outpatient services or, if a higher level of care need is identified through assessment, connected to residential or detoxification services.

These one-time funds will support the initial expansion of addiction services which will be sustained through fee for service billing. The sustainability plan is supported through the recent Oklahoma IMD waiver which included residential substance abuse services among the Medicaid reimbursable services and the July 1, 2021 expansion of Medicaid.
**Education/Media:**
Training will be offered to both the public and private provider network to expand access to evidence based practices, including interventions for methamphetamine and other simulants. ODMHSAS will provide social media and other communications around identifying treatment needs, prevention, and accessing care.

These one-time funds will be used as enhancements to the public and private treatment provider network. The ODMHSAS will prioritize models that allow for trainer development which will support the sustainment of ongoing training opportunities.

**Harm Reduction:**
The ODMHSAS will expand harm reduction approaches throughout the system including needle exchange and distribution of fentanyl strips.

These one-time funds will support the initial surge in demand for harm reduction approaches due to recently passed legislation supporting needle exchange programs and the recent availability of fentanyl strips.

**Housing and Recovery Supports:**
The ODMHSAS will enhance the network of housing and recovery support services available to individuals in addiction treatment. Housing opportunities will include support to expand the network of Recovery Residences. Recovery support services includes expanding peer and employment support to individuals receiving services in addiction treatment agencies.

These one-time funds will be sustained through multiple avenues of fee for service reimbursement including Medicaid compensation for services provided by peer recovery support specialists and employment specialists.

3. Describe your state’s progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

See #2
4. Describe your state’s progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.

See #2

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

See #2. In addition, for prevention:

The ODMHSAS will continue to partner with an array of community-based organizations (non-profits, tribes, universities), LEAs and the State Department of Education, and the Oklahoma Conference of Churches, among others to implement the primary prevention services proposed.

6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

See #2. In addition, for prevention:

Community-based prevention providers are required to develop strategic plans based on the SPF process. This stepped process includes the intentional assessment and identification of populations of focus as well as disparate population(s). Providers are required to report services and reflect regularly on how their primary prevention services are informed by, designed with, and serving disparately impacted populations of focus. The Oklahoma prevention system adopted SAMHSA’s use of developing disparity impact statements, extending this practice in our work. The ODMHSAS monitors prevention providers for this and provides ongoing training and consultation to continually improve.

7. Describe the state’s efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

See #2
8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.

See #2

9. Describe your state plans for enhancing your state’s prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside) a. The impact of increased access to marijuana and the state’s strategies to prevent misuse by the underage population. b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse. c. How the state is using equitable strategies to reduce disparities in the state’s prevention planning and approaches. Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer’s Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document “ARPA Funding Plan 2021 (SA).”

The ODMHSAS is enhancing the state prevention system infrastructure by investing in additional prevention workforce, data collection, and service delivery in high need communities and schools. Included in this work, which is based on the Strategic Prevention Framework, is the assessment of risk and protective factors, including adverse experiences, in the state’s largest youth assessment known as the Oklahoma Prevention Needs Assessment and used for prevention planning and evaluation. This data, and other sources needed to inform prevention services, will be made available in a public facing data visualization to both demonstrate and further increase capacity of organizations across the state to understand the nature/scope of prevention needs. Also included in this strategic investment is the prioritization of prevention services for problems related to marijuana and alcohol consumption, among others, from which communities may select to address based on data and readiness in their areas. Service providers may select, based on local data, evidence-informed prevention services to provide such as preventing youth access to alcohol or marijuana via commercial or non-commercial settings, developing community or school policies, and providing direct prevention services to youth, families, and communities at large. Oklahoma’s strategic prevention plan includes guiding principles adopted by the prevention system that inform our selection and implementation of strategies, including guiding principle #4 – our services are inclusive, culturally informed, and seek to maximize health for all. This value is rooted in the SPF process that is required of prevention services in Oklahoma and proactively utilized by the schools and communities receiving funds under the SAPT Block Grant. The ODMHSAS will provide training, performance improvement opportunities, and monitor for adherence to these principles. Community-based prevention providers are required to develop strategic plans based on the SPF process. This stepped process includes the
intentional assessment and identification of populations of focus as well as disparate population(s). Providers are required to report services and reflect regularly on how their primary prevention services are informed by, designed with, and serving disparately impacted populations of focus.

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

Not applicable
SABG: COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state's SUD prevention, treatment, and recovery services systems in the context of COVID-19.

Common reactions during this time have included the addition of or increase of the following amongst Oklahomans: worry, anxiety, panic, fear of unknown; social withdrawal; difficulty concentrating or sleeping; change in sleeping or eating routines; feeling helpless, confused, angry; feelings of loss or grief; financial concerns and fears; fears around health or the health of loved ones; feeling of being “on edge” - irritable, cranky, short with people; and feelings of being low - hopeless, sad, apathetic; feelings of being detached. These additional stressors and the amount of time that people have had to endure them, has resulted in a pronounced increase in need for substance use disorder prevention, treatment and recovery services that exceeds our current system capacity.

2. Describe how your state's spending plan proposal addresses the needs and gaps, including gaps in equity.

The ODMHSAS spending plan proposal for Oklahoma addresses the needs/gaps identified in 1. Above:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>$9,291,914</th>
<th>See description below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Prevention (20%)</td>
<td>$3,214,843</td>
<td>See description below</td>
</tr>
<tr>
<td>PPW</td>
<td>$2,763,748</td>
<td>See description below</td>
</tr>
<tr>
<td>Administration</td>
<td>$803,711</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment**
- Continue development of medically supervised detoxification services, methamphetamine continuum of care, and further development of continued care and crisis services focusing on addiction.

    **Methamphetamine Treatment and Care**
    - Enhancing capacity for treatment systems to better address stimulant addiction, including:
    - extension of treatment duration;
    - expansion of gender-specific trauma-based treatment approaches;
    - relapse prevention interventions; and
    - infusing job readiness and supportive housing programming that supports long-term recovery.
### Primary Prevention (20%)

<table>
<thead>
<tr>
<th>Services</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based primary prevention services (coalitions)</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Family/Faith sector primary prevention services (SFP)</td>
<td>$480,000</td>
</tr>
<tr>
<td>Adolescent Screening and Brief Intervention services</td>
<td>$700,000</td>
</tr>
<tr>
<td>School-based primary prevention services</td>
<td>$200,000</td>
</tr>
<tr>
<td>Prevention needs assessment data visualization (Google)</td>
<td>$95,000</td>
</tr>
<tr>
<td>Oklahoma Prevention Needs Assessment expansion</td>
<td>$235,000</td>
</tr>
</tbody>
</table>

#### Google Dashboards

- Identifying Oklahomans most at risk for mental health and addiction issues through an enhanced partnership with Google and its subsidiaries. Enhancing the software will allow the ODMHSAS:
  - real time access to multiple data sources through a modern web-based platform;
  - increased accessible user interface to investigate and iterate on raw data; and
  - internal and external dash-boarding capabilities that allow for a more granular analysis by building out a variety of health application programming interfaces (API) that can better identify trends and high-risk areas to outreach, deploy early intervention, and implement targeted prevention strategies.

### PPW

<table>
<thead>
<tr>
<th>Services</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training in EBPs</td>
<td>$150,000</td>
</tr>
<tr>
<td>Expand Halfway House and different levels of recovery residence support for PPW</td>
<td>$1,093,748</td>
</tr>
<tr>
<td>Family Treatment Court training and start up</td>
<td>$500,000</td>
</tr>
<tr>
<td>Parent Child Assistance Program Pilot (EBP)</td>
<td>$270,000</td>
</tr>
<tr>
<td>Family of Care and Plans of Safe Care Portal</td>
<td>$500,000</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Program Support Staff (1 FTE to assist with PPW residential and OP, and 1 FTE staff to assist with SAFER implementation and OP, and .50 FTE program assistant)</td>
<td>$250,000</td>
</tr>
</tbody>
</table>

All services above would be inclusive of all PPW with children who have a SUD. These activities will be ancillary services to the exist outpatient and residential treatment services provided, to ensure a holistic approach to care and to increase the continuum of care, recovery and supports. The EBPs will be for the Trauma based EBP training designed to meet the needs of this population and EBP training for Methamphetamine but can be used for any other disorder.

3. If your state plans to utilize the funds for crisis services, describe how the state will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.

   - *Not Applicable.*

4. If your state plans to utilize the funds for OUD, AUD, and/or TUD MAT services, describe how the state will implement these evidence-based services. Please reference the SAMHSA Evidence-based Practices Resource Center when considering selection of appropriate services.

   - See information in 2. above.

5. Explain how your state plans to collaborate with other departments or agencies to address the identified needs.

   - See information in 2. above.

6. If your state plans to utilize any of the waiver provisions listed above, please explain how your state will implement them with these funds and how the waiver will facilitate the state’s response to COVID-19 pandemic and its deleterious impacts. (These waivers are only applicable to these COVID Relief supplemental funds and not to the standard SABG funds). Grantees will be required to provide documentation and track use of such waivers.
7. If your state plans to make provider stabilization payments, the proposal must include at a minimum the following: **Not Applicable**
   a. The period that the payments will be made available i.e., start date and end date.
   b. The total proposed amount of COVID-19 Relief funds for this purpose.
   c. The methodology for determining support/stabilization payments.
   d. Provider eligibility criteria (e.g., need based).
   e. Provider request approach/procedure.

8. If states plan to use COVID-19 Relief funds for targeted housing costs, the proposal must include at a minimum the following: **Not Applicable**
   a. The proposed amount of award amount for this purpose.
   b. Methodology for determining rental and security deposit payments.
   c. Eligibility criteria for payment of rent or security deposit.
   d. Proposed approach/procedures for individuals to request rental assistance.
July 12th, 2019

Commissioner - Oklahoma Department of Mental Health and Substance Abuse Services
2000 N Classen Blvd.
Oklahoma City, OK 73106
Suite E600

RE: Delegation of Authority

Dear Commissioner:

This is to reaffirm that the Oklahoma Department of Mental Health and Substance Abuse Services is by statute, the State authority for mental health and substance abuse services.

I hereby delegate authority to the Commissioner of the Department as the Oklahoma Approving Authority on all grant applications and cooperative agreements developed and submitted on behalf of the Department pending the Department has received approval from the Oklahoma Secretary of Health and Mental Health. This authority includes authorization to sign funding agreements and certifications, to provide assurances of compliance, and to perform similar acts relevant to the administration of grants and cooperative agreements deemed to fulfill the mission of the Oklahoma Department Mental Health and Substance Abuse Services. This delegation of authority is effective until such as time it is rescinded.

I further certify that the responsibility for management of the grants will be vested in the Department of Mental Health and Substance Abuse Services. The Department will be responsible to the Federal government, the Legislature of the State of Oklahoma, and to this office for carrying out grant provisions.

Sincerely,

J. Kevin Stitt
Governor
**State Information**

**Chief Executive Officer’s Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]**

**Fiscal Year 2022**

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1911</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x</td>
</tr>
<tr>
<td>Section 1912</td>
<td>State Plan for Comprehensive Community Mental Health Services for Certain Individuals</td>
<td>42 USC § 300x-1</td>
</tr>
<tr>
<td>Section 1913</td>
<td>Certain Agreements</td>
<td>42 USC § 300x-2</td>
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<td>Section 1914</td>
<td>State Mental Health Planning Council</td>
<td>42 USC § 300x-3</td>
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<tr>
<td>Section 1915</td>
<td>Additional Provisions</td>
<td>42 USC § 300x-4</td>
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<tr>
<td>Section 1916</td>
<td>Restrictions on Use of Payments</td>
<td>42 USC § 300x-5</td>
</tr>
<tr>
<td>Section 1917</td>
<td>Application for Grant</td>
<td>42 USC § 300x-6</td>
</tr>
</tbody>
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<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee’s policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”

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generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: Carrie Slatton-Hodges

Signature of CEO or Designee: ________________________________

Title: Commissioner Date Signed: ________________________________

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
QUESTIONS

SAMHSA requests that the following information is included when submitting the proposals:

1. **Identify the needs and gaps of your state’s mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.**

   In Oklahoma, as has been the case for decades, the need for services in all levels of care in the mental health continuum outpaces resources. Because of limited resources, services are primarily targeted to address the needs of the most seriously ill; this means for persons who experience ongoing, persistent medical issues associated with mental illness or addiction, persons who are in crisis or have been found to be dangerous to self or others.

2. **Identify the needs and gaps of your state’s mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.**

   With the July 2022 launch of 988 as the national behavioral health crisis line, the ODMHSAS has created a comprehensive crisis response framework with components being launched throughout the upcoming year. The framework was developed through national consultation and follows the strategies proposed in the SAMHSA National Guidelines for Behavioral Health Crisis Toolkit and the Crisis Now model. Three pillars of services will ensure there’s always someone to talk to, someone to respond, and somewhere to go. Talk to- The ODMHSAS is seeking to implement an ‘air traffic control’ type 988 call center which incorporates the latest call center, dashboards, and GPS/dispatch technology. Respond- The ODMHSAS is seeking to implement statewide mobile crisis teams (a therapist and peer/case manager) which will be dispatched from the call center to respond in the community 24/7 to provide on-site de-escalation services when the call center is not able to address the immediate needs. Both the call center and mobile crisis teams will provide outpatient appointment scheduling and follow up services to individuals served to ensure they were connected to outpatient services. Somewhere to go: The ODMHSAS is expanding urgent recovery and crisis centers to ensure local, community-based opportunities to provide respite and immediate access to psychiatric, nursing, clinical, and peer staff to address urgent needs.
3. Describe your state’s spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.

**Budget**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
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<tbody>
<tr>
<td>10% eSMI</td>
<td>$1,570,805.52</td>
</tr>
<tr>
<td>5% Crisis Services</td>
<td>$785,402.60</td>
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<tr>
<td>Infrastructure</td>
<td>$9,000,000</td>
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<tr>
<td>Education/Media</td>
<td>$500,000.00</td>
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<tr>
<td>Services</td>
<td>$3,851,843.88</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$15,708,052.00</strong></td>
</tr>
</tbody>
</table>

**eSMI:**
Additional training and technical assistance on evidence-based practices for individuals with SMI, especially eSMI and FEP. Expansion of outreach and engagement efforts for youth and young adults including schools, colleges, universities, and medical offices. These one-time funds will be used as enhancements to the provider network. The ODMHSAS will prioritize models that allow for trainer development which will support the sustainment of ongoing training opportunities. The expansion of outreach and engagement efforts will be sustained through increased fee for service reimbursement opportunities.

**5% Crisis Services:**
Establishing multidisciplinary mobile crisis teams statewide to intervene wherever crisis is occurring for adults. These teams are dispatched through the 988 call center and also work closely with community-based treatment providers, police, crisis hotlines, and hospital emergency personnel. Mobile teams will provide onsite de-escalation and evaluations, warm hand-offs to outpatient services, and help facilitate adults accessing higher levels of care, including urgent, crisis, and hospitalization if needed. These one-time funds will be used to support the establishment of statewide mobile crisis teams as part of the 988 state preparedness plans. Mobile crisis teams will be supported in developing practices to identify Medicaid and third party eligibility for reimbursement to sustain the services.

**Infrastructure:**
Enhancement of the state-operated facility EHR (Avatar) will transform the network of 11 statewide facilities which includes outpatient, crisis, and hospital/inpatient care to improve continuity of care, transitions to and from higher levels of care, improved accuracy for bed availability reports, and standardization of clinical pathways across the system. Includes equipment to develop capacity for electronic signatures, which will support the ongoing expansion of telehealth services, and 15-minute bed checks across crisis and inpatient care. (Per funding guidelines, no tablets or other devices will be distributed for client access to care). The ODMHSAS has partnered with a nationally recognized and experienced EHR provider (Netsmart) and consultant group (Afia) to ensure state and national health IT standards are incorporated.
Establish 24/7 statewide call center with clinical triage for the roll out of 988, including accessing state-of-the-art technology to ensure responsiveness, including online 24/7 chat platform technologies, next day appointment scheduling, dispatching mobile crisis teams, and peer follow up services to ensure connection to care after calls and coordination of resources, such as transportation, as needed to make appointments.

These one-time funds will provide the purchase of the enhancement of the EHR and the initial technology purchase of the 988 call center.

**Education/Media:**
Education, marketing, and communications around accessing mental health services, including 988, crisis continuum, and CCBHCs with targeted priority groups including individuals with SMI including FEP.

These one-time funds will support the development of communications and marketing information which will continue to be used after the end of the project period.

**Services:**
Development of a centralized care coordination team to support individuals with repeated engagements in higher levels of mental health care and crisis interactions to ensure continuity of care and engagement in outpatient and support services.

Expansion of telehealth service capacity, including telehealth therapists to provide support to the existing telehealth infrastructure. Among other populations to be served, these therapists will ensure ipads already distributed to law enforcement officers throughout the state are answered and immediate needs addressed.

These one-time funds will support the initial development and support of the care coordination team. The decrease in higher levels of care, including hospital and crisis readmissions, will support the sustainability of the team. The expansion of telehealth which will be sustained through fee for service billing from the telehealth clinicians. This sustainability plan is supported through the July 1, 2021 expansion of Medicaid which dramatically increases the percentage of the population with a funding source for behavioral health services.

4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state’s system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.

See #2
5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

The ODMHSAS will continue its strong history of collaboration with community partners. As an example, since February 2021, the ODMHSAS has met monthly with a group of crisis, treatment, and recovery support services stakeholders, 911 officials, individuals with lived experience, and NSPLs to discuss needs for coordination of care for 988 launch.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

See #3

7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionatley high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

see #3

8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

See #3
MHBG: COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state’s mental health services in the context of COVID-19.

Symptomology of the current clients that we serve has increased during this time of uncertainty with COVID-19, and individuals identified with symptomology meeting criteria for services, including individuals with early SMI/FEP, has become more visible. Common reactions during this time have included the addition of or increase of: worry, anxiety, panic, fear of unknown; social withdrawal; difficulty concentrating or sleeping; change in sleeping or eating routines; feeling helpless, confused, angry; feelings of loss or grief; financial concerns and fears; fears around health or the health of loved ones; feeling of being “on edge” - irritable, cranky, short with people; and feelings of being low - hopeless, sad, apathetic; feelings of being detached. These additional symptoms and the amount of time that clients have had to endure them, has resulted in a pronounced increase in need for outreach and crisis care/services, that exceeds our current system capacity.

2. Describe how your state’s spending plan proposal addresses the needs and gaps.

The ODMHSAS spending plan proposal for Oklahoma addresses the needs/gaps identified in 1. Above:

<table>
<thead>
<tr>
<th>Component</th>
<th>Amount</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Care (5%)</td>
<td>$454,707</td>
<td>See description below</td>
</tr>
<tr>
<td>eSMI/FEP (10%)</td>
<td>$909,414</td>
<td>See description below</td>
</tr>
<tr>
<td>Mobile Crisis Teams</td>
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<td>See description below</td>
</tr>
<tr>
<td>988 Call Center</td>
<td>$2,000,000</td>
<td>See description below</td>
</tr>
<tr>
<td>Administration</td>
<td>$454,707</td>
<td></td>
</tr>
</tbody>
</table>

**Crisis Care (5%)**

- Expansion of Urgent Recovery Centers/Crisis Centers: Urgent Care and Crisis Centers are places of stabilization and offer the community a no wrong door access to mental health and substance use care. These facilities operate similar to a hospital emergency department that accepts all walk-ins, mobile crisis team, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages and clinical conditions regardless of acuity, informs program staffing, physical space, structure and use of chairs and recliners in addition to beds, offering flexible capacity and flexibility within a given space. These facilities provide assessment and support, and are staffed 24/7/365 with a multidisciplinary team. This team includes but is not limited to psychiatrists, nurses, licensed behavioral health practitioners and peers with lived experience similar to the population served.
eSMI/FEP (10%)
- Implement additional training programs and supervision to grow provider expertise in evidence-based practices for individuals with eSMI (including FEP). Focus will be on growing therapist expertise in Cognitive Behavioral Therapy (CBT) and in Recovery-Oriented Cognitive Therapy (C-TR). In addition, this funding will allow expansion of outreach and engagement efforts, including collaboration with college/university, medical hospital personnel, and other entities that serve youth and young adults, to help identify individuals with eSMI and engage in treatment.

Mobile Crisis Teams
- Establishing multidisciplinary mobile crisis teams statewide to intervene wherever crisis is occurring for adults. These teams are dispatched through the 988 call center and also work closely with community-based treatment providers, police, crisis hotlines, and hospital emergency personnel. Mobile teams will provide onsite de-escalation and evaluations, warm hand-offs to outpatient services, and help facilitate adults accessing higher levels of care, including urgent, crisis, and hospitalization if needed.

988 Call Center
- Establish 24/7 statewide call center with clinical triage, setting clinical standards and sector-wide best practices, providing constant quality assurance, training, suicide risk and other assessments, and guidelines to ensure quality, effective help for people in crisis.
- Accessing state-of-the-art technology to ensure responsiveness, including online 24/7 chat platform technologies, next day appointment scheduling, dispatching mobile crisis teams, and peer follow up services to ensure connection to care after calls and coordination of resources, such as transportation, as needed to make appointments.
- Statewide marketing and communications around 988 so that all Oklahomans are aware of the services offered and it becomes the standard response when experiencing a mental health crisis.
- Collaborates with 911 to receive transfers of mental health calls which don’t require law enforcement or emergency medical response.

3. Describe how the state will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The five percent crisis services set-aside applies to these funds.
- See response in 2. above.
4. Explain how your state plans to collaborate with other departments or agencies to address the identified needs.

- See response in 2. above.

5. If your state plans to utilize any of the waiver provisions or the recommendations listed in this guidance, please explain how your state will implement them with these funds. (These waivers are only applicable to these COVID-19 Relief supplemental funds and not to the regular or FY 2021 MHBG funds. States will be required to provide documentation ensuring these funds are tracked separately.)

- Not Applicable.

Revision Request – Questions

1) Mobile Crisis Teams. What about children/adolescents? What is the state doing to address this population?

Oklahoma has implemented the System of Care: Strengthening Our CareNet (SOC2) initiative to increase access to and enhance excellence of the statewide System of Care (OKSOC) for all children and youth, 0-21, with serious emotional disturbances and their families, and for particular subsets of children and youth which included the creation of an improved crisis system for all children and families statewide that is standardized and sustainable. Oklahoma has developed a best practice model for crisis services, building on lessons learned in a current pilot program, and research of successful SOC crisis models very similar to the New Jersey and Wraparound Milwaukee models. The objective is to require the crisis services prior to admission to higher levels of care, currently the crisis system is diverting 75% of referrals from going to higher levels of care to community based services with a Wraparound process for those with the most complex needs. This service is available to over 6,000 children and youth currently receiving OKSOC services annually, but to all OK children in need of crisis behavioral health response from the public behavioral health system.

As a part of the reduction of hospitalization for children, the Statewide Mobile Response and Stabilization Crisis System provides a rapid, community-based mobile crisis intervention services for children, youth and young adults up to the age of 25 who are experiencing behavioral health or psychiatric emergencies.

2) 988 Call Center. In reference to your response in this section above: “Statewide marketing and communications around 988 so that all
Oklahomans are aware of the services offered and it becomes the standard response when experiencing a mental health crisis.”

This marketing and communication cannot be to the general population; it must target the SMI/SED population. For example, brochures and posters can be places in provider’s offices, but you cannot pay for billboard/radio/tv ads with MHBG dollars. Please rewrite the initiative to address the appropriate audience.

Implement a statewide marketing and communications plan about 988 that is targeted to the SMI/SED populations. Marketing efforts include developing and disseminating print and digital promotional materials targeted toward the SMI/SED populations.
July 12th, 2019

Commissioner - Oklahoma Department of Mental Health and Substance Abuse Services
2000 N Classen Blvd.
Oklahoma City, OK 73106
Suite E600

RE: Delegation of Authority

Dear Commissioner:

This is to reaffirm that the Oklahoma Department of Mental Health and Substance Abuse Services is by statute, the State authority for mental health and substance abuse services.

I hereby delegate authority to the Commissioner of the Department as the Oklahoma Approving Authority on all grant applications and cooperative agreements developed and submitted on behalf of the Department pending the Department has received approval from the Oklahoma Secretary of Health and Mental Health. This authority includes authorization to sign funding agreements and certifications, to provide assurances of compliance, and to perform similar acts relevant to the administration of grants and cooperative agreements deemed to fulfill the mission of the Oklahoma Department Mental Health and Substance Abuse Services. This delegation of authority is effective until such as time it is rescinded.

I further certify that the responsibility for management of the grants will be vested in the Department of Mental Health and Substance Abuse Services. The Department will be responsible to the Federal government, the Legislature of the State of Oklahoma, and to this office for carrying out grant provisions.

Sincerely,

J. Kevin Stitt
Governor
## State Information

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Carrie Slatton-Hodges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Commissioner</td>
</tr>
<tr>
<td>Organization</td>
<td>Oklahoma Department of Mental Health and Substance Abuse Services</td>
</tr>
</tbody>
</table>

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**Signature:**

**Date:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

Not Applicable
Planning Steps

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

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
PLANNING STEPS

Step One: Assess the Strengths and Organizational Capacity of the Service System to Address the Specific Populations

Overview of Oklahoma’s Prevention, Early Identification, Treatment, and Recovery Support Systems.

Services and supports are available statewide through a network of provider and community-based programs. These include 13 Community Mental Health Centers (CMHCs), 70 substance use disorder treatment providers, 17 prevention organizations and 53 specialty providers, including housing, advocacy, and consumer and family operated programs. Oklahoma is moving towards a Certified Community Behavioral Health Clinic model. Oklahoma’s current CMHCs are elevating their standards and service array to meet the criteria to become a CCBHC. Currently 6 of the 13 CMHCs have become CCBHCs providing services in 77 individual sites. These CCBHCs are required to provide care coordination and care management to ensure integrated behavioral health and health care. In addition, there are 2 RA1SE NAVIGATE programs to assist individuals who are experiencing First Episode of Psychosis (FEP), along with 1 FEP Crisis Care program, and 14 statewide early Serious Mental Illness (eSMI) Outreach Programs provided through Community Mental Health Centers to develop and maintain collaborative partnerships with local higher education institutions and local hospitals to connect with the age range that is most at risk for eSMI.

System Structure

As the Single State Agency for Substance Abuse and the State Mental Health Authority, the ODMHSAS fulfills state level responsibilities as regulator and purchaser of services. In some areas of the state, and with specific levels of care, the ODMHSAS also operates as a direct provider of services. Other state agencies collaborate with the ODMHSAS to fulfill similar roles within their authority. Regional and local responsibilities are typically carried out by specific organizations with which the ODMHSAS contracts.

The ODMHSAS Central Office in Oklahoma City provides planning, training, technical assistance, oversight, fiscal and accountability support for the entire system. Key Central Office functions include Support for Treatment and Recovery Services, Decision Support Services, Information Technology Services, Consumer Advocacy and Wellness, the Inspector General, Human Resources Management and Development, Finance, Legal, Grants Management, and Provider Certification. All leadership and management structures are organized under the ODMHSAS Commissioner and her executive staff including the Chief Operating Officer, Chief Clinical Integration Officer, Chief Clinical Strategy Officer, and Chief Communications Officer.

Licensure (certification) of most treatment and support service organizations is statutorily required and administered through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Provider Certification Division. The ODMHSAS
also supervises mandated direct care certifications for Behavioral Health Case Managers, Peer Recovery Support Specialists, and the Alcohol and Drug Substance Abuse Course process (organizations, individual assessors and course facilitators, related to drivers’ licenses administrative law reinstatement).

On a daily basis, approximately 3,399 behavioral health staff provide outpatient and other community-based services to children, youth and adult consumers statewide. The majority of these are employed as case managers, counselors, social workers, psychologists, nurses and psychiatrists at the CMHCs. However, other providers are represented in this workforce including Peer Recovery Support Specialists, Family Support Providers, and residential support staff. The ODMHSAS provides ongoing training and performance improvement opportunities to all providers throughout the system, including employees of the ODMHSAS and staff from partnering organizations. The ODMHSAS Human Resources Development training programs recorded combined audiences of over 28,945 participants from all areas of Oklahoma in state fiscal year 2019. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce. Over 1.2 million telehealth services to over 100,000 individuals were provided by the treatment network in fiscal year 2021.

Prevention Services

Community Based Prevention Services (CBPS) providers are active community coalitions that are developing community level prevention work plans. Community level prevention work is based on the Strategic Prevention Framework and aligned with state prevention priorities. Services focus on achieving sustainable, population level outcomes. The ODMHSAS administers Responsible Beverage Service and Sales Training (RBSS) as an overarching moniker of Oklahoma’s underage drinking prevention initiative. Synar inspections and the delivery of AlcoholEdu in Oklahoma schools. No SAPT Block Grant funds are used for enforcement, only training and technical assistance and support services to communities and law enforcement agencies. Other programs administered through the ODMHSAS prevention initiatives include the Oklahoma Partnership Initiative funded by the Administration on Children and Families; Screening, Brief Intervention, and Referral to Treatment (SBIRT) services funded by SAMHSA Center for Substance Abuse Treatment, state and foundation sources; the Office of Suicide Prevention funded by the SAMHSA Center for Mental Health Services (CMHS) and state appropriated funds; Mental Health First Aid training program funded by state appropriated resources; the Strategic Prevention Framework (SFP) Partnerships For Success and SPF Rx programs, the State Opioid and Stimulant Response Grant, Prescription Drug Overdose project, First Responders CARA project funded by SAMHSA Center for Substance Abuse Prevention and state appropriated funds and Oklahoma’s Prescription For Change initiative supported by state appropriated funds. An additional emerging prevention services includes a partnership with the Oklahoma Department of Education and the implementation of Good Behavior Game (GBG) and a Support Center for Oklahoma schools and students.
Early Identification

Oklahoma has two urban areas with a population large enough to support a full RA1SE NAVIGATE Early Treatment Program (according to the formula utilized by the implementation team contracted to train and consult with Oklahoma on implementing this evidence-based practice.). Currently Oklahoma has full RA1SE NAVIGATE Programs in both of those urban areas. Red Rock Behavioral Health Services serves Oklahoma County, and Family and Children’s Services of Oklahoma serves Tulsa County. In addition, Oklahoma has one First Episode Psychosis (FEP) Crisis Care program in Oklahoma County, and statewide early Serious Mental Illness (eSMI) Outreach Programs provided through 14 Community Mental Health Center service areas to develop and maintain collaborative partnerships with local higher education institutions and local hospitals to connect with the age range that is most at risk for eSMI.

Mental Health Services

The 13 CMHCs referenced earlier serve the state with programs established in approximately 70 cities and towns. Department employees operate four CMHCs in Lawton, McAlester, Norman and Woodward. The other 9 CMHCs are private, nonprofit organizations under contract with the Department. All CMHCs are also Medicaid providers and access funding from a variety of other sources. Community Based Structured Crisis Centers (CBSCCs) for adults operate in Oklahoma City, Tulsa, Clinton, Norman, Muskogee, Sapulpa and Ardmore. The ODMHSAS contracts with other organizations to provide community based mental health and recovery support services including statewide advocacy organizations, independent clubhouses, a peer drop-in center, and housing services and supports. Adult psychiatric inpatient services are provided at Griffin Memorial Hospital in Norman, the Oklahoma Forensic Center in Vinita and at smaller inpatient units located in McAlester, Ft. Supply, Tulsa and Lawton. The ODMHSAS funds four urgent care centers in the following areas: Oklahoma City, Tulsa, Sapulpa and Ardmore. The Urgent Care Centers provide outpatient services to include medication management for persons needing immediate care in order to prevent a psychiatric emergency. The Centers also provide 23-hour respite and observation in order to divert persons as indicated from inpatient or CBSCC placement.

Substance Use Disorder Services

The substance use disorder (SUD) treatment and recovery services funded through the ODMHSAS service system are provided at 70 facilities, covering all 77 Oklahoma counties. The intention is to offer a full recovery-oriented system of care. All SUD treatment organizations must be state licensed (certified). Facilities can be licensed as a basic Alcohol and Drug Treatment Program providing a specific service set or as a Certified Comprehensive Addiction Recovery Center (CCARC) providing a full continuum of care. There are currently nine CCARCs throughout the state. All providers must be Medicaid compensable and many accept other types of third party payment and self-payment. The ODMHSAS funded services are primarily purchased through contracts with
private, for-profit and non-profit, certified agencies to provide multiple levels of withdrawal management, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations. These agencies include SUD treatment facilities, community mental health centers, community action agencies, youth and family services agencies, and schools. Among the contracted facilities, the University of Oklahoma Health Sciences Center provides workforce development trainings screening, assessment and treatment planning for children with Fetal Alcohol Spectrum Disorder. An essential component to the recovery system is the state’s network of Oxford Houses. Currently, there are 116 Oxford Houses throughout the state with more in development. Most of the Oxford Houses have accessed loans from a revolving loan fund administered by the ODMHSAS. Oxford houses have become more open to MAT residency resulting in an increase of MAT residents. Due to the acceptance of MAT residents by Oxford House, the ODMHSAS utilized SOR grant funds to employ two additional outreach workers specializing in MAT. The ODMHSAS also directly operates three SUD residential treatment facilities staffed with state employees. Oklahoma Alliance for Recovery Housing (OKARR) launched in January 2020 as a private, not for profit agency to promote access to recovery supportive living environments and provide certification as a state affiliate of the National Alliance for Recovery Residences (NARR). 46 recovery residences with over 850 beds have been certified in Oklahoma and are following best practices within the social model of recovery.

MAT is provided through the CMHC’s, CCARC’s, and OTP’s (Opioid Treatment Programs). The number of CMHC’s and CCARC’s has already been addressed in previous sections. There are 17 Opioid Treatment Programs, serving 10 counties. They are mandated to be certified by the ODMHSAS, in addition to having certification/approval by SAMHSA, DEA, CARF, and OBNDD. The OTP’s are private, for profit organizations. Currently, the ODMHSAS is only contracting with two of the OTP’s. However, in the very near future, the ODMHSAS will be able to contract with more of the OTP’s. Currently, the ODMHSAS is able to contract for MAT services, at the CMHC’s, CCARC’s, and the two OTP’s through the SOR grant. From September 2018 to May 2021, 3,973 consumers received treatment services, 5,054 consumers received medication treatment services and 6,706 consumers received recovery support services. Through this same grant, evidence-based trainings, such as Community Reinforcement Approach/Adolescent Community Reinforcement Approach, Contingency Management (CM), Recovery Management Check-ups and Support (RMCS), and Trauma Recovery and Empowerment Model (TREM) have been provided to the providers.

The ODMHSAS currently has 18 specific outpatient contracts for adolescent substance use. The ODMHSAS contracts with one male residential treatment program, in Tulsa, for 24 beds that utilizes Equine therapy as a part of the programming. There is one state operated residential facility. The ODMHSAS does have a contract with Street School, an alternative school, to provide substance use education to teachers to help them respond therapeutically to those students who have a SUD. This alternative school provides screening, assessment and therapy through other financial means. CMHC and SUD providers have been offered training and certification in the Community Reinforcement
Approach and Adolescent Community Reinforcement Approach. All outpatient contractors are eligible to provide early intervention, outpatient, and intensive outpatient as well as other ancillary services such as outreach, peer recovery for 16 and up, wellness, rehab, etc. All contracted treatment agencies whether a community mental health center or a substance use disorder treatment agency are to provide integrated co-occurring services for children and adolescents.

Oklahoma has three children’s crisis centers in the following cities: Red Rock in Oklahoma City, The Calm Center in Tulsa, and Children’s Recovery Center in Norman. Each of these crisis centers are legislatively required to provide detoxification for children and adolescents if needed. These detox services are in addition to the 18 specific contracts for adolescent substance use.

In addition to training CMHCs contracted with the ODMHSAS to provide adolescent and young adult substance use services, the ODMHSAS has also trained several other CMHSs in the EBPs Motivational Interviewing, GAIN SS, Community Reinforcement Approach and Adolescent Community Reinforcement Approach to help improve the services they provide to adolescents and young adults.

Drawing on best practices for substance use disorder adolescents and young adults, and in response to the opioid crisis, we have implemented ease of access for MAT services for any adolescent or young adult who may meet the requirements for an SUD admission to a higher level of care. ODMHSAS is building a recovery-oriented systems of care for adolescents and young adults who are struggling with a substance use disorder. Trainings surrounding best practices for treatment of adolescents, youth and their families will be incorporated to help support infrastructure of EBPs for substance use disorder.

According, to Office of Juvenile Affairs (OJA) and Oklahoma Depart. of Human Services (OKDHS), Adolescents in state custody in our large metropolitan show statistically significant overrepresentation of African American adolescents and transitional aged youth who have in custody with law enforcement contact. Tulsa and Oklahoma counties were the top two counties by arrest, adjudications, and referrals.

OJA and OKDHS estimates that 79% of youth in their group homes have SUD, and 30% of the youth in their custody are in need of mental health and substance use services and supports. Evidence shows early intervention and appropriate referrals and supports in place for these youth show a decrease recidivism. By continuing collaborations and partnerships with other youth serving agencies we will bring supports to identify youth who are considered to be at risk within these systems for mental health, co-occurring or substance use disorders and link to appropriate supports and services.

**Problem Gambling Treatment Services**

The Oklahoma Gaming industry is represented by over 120 casinos, four horse tracks/racinos, and the Oklahoma Lottery. The first prevalence study in the State of Oklahoma was conducted in 2015 on those individuals who might have a problem with gambling. Many subgroups of the population have problem gambling prevalence above
the adult average, including adolescents, African-Americans, individuals who are Hispanic, Asians, American Indians, lower socio-economic groups, men, those with substance use and mental health co-morbid conditions, military, college students and casino workers. The impact of problem gambling on the elderly is also an area of attention. Stigma continues to remain a major barrier to people seeking treatment.

Resources to fund treatment for problem gambling behaviors are limited, but the 2005 Oklahoma Education Lottery Act and the Oklahoma Horse Racing State Tribal Gaming Act authorized the ODMHSAS to receive $750,000 per year to provide problem gambling education and treatment. $250,000 per year comes from the Native American gaming and $500,000 from the Oklahoma Lottery. In FY 2014, legislation was approved directing the Oklahoma Lottery to increase funding for program gambling services by $250,000. In addition to funding authorized, state statute requires certification (licensure) for programs that provide problem gambling treatment services. The ODMHSAS Provider Certification administers this certification process, in accordance with OAC 450:65.

Effective July 1, 2014, ODMHSAS certification rules were revised for CMHCs, Alcohol and Drug Treatment Programs, and Comprehensive Community Addiction Recovery Centers to allow for outpatient gambling disorder treatment services as a part of services delivered. As projected more of the aforementioned programs have become providers of gambling disorder treatment services, resulting in a decrease in certified gambling treatment programs. However, due to an increase in the provision of gambling services offered by the aforementioned programs, greater geographical coverage has increased for those who need treatment services. In addition, certified Mental Health and Substance Use Disorder treatment agencies continue to administer the Brief BioSocial Gambling Screen at a reimbursement rate of $5.00 per screen. The goal is to continue to increase screening among individuals seeking mental health and/or substance use disorder treatment, to better assess individual comprehensive needs and to allow for intervention on problem gambling issues along with other presenting issues.

In addition to gambling treatment services, the ODMHSAS funds the Oklahoma Association on Problem and Compulsive Gambling for advocacy, training, outreach and prevention services. Oklahoma residents can access services by calling Oklahoma's 24-hour toll-free Problem Gambling Helpline at 1-800-522-4700.

**Services for Children and Their Families**

Systems of Care are the preferred approach to coordinate services for children and their families. The Oklahoma Systems of Care Initiative (OKSOC) is strategically designed to have local Systems of Care available to children, youth and their families in all 77 counties. Currently, Oklahoma has 80 local Systems of Care sites that cover 77 counties. Funding from SAMHSA and the Oklahoma Legislature has been leveraged to facilitate development of the OKSOC. CMHCs host most of the local Systems of Care sites, and work in equal partnership with local teams and community organizations to ensure that children with Serious Emotional Disturbances (SED) and their families have access to the full array of services they need and want. Community Based Structured Crisis Centers
for children, in Oklahoma City and Tulsa, address the emergent needs of children and their families. The ODMHSAS also operates the Children's Recovery Center in Norman to provide inpatient and residential services for children up to the age of 18 with mental health, substance use, or co-occurring disorders.

Oklahoma continues to support initiatives implemented through the Strengthening our Care Net (SOC^2) to increase access and enhance excellence of the statewide System of Care (OKSOC) for all children and youth, 0-21, with serious emotional disturbances and their families, and for particular subsets of children and youth by: implementing and enhancing best practices and EBPS, providing outreach, TA and engagement approaches for children, youth, young adults, and their families. In addition to strengthening the workforce development efforts toward creating capacity and capability in local SOCs across the state to better serve the needs of infants, young children, young adults, and their families.

To accomplish all objectives, policy and partnership changes will be implemented, including:

- expanding and better supporting the roles of family support providers and youth and young adult peer recovery support specialists;
- using outcome data to obtain additional state funding and identify new funding opportunities;
- better recruiting, retaining and
- strengthening the workforce skills in implementing EBPs with high fidelity to the models; and
- building on an already robust regional training and infrastructure and university partnerships to ensure a workforce trained and prepared to deliver effective services

ODMHSAS has now developed the Oklahoma's Youth Crisis Mobile Response; an integral component of Oklahoma Systems of Care (OKSOC) and founded on the OKSOC values and principles. These principles provide the driving force for the provision of behavioral health services to Oklahoma’s children, youth, young adults, and families.

Youth Crisis Mobile Response provides statewide rapid, community-based mobile crisis intervention services for children, youth, and young adults up to the age of 25 who are experiencing behavioral health or psychiatric crises. The Crisis Call Center, located in Oklahoma City, OK, provides Call Center Services for 76 of 77 counties across Oklahoma. They administer caller satisfaction surveys for all calls and mobile responses. The Call Center is Alliance for Information and Referral Systems (AIRS) and American Association of Suicidology (AAS) accredited and all staff are trained in Applied Suicide Intervention Skills (ASIST), active listening, de-escalating and safety planning skills. A Licensed Professional Counselor is on staff full-time to address emergent clinical needs.

In FY 2021 the Youth Crisis Mobile Response:

- Served 6,188 children and youth
- Higher level of care diversion rate – 81.15%
- Return to class versus suspension or detention/ISS – 89.3%
SOC2 has implemented successful outreach approaches to identify youth and young adults with early signs and symptoms of SED, SMI, or first episode psychosis (FEP) and will continue this implementation as ODMHSAS was awarded the Oklahoma Healthy Transitions Initiative-2 (OHTI-2) that will begin October 1st, 2021. The ODMHSAS will partner with local treatment providers to create a strong, deep and wide safety net for young adults in transition (YATs), ages 16-25, with serious emotional disturbance (SED) or serious mental illness (SMI).

As mentioned previously, the ODMHSAS is building an early childhood SOC network statewide. The goal of this network is to work with local partners from the early childhood community to expand the expertise of the OKSOC providers to better serve children ages 0-5 and their families. Training in the following EBPs has been, and will continue to be, provided: Infant Massage, Circle of Security and Child Parent Psychotherapy. To support continued efforts to best meet the needs of children 0-5 and their families, ODMHSAS provides technical assistance opportunities on an "as requested" basis. A foundational training series has also been developed that educates clinicians serving the 0-5 population on appropriate assessment and diagnostic procedures and provides an entry point into work with the 0-5 population.

The ODMHSAS along with The OHCA will sunset the Health Home program on September 15, 2021. All integrated care initiatives and care coordination will now be provided through the growing and successful Certified Community Behavioral Health Clinics (CCBHC) model.

School-based services are working to establish new Behavioral Intervention Services and Support (BISS) provider networks throughout the remaining 200+ school district in Oklahoma. Currently there’re 84 BISS providers in Oklahoma working within tiered service continuum for youth within the school setting. Continuum of Supports: BISSS utilizes a school-wide structural framework with a 3-tiered intervention for identifying and addressing academic and behavioral issues for students. The goal of a tiered approach is to create a school culture and behavioral supports that encourage and improve academic, behavioral, and social outcomes for all students. This allows for a continuum of supports to be provided based on the identified risk, character, and severity of students’ issues and needs.

SPARCS is a manually-guided and empirically-supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma and/or separate types of trauma. It was designed to address the needs of adolescents who may still be living with ongoing stress and experiencing problems in several areas of functioning including difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. SPARCS has been successfully implemented with at-risk youth in various service systems in over a dozen states. Partnerships with adolescent substance use providers to work within secondary school systems will be a focus. School based services will look to leverage
the existing adolescent substance abuse provider infrastructure to provide SPARCS curriculum to high school students. The plan is to leverage SPARCS and implement the collection of outcomes data for program participants.

The ODMHSAS contracts with Family Treatment Courts (FTC) located in Kay, Oklahoma, Tulsa, and Okmulgee County. The FTC is a specialty court that focuses on caregivers battling substance use disorders whose children were removed from the home and put into state custody. The court utilizes a multidisciplinary team made up of the Judge, District Attorney, Coordinator, Attorney’s, treatment providers, and child welfare to monitor and staff the case. In a FTC, substance use treatment and case management services form the core of the intervention. The FTC’s emphasize coordinating these functions with those of child welfare. In addition, participants must attend frequent review hearings during which the judge reviews their progress and administers behavioral based responses. Participants will receive varying rewards throughout the program to incentivize positive behavior and individualized therapeutic responses to negative behaviors. The overall goal for the participant is family reunification.

ODMHSAS has been awarded multiple implementation grants to implement an FTC as well as multiple enhancement grants to enhance treatment services within the existing FTC’s. In an effort to improve outcomes for substance using pregnant and postnatal women and their newborns, ODMHSAS applied for and was awarded the Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) initiative. This initiative provides the platform for intentional strategic education and training around the importance of treating women prenatally and post-natally using plans of safe care. Out of the QIC-CCCT initiative, ODMHSAS applied and received In Depth Technical Assistance (IDTA) from the Center for Children and Family Futures (CFF) to continue the goals and initiatives identified in the QIC-CCCT project. ODMHSAS and Dr. Margaret Lloyd from the University of Connecticut were awarded a National Institute of Justice research grant to develop an instrument measuring FTC compliance with the National Family Treatment Court Best Practice Standards to conduct the most robust analysis of FTC outcomes to date. This project titled the Oklahoma Multi-Site Family Treatment Court Model Standards Study (OKMSS) will span five years and occur in each of the four contracted Oklahoma counties with FTC dockets: Oklahoma, Tulsa, Okmulgee, Custer-Washita and Kay. The development of the FTC Best Practice Standards was a collaborative effort between national organizations, content experts, and federal agencies. Children and CFF partnered with the National Association of Drug Court Professionals (NADCP) under the leadership of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and with the assistance of representatives from the Children’s Bureau and the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, CFF has agreed to coach state level staff at ODMHSAS to provide technical support and education to the FTC’s in Oklahoma utilizing the Family Treatment Court Best Practice Standards.

Oklahoma’s STARS Program: ODMHSAS has partnered with the University of Oklahoma Health Sciences Center at Children’s Hospital as well as the A Better Chance Clinic to launch Oklahoma’s Substance Use Treatment and Access to Recovery and Supports
(STARS) Program. STARS is designed to increase the well-being of and improve permanency outcomes for children and families affected by or exposed to opioids or other substance use. As a part of these efforts, the STAR Prenatal Clinic provides comprehensive specialized prenatal care for women with substance use disorders in pregnancy in a collaborative environment, with an emphasis on coordination of care with supportive psychosocial services and substance use treatment providers. This STARS program’s focus is to develop training and cross-training to increase the knowledge base of the medical, therapy, and child welfare systems; enhance the well-being of children, parents, and families and improve safe and permanent caregiving relationships; improve retention in substance use treatment and successful completion of treatment for parents; facilitate the implementation, delivery, and effectiveness of prevention services and programs for at-risk families; decrease the number of out-of-home placements for children by enhancing the safety of children prior to delivery; and decrease the number of out-of-home placements for children at-risk of removal.

Through the efforts of the STARS Program, 119 individuals have given birth at the STAR Prenatal Clinic with 82% able to go home with their infants at the time of discharge. The STAR Clinic has also implemented further innovations such as the inclusion of prenatal consultations for all patients, the addition of Peer Recovery Support Specialists (PRSS) as a support service to all patients, a decrease in discharge follow-up from 6 weeks to 2 weeks, and the adoption of Family Care Plans as a mechanism to further empower and provide ownership to the mom’s along their recovery journey.

**Disaster Responses Infrastructure and Services**

The ODMHSAS Disaster Coordinator is the designated coordinator for disaster response in partnership with local, state, and federal entities that mobilize following a disaster. The SAMHSA Disaster Technical Assistance Center (DTAC) and the Federal Emergency Management Agency (FEMA) provide additional resources. In addition, ODMHSAS works closely with the Oklahoma Department of Health in providing volunteers and training through the Oklahoma Medical Reserve Corps. Through the Medical Reserve Corps Stress Response Team, ODMHSAS in conjunction with OSDH maintains a database of approximately 150 licensed behavioral health disaster volunteers.

Per FEMA, Oklahoma has the 3rd highest disaster rate in the Nation. During the past several years Oklahoma has experienced multiple natural disasters and because of this, intense focus has been on continued community collaboration, volunteer infrastructure, and training. Approximately 700 clinicians have been trained in Psychological First Aid (PFA) to assist as first responders in the communities affected by disaster.

**American Indians/Alaska Natives (AI/AN)**

Oklahoma has the second largest Native American population after California and is home to 38 federally recognized tribes. In 2018, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 366,706 comprising 9.3 percent of the state’s total population.
The Oklahoma Department of Mental Health and Substance Abuse continues to actively develop partnerships with tribal governments and other tribal serving organizations to ensure maximum and effective prevention and treatment efforts within communities. These efforts are made available through all of our departments and tribal liaison in the following: training, technical assistance, data provision, data collection, and meetings of collaboration and consultation.

Activities for the last year include formal consultations, collaborations, and partnerships with the 39 tribes located in the state of Oklahoma. The tribal liaison for the department attended community meetings, tribal grant advisory councils, tribal consortiums, tribal state workgroups, and responded to technical assistance requests from tribal governments, tribal organizations and state contracted agencies. Topics addressed during these activities included prevention, substance abuse treatment, drug court, opioid crisis, reentry programs and cultural competence. In order to address this in a more collaborative manner, the ODMHSAS supported the development of the Tribal Behavioral Health Association. This is attended by tribal and state partners and these efforts will continue to be supported.

The Certified Community Behavioral Health Clinics (CCBHC) also focus on outreach to AI individuals and have approached tribal nations and Indian Health Service clinics about establishing processes for referrals and linkages. The children's SOC wraparound teams also work to reach out to AI families.

In addition, the ODMHSAS Prevention Division works with tribal partners to coordinate the prevention portion of the Substance Abuse Block Grant, state appropriated prevention, and federal discretionary funds with certain tribal prevention resources to scale prevention services. Braided infrastructure around data collection and analysis (including a combined State and Tribal Epidemiological Outcomes Workgroup, or STEOW), resource allocation and planning, prevention workforce training, and the Evidence-Based Practices Workgroup (EBPW) have allowed Oklahoma to leverage prevention resources for maximum reach.

Military Personnel (Active, Guard, Reserve and Veteran) and their Families

The ODMHSAS has a partnership with the Oklahoma Department of Veterans Affairs to work collaboratively on specific prevention initiatives. Specialty courts designated as Zone4Vet status have been established. Treatment court programs apply for special designation as a Zone4Vet program through an application with criteria such as early identification of justice-involved veterans, personnel trained in veteran services and treatment needs, and collaborative partnerships with community veteran partners. A Peer Recovery Support Service Veteran certification was developed and is currently being offered. Military members and their families are a focus for the CCBHCs. Before being certified, they CCBHCs held triable listening sessions to identify gaps in services and staff received training provided by the Indian Health Clinic in Oklahoma City. An overview of CCBHC development was presented to the Veterans Alliance. A meeting was held
between CCBHC staff and Major General Deering, Secretary of Veteran Affairs and the Executive Director of the Oklahoma Department of Veteran Affairs, to educate on the CCBHC and how this evolution of services could benefit veterans, dishonorable discharged veterans, and individuals that are inactive duty but still in the reserves.

To better target military families and veterans, the ODMHSAS has modified its data collection system to identify active military members, family members of active military members, and veterans.

**Targeted Services for Individuals Involved in the Criminal or Juvenile Justice Systems**

The ODMHSAS collaborates with various partners within criminal justice and law enforcement to provide a variety of services. The Sequential Intercept Model is used in strategic planning and aligning of resources for the greatest impact in terms of reducing involvement with criminal justice for adults and children with behavioral health treatment needs. Brief descriptions of related activities follow.

- **Crisis Intervention Training (CIT)** is a community effort partnering both law enforcement officers and the community together for common goals of safety, understanding, and service to individuals with mental illness and their families. Officers participate in a 5-day, 40-hour CIT program hosted by ODMHSAS. The training program consists of sections taught by mental health and substance abuse treatment experts, specially trained officers, local Community Mental Health Centers, and representatives from the National Alliance on Mental Illness (NAMI). The training prepares officers to safely de-escalate a crisis, determine the need for emergency treatment, and get the individual to professional treatment as quickly as possible. In the last six years, ODMHSAS and all supporting CIT partners, have trained around 800 law enforcement officers throughout the state. In Oklahoma County alone, CIT-trained officers have saved nearly $1,000,000 in jail costs and over $500,000 in hospital costs through deescalating mental health crisis and diverting individuals to crisis centers. CIT programs have been modified for detention officers and other law enforcement populations.

- **Law Enforcement Training** is offered by ODMHSAS staff to fulfill CLEET continuing education needs. Classes can be offered from an existing course list or tailored to the needs of agencies. ODMHSAS has also expanded access to training by offering a virtual eLearning library with 10 one hour courses available on demand to officers providing free CLEET continuing education credits. In order to ensure all of the training options available for law enforcement to receive their annual 2-hour mental health continuing education, the ODMHSAS entered into an agreement with CLEET to review all coursework submitted to them for specific mental health hour approval.

- **Pretrial Support** is offered to pretrial service agencies, courts, and jails in order to expedite bond decisions that encourage rehabilitation, public safety, and coordination with community-based providers. ODMHSAS also provides free
certification training on the use of validated pretrial risk assessment tools as well as other pretrial best practices, including access to the ODMHSAS web-based pretrial data collection system.

- **Day Reporting** is a pretrial bond program designed to serve individuals with serious mental illness and those with co-occurring mental health and addiction disorders who are awaiting sentencing for qualifying criminal offenses. Due to limited resources, this service is only operational in Oklahoma County. Services are provided by NorthCare and serves persons in the custody of the Oklahoma County Sheriff. The savings from Day Reporting participants not awaiting sentencing in jail ($7,056,377) equates to adding an additional 9 peace officers to the local law enforcement agencies for each year that this program has operated (began in 2005). These savings have been realized through a better than 96 percent decrease in participant arrests, days spent in jail and needed inpatient hospital days.

- **Offender Screening**, as authorized by 43A O.S. 3-704, are conducted by ODMHSAS certified treatment providers to determine felony offenders’ risk to reoffend as well as identify substance use and mental health treatment needs. Using these validated screening instruments, referral recommendations are made for prison-alternative sentences that best meet the offender’s needs and increase the likelihood of successful prison diversion. By serving as central screening hubs, county jail-based screenings save diversion program resources and avoid duplicative assessment processes. Offender Screening has reduced the average time an offender spends awaiting sentencing by 57 days, resulting in $15.5 million in jail day savings. Counties without offender screening experienced an increase in the percentage of non-violent prison receptions that was approximately twice that of counties with offender screening. ODMHSAS has made Offender Screenings available in all 77 counties. To date, over 40,000 screens have been completed and nearly 35,000 final dispositions recorded. An estimated 82 percent of those screened individuals are eligible for diversion programs, including treatment services and other.

- **Drug Courts** annually cost $5,000 compared to $19,000 for incarceration. That alone is a significant benefit. But what really tells the story are the improved outcomes. Drug Court graduates are much less likely to become incarcerated compared to released inmates. Measured program outcomes include 96.5 percent drop in unemployment, a 159.1 percent jump in monthly income, a 92.7 percent increase in participants with private health insurance and better than 80 percent of graduates are able to again live with their children. A tracking study of over 4,000 graduates monitored for a five-year period demonstrated earnings of better than $204 million that resulted in an estimated $6.1 million in tax revenue paid to the state. Had these graduates been incarcerated, instead of in drug court, it would have cost the state an additional $191.6 million (average sentence of three years each).
• **Mental Health Court** outcomes, like drug court, are impressive. Graduates of mental health courts are nearly 8 times less likely to become incarcerated compared to released inmates, and nearly 14 times less likely to be incarcerated than released inmates who have been diagnosed as having a serious mental illness. Program graduates have seen a 55 percent drop in unemployment, a 96 percent decrease in arrests and an 89 percent decrease in the number of days spent in jail. There are currently mental health courts in 28 Oklahoma counties.

• **Misdemeanor/Early Diversion Programs** partner criminal justice accountability with evidence-based substance abuse and mental health treatment services to decrease future involvement with the criminal justice system. Misdemeanor Diversion general operate within two models (1) Misdemeanor Treatment Court programs which are highly structured programs. They include, but are not limited to, regular court appearances, case management, supervision, random drug screens, group and individual therapy by certified treatment agencies; or (2) Deferred Adjudication Treatment programs which provide diversion strategies, such as deferred prosecution agreements, as the legal mechanism for participation. The participant receives individualized treatment services provided by certified treatment agencies without the supervision of the court. Treatment providers report to the DA when a participant is non-compliant with services. There are currently 13 counties operating misdemeanor/early diversion programs.

• **Veteran Support** is provided by ODMHSAS through the Zone4Vets initiative. Zone4Vets is a special distinction that criminal justice programs, such as treatment courts, can earn by meeting a set of research-supported criteria which review operational standards and policies. Programs receiving the Zone4Vets distinction have, for example, enhanced their collaboration with community veteran resources, received specialized training, and have amended their policies and operations to more quickly identify justice-involved veterans in their criminal justice systems. Several programs across the state have received Zone4Vets honors and are providing exceptional care to veterans in their communities.

• **Municipal Diversion Program.** In partnership with the City of Midwest City and the Midwest City Police Department, the ODMHSAS offers treatment diversion opportunities to the citizens of Midwest City charged with a municipal offense. Midwest City hosts the largest municipal jail in the state. The program was created in an effort to reduce the recidivism of municipal offenders by offering individualized behavioral health treatment in lieu of traditional case processing.

• **Reentry Teams, Discharge Planners, and Co-Occurring Treatment Specialist.** The state funds four Reentry Intensive Care Coordination Teams (RICCTs). These contracts with community based teams include a specifically trained Intensive Case Manager and a Peer Recovery Support Specialist to provide success oriented and strengths-based reentry support following incarceration. The ODMHSAS provides seven Discharge Planners to work in targeted correctional facilities. Discharge Planners work alongside prison treatment staff to
identify and assist inmates preparing for reentry who are expected to have ongoing mental health and substance abuse treatment needs.

The Discharge Planners, Co-occurring Treatment Specialists and the RICCT staff work under the supervision of the Manager of Correctional Criminal Justice and Reentry Services and under the direction of the ODMHSAS Director of Criminal Justice Services with full support from the Department of Corrections.

- **Benefits Reinstatement for Returning Inmates.** In 2010, SAMHSA published a report summarizing the collaborative work between the DOC, the ODMHSAS, and other state and federal partners in conjunction with Mathmatica Policy Research, Inc. (MPR). The report, “Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions” (DHHS, 2010) evaluated the methodologies in place in Oklahoma whereby people with SMI, upon discharge from prison, have immediate access to the Medicaid and disability benefits for which they are eligible. Due to a partnership with the local Social Security Administration office, and the Department of Disability Determination, a memorandum of understanding allows applications for public benefits for eligible offenders, including SSI, SSDI, and Medicaid, to begin at least four months prior to release from the DOC facility. This process is an integral part of the prison based discharge planning and reentry function. The findings suggested the model as one applicable to other states and other types of public institutions including state hospitals referred to in Social Security parlance as IMDs (Institutes for Mental Disease). The report is available at [http://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf](http://store.samhsa.gov/shin/content/SMA10-4545/SMA10-4545.pdf)

- **Community-Based Services to Probationers and Parolees.** Through the existing network of non-profit community-based treatment agencies, the ODMHSAS provides services to probationers and parolees throughout the state. Data is collected through the Medicaid Management Information System to identify the referral source and criminal justice status of clients to allow ODMHSAS to provide services data, outcomes, and capacity information related to this population.

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**Mental Health Block Grant Criterion**

**Children with Serious Emotional Disturbances (SED) and Their Families-**  
As referenced above, the CMHC network and the coordinated OKSOC sites provide statewide coverage for the comprehensive services available for children with SED and their families. All sites must be capable of screening and treating or referring children and youth with separate or co-occurring substance use disorders. Local affiliation agreements and memoranda of understandings with substance use treatment providers assure
adequate access to a wider range of services needed by the children and their families. In FY2021, a total of 82,603 children under age 18 were served in the ODMHSAS system by both mental health and substance use disorder providers; 28,810 children with SED. Additional information is provided below to address specific MHSBG requirements.

- **Mental Health and Rehabilitation Services for Children with SED.** CMHCs, CCBHCs and SOC sites (sometimes one and the same and sometimes collaborating partners) ensure that children with SED and their families have access to basic services, specifically crisis intervention, evaluation and treatment planning, medication and psychiatric services, and case management services. Additional services for children and their families are listed below.
  
  o Home-based services  
  o Family therapy  
  o Diagnosis-related education  
  o Client advocacy  
  o Outreach  
  
  o Peer family support  
  o Family self-sufficiency (housing)  
  o Socialization  
  o School-based services  
  o Wraparound/flexible funds  
  o Care Coordination

- **Health/Medical, Vision and Dental Services.** Care Coordination to assist parents and children in accessing treatment for health conditions ranging from vision and hearing problems to chronic illnesses. The Oklahoma Health Care Authority (OHCA) is designated to administer the Children’s Health Initiative Program (CHIP). School-based health services are organized by the OHCA through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Many schools hire nurses to implement targeted health programs related to EPSDT to help parents access early and preventative care for their children. The program is in 74 of Oklahoma’s 77 counties. CMHCs, CCBHCs and SOC sites are developing collaborations with Federally Qualified Health Centers (FQHCs), tribal health services, clinics, homeless clinics and county health departments. Oklahoma is moving from Health Home to CCBHC model of integrated care. CCBHCs, for children with SED, integrate behavioral health care and primary care services by: 1) directly providing primary care in-house performed by a qualified employee, or purchasing through a contract; or 2) establishing written agreements with external primary care providers and ensuring the coordination of care and treatment for identified physical care issues.

- **Employment and Vocational Services.** The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has adopted Individual Placement and Supports (IPS) as their standard evidence-based supported employment and education model. The ODMHSAS believes that the best way to support self-sufficiency for those assisted with employment is to reinforce rapid entry into the competitive labor market integrated with supportive services as soon as the person feels ready. This focus on the participant’s choice and strengths aligns closely with other evidence-based practices models followed by the ODMHSAS and affiliated providers and has allowed for better service provision for
Oklahoma’s most vulnerable. IPS has expanded to fifteen teams serving 23 counties across the state of Oklahoma funded through various grants, including the Mental Health Block Grant; and the State Opioid Response grant. On July 1, 2018, the ODMHSAS activated IPS specific billing codes, and the IPS credential process for IPS employment specialists and supervisors. This allows for providers to submit payment claims for delivery of IPS services to ODMHSAS.

- **Housing Services.** Housing services and homeless outreach services for families with children are provided in the same manner by which they are provided to adults. This is summarized elsewhere in this application. In addition to accessing an array of supportive and subsidized housing options, providers are able to utilize the ODMHSAS flexible funds to address immediate and short-term needs to stabilize family housing situations.

- **Special Education.** Under the provision of the Individuals with Disabilities Education Act, children who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs particularly affiliated with local Systems of Care are actively involved in supporting families and children for whom an IEP is needed.

- **Case Management.** Children and youth with an SED who want to access the full continuum of public behavioral services are assigned a case manager (care coordinator) to work closely with the youth and family to coordinate the development of an integrated treatment and wraparound plan. Members of the wraparound team design a family and youth directed plan to address key needs on behalf of the children receiving services.

- **Substance Use Disorder Services and Services for Children with Co-Occurring Disorders.** ODMHSAS funded substance use disorder treatment providers, CMHCs, Health Homes, and local SOCs provide specific substance use disorder treatment and support services across the life span. All treatment providers are to meet minimum requirements to be co-occurring capable service treatment sites.

- **Other Activities Leading to Reduction of Hospitalization.** CMHCs and other community-based providers offer screening and early intervention services to diminish the need for out-of-home placements, including inpatient treatment. Collaboration between providers also facilitates more integrated discharge planning as children and their families prepare for transition from out-of-home placements. This continues to result in lower hospitalization rates and shorter lengths of stay – particularly in Systems of Care communities. Health Homes are now responsible to ensure a smooth transition of care between any and all higher levels of care and HH services, including having formal agreements in place to facilitate this.

As a part of the reduction of hospitalization for children, the Statewide Mobile Response and Stabilization Crisis System provides a rapid, community-based
mobile crisis intervention services for children, youth and young adults up to the age of 25 who are experiencing behavioral health or psychiatric emergencies. Approximately 7,000 kids were served in SFY2018.

- **System of Integrated Services and Systems of Care for Children and Their Families.** A rich array of state and local partners collaborate to assure a system exists to integrate services appropriate for the multiple needs of children. The Systems of Care is the centerpiece of service integration on behalf of children with SED and their families. Oklahoma began to implement local Systems of Care in 2000. Mental Health Block Grant funding provided a portion of the initial resources to support the first two Systems of Care sites. Currently, there are 80 Systems of Care communities covering 74 counties. Other communities are in the formative stages of Systems of Care development. The state-level Systems of Care State Advisory Team oversees the overall operations of the Systems of Care communities. In addition, each local community has a team comprised of agency staff, community members, parent advocates and family members.

- **Transition Services.** ODMHSAS was awarded the Oklahoma Healthy Transitions Initiative-2 (OHTI-2) that will begin October 1st, 2021. The ODMHSAS will partner with local treatment providers to create a strong, deep and wide safety net for young adults in transition (YATs), ages 16-25, with serious emotional disturbance (SED) or serious mental illness (SMI). We will create a seamless transition across the child and adult systems that maximize resources across sectors. The sustainable system will muster all available resources ensuring an effective, culturally competent system delivering developmentally appropriate services and supports.

- **Social Marketing.** Social marketing is the practice of using commercial marketing strategies to drive behavior change around a social issue. Social marketing more specifically is a process of planning that can be used by an organization or system to foster positive behavioral change within a community through an audience focused approach of communication and outreach efforts without financial gain to the marketer. Oklahoma Systems of Care utilizes social marketing to increase awareness of the behavioral health needs of children, youth, and young adults; reduce stigma associated with mental illness and substance abuse; promote mental health; and demonstrate that Wraparound is the premier intervention for children and youth with SED and their families. Social marketing strategies and communications play a vital role in communicating these important messages to stakeholder groups throughout the state. Ultimately, social marketing efforts assist with the successful statewide implementation of Systems of Care as Oklahoma’s comprehensive approach to children’s behavioral health services. Annual Children’s Mental Health Awareness Day activities have been coordinated in various formats.

The 2020 Children’s Behavioral Health Conference for the first time ever was held in a virtual setting. This year there were prerecorded sessions that was made available on
June 8th while the live portion of the conference was on June 10th – 12th. This three-day event expanded by offering not only three days of live online sessions but more than 50 prerecorded sessions that you will be able to access throughout the duration of this event. Participants will be provided with practical tools they can utilize in their agencies and communities to assist with facilitating treatment, recovery and wellness. All sessions were available through June 26th.

The 2021 Children’s Behavioral Health Virtual Conference theme was “Powering through the Pandemic and Inspiring Hope”. This year’s conference provided three days of live webinars along with multiple pre-recorded sessions available throughout the duration of this event. The pre-recorded sessions were available May 17th while the live portion of the conference kicked off May 19th – 21st. All recorded sessions were available through June 11th. We also offered specific tracks as pre-institutes to the conference. The YOUTH TRACK was held virtually May 18th for youth and young adults aged 13-25. The Youth Track provided an opportunity for youth to hear from other youth, youth adults, and special presenters. The family track was held virtually on May 17th for family members of children, youth and young adults. Sessions were from 9am to 4pm including fun self-care gathering during the noon hour. Topics included caregiver tools, fetal alcohol syndrome, IEPs, stories of hope, and the honor of caregiving. The Wraparound (Frontline) Conference, a Pre-Institute was an opportunity for frontline staff who are providing Wraparound or Service Coordination to children, youth, young adults and their families within the Oklahoma System of Care who are facing complex behavioral health challenges to learn skills and concepts that will help them better serve families, to re-energize their work and to connect with each other to develop the network of support statewide.

- **Emergency Service Provider Training on Behalf of Children, Youth and Their Families.** The ODMHSAS provides numerous training opportunities for staff development each year. The Annual Children’s Behavioral Health Conference brings together approximately 1,000 participants. Many attendees work in first response settings, including emergency rooms, ambulance services and law enforcement. Local Systems of Care partners also engage law enforcement and other first responders in various trainings, planning and wraparound work on behalf of children and families. The ODMHSAS Prevention Division also provides training in various suicide intervention and crisis techniques to emergency room, health personnel, law enforcement staff and school districts.

**Adults with Serious Mental Illnesses (SMI)-**

The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI. In recent years, this system has also intentionally expanded to proactively support diversion from the criminal justice system. Initiatives within this realm include in Mental Health Courts serving 19 Oklahoma counties with an additional 7 counties being planned, a day reporting center in Oklahoma City, jail-based screenings in both Tulsa and Oklahoma City, statewide training in the Memphis Model Crisis Intervention Training (CIT) program, prison-based treatment for co-occurring mental health and substance use disorders, prison-based discharge planners, and community-
based re-entry intensive care coordination teams. In FY2019, a total of 90,051 adults over age 18 were served in the ODMHSAS system by both mental health and substance use disorder providers; 48,501 adults with SMI.

**Mental Health and Rehabilitation Services.** CMHCs, by regulation, must provide the following basic services:

- Crisis Intervention
- Medication and psychiatric services
- Case Management
- Evaluation and treatment planning
- Therapy services
- Psychosocial rehabilitation

Additional information is provided below to address specific MHBG requirements regarding service to adults.

- **Employment Services.** CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by the ODMHSAS and specific service codes provide claims and reimbursement data for this. In addition, HOPE Community Services offers a supported employment program. Transitional employment programs are provided by Thunderbird Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by Clubhouse International (formerly the International Center for Clubhouse Development). The ODMHSAS and the Oklahoma Department of Rehabilitation Services (OKDRS) assist with funding various activities within this array of employment services and utilize a memorandum of understanding to coordinate and monitor related activities.

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has adopted Individual Placement and Supports (IPS) as their standard evidence-based supported employment and education model. The ODMHSAS believes that the best way to support self-sufficiency for those assisted with employment is to reinforce rapid entry into the competitive labor market integrated with supportive services as soon as the person feels ready. This focus on the participant’s choice and strengths aligns closely with other evidence-based practices models followed by the ODMHSAS and affiliated providers and has allowed for better service provision for Oklahoma’s most vulnerable IPS has expanded to fifteen teams serving 23 counties across the state of Oklahoma funded through various different grants, including the Mental Health Block Grant; and the State Opioid Response grant. On July 1, 2018, the ODMHSAS activated IPS specific billing codes, and the IPS credential process for IPS employment specialists and supervisors. This allows for providers to submit payment claims for delivery of IPS services to ODMHSAS. We have also added benefits counseling by Certified Work Incentives Counseling to our IPS teams. Their main role is to provide intensive counseling about benefits and the effect of work on those benefits.
At the end of FY21, IPS participants were earning an average hourly wage of $10.50. The competitive employment rate is 30.4% which is impressive due to the pandemic.

**ASPIRE** is the Advancing State Policy Integration for Recovery and Employment initiative was awarded to Oklahoma in March 2021. This project is a statewide initiative that is geared toward bringing key stakeholders together to advance state policy regarding using employment though competitive integrated employment as a recovery tool. Oklahoma was chosen as one of seven states nationwide. Key agencies participating include ODMHSAS, Oklahoma Healthcare Authority, NAMIOK, Oklahoma Department of Veteran Affairs, Oklahoma Rehabilitation Council, Department of Rehabilitation Services, Oklahoma Office of Workforce Development, Oklahoma Employment Security Commission and Oklahoma State Department of Education.

**NextGen** project is a research project with the Weststat and Mathematic groups and Social Security Administration. It hopes to determine if those exiting jails and offered IPS services will have a better recidivism rate that those that are not offered IPS services. Oklahoma was selected for two of the five sites. Rogers County Detention Center/GLMHC and Cleveland County Detention Center/ODMHSAS embedded at COCMCH will serve over 400 exiting incarceration teams. Their main role is to provide intensive counseling about benefits and the effect of work on those benefits.

- **Housing Services.** Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specific housing services for people with mental illness are available in urban and rural settings and are funded through the ODMHSAS, the U.S. Department of Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some housing continues to be developed in settings specifically for persons with mental illness (i.e., HUD funded Section 811 and HUD SHP projects), the ODMHSAS continues to place an emphasis on creating opportunities for more integrated housing, including permanent scattered site housing with available support services. Some stakeholders continue to encourage the development of transitional housing services to meet the needs of consumers whose current level of recovery would make it difficult to have success in a supported housing model.

Additional housing related service and supports embedded in the system for adults with SMI include flexible funds available to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; a smaller subsidy program for transition youth
living in rural areas (added through grant funding in FY 2014); and Residential Care Facilities can receive a higher rate for services if they successfully meet criteria for designation as a Recovery Home.

- **Education Services for Adults with SMI.** Adult basic education, like GED classes, is offered on site at two clubhouse programs, and at some CMHCs. CMHCs and other providers also offer advocacy and support services to assist consumers with accessing GED classes within the community, as well as, other community based educational opportunities (i.e., technology centers, trade schools, colleges, universities) and promoting ongoing educational success. Through the ODMHSAS Individual Placement Services (IPS) program, training on “How to Get a GED” is offered for providers and other community stakeholders.

- **Substance Use Disorder Services Within CMHCs including Services for Persons with Co-Occurring Disorders.** All CMHCs are also certified as substance use disorder service providers and receive both mental health and substance use disorder funding for persons with SMI and co-occurring substance use disorders. Specialty substance use disorder treatment providers also collaborate with CMHCs for mental health assessment and other CMHC services as needed. Individualized, gender and culturally specific substance use disorder treatment is required of all providers.

- **Medical, Vision and Dental Services.** Case management services have historically been the major option by which adult consumers in the ODMHSAS system are assisted to access medical, vision, and dental services. Access has been more likely for Medicaid beneficiaries. The ODMHSAS and providers have continued focus on the primary health needs of adults with SMI. Collaborations continue with Federally Qualified Health Centers (FQHCs), tribal health and Indian Health services, homeless clinics, county health departments, and pro bono health care providers. Dental services are also provided in local communities through free dental clinics and pro bono providers. Oklahoma is moving from Health Home to CCBHC model of integrated care. CCBHCs will build upon the foundation of integrated care established by Health Homes to continue to provide and/or coordinate both physical and behavioral healthcare. of the CCBHCs integrate behavioral health care and primary care services by: 1) directly providing primary care in-house performed by a qualified employee, or purchasing through a contract; or 2) establishing written agreements with external primary care providers and ensuring the coordination of care and treatment for identified physical care issues.

- Oklahoma also has a SAMHSA grant, Promoting Integration of Primary and Behavioral Health Care (PIPBHC). PIPBHC is a 5-year grant that supports the promotion of integrating and collaboration between primary care and behavioral health care services and promoting availability of integrated care services related to screening, prevention, diagnosis, and treatment of mental illnesses, substance use disorder, and co-occurring physical health conditions and chronic
The goal of the grant is to serve a total of 2,000 people by the end of year five. There are four CCBHC’s that have partnered with FQHC to provide services, CREOKS partner with Arkansas Verigris and Northeastern Oklahoma Community Health (NeoHeath), Family and Children’s partner with Morton (FQHC), Green Country partnered with NeoHealth (FQHC), and Northcare partner with Variety Care (FQHC). These partnerships will ensure that primary care, including prevention, wellness activities, tobacco cessation, screening assessment, and needed services, are an integral part of the behavioral health system, and are accessible to all who access our system regardless of pay source.

- **Support Services and Psychiatric Rehabilitation.** All ODMHSAS certified CMHCs must provide a clubhouse or general psychiatric rehabilitation program, or individual and group rehabilitation services. Clubhouse programs must be certified by Clubhouse International (formerly the International Center for Clubhouse Development). CMHCs typically elect to provide either a general psychiatric rehabilitation program or individual and group rehabilitation services, which are reviewed under their state CMHC certification (licensure). In addition, two clubhouses certified by Clubhouse International currently operate independent of CMHCs -- Crossroads Clubhouse (Tulsa) and Thunderbird Clubhouse (Norman).

- **Case Management.** Case management is funded both by the ODMHSAS and the Medicaid program. Since the mid-1990s the ODMHSAS has promulgated the strengths based, person centered case management model to support case management activities in all community and facility settings. Case management services follow a plan approved by the service recipient and qualified staff. Billable activities include referral, linkage, advocacy and follow-up support provided in partnership with the consumer to assist with self-sufficiency and successful integration into community life. All staff that provides publicly funded behavioral case management services are statutorily required to be certified by the ODMHSAS, or possess Oklahoma certification as an Alcohol and Drug Counselor (CADC), or possess Oklahoma licensure as a Behavioral Health Professional (or under state supervision). For ODMHSAS Certification as a Behavioral Health Case Manager, applicants must complete a specified curriculum and examination to be eligible. There were 3,299 individuals certified as Case Managers in 2018. A dedicated website (http://www.ok.gov/odmhsas/Mental_Health/Behavioral_Health_Case_Management/index.html) provides access to the ODMHSAS certification information for case managers. Multiple entry points are available to attain certification. The ODMHSAS provides options for on-line training of specific elements as well as the ability to test at numerous locations statewide to qualify as reimbursable case managers. The ODMHSAS also recognizes the value of potential workforce members who have case management life experience and maintains a certification option for applicants with 60 college credit hours or a high school diploma with 36 total months of experience working with persons who have a mental illness, additional to those who have completed traditional degree-based programs.
Other Activities Leading to Reduction of Hospitalization. Oklahoma’s service culture embraces a strengths-based and person-centered approach which begins with a thorough assessment of consumer interest, strengths and needs, and the formation of a plan to assist the consumer with successfully achieving their identified goals. The resources and supports necessary for community success are identified and facilitated through collaborative efforts among the consumer, their support systems, and the service provider. This level of focus helps to reduce the use of hospital or other institutional based resources. CMHCs are monitored to assure that services include cooperative discharge planning with inpatient programs and crisis units, early response and crisis intervention programs, and community partnerships with law enforcement. Community Based Structured Crisis Centers provide short term stays and stabilization in lieu of placement in inpatient facilities. Urgent Care Centers in five locations, offer 23-hour 59 minute stabilization services. Other modalities, such as Program of Assertive Community Treatment (PACT), provide intervention, coordinated care, and successful community integration. Enhancements of early intervention and transitional services for individuals who interface with the criminal justice system also prevent the use of hospitalization as well as incarceration. Further, the Enhanced Tier Payment System (ETPS) discussed elsewhere in this application provides an enhanced payment based, in part, on meeting lower inpatient utilization targets.

As of October 2016, Oklahoma state law implemented Assisted Outpatient Treatment under Oklahoma Title 43A to ensure that adults with serious mental illness (SMI) can receive services through civil commitment process. The civil commitment process is unique because it does not have any association with criminal charges. The AOT order helps to ensure a mechanism for treatment and unifies community partners in the approach of client’s care. The community partners that commonly work together include Mental Health and Substance Use Disorder Service Providers, Law Enforcement, Court Staff, and essential Community Partners. AOT referrals can be sent by Community Partners, family, friends of the individual. Once referral is received the local staff will access to determine if criteria is met for an AOT order. The AOT order last for one year with Judges requesting updates throughout the order. The AOT Mental Health and Substance Use Disorder Providers provide consumers with a strength-based, non-threatening process for ensuring that adults with serious mental illness (SMI), who do not recognize the need for treatment have access to participate in treatment. Treatment also includes targeted Case Management, Peer Recovery Support Specialist, Therapy, Doctors, Rehabilitation options, and Medication Management. AOT can be viewed as a preventative measure to be prevent future law enforcement interactions, jail stays, inpatient hospitalizations, and emergency room visits.

ODMHSAS has been selected and awarded two AOT grants by SAMHSA. The first AOT grant was in Oklahoma, Tulsa, Rogers, Washington, Ottawa, and Delaware Counties. The first AOT grant ended in October 2020, and the current AOT grant began July 2021. The second AOT grant is concentrated in the following Oklahoma Counties Canadian, Pottawatomie, Payne, Mayes, and Kay. AOT II projected goals include serving 45 clients in year one, 75 clients in year two, and 100 clients in both year three and year four. Outcomes that are going to be measured before an individual enters treatment and after
one year in treatment include nights spent in psychiatric hospitalization, times admitted
to emergency room for mental health, number of times admitted to psychiatric hospital,
number of arrests, and number of days spent in jail. Having the grant greatly impacts the
ability to provide essential infrastructure and processes to help ensure longevity of the
program even after the grant ends.

- **Emergency Service Provider Training.** The ODMHSAS provides numerous training
opportunities for staff member development throughout the year to enhance skills
needed when they encounter adults with SMI. The training announcements are
distributed to individuals and organizations statewide, including emergency health
workers. Many participants work in first response settings, including emergency
rooms, ambulance services and law enforcement. Law enforcement jurisdictions
also collaborate with the ODMHSAS to cross train staff in diversionary and
proactive responses with people who may be experiencing mental illness or
addiction symptoms. The Memphis Model Crisis Intervention Training (CIT) is
widely utilized. The ODMHSAS staff also provides training in various suicide
intervention and crisis techniques to emergency room and other health personnel.
The state has expanded training offerings of Practical Front Line Assistance and
Support for Healing (PFLASH), Psychological First Aid (PFA), Question, Persuade
and Refer (QPR), and other early intervention response techniques to non-mental
health professionals, including first responders.

**Targeted Services for Individuals who are Homeless.** Some of the treatment and
supports for adults and children who are homeless are described elsewhere in this
application. Additional services targeted for individuals who are homeless are described
below.

- **Outreach Initiatives and Projects in Assistance for Transition from Homelessness
(PATH).** The PATH allocation for Oklahoma for grant year 09/01/2018 –
08/31/2019 is $452,820. PATH programs are located in areas with the highest
numbers of people who are homeless: Oklahoma City and Tulsa, and in the rural
communities of Tahlequah (located in northeast Oklahoma) and McAlester
(located in southeast Oklahoma). Services primarily focus on outreach and case
management (including referrals for primary health services, job training,
educational services and relevant housing services) but also include screening and
diagnostic treatment services, community mental health services, habilitation and
rehabilitation services, alcohol and drug treatment, staff training and housing
services. Individuals who are identified as homeless and having a serious mental
illness are engaged in treatment and support services with efforts made to
integrate them into services.

- **Substance Use Disorder Outreach.** The ODMHSAS also provides support to two
urban-based substance use disorder treatment programs for outreach activities.
Outreach activities target high-risk drug using individuals, many of whom are
homeless and impacted by both mental illness and addiction problems. The
outreach workers gain their trust, educate them about HIV/AIDS, communicable
diseases, and the harm caused by IV drug use, provide tests for HIV if requested, and assist with linkages to treatment programs.

- **The Tulsa Day Center for the Homeless.** This urban program provides linkages with needed mental health and community services on behalf of adults and children who present at their site, including assistance with accessing housing. In addition, they provide supportive services to people who leave the shelter and become housed to help ensure transition success and reduce recidivism. The goal of the Tulsa Day Center for the Homeless is to provide clients with homeless programs that will lead to successful re-housing and self-sufficiency.

- **HUD Continuum of Care (CoC) Projects.** These sites are operated by two CMHCs, Central Oklahoma Community Mental Health Center (McClain County and Norman Permanent Housing) and Hope Community Services (Balance of State). Each facilitates HUD permanent supportive housing projects that provide rental assistance to homeless persons with mental illness or co-occurring mental illness and substance use disorders. These projects assist participants with accessing and maintaining permanent housing. In addition to rental assistance, the projects also provide supportive services to help individuals achieve a sustained level of self-sufficiency. Other CMHCs also participate in local Continuums of Care.

- **Discharge Planning Bridge Subsidy Program.** The ODMHSAS provides targeted funds to assist very low-income individuals (age 18 and older) with mental illness or co-occurring mental illness and substance use disorders who are homeless or at risk of becoming homeless, as they discharge from psychiatric inpatient care, DOC, or age out of the foster care system. The primary focus is to access decent, safe, sanitary, and affordable housing. The funds assist with housing costs such as rent, utility costs, rent deposits and utility deposits. This program will make sure that each eligible person has the option to receive any supports or services he or she needs. This assistance can be accessed statewide.

- **Safe Havens.** Safe havens emphasize a housing first approach and allow individuals to remain in that housing even if they do not want to seek treatment. Oklahoma will continue to utilize MHBG funds for safe haven housing in state FY2020 and FY2021. Safe Haven services assist homeless persons in building relationships with mental health service providers, access community programs, and facilitate the eventual transition to permanent housing. Current safe haven programs are in Tulsa and are operated by the Mental Health Association of Oklahoma.

**Targeted Services for Individuals in Rural Areas.**

Individuals in rural areas generally have access to overall treatment and support systems described in earlier portions of the section. However, 59 of Oklahoma’s 77 counties are considered rural or frontier and the ODMHSAS continues to focus on improved access and providing services in more effective ways for adults and children in rural areas. Examples are discussed below.
• **Children and their Families in Rural Areas.** All rural CMHCs provide case management services to children. Most of the treatment is provided in the child’s home or a community-based location. Transportation continues to be a problem in rural areas of the state. Of the state’s 74 Systems of Care counties, 71 are located within rural settings. These sites engage a broad stakeholder base to coordinate care, leverage resources, and improve services to children and their families in rural settings.

• **Adults Accessing Mental Health Services in Rural Areas.** Ten CMHCs serve the rural areas of the state. All offer the required mental health services and also purchase or provide local acute inpatient treatment or crisis services to stabilize individuals on emergency orders of detention. Case management services and flexible funds for case managers in rural areas provide in-home support for isolated individuals and assist in purchasing needed goods and services not otherwise available. Most ODMHSAS certified residential care facilities are located in rural counties in the far northeast corner of the state. CMHCs target additional services to these facilities including general psychosocial rehabilitation day programs, social skills training, case management, and medication clinics.

• **Substance Use Disorder Treatment and Supports in Rural Areas.** ODMHSAS Telehealth Services include mental health treatment and follow ups for adults, children and families, substance use disorder services, telecourt, drug court and family drug court for all Oklahoman's in need. ODMHSAS Telehealth Service provides access in most substance use disorder treatment facilities.

• **Technology Supports in Rural Areas.** ODMHSAS maintains a statewide telemedicine network. Units are placed in CMHCs and satellite locations serving rural settings. These units increase access to services and information including medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. The ODMHSAS is utilizing the latest in software-based access to provide simple, cost effective, telehealth connectively to the "most remote" areas of Oklahoma. In FY18 40,737 rural Oklahoman's received ODMHSAS services that would not have received services.

• **Statewide Prevention Services.** The ODMHSAS divides Oklahoma into 17 substance abuse prevention regions that cover all 77 counties within the state. Each region is served by a Regional Prevention Coordinator. All contractors within this system are required to provide a basic level of core prevention services throughout the region, as well as identify areas of high need based on data.

**Services for Older Adults.** Services to older Oklahomans are available at CMHCs through the general array of adult program services, but specific services targeting older adults and designated older adult staff are limited. Limited resources have prevented expansion of these efforts, however, over the last 2-year period we have been able to
implement several older adult specific initiatives. During each of the last 2 years, the ODMHSAS has partnered with the Oklahoma Mental Health and Aging Coalition, the Oklahoma Healthy Aging Initiative, the Fran and Earl Ziegler College of Nursing at the University of Oklahoma, and the Anne and Henry Zarrow School of Social Work at the University of Oklahoma to facilitate a Positive Aging Institute to help increase provider and community knowledge regarding the unique considerations when serving older adults. In summer of 2018, the ODMHSAS held the first day-long older adult specialty training for Peer Recovery Support Specialists (PRSS). In fall of 2018, the ODMHSAS held the first Mental Health First Aid for Older Adults training. Just recently the ODMHSAS has provided intensive training and follow-up consultation on the evidence-based practice of Cognitive Behavioral Therapy (CBT) in the treatment of older adults for 6 designated older adult specific pilot project sites: 3 within Health Home settings, and 3 within substance use disorder treatment settings. The ODMHSAS continues to collaborate with stakeholders from the Aging community to offer training on the unique considerations regarding mental health and older adults. In addition, the ODMHSAS is an active participant in the Oklahoma Mental Health and Aging Coalition, which provides a forum where a variety of stakeholders advocate for increased, accessible and culturally appropriate services for older Oklahomans. Additionally, the Coalition provides statewide mental health, substance use, prevention and treatment education and advocacy, and partners with other networks that provide services to older adults to integrate and cross-train networks.

Comprehensive Substance Use Disorder Services

Comprehensive substance use disorder services for children, youth, and adults. As described earlier, substance use disorder (SUD) services are provided through a statewide network of providers that work collaboratively to assure good access and quality care. Key functions performed by providers and ODMHSAS personnel include referral, reporting, monitoring and technical assistance and peer review. Each of those functions is briefly described below to set the context within which specific SAPTBG targeted populations are served.

Substance Use Disorder Treatment Referrals. The ODMHSAS is committed to making accurate and appropriate referrals for all individuals into and outside of the SUD services arena. The ODMHSAS contractually requires SUD treatment providers to address both substance use and mental health needs of consumers. To aid providers in screening clients for co-occurring disorders, screening tools are recommended but treatment providers may use the co-occurring instruments of their choice. In addition, the Addiction Severity Index (ASI) and the current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM) instruments continue to be the backbone of
the SUD screening and assessment. The ODMHSAS continues to provide regular ASI and ASAM trainings. The ODMHSAS has developed an instrument to determine the level of service needed based on the ASAM criteria. The Oklahoma Determination of ASAM Service Level identified level of need for each of the six ASAM Dimensions and matched the need to a particular level of care.

*Capacity Reporting.* Residential programs utilize an on-line capacity reporting system to provide the ODMHSAS with a daily accounting of priority and non-priority individuals waiting to be admitted into treatment. A member of ODMHSAS administrative staff regularly reviews the time from placement on the residential SUD treatment list to treatment entry. This ensures all SAPTBG requirements are met and helps identify problems to be corrected. The ODMHSAS staff works with providers to help admit priority individuals into the first openings available. State staff also notes priority status populations daily in the agency reports to ensure that priority individuals are moving into openings within the required time frames. Non-priority status populations places on wait lists for residential treatment are engaged by outpatient providers in interim services. Outpatient treatment openings are typically more available and there are no waiting lists for those services.

*Service Monitoring and Technical Assistance.* Oklahoma monitors substance use disorder treatment providers by assigning Field Services Coordinators (FSCs) to specific state-operated and contracted programs for ongoing contract compliance reviews. The FSCs are the primary contacts for assigned providers, visiting the agencies and conducting on-site and/or desk reviews as well as reviewing provider staffing, services and performance reports. Plans of correction may be provided as needed and technical assistance is provided by the FSC or other ODMHSAS staff per the findings of the on-site and/or desk review. The FSCs also provides other technical assistance as needed.

*Peer Review.* The ODMHSAS continues request that substance abuse block grant funded providers coordinate peer reviews with other similarly funded providers throughout the state and forward a copy of the review to the ODMHSAS. That system continues to work well. Approximately 40% of the substance abuse block grant funded treatment providers received peer reviews in FY2018.

*Partnerships.* Collaborations are discussed in the Environmental Factors and Plan section of this application, #20, in which the range of partnerships all services within the ODMHSAS system are described. Specific to substance use disorder services these viable partnerships have resulted in more services and improved access for Oklahomans in need of substance use disorder treatment.

A range of recovery and support services are provided within the substance use disorder treatment services network and specific services funded by the ODMHSAS are listed in other sections of this application. A strength of the system continues to be the manner by which services are delivered to target populations mandated by SAPTBG requirements. Those are detailed below.
- **Persons who Inject Drugs.** Persons who inject drugs are served by all ODMHSAS substance use disorder service providers and state operated facilities. As a priority status population, clients involved with IDU are able to access residential substance disorder treatment within a few days of initial contact. Interim services are required by contract for persons who inject drugs who providers are not able to admit upon requesting treatment. Contracts also require providers to meet the 14-120 day standard. In addition, residential programs are contractually required to report their capacity and waiting list information to the ODMHSAS daily. Contract monitoring takes place at least annually.

Outreach services are contracted with two treatment providers in the largest metropolitan communities, Oklahoma City and Tulsa. These areas also represent the largest populations of persons who inject drugs. The contract requires the use of an evidence-based outreach model such as, but not limited to, the National Institute on Drug Abuse (NIDA) Indigenous Leader Outreach Model, the NIDA Standard Intervention Model for Drug Users, or the health education model as described in Rhodes, F., et al., *AIDS Intervention Program for Injection Drug Users*. Outreach staff visits their local downtown and high-risk areas in which homeless and persons who use drugs congregate. Information and education is discussed and distributed, HIV testing is provided with consent, and referrals and linkages to social services and treatment programs are made.

- **Adolescents with Substance Use Disorder Problems.** Oklahoma provides early intervention services for adolescents through adolescent specific contracted service providers that work closely with school systems in their areas, providing brief interventions for high-risk students through individual and group sessions at schools. Students are referred for additional treatment if needed. Another early intervention program called “Together with Communities” targets the communities around the Santa Fe South charter school, which uses the Celebrating Families curricula made available by the school to the community served.

Adolescent treatment services include two adolescent substance use disorder and co-occurring residential programs. Tulsa Boys Home has 24 male beds and offers Equine Therapy to their residents. The Children’s Recovery Center is a state-run facility that has 55 beds and the capacity to serve kids with mental health, addiction and co-occurring needs. The units are divided into 12 co-ed crisis beds and 43 residential beds. The residential beds are then divided by dorm with girls and boys treated separately (26 female and 17 male). Each dorm has two sides. Youth with co-occurring needs are served on both sides of a girls or boys dorm, but youth with primary addiction issues are served on one side, and kids with primary mental illness are served on the other side.

Peer Recovery Support Services is a Medicaid compensable service for adolescents age 16 and 17. The availability of peer support services for adolescents provides a more comprehensive continuum of services available to the adolescents served. The staff members who provide Peer Recovery Support
Services must be Certified by the ODMHSAS as a Peer Recovery Support Specialist (PRSS). A specialized training component on adolescents and young adults is incorporated in the curriculum for PRSS Certification.

In addition to the services listed above, the CMHCs and other substance use providers deliver outpatient treatment to youth with substance use and co-occurring mental health and substance use disorders.

- **Targeted Services for Underserved Individuals from Racial and Ethnic Minority Populations and LGBT Populations.** Oklahoma contracts with an agency in the more populous Oklahoma City area to provide LGBT services. Provider staff members are trained in sexual orientation sensitivity and LGBT competency and utilize CSAT’s *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals*. Family education support groups are offered for family members as defined by the customer. Client Satisfaction Surveys are requested of customers to report their experiences related to service quality, access, and outcomes.

Substance use disorder service providers also work with police, social workers, community outreach workers, substance use disorder agencies, health care providers, religious leaders, and others to provide training and education on various aspects of substance use disorder issues of the unique social and cultural needs of the LGBT community. Other underserved minority populations are targeted with specific substance use disorder programs.

- **Women who are Pregnant and have a Substance Use Disorder.** The Addiction Severity Index (ASI) and the current addition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM) are utilized to assess the severity and placement needs of all clients. Pregnant women assessed as needing outpatient substance use disorder services are able to admit into any outpatient program of their choice in the state. Pregnant women that are located in the following counties: Creek, Cherokee, Tulsa, Okmulgee, Wagoner, Muskogee, and Osage, are able to participate in the Oklahoma Families First Project. This is a three-year SAMHSA funded grant that seeks to enhance outpatient services for pregnant women and their families. The grant focuses on a family treatment approach to improve services, parenting, and attachment, expanding case management and resources and providing a system change in the treatment of pregnant or postpartum women and their children. Pregnant women assessed as needing outpatient substance use disorder services are able to admit into any outpatient program of their choice in the state. Pregnant women assessed at a higher level and needing a residential program are able to choose whether they prefer admittance to a pregnant women and women with children (WWC) facility, a female residential program or a co-ed facility. Upon entering a program, women receive individualized, culturally competent, gender-specific services that, along with treatment services, may include dietary information; parenting classes; case management services to help with housing, employment, education, food stamps or other basic needs; and
assistance with integrating back into the community. Additional needs identified by the ASI, such as mental health needs, are also included in the individualized plan for treatment. Transportation to services is provided when needed.

- **Parents with Substance Use Disorders who have Dependent Children.** Oklahoma contracts with five residential programs to provide services for women with dependent children (WWC) and one WWC halfway house treatment program. All five residential programs participate in the Oklahoma Pregnant and Post-Partum Women grant funded by SAMHSA. This is a five-year grant opportunity that seeks to enhance residential women’s treatment services through utilizing evidence-based practices that improve parenting, attachment, and a family-focused approach to treatment. The halfway house for WWC also operates a residential treatment program for women only. The Oklahoma City Housing Authority collaborates with the ODMHSAS to provide women a sober-living environment in which they can focus on their family, especially their dependent children, while continuing to work on recovery. Each resident must continue to attend self-help groups and work with the onsite case manager to address their educational, employment, mental health and other goals while easing back into the community. Additional options for transitional sober housing are in place and expanding currently. Another program administers behavioral and developmental assessments for children who may have been exposed to alcohol or other drugs prenatally. All WWC providers must give priority status to pregnant women, treat the family as a unit, provide a comprehensive range of services to women and their children either directly or through linkages with community-based organizations, including case management to assist in establishing eligibility for public assistance programs provided by federal, state, or local governments; employment and training programs; education and special education programs; drug-free housing for women and their children; Head Start; and other early childhood programs and promote and facilitate children’s access to the fullest possible range of medical services available, such as health screening; well-child health care; screening in speech, language, hearing, and vision; and verify immunization records. All programs must document biopsychosocial assessments for the parent and for the children accompanying their parent into treatment. Case management services are offered to all parents and children. Transportation to ancillary services is also provided as needed. Oxford House has multiple houses for women with children and two houses (one in Oklahoma City and one in Tulsa) for men with dependent children.

The ODMHSAS contracts with the OKDHS to provide appropriate outpatient substance use treatment services to applicants for Temporary Assistance for Needy Families (TANF) benefits, participants of TANF, or persons involved in the child welfare system due to parental/caregiver’s use of substances interfering with parenting and safety of children in the home. On November 1, 2012, legislation became effective requiring screening of all persons applying for TANF benefits to rule out substance use disorders and use of illegal substances; if the screening indicates the need for further assessment, contracted agencies provide the
assessment. When TANF applicants require assessment, a drug test to rule out the use of illegal drugs in the past 30 days is conducted following the assessment. Due to TANF benefits being tied to the results of substance use screening and assessments, availability of services are needed in each of the 77 counties in Oklahoma. Oklahoma currently contracts with 33 TANF/CW substance use disorder treatment providers. OKDHS funds the ODMHSAS position of the Coordinator of TANF/CW and Women Specific Services. The Coordinator closely monitors the contracts to ensure providers meet timeframes for access to services in order for referrals to comply with federal timeframes regarding TANF applications and the Adoption and Safe Families Act timeline for CW involved families. Nine contracted TANF/CW treatment providers offer the evidence-based Celebrating Families Program for TANF/CW referrals. Four contracted agencies provide Strengthening Families and Celebrating Families Programs for the TANF/CW population. Many TANF/CW contracted treatment providers offer gender specific and trauma specific services.

Family treatment court programs continue to collaborate with the TANF/CW providers to serve the CW population.

- **Services for Persons with or At Risk of Contracting Communicable Diseases: Individuals with Tuberculosis; Persons with or At Risk for HIV/AIDS.** The ODMHSAS substance use disorder service providers are contractually required to make tuberculosis services available to individuals receiving substance use disorder treatment and to provide interim services for individuals waiting for admission. The required services include counseling, screening and treatment when needed. Tuberculosis services are provided through local Oklahoma State Department of Health (OSDH) facilities, or through other community health care programs. The ODMHSAS provider contracts require adherence to infection control procedures as established by the Centers for Disease Control and Prevention.

Oklahoma is not an HIV designated state and, as such, does not provide early intervention programs for HIV/AIDS. However, Oklahoma Administrative Code (OAC 450) requires all ODMHSAS certified programs provide or arrange access to education, counseling and testing for HIV, AIDS and STDs for consumers and their partners as requested.

*Certified Community Behavioral Health Centers (CCBHC).* In December 2016, Oklahoma was awarded the Medicaid Demonstration project for Certified Community Behavioral Health Centers. This demonstration will increase the capacity to serve individuals that qualify for Medicaid and allow state dollars to more effectively serve individuals that are uninsured or underinsured. This Demonstration requires promotion and increased services for individuals with a primary or secondary substance use disorder as well as co-occurring and mental health disorders. All CCBHCs are also required to provide 9 core services through designated collaborations or through the agency itself and 4 of the 9 are required to be provided by the CCBHC. The 4 required include crisis services, screening,
assessment, diagnosis and risk assessment, treatment planning, and outpatient mental health and substance use services which includes Level I withdrawal management and highly suggested to do Level II. The additional 5 that can be a DCO or provided by the CCBHC include outpatient primary care, screening and monitoring, community mental health care for Veterans, targeted case management, peer, family support & counselor services, psychiatric, and rehab services. This will be a new process for these CCBHCs.

The payment structure is a per member per month rate. The demo sites’ Special Populations were changed to match the SPA sites’ Special Populations. There are 2 Special Populations. Special Population 1 is adults and Special Population 2 is children-both focusing on Oklahoma’s “Most in Need”. The special populations will be identified through data review of individuals with multiple risk factors, such as hospitalizations, emergency room visits, crisis center encounters, and/or recent discharge from a hospital for psychiatric reasons.

The CCBHC demonstration continues to be extended incrementally. The 3 providers under the demonstration will continue to provide services as required by the SAMSHA demonstration until the demo expires.

Oklahoma was the first CCBHC state with an approved State Plan Amendment for CCBHC services. Oklahoma will be able to continue to provide CCBHC services with no interruption with the State Plan Amendment. Currently there are 3 CCBHC sites approved and providing services under the SPA.

The payment structure under the Oklahoma State Plan Amendment for CCBHC remains a per member per month rate. The SPA changed the populations with enhanced rates from 5 special populations, as in the demo, to 2 special populations under the SPA. Special Population 1 is adults Special Population 2 is children, both focusing on Oklahoma’s “Most In Need”. The special populations will be identified through data review of individuals with multiple risk factors, such as hospitalizations, emergency room visits, crisis center encounters, and/or recent discharge from a hospital for psychiatric reasons.

The remaining individuals served at a CCBHC under the SPA will be considered in standard population and receive the standard per member per month rate.

The ODMHSAS is using state allocated and may use some block grant dollars, to serve the indigent population, in the same formula that has been chosen for the demonstration. Although, limited dollars, the CCBHCs are required to serve all those who meet criteria and need mental health and substance abuse services across the lifespan.

The CCBHCs, in total, include six Community Mental Health Agencies that cover 77 sites. Each agency had to pass a rigorous new certification specifically designed for this comprehensive fully integrated service model.
In April the ODMHSAS was awarded 7.2 million dollars to address the opioid crisis in Oklahoma, through the Opioid State Targeted Response (STR) grant. The Oklahoma Opioid STR integrated System of Care (ISOC) will serve persons with, or at risk for Opioid Use Disorder (OUD) statewide. The ISOC will include promotion, prevention, early intervention, treatment, and recovery supports. The goal is to provide treatment to 2,200 people over two years, and to distribute 7,000 naloxone kits available to help those in need. This ISOC will be built within the robust comprehensive ODMHSAS system that includes Certified Community Addiction and Recovery Centers (CCARCs), Community Mental Health Centers (CMHCs), and Certified Community Behavioral Health Clinics (CCBHCs). Oklahoma welcomes this opportunity to more fully address the opioid crisis. Through this much-needed SAMHSA funding, the ODMHSAS will create an integrated system of care (ISOC). The ISOC goals encompass prevention services that will save lives in the future through decreasing opioid and heroin overdose and non-medical use of prescription drugs. In addition, the ISOC will provide early and easy access to services through: outreach; early identification and linkage to appropriate levels of treatment; crisis intervention and linkage to appropriate level of treatment; and recovery support services, all of which will save lives today. Oklahoma’s ISOC will ensure that those with or at risk of opioid addiction are afforded every opportunity to achieve recovery and become productive citizens with bright futures. Lives will be saved today, families will be preserved, and futures will be reclaimed.

Measurable goals and objectives include: 1) Develop and disseminate messages aimed to prevent abuse of opioids and increase service utilization; 2) Mobilize community outreach workers to deliver training, disseminate material, drive service referrals, and increase local action on opioid prevention; 3) Train the primary care workforce in non-opioid alternative to pain management and safe opioid prescribing; 4) Train workforce in best practices; 5) Implement a model of practice facilitation in selected areas focusing on uptake of opioid prescribing guidelines; 6) Enhance the Prescription Drug Monitoring Program; 7) Expand overdose education and naloxone distribution statewide; 8) Engage comprehensive treatment agencies and crisis units to fill gaps and provide a fuller array of services; 9) Employ strategies to increase access to treatment for persons with or at risk for OUDs, including those who are uninsured and underinsured; 10) Identify, refer and provide treatment for those coming out of jails and prisons; 11) Identify those most in need of treatment through data analysis, and require comprehensive treatment agencies to outreach and engage into treatment; 12) Require comprehensive treatment agencies to maintain waived prescriber on staff; 13) Provide additional 60 slots of high intensity residential services; 14) Develop increased capacity in Oxford Houses for those with OUD; 15) Expand capacity for peer recovery support providers to deliver services; 16) Train all levels of staff in evidence-based practices; 17) Provide consultation for prescribers of Medication Assisted Treatment; and 18) Conduct comprehensive evaluation of all activities.

The ODMHSAS contracted with a total of 23 agencies which represent 14 community mental health centers, 11 certified community addiction recovery centers, and three behavioral health clinics. The Opioid STR grant will increase access and number of therapeutic services to individuals that have an opioid use disorder or who have had an
opioid use disorder in the past primary or secondary diagnosis or choice of drug. These funds will all those individuals that are uninsured or underinsured the opportunity to receive medication assisted recovery if appropriate. Other services include peer recovery supports designed specifically for individuals with an SUD and/or medication assisted recovery. These funds will assist individuals reentering the community from prison by connecting them with treatment services. Naloxone kits will be expanded to adult drug courts and first responders. Trainings will be provided to increase the number of Data 2000 waivered physicians, physician assistants, and nurses to prescribe medications. The ODMHSAS will partner with Oklahoma State University Health Science Center to provide consultation, training, and support to prescribers. All treatment agencies will have a trained staff and supervisor in the Community Reinforcement and Adolescent Community Reinforcement Approach to make this EBP available to serve this population. Seeking Safety is being trained and expanded to address the potential trauma an individual with SUD may have experienced.

Prevention

The primary function of Prevention Services is to plan, direct, manage, evaluate and guide strategies to prevent substance use and mental health problems in the state of Oklahoma. Prevention is viewed as a proactive process by which conditions that promote well-being are created and risk factors are reduced. Prevention activities empower individuals, organizations, and communities to meet the challenges of life events and transitions by creating conditions and reinforcing individual and collective behaviors that lead to healthy communities and lifestyles. The Oklahoma Plan to Prevention Mental, Emotional and Behavioral Disorders is available for download on the Department’s website. The mission of Prevention Services Division is to: (1) Implement effective prevention strategies that are evidence-based and accountable; (2) Leverage the power of community leadership; and (3) Enhance the capacity of communities, schools, healthcare providers, workplaces, and families to forever practice prevention.

Communities are an effective organizing force for bringing evidence-based policies and programs to scale. With the understanding that local issues need local solutions and local leadership, the ODMHSAS will support community and neighborhood-level prevention coalitions across the state to provide community-based prevention services with local partners such as county/municipal governments, school districts, faith communities, and businesses. The ODMHSAS funds over 30 Prevention Works coalitions in communities and college campuses. The community coalitions plan and implement a localized prevention strategy that aligns with the state’s strategic substance use prevention priorities – alcohol, marijuana, opioids, and stimulants. Campus-based Prevention Works
coalitions focus on substance use prevention and suicide prevention. Coalitions implement evidence-based prevention strategies. Coalitions are comprised of local residents, governmental and nongovernmental organizational leaders, schools, young people, and many more to systematically:

- Assess their communities’ prevention needs based on epidemiological data;
- Build local capacity to implement the change project;
- Develop a strategic plan;
- Implement effective community prevention policies, practices, programs; and
- Evaluate their efforts for outcomes.

The ODMHSAS also coordinates federal and state prevention funds to integrate evidence-informed prevention services into other key sectors of everyday living in Oklahoma – schools, healthcare practices, faith communities, businesses-employers, and families. Included in this strategic prevention approach are primary prevention services such as: Multi-Tiered Systems of Support initiatives, Botvin LifeSkills Training and PAX Good Behavior Game in PK-12 schools; SBIRT-OK for adolescents in primary care offices and other community-based settings; Strengthening Families Program with the Oklahoma Conference of Churches; alcohol service employee training for retailers; the Family Field Guide parent warmline and campaign; and the OK I’m Ready communications campaign among many more. Additionally, the ODMHSAS funds an array of prevention and promotion services in Oklahoma addressing overdose, suicide, and youth/adult mental health outcomes as well as data collection, prevention training, and prevention workforce development & consultation services.
Planning Steps

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

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system of care. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:
PLANNING STEPS

Step Two: Identify the Unmet Service Needs and Critical Gaps within the Current System

Introduction. Step One in this Section summarized services and supports currently in place for behavioral health prevention, early intervention, treatment and support for Oklahomans. That review also identified a listing of access, disparity, capacity, and resource issues that are continually under review by the ODMHSAS. Step Two now addresses many of those in more detail and to more clearly articulate priorities for Oklahoma within the context of this combined SAPT and MHS Block Grant application for FFYs 2020-2021. Priorities are listed in Step Three of this Section.

A summary is included for each topic listed below to provide an overview of unmet service needs and critical gaps related to that systemic issue or target population. Data sources are cited to quantify, to the extent possible, that these are contemporary issues for Oklahoma and levers for actions the ODMHSAS will implement to address our mission and the goals of the block grant program.

Key data have been provided by the Oklahoma State Epidemiological Outcomes Workgroup (SEOW). The SEOW is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in Oklahoma. This workgroup, funded through a Federal grant from SAMHSA/CSAP, was established by the ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma’s SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state. Other primary sources have induced the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and peer reviewed journal articles.

Overview of Oklahoma. According to the 2019 Census population estimates, Oklahoma has a population of 3,956,967 and ranks 20th in area among the 50 states, spanning nearly 70,000 square miles. Oklahoma is comprised of 77 counties with a population density of 54.7 persons per square mile. There are four metropolitan statistical areas and two combined statistical areas. Youth (under 18 years of age) are 24.3% of the population in Oklahoma. Females comprise 50.5% of the population. The census estimates 74% of the population is White; 7.8 percent is Black; 9.4% is American Indian/Alaska Native; 2.4% is Asian; 0.2% percent is Native Hawaiian and Other Pacific Islander; and 6.3% are of two or more races. Oklahoma also has a Hispanic/Latino population of 11.1%. Of note, is the American Indian/Alaska Native population. Oklahoma has the second largest Native American population after California and is home to 38 federally recognized tribes. The median household income for 2015-2019 is $52,1917 compared to the US median income of $65,712. The percentage of persons below poverty level is 15.2% which is higher than the national percentage of 13.4%1.
Health Status for Behavioral Health Consumers with Complex Health Needs. According to the America's Health Rankings® 2018, Oklahoma ranks 43rd for overall health status. The state ranked 49th for non-medical drug use, 41st for frequent mental distress, 39th for depression, 43rd for premature deaths, 41st for suicide, 44th for frequent physical distress, 43rd for multiple chronic conditions, 42nd for high blood pressure, 43rd for high cholesterol, 47th for obesity, 49th in exercise, 49th in fruit and vegetable consumption, and 49th in physical inactivity. The 2019 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance, with the state at 46th on access and affordability, 49th on avoidable hospital use and costs, 49th on healthy lives, and 49th on prevention and treatment. Many factors contribute to this ranking and review of some of those is essential to highlight how those impact individuals with mental health or substance use disorders or those at risk of developing a behavioral health disorder. Data on general health status and information specific to tobacco use are included below.

**Death and Mortality.** Unhealthy lifestyles and behaviors contribute to most of today’s leading causes of death. Health risk factors include smoking, physical inactivity and obesity.

- Oklahoma has the highest rate of death due to heart disease in the nation. In 2017, 10,772 Oklahomans died from heart disease.
- The State’s chronic lower respiratory disease is ranked second compared to other state rates in 2017.
- Cancer and diabetes are both ranked fourth compared to other states, with cancer attributing to 8,203 deaths and diabetes responsible for 1,398 deaths in 2017.
- Oklahoma is ranked fifth for chronic liver disease/cirrhosis, resulting in 670 deaths in 2017. Oklahoma’s 2017 rate was 38% higher than the U.S. rate.
- The rate of specific causes of death varies among racial groups, with persons of color having higher rates. American Indians and Blacks diabetes death rates are more than twice those of Whites in Oklahoma (64.6 and 61.8 vs. 25.8, respectively). The rates for these two populations are also higher for heart disease and influenza/pneumonia deaths.

**Tobacco Use**

- In 2017, 20.2% of adult Oklahomans smoked. Nationally, the rate was 17.1%.
- In 2017, 12.5% of high school students in Oklahoma smoked cigarettes on at least one day in the past 30 days. Nationally, the rate was 8.8%.
- In 2017, 7.1% of adults used e-cigarettes and 7.4% used smokeless tobacco.
- In 2017, 16.4% of high school students in Oklahoma used electronic vapor products on at least one day in the past 30 days. Nationally, the rate was 13.2%.
• In 2017, 9.2% of high school students in Oklahoma used chewing tobacco, snuff or dip on at least one day in the past 30 days. Nationally, the rate was 5.5%.7
• In 2017, 8.2% of high school students in Oklahoma smoked cigars, cigarillos or little cigars on at least one day in the past 30 days. Nationally, the rate was 8.0%.7

The high rate of tobacco use in Oklahoma is especially troubling when working with people with mental illnesses and addictions.

• The report that about 50% of people with behavioral health disorders smoke.13
• People with mental illnesses and addictions smoke half of the cigarettes produced, and are only half as likely as other smokers to quit.13
• Smoking-related illnesses cause half of all deaths among people with behavioral.

In February of 2015, Oklahoma implemented a Health Home service delivery model to improve care coordination and service integration, with the goal to improve health outcomes and controlling future health care costs for individuals with Serious Mental Illness or Serious.

In October 2016, Oklahoma was one of only eight (8) states selected by SAMHSA and the Centers for Medicare/Medicare Services (CMS) to pilot the new system, Certified Community Behavioral Health Clinics (CCBHCs). The CCBHCs represent an opportunity for states to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services. There are three behavioral health clinics participating in this program. In 2020 a CMS CCBHC state plan amendment (SPA) was approved and three additional CCBHCs are certified under the SPA and all CMHCs are expected to become CCBHCs. Due to the success of the CCBHC model, ODMHSAS is sunsetting the HH model in the fall of 2021.

In addition, the ODMHSAS Wellness Division has worked with treatment providers on tobacco cessation methods and implemented a process through which online referrals can be made from behavioral health providers to the OK Tobacco Helpline to assist persons with quitting tobacco.

A Wellness Coach training and certification for staff working in treatment facilities has been implemented. Wellness coaches work with individuals to promote good physical health.

Serious Mental Illness (Adults) Prevalence and Services Access. In SFY2021, 68,383 persons with the SMI designation was served through the Oklahoma publically funded behavioral health system. This represents 62% of the 111,137 adults served.9
• According to the NSDUH 2016-2017 Report, Oklahoma is ranked 10th for serious mental illness in the past year, with a rate of 5.43% compared to the national rate of 4.91%. \(^{10}\)

• While 15.82% received mental health services in the past year in Oklahoma, the State rank is 31st. \(^{10}\)

In addition to serious mental illness, the State is also higher for any mental illness and major depressive episodes in the past year than the national average.

• Oklahoma has a higher rate of “any mental illness in the past year” than the US rate, 22.54%, 19.86%, respectively. Oklahoma has the 11th highest rate in the nation. \(^{10}\)

• The State is ranked 11th in the nation for “major depressive episode” in the past year and has a higher rate at 8.82% vs. 7.51%. \(^{10}\)

The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI. CMHCs, by regulation, must provide crisis intervention, medication and psychiatric services, case management, evaluation and treatment planning, therapy services, and psychosocial rehabilitation. In addition, clients are provided with job location and placement, housing assistance, educational services, case management services and other needed supports.

Serious Emotional Disturbance (Children and Youth) SED Prevalence/Penetration. Based on SAMHSA 2017 estimates (the most recent estimates) 28,873 – 57,753 children have an SED in Oklahoma. \(^{11}\)

• In state FY2021, the total number of children 0-18 served was 82,603. The total number of children 0-18 years with an SED designation served was 28,810 (34.9%). \(^{9}\)

The 14 CMHC are participating in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local SOC sites that cover 74 counties. The SOC sites work in equal partnership with local teams and community organizations to ensure that children with Serious Emotional Disturbances (SED) and their families have access to the full array of services they need and want. Community Based Structured Crisis Centers for children, in Oklahoma City and Tulsa, address the emergent needs of children and their families.

Substance Abuse
According to the NSDUH 2016-2017 report, Oklahoma is higher on several measures than the national rate.

• *Illicit drug use other than marijuana in the past month* for persons 12 years and
older was 3.36, compared to the US rate of 3.31 and ranks 34th in the nation.\textsuperscript{10}

- \textit{Alcohol Use Disorder in the Past Year} for person 12 years and older the State rate was 5.47 compared to the national rate of 5.47.\textsuperscript{10}

- \textit{Substance Use Disorder in the Past Year} for person 12 years and older the Oklahoma rate was 7.65 versus the US rate of 7.41; for persons 18 years and older the State rate was 8.01 versus the US rate of 7.41.\textsuperscript{10}

- \textit{Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year} for person 12 years and older the Oklahoma rate was 7.08 compared to the national rate of 6.88; for persons 18 years and older the State rate is 7.40 versus the US rate of 7.18.\textsuperscript{10}

- \textit{Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year} for person 12 years and older the State rate was 5.18 compared to the US rate of 5.09; for persons 18 years and older the Oklahoma rate was 5.51 versus the national rate of 5.44.\textsuperscript{10}

The substance use disorder (SUD) treatment and recovery services network is comprised of 70 facilities, serving all 77 Oklahoma counties. The intention is to offer a full recovery oriented system of care. All SUD treatment organizations must be certified by ODMHSAS. Facilities can be licensed as an Alcohol and Drug Treatment Program providing a traditional addiction service set or as a Certified Comprehensive Addiction Recovery Center (CCARC) providing more comprehensive addiction services, including MAT. All ODMHSAS contracted providers must be dually contracted with OHCA to receive Medicaid reimbursement for compensable services. Many also accept other types of third party payment and self-payment. The ODMHSAS funded services are primarily purchased through contracts with private treatment services to provide multiple levels of withdrawal management, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations.

\textbf{Opioid Epidemic.} Like in many states, opioid abuse has become a public health crisis in Oklahoma. For several years, the ODMHSAS and its partners have been working to abate the problem. While opioid abuse has decreased, there is still a lot to be done.

Data from NSDUH 2010-2012 report showed Oklahoma led the nation in non-medical use of painkillers, with more than 8\% of the population aged 12 and older abusing/misusing painkillers.\textsuperscript{33} Oklahoma is also one of the leading states in prescription painkiller sales per capita. Since then, Oklahoma has made great strides in combatting this epidemic although there is a long way to go.
In Oklahoma, an estimated 43% of drug overdose deaths involved opioids in 2018 totaling more than 308 fatalities (a rate of 7.8).\textsuperscript{21}

Deaths involving prescription opioids declined from 251 in 2017 to 172 (a rate of 4.3) deaths in 2018.\textsuperscript{21}

Among opioid-involved deaths, those involving heroin or synthetic opioids other than methadone (mainly fentanyl and fentanyl analogs) remained steady with a respective 84 (a rate of 2.2) and 79 (a rate of 2.0) deaths reported in 2018.\textsuperscript{21}

In 2018, Oklahoma providers wrote 79.1 opioid prescriptions for every 100 persons—compared to average U.S. rate of 51.4 prescriptions.\textsuperscript{21}

In 2019, Oklahoma ranked within the top seven of states with the highest opioid dispensing rate at.\textsuperscript{23}

To combat opioid abuse, the ODMHSAS is focused on increasing access to medication-assisted treatment (MAT), reducing unmet treatment needs and reducing overdose related deaths through the provision of prevention, treatment, and recovery activities. In addition, the ODMHSAS also distributes naloxone kits to first responders, treatment agencies, and those in need.

**Persons Who Inject Drugs (PWID).** Persons who inject drugs are at risk for a number of unwanted health issues, including HIV and Hepatitis C. Because of the illegal status of most drugs that are injected and the perceived stigma of injection drug use, many PWIDs do not seek medical attention.

- In 2017, 9.7% (3,690) of the 38,226 new HIV diagnoses were attributed to IDU. Among males, 8.6% (2,655) of new diagnoses were transmitted via IDU or male-to-male sexual contact and IDU. Among females, 14.2% (1,035) of new diagnoses were transmitted via IDU.\textsuperscript{21}

- Of the new HIV diagnoses in 2017, 299 occurred in Oklahoma—a rate of 9.2. Among males, 18.0% of new HIV diagnoses were attributed to IDU or male-to-male sexual contact and IDU. Among females, 18.0% of new HIV diagnoses were attributed to IDU.\textsuperscript{21}

- In 2017, 6,216 persons were living with a diagnosed HIV infection in Oklahoma—a rate of 127.3. Of those, 14.5% of male cases were attributed to IDU or male-to-
male sexual contact and IDU. Among females, 20.5% were living with HIV attributed to IDU.\textsuperscript{21}

- In 2017, 6,216 persons were living with a diagnosed HIV infection in Oklahoma—a rate of 127.3. Of those, 14.5% of male cases were attributed to IDU or male-to-male sexual contact and IDU. Among females, 20.5% were living with HIV attributed to IDU.\textsuperscript{21}

- In 2017, there were an estimated 44,700 new cases of acute HCV. Among case reports that contained information about IDU, 86.6% indicated injection drug use prior to onset of acute, symptomatic HCV.\textsuperscript{21}

- In 2017, 46 cases of acute HCV (a rate of 1.2) were reported in Oklahoma.\textsuperscript{21}

- In Oklahoma, there are an estimated 53,900 persons living with Hepatitis C (2013-2016 annual average), a rate of 1,840.0 cases per 100,000 persons.\textsuperscript{21}

Outreach services to PWIDs are contracted with two treatment providers in the largest metropolitan communities, Oklahoma City and Tulsa. These areas also represent the largest populations of PWIDs. The contract requires the use of an evidence-based outreach model such as, but not limited to, the National Institute on Drug Abuse (NIDA) Indigenous Leader Outreach Model, the NIDA Standard Intervention Model for Drug Users, or the health education model as described in Rhodes, F., et al., \textit{AIDS Intervention Program for Injection Drug Users}. Outreach staff visits their local downtown and high-risk areas congregate homeless and/or drug using populations are. Contractors provide information, education, HIV testing with consent, and referrals and linkages to social services and treatment programs are made.

\textbf{Persons at Risk for Tuberculosis.} Although the number of people with disease has declined, TB remains a public health concern in Oklahoma. Oklahoma currently ranks #25 in the U.S. for TB disease.\textsuperscript{7} There were 67 reported cases of Tuberculosis in Oklahoma in 2020.\textsuperscript{24}

\section*{Access and Disparities Impacting Specific Populations.}

Data on substance use and mental illness rates for adults and children are presented here to describe the prevalence of these disorders in Oklahoma and quantify gaps in terms of service penetration and unmet treatment needs.
American Indians. The U.S. Commission on Civil Rights, in its report, Broken Promises: Evaluating the Native American Health Care System, states that it has long been recognized that American Indians are dying of diabetes, alcoholism, tuberculosis, suicide, and other health conditions at shocking rates. Beyond disturbingly high mortality rates, American Indians also suffer a significantly lower health status and disproportionate rates of disease compared with all other Americans. The disparities in healthcare are especially significant for Oklahoma with the second highest percentage of American Indians as compared to all other states.

- In 2018, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 377,955, comprising 9.4 percent of the state’s total population and ranking Oklahoma second among all states for the number of AI/AN in its population.¹

- According to the CDC, AI/AN have the highest prevalence of cigarette smoking compared to all other racial/ethnic groups in the United States. AI/AN have a higher risk of experiencing tobacco-related disease and death due to high prevalence of cigarette smoking and other commercial tobacco use.²⁵,²⁶

- Cardiovascular disease is the leading cause of death among AI/AN.²⁷,²⁸

- Lung cancer is the leading cause of cancer deaths among AI/AN.²⁵,²⁷,²⁸,²⁹

- Diabetes is the fourth leading cause of death among AI/AN.²⁷,²⁸ The risk of developing diabetes is 30–40% higher for smokers than nonsmokers.³⁰

- More American Indian/Alaska Native women smoke during their last 3 months of pregnancy—26.0% compared to 14.3% of whites, 8.9% of African Americans, 3.4% of Hispanics, and 2.1% of Asians/Pacific Islanders.³¹

American Indian/Alaska Natives (AI/AN) have the highest rates of suicide of any racial/ethnic group in the United States.³²

- The rates of suicide in this population have been increasing since 2003 and in 2015, AI/AN suicide rates in the 18 states participating in the National Violent Death Reporting System (NVDRS) were 21.5 per 100,000, more than 3.5 times higher than those among racial/ethnic groups with the lowest rates.³²
Suicide rates are higher with AI youth as well. A study using data from the National Violent Death Reporting System compared non-Hispanic Al/AN and non–Hispanic white decedents from 2003-2014.32

- The suicide rate for ages 10-17 for AI/NA was 9.8% compared to 2.5% for whites.32

- For age group of 18-24 years, the AI/NA rate was 25.9% compared to 8.6% of non-Hispanic whites.32

The ODMHSAS Tribal Liaison position has assisted with facilitating collaboration among the state and tribal nations, and to address the unique aspects of tribal and state government relationships. The ODMHSAS established a Tribal Consultation Policy, an important step in standardizing an approach with tribal nations that fits with the parameters of their sovereignty as nations and also fits within state policy.

In addition, the ODMHSAS Prevention Division works with tribal partners to coordinate the prevention portion of the Substance Abuse Block Grant, state appropriated prevention, and federal discretionary funds with certain tribal prevention resources to scale prevention services. Braided infrastructure around data collection and analysis (including a combined State and Tribal Epidemiological Outcomes Workgroup have allowed Oklahoma to leverage prevention resources. Administrative partnerships include competency collaborations and treatment court team participation to offer choice of services to program participants.

The CCBHCs focuses on outreach to AI individuals and have approached tribal nations and Indian Health Service clinics about establishing processes for referrals and linkages. The children’s wraparound teams work to reach out to AI families. African American Children. While Black or African Americans comprise only 7.8 percent of the Oklahoma population, they are too often overrepresented in negative consequences.

- Oklahoma is one of 12 states in the nation that suspended both female and male black students at a higher rate than their white peers, according to a U.S. Department of Education report.89
- Schools in Oklahoma expel more students than any other state, at a rate nearly five times higher than the national average. Black students receive nearly 4 in 10 expulsions.90
- Black youth were arrested at a rate three times greater than their white peers in FY 2013 in the State.91
- Detention rates for black Oklahoma youth are nearly 6 times greater than for white youth. American Indian youth detention rates are twice as high compared to whites.92

According to a national study published in the International Journal of Health Services,
minorities are overrepresented in the criminal justice system and underrepresented in the receipt of mental health care. Although both White and Black youth saw sharp reductions in crime and violence between 2000 and 2017, Black teenagers remained about twice as likely to be arrested for a drug offense and three times more likely to be arrested overall in Oklahoma. Racial disparities grow worse at each step; disparate arrest rates are amplified when it comes to incarceration, with Black youth 6.4 times more likely to be incarcerated than White youth.

The ODMHSAS is working to increase the number of African American children served in urban communities with high percentages of African American population. To accomplish this, partnership will be developed and implemented with communities and schools for outreach, treatment, and support.

Adults with Criminal Justice Involvement. According to NAMI, in a mental health crisis, people are more likely to encounter police than get medical help. As a result, 2 million people with mental illness are booked into jails each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition.33

- In state prisons, 73 percent of women and 55 percent of men have at least one mental health problem.34
- In federal prisons, 61 percent of women and 44 percent of men have at least one mental health problem.34
- In local jails, 75 percent of women and 63 percent of men have at least one mental health problem.34

Given Oklahoma's notorious distinction of having the second highest incarceration rate in the nation for males and the highest female incarceration rate, this means that a great number of mentally ill Oklahomans are simply warehoused in criminal justice facilities.

- As of August 5, 2021, Oklahoma has 25,338 incarcerated people (excluding 642 persons held in county jails due to bed shortages in the prisons).

In the most recent Bureau of Justice study of substance use disorders in jail inmates (2002) found:

- More than two-thirds of jail inmates were found to be dependent on or to abuse alcohol or drugs.
- Two in five inmates were dependent on alcohol or drugs, while nearly one in four abused alcohol or drugs, but were not dependent on them.
- In 2019 there were 15,365 adults arrested for drug-related crimes and 21,725 arrested for alcohol-related crimes.36 For the same time period, there were 1,002 juvenile drug arrests and 351 juvenile alcohol arrests. These numbers do not
include arrests for crimes resulting from alcohol and drug abuse, such as check forgery, burglary, disorderly conduct, and vagrancy.

Oklahoma uses the Sequential Intercept Model is used in strategic planning and aligning of resources for the greatest impact in terms of reducing involvement with criminal justice for adults and children with behavioral health treatment needs. Points of interception include 44 Drug Courts; 13 Mental Health Courts; an Offender Screening Program, providing pre-sentence risk and need information to judges, district attorneys, and defense attorneys in order to recommend the best diversion options available for an offender; CIT training; Reentry Teams, consisting of specifically trained Intensive Case Manager and a Peer Recovery Support Specialist; and ODMHSAS staff co-located within the Department of Corrections to provide reentry support.

The ODMHSAS is providing training on Statewide Moral Reconciliation Therapy (MRT), an evidence based curriculum designed to reduce criminogenic behavior. Training is provided to community-based providers, judges, attorneys, and others on the Risk Need Responsivity (RNR) model which an evidence-based offender management strategy that in short matches the appropriate amount and type of supervision and treatment to individuals to reduce their likelihood of recidivism. Also, training is provided on evidence-based pretrial programming, teaching pretrial service agencies and courts to identify appropriate bond conditions to enhance pretrial success.

Military Personnel and Families. The first of four goals of the White House Report: Strengthening Our Military Families, is to enhance the well-being and psychological health of the military family. The report recognizes with the increased exposure to combat stress due to longer and more frequent deployments, there has been a growing number of service members with behavioral health needs. Further, it recognizes that military families are not immune to the stresses of deployment and cites a growing body of research on the impact of prolonged deployment and trauma-related stress on military families, particularly spouses and children.

- There are currently 19,802 active duty military personnel in Oklahoma.40
- There are 13,031 Oklahomans active in the Reserve Forces.40
- Oklahoma has 23,831 military civilians.40
- As of September, 2017, there were 303,208 veterans in Oklahoma, 10.26 percent of the adult population.41
- Of the Oklahoma veterans, 55 percent which are under the age of 65 years and 31.7 percent are receiving disability compensation.41

According to the National Center for PTSD, the number of veterans with PTSD varies by
service era and ranges from 12 to 30 percent.\textsuperscript{42}

- **Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF):** About 11-20 out of every 100 Veterans who served in OIF or OEF have PTSD in a given year.\textsuperscript{42}
- **Gulf War (Desert Storm):** About 12 out of every 100 Gulf War Veterans have PTSD in a given year. There are 112,895 Gulf War veterans in Oklahoma.\textsuperscript{42}
- **Vietnam War:** About 15 out of every 100 Vietnam Veterans (or 15\%) were currently diagnosed with PTSD at the time of the most recent study in the late 1980s, the National Vietnam Veterans Readjustment Study (NVVRS).\textsuperscript{42}
- It is estimated that about 30 out of every 100 of Vietnam Veterans have had PTSD in their lifetime.
- There are 111,313 Vietnam veterans residing in Oklahoma.\textsuperscript{42}

According to the 2018 Office of Mental Health and Suicide Prevention (OMHSP) National Suicide Data Report, the number of military suicides a day was 20.6. Of those 16.8 were veterans and 3.8 were active-duty service members guardsmen and reservists.\textsuperscript{43}

- In 2016, the Oklahoma veteran suicide rate was 35.9 compared to the national veteran suicide rate of 30.1 and the overall Oklahoma suicide rate of 26.9. Rates are per 100,000 population.\textsuperscript{43}

The ODMHSAS has a partnership with the Oklahoma Department of Veterans Affairs to work collaboratively on specific prevention initiatives. Treatment courts designated as Zone4Vet status have been established. Treatment court programs apply for special designation as a Zone4Vet program through an application with criteria such as early identification of justice-involved veterans, personnel trained in veteran services and treatment needs, and collaborative partnerships with community veteran partners. A Peer Recovery Support Service Veteran certification was developed and is currently being offered. Military members and their families are a focus for the CCBHCs. Before being certified, they CCBHCs held triable listening sessions to identify gaps in services and staff received training provided by the Indian Health Clinic in Oklahoma City. An overview of CCBHC development was presented to the Veterans Alliance. A meeting was held between CCBHC staff and Major General Deering, Secretary of Veteran Affairs and the Executive Director of the Oklahoma Department of Veteran Affairs, to educate on the CCBHC and how this evolution of services could benefit veterans, dishonorable discharged veterans, and individuals that are inactive duty but still in the reserves.

To better target military families and veterans, the ODMHSAS has modified its data collection system to identify active military members, family members of active military members, and veterans.

**LGBT Community.** According to studies done by the UCLA School of Law Williams Institute, 3.8 percent or 149,837 Oklahomans are a member of the LGBT community.\textsuperscript{44}
Compared to people that identify as straight, LBGT individuals are 3 times more likely to experience a mental health condition.\(^{45}\)

LGBT youth are 4 times more likely to attempt suicide, experience suicidal thoughts, and engage in self-harm, as compared to youths that are straight.\(^{45}\)

For transgender individuals, 38-65% experience suicidal ideation.\(^{45}\)

An estimated 20-30% of LGBT individuals abuse substance, compared to about 9% of the general population.\(^{45}\)

25% of LGBT individuals abuse alcohol, compared to 5-10% of the general population.\(^{45}\)

LGBT individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse.\(^{46}\)

The ODMHSAS contracts with an agency in the more populous Oklahoma City area to provide LGBT services. Provider staff members are trained in sexual orientation sensitivity and LGBT competency and utilize CSAT’s *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals*. Family education support groups are offered for family members as defined by the customer.

**Older Oklahomans.** The proportion of Oklahoma’s population that is over 60 is growing while the proportion that is under 60 is shrinking. The US Census Bureau estimates that more than 24 percent of Oklahoma’s population will be over age 60 by the year 2030, an increase of close to 25 percent from 2012.\(^{49}\)

It is estimated that 20% of people age 55 years or older experience some type of mental health concern.\(^{47}\)

The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder).\(^{47}\)

Mental health issues are often implicated as a factor in cases of suicide.\(^{48}\)

Older men have the highest suicide rate of any age group.\(^{48}\)

Baby boomers are distinct compared with past generations as they came of age during the 1960s and 1970s, a period of changing attitudes toward and rates of drug and alcohol use.\(^{50}\)

The prevalence rates of substance use disorder (SUD) have remained high among this group as they age,\(^{51}\) and both the proportions and actual numbers of older adults needing treatment of SUD are expected to grow substantially.
Drug or alcohol abuse among the elderly is particularly dangerous because senior citizens are more susceptible to the deteriorating effects of these substances. Individual over 65 have a decreased ability to metabolize drugs or alcohol along with an increased brain sensitivity to them.52

- Despite increasing rates of illicit and prescription drug misuse among adults older than 65 years, alcohol remains the most commonly used substance among older adults.58

To meet the treatment needs of older adults, the ODMHSAS is providing training to service providers and other stakeholders to improve skill and knowledge in serving older adults. In addition, the ODMHSAS is an active participant in the Oklahoma Mental Health and Aging Coalition, which provides a forum where a variety of stakeholders advocate for increased, accessible and culturally appropriate services for older Oklahomans. The Coalition provides statewide mental health, substance use, prevention and treatment education and advocacy, and partners with other networks that provide services to older adults to integrate and cross-train networks.

**Pregnant Women.** Research shows that use of tobacco, alcohol, or illicit drugs or misuse of prescription drugs by pregnant women can have severe health consequences for infants. This is because many substances pass easily through the placenta, so substances that a pregnant woman takes also reach the fetus.59 Recent research shows that smoking tobacco or marijuana, taking prescription pain relievers, or using illegal drugs during pregnancy is associated with double or even triple the risk of stillbirth.60 Estimates suggest that about 5 percent of pregnant women use one or more addictive substances.61

Oklahoma statute requires the Department of Human Services to establish and maintain an up-to-date Record of Infants Born Exposed to Alcohol and Other Harmful Substances. For purposes here, "harmful substances" means intoxicating liquor or a controlled dangerous substance. While this statute has been in place for several years, the ability to routinely collect this data is limited to the information received from the health care professionals. While reporting from the large hospitals within the state is typically good, some of the smaller more rural hospitals do not have the capability to do the type of testing necessary or do not have it on site.

The most reliable testing mechanism is the collection and testing of the newborn’s meconium. The presence of substances in the meconium has been proposed to be indicative of in utero substance exposure up to five months before birth, a longer historical measure than is possible by urinalysis. As most hospitals must send the meconium sample to an outside lab, which requires more time, often the child has discharged from the facility before the results are received. Data from the Oklahoma State Department of Health Maternal and Child Health show that in 2016 (the most recent period available) 1,557 infants had a diagnosis due to prenatal AOD use.
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<td>Neonatal withdrawal symptoms from maternal use of drugs of addiction</td>
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<td>Withdrawal symptoms from therapeutic use of drugs in newborn</td>
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<td>Newborn affected by maternal use of other drugs of addiction</td>
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<td>Q86.0</td>
<td>Fetal alcohol syndrome (dysmorphic)</td>
<td>30</td>
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<tr>
<td>Total</td>
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<td>1,558</td>
</tr>
</tbody>
</table>

Note: Data from a large teaching hospital in a large urban area was unavailable.

The Oklahoma Department of Human Services data indicates parental substance abuse is the second most cited reason for removal.\(^6^2\)

To ensure pregnant women are accessing treatment as quickly as possible, the ODMHSAS has created an electronic wait list for residential treatment, with priority given to pregnant women.

**Women with Dependent Children.** Findings from the literature suggest that children of substance-abusing parents have a high risk of developing physical, mental health and behavioral problems. In addition, parental substance abuse has been linked to ongoing behavioral problems, such as adolescent drug use. According to NSDUH data, an annual average of 8.7 million children aged 17 or younger live in households in the United States with at least one parent who had an SUD (Figure 1). This represents about 12.3 percent of children aged 17 or younger who resided with at least one parent with an SUD. An annual average of 1.5 million children aged 0 to 2 (12.8 percent of this age group), 1.4 million children aged 3 to 5 (12.1 percent of this age group), 2.8 million children aged 6 to 11 (11.8 percent of this age group), and 3.0 million children aged 12 to 17 (12.5 percent of this age group) lived with at least one parent who had an SUD.\(^6^3\)

Applying the percentages to Oklahoma data, which has more population under the age of 18 than the US, there are 79,528 children under the age of 18 who live with a parent who has abused alcohol or an illicit drug in the last year. Another 98,691 children had a parent who abused or was dependent on alcohol and 28,745 had a parent abusing or dependent on illicit drugs.

Oklahoma contracts with five residential programs to provide services for women with dependent children (WWC) and one WWC halfway house treatment program. The
halfway house for WWC also operates a residential treatment program for women only. The Oklahoma City Housing Authority collaborates with the ODMHSAS to provide women a sober-living environment in which they can focus on their family, especially their dependent children, while continuing to work on recovery. All WWC providers must give priority status to pregnant women, treat the family as a unit, provide a comprehensive range of services to women and their children either directly or through linkages with community-based organizations, including case management to assist in establishing eligibility for public assistance programs provided by federal, state, or local governments; employment and training programs; education and special education programs; drug-free housing for women and their children; Head Start; and other early childhood programs and promote and facilitate children’s access to the fullest possible range of medical services available, such as health screening; well-child health care; screening in speech, language, hearing, and vision; and verify immunization records. The EBPs, Strengthening Families and Celebrating Families, are used provided to families with parental substance use disorders.

The ODMHSAS has implemented an electronic residential bed availability list for individuals assessed for levels of care. This includes the identification of parenting women. The number and ages of the children attending residential treatment with their mothers are provided in the wait list to ensure the appropriate treatment facility is available.

**Persons Impacted by Trauma.** Results from the Adverse Childhood Experiences (ACE) Study indicates that childhood abuse and household dysfunction lead to the development of the chronic diseases that are the most common causes of death and disability in this country. A strong relationship is shown between the number of adverse childhood experiences and reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, suicide attempts, sexual promiscuity, and sexually transmitted diseases. Traditionally viewed as public health or mental health problems, these behaviors appear to be coping mechanisms for people who have had adverse childhood experiences. Trauma-Informed Services can address the impact of trauma on people’s lives and facilitate trauma recovery.

Oklahoma ranks high for several social ills that have been linked to ACE scores. A few examples:

- No. 2 in female incarceration rates
- No. 1 in the nation in incarceration rates when other factors such as the juvenile and jail populations are included, according to a 2018 study by the nonprofit organization Prison Policy Initiative.
- No. 2 in heart-disease mortality
- No. 2 in male incarceration rates
• No. 1 in divorce with 4.4 divorces per 1,000 populations. 13.1% of the state population reporting at least one marriage as ending in that manner, according to U.S. Census Bureau American Community Survey statistics for 2013-17.

• No. 2 in cancer deaths per capita, according to the U.S. Centers for Disease Control and Prevention.

• No. 14 per capita in substantiated child abuse cases, according to the U.S. Department of Health and Human Services.

The 2003, 2007, and 2011-2012 National Survey of Children’s Health directed by the Health Resources and Services Administration found Oklahoma has consistently high prevalence.

• Using a threshold of four or more ACEs (a threshold above which there is a particularly higher risk of negative physical and mental health outcomes), the 2011-2012 survey found Oklahoma, Montana and West Virginia had the highest percent of children in this classification.79

• Oklahoma and Montana were tied 17 percent for children with three or more, the highest rate in the nation.79

• In fact, 38% of Oklahoma children in the survey had one or two ACEs and 17% had three or more Aces.79

• Oklahoma’s most common ACEs were attributed to economic hardship (30%), divorce (30%), alcohol (17%), violence (13%), and mental illness (12%).79

The ODMHSAS utilizes the Seeking Safety curriculum which addresses trauma, mental illness and substance use disorders for adults and adolescents. All staff serving adults are CMHCs are required to do Cognitive Processing Therapy training online or in person. All CMHC staff must annually complete trauma informed training. For children, there are multiple statewide EBPs, including Trauma Focused Cognitive Behavioral Therapy, and Child Parent Psychotherapy. The ODMHSAS now requires the PCL-5 screening and the ACE score submitted at admission for every person 18 years or older. The Child and Adolescent Trauma Screen (CATS) is required at admission for person less than 18 years or age.

**Early Serious Mental Illness.** The American Psychiatric Association states that major mental illnesses such as schizophrenia or bipolar disorder rarely appear “out of the blue.” Most often family, friends, teachers or individuals themselves begin to recognize small changes or a feeling that “something is not quite right” about their thinking, feelings or behavior before an illness appears in its full-blown form. Without timely and effective care, symptoms and functional impairments worsen, and individuals are at high risk for suicide, substance misuse, school dropout/unemployment, criminal Justice involvement, and
involuntary hospitalization, including Emergency Department use.

- In 2017, the NIMH funded Mental Health Research Network estimated that there are approximately 114,000 new cases of psychosis each year in the US. The ODMHSAS is developing a full continuum of care for person with first episode psychosis and early serious mental illness. There are currently two Navigate programs operating in the two largest metro areas and one First Episode Psychosis Crisis Care program. In addition, a plan for CMHCs to build collaborative relationships with counselors and counseling centers at universities, community colleges and technology centers and provide training and technical assistance to intervene at the earliest juncture. As well as build relationships with area hospitals who might receive patients that are initially struggling with mental health issues. In addition, the ODMHSAS is planning to implement and expand EBP treatment services to ensure access and availability for individuals with SMI. A five-day training is scheduled for Intensive Cognitive Behavioral Therapy with content experts from the Academy of Cognitive Therapy with a focus on youth and young adults and SMI and psychosis, including Recovery Oriented Cognitive Therapy approaches.

*Individuals with SMI or SED in rural areas.* According to the 2018 Census estimate, 64% of the State’s population lives in an urban area, with one-third residing in a rural or frontier area. Rural Oklahomans are disadvantaged in many ways. According to the USDA Economic Research Service (ERS), the average per capita income for Oklahomans in 2019 was $47,341, although rural per capita income lagged at $40,232. The ERS reports that the poverty rate in rural Oklahoma is 17.6%, compared with 13.7% in urban areas of the state. Of the rural population, 13.7% has not completed high school, while 11.1% of the urban population lacks a high school diploma. The unemployment rate in rural Oklahoma is 3.5%, while in urban Oklahoma, it is 3.2%.

All of these things lead to barriers to care for many Oklahomans who live in areas without the appropriate level of care and who do not have resources to get to the needed services. For persons with SMI or SED, the barriers are even greater. Telehealth is a primary strategy used by the ODMHSAS to increase access to mental health and substance use disorder information and services to underserved areas. Through the Oklahoma TeleHealth Network, Oklahomans who were once unable to receive services due to geographical, economic and workforce barriers are now able to receive the care that they desire.

- Of the 128,581 persons served through the ODMHSAS treatment system in FY2019, 49.2 percent resided in a rural county.
• In fiscal year 2021, 107,593 Oklahomans were given behavioral health care services via Telehealth.\(^8^5\)

• For this same year, 1,204,396 services were delivered via telehealth.\(^8^5\)

The ODMHSAS promotes the use of telehealth and has consistently increased the number of services that can be provided through this means.

**Individuals with SMI or SED in the homeless population.** According to the U.S. Interagency Council on Homelessness, Oklahoma has a homeless population of 3,932 in 2020. Using the US Department of Housing and Urban development’s estimate of 46 percent of the homeless population live with severe mental illness and/or substance use disorders, there are 1,810 homeless individuals who could benefit from treatment.

The ODMHSAS participates in the PATH program and locates programs in the areas with the highest number of people who are homeless. Services primarily focus on outreach and case management (including referrals for primary health services, job training, educational services and relevant housing services) but also include screening and diagnostic treatment services, community mental health services, habilitation and rehabilitation services, alcohol and drug treatment, staff training and housing services. Individuals who are identified as homeless and having a serious mental illness are engaged in treatment and support services with efforts made to integrate them into services.

There are two HUD Continuum of Care (CoC) Projects operated by two CMHC. Each facilitates HUD permanent supportive housing projects that provide rental assistance to homeless persons with mental illness or co-occurring mental illness and substance use disorders.

The ODMHSAS provides targeted funds to assist very low-income individuals (age 18 and older) with mental illness or co-occurring mental illness and substance use disorders who are homeless or at risk of becoming homeless, as they discharge from psychiatric inpatient care, DOC, or age out of the foster care system.

Oklahoma utilizes MHBG funds for safe haven housing, a housing first approach and allow individuals to remain in that housing even if they do not want to seek treatment.

**Individual Placement and Support (IPS)** supports people with serious mental illness and/or co-occurring substance use disorders in their efforts to achieve steady, meaningful employment in mainstream competitive jobs, either part-time or full-time. This stands in contrast to other vocational rehabilitation approaches that employ people in sheltered workshops and other set-aside jobs.

IPS has been extensively researched and proven to be effective compared to standard employment services.
IPS is based on 8 principles.

- Employment services are integrated with mental health treatment services.
- Competitive employment is the goal.
- Personalized benefits counseling is provided.
- The job search starts soon after a person expresses interest in working.
- Employment specialists systematically develop relationships with employers based upon their client’s preferences.
- Job supports are continuous.
- Client preferences are honored.

Sorting out the effects of unemployment on mental health is complicated by the fact that the cause-and-effect relationship can work in both directions: unemployment may worsen mental health, and mental health problems may make it more difficult for a person to obtain and/or hold a job. Unemployment contributes to low or no income, stigma and loss of self-esteem, and increased isolation. Conversely, being employed can be an important step to recovery, improving self-esteem and confidence, and reducing psychological distress.

For individuals treated for substance use disorder in FY2018, less than half (43.2%) were employed full or part-time. For individuals seen for mental health issues, only 22% were employed full or part-time. It is even worse for person with SMI, with only 17.5% having any employment.88

**Case management** is defined as “a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services” by the National Association of State Mental Health Program Directors (NASMHPD). This also includes providing “linkages and training for the patient served in the use of basic community resources, and monitoring of overall service delivery.” The Healthy People 2020 Report acknowledges that things such as housing quality, social support, employment opportunities, and work and school conditions can influence mental health risk and outcomes. As the ODMHSAS moves forward with more integrated healthcare, it’s vital that there are trained staff to coordinate services and provide necessary referrals and linkages.

**Persons at Risk for Tuberculosis.** While the national rate of tuberculosis in the US was 2.7 per 100,000 population in 2018, the rate in Oklahoma was 1.9, up from 1.4 percent from 2017.64 In 2017, 74 cases were reported in Oklahoma.64

**Prevention and Early Identification.**
Suicide Prevention. According to the Centers for Disease Control and Prevention (CDC) in 2019 (the most recent year for which full data are available), more than 47,500 suicides were reported, which is about one death every 11 minutes. The number of people who think about or attempt suicide is even higher. In 2019, 12 million American adults seriously thought about suicide, 3.5 million planned a suicide attempt, and 1.4 million attempted suicide.

- Of persons who complete suicide, 40 percent had made a previous attempt. Previous suicide attempts serve as a risk factor for completed suicide.

- Suicide risk is 37% higher in the first year after deliberate self-harm than in the general population.

- Those with substance use disorders are six times more likely to complete suicide than those without. The rate of completed suicide among men with alcohol/drug abuse problems is 2-3 times higher than among those without a problem. Women who abuse substances are at 6-9 times higher risk of suicide compared to women who do not have a problem.

- The 2019 suicide rate in Oklahoma was 29.3/100,000 compared to the U.S. rate of 14/100,000. Oklahoma had the 8th worse suicide rate in the nation.

- On average, two Oklahomans ages 10-24 die by suicide every week. Suicide is the second leading cause of death for this age group and rates have been increasing over the past 10 years. Data from the Oklahoma Violent Death Reporting System (OKVDRS) show that in 2016, more Oklahoma youth ages 10-24 died by suicide than from cancer, heart disease, HIV, chronic lower respiratory disease, complicated pregnancies, congenital anomalies, influenza and pneumonia combined.

- The veteran suicide rate was 2 times higher than the rate among non-veterans (39.2 and 18.2, respectively) in Oklahoma from 2015.

- Suicides comprised 68% of all violent deaths.

- Suicide is the most common type of violent death in Oklahoma.

- Suicide deaths outnumber homicides by almost three to one. For males, the suicide rate is higher than that of homicide, heart disease and cancer.

- When gender and race are accounted for, only non-Hispanic Black males have a higher murder rate than suicide rate.

- For males, the highest rate was for the age group of 85+ years (66.5), followed by the age group 75-84 years (41.5) and 25-34 years (40.1).
For females, the age group 45-53 years have the highest suicide rate (16.1) followed by 34-44 years (39.9).

The ODMHSAS provides evidence-based suicide prevention training to k-12 faculty and staff, works with education staff to implement effective policies and procedures for fostering a healthy pathway for students at risk for and those impacted by suicide. EBP trainings are also given to faculty, staff and students at colleges and universities. The ODMHSAS provides technical assistance and guidance to the Oklahoma Suicide Prevention Council and oversees and coordinates revisions and updates to the Oklahoma State Plan for Suicide Prevention. ODMHSAS staff actively participate in the Oklahoma Tribal Behavioral Health Association, Oklahoma City and Tulsa SAMHSA/VA Mayor’s Challenge to Prevent Suicide among Service Members, Veterans and their Families, and other workgroups/coalitions with a focus on preventing suicide.

A suicide prevention protocol is place for all ODMHSAS contracted mental health treatment facilities. At admission and at each six-month update, clients are given the PHQ 9 screening. If positive, the Columbia Suicide Severity Rating Scale assessment is administered. If positive for history but no current suicidal ideation, the Columbia is repeated every three months. If there is current suicidal ideation, client participates in the Collaborative Assessment and Management of Suicidality (CAMS) therapeutic framework.

**Early Screening and Referral.** Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels, with the goal of reducing and preventing related health consequences, disease, accidents, and injuries. While most of the attention given to alcohol and drug issues has been focused on alcohol and illicit drug users who meet the clinical criteria for substance dependence, risky users incur more adverse consequences and costs at the population level. Even if they are not dependent on alcohol, people who drink above the recommended guidelines (up to one drink per day for women and up to two drinks per day for men) face a number of health risks. Risky drinkers, though individually less likely to experience alcohol-related problems than those who are alcohol-dependent, make up the greater portion of the general population; thus more harm is caused by the population of risky drinkers. SBIRT provides the opportunity to intervene with this group to prevent serious consequences. Although Oklahoma’s prevention efforts have been successful in decreasing under age and heavy drinking, work must continue to ensure these trends continue.

- From 2009-2018, 1,864 people were killed in crashes involving an alcohol-impaired driver.\(^8\)

- Adolescents who use alcohol may remember 10% less of what they have learned than those who don’t drink.
Lower reading and math scores are linked to peer substance abuse. On average, students whose peers avoided substance use had test scores that were 18 points higher for reading, and 45 points higher for math.

If the challenges in students’ learning, such as the problems directly related to underage drinking, are not addressed, then our youth will not be able to maximize their academic potential.81

In Oklahoma results from SBIRT screenings have shown that only 19 percent of those screened need more than a brief education on depression; only three percent need more than brief education on drug use; and only four percent need more than a brief education on healthy drinking habits. Screening catches 41.2 percent of people with a substance use or depression need that may otherwise never receive treatment (18.1% brief intervention; 23.1% brief intervention of referral to treatment).74

**Individuals in Need of Primary Substance Abuse Prevention.** The primary function of Prevention Services is to plan, direct, manage, evaluate, and guide strategies to prevent substance use and mental health problems in the state of Oklahoma. Prevention is viewed as a proactive process by which conditions that promote well-being are created and risk factors are reduced. Prevention activities empower individuals, organizations, and communities to meet the challenges of life events and transitions by creating conditions and reinforcing individual and collective behaviors that lead to healthy communities and lifestyles. The Oklahoma Plan to Prevention Mental, Emotional and Behavioral Disorders is available for download on the [Department’s website](#). The mission of Prevention Services Division is to: (1) Implement effective prevention strategies that are evidence-based and accountable; (2) Leverage the power of community leadership; and (3) Enhance the capacity of communities, schools, healthcare providers, workplaces, and families to forever practice prevention.

Communities are an effective organizing force for bringing evidence-based policies and programs to scale. With the understanding that local issues need local solutions and local leadership, the ODMHSAS will support community and neighborhood-level prevention coalitions across the state to provide community-based prevention services with local partners such as county/municipal governments, school districts, faith communities, and businesses. The ODMHSAS funds over 30 Prevention Works coalitions in communities and college campuses. The community coalitions plan and implement a localized prevention strategy that aligns with the state’s strategic substance use prevention priorities – alcohol, marijuana, opioids, and stimulants. Campus-based Prevention Works coalitions focus on substance use prevention and suicide prevention. Coalitions implement evidence-based prevention strategies. Coalitions are comprised of local residents, governmental and nongovernmental organizational leaders, schools, young people, and many more to systematically:
Assess their communities’ prevention needs based on epidemiological data;
Build local capacity to implement the change project;
Develop a strategic plan;
Implement effective community prevention policies, practices, programs; and
Evaluate their efforts for outcomes.

The ODMHSAS also coordinates federal and state prevention funds to integrate evidence-informed prevention services into other key sectors of everyday living in Oklahoma – schools, healthcare practices, faith communities, businesses/employers, and families. Included in this strategic prevention approach are primary prevention prevention services such as: Multi-Tiered Systems of Support initiatives, Botvin LifeSkills Training and PAX Good Behavior Game in PK-12 schools; SBIRT-OK for adolescents in primary care offices and other community-based settings; Strengthening Families Program with the Oklahoma Conference of Churches; alcohol service employee training for retailers; the Family Field Guide parent warmline and campaign; and the OK I’m Ready communications campaign among many more. Additionally, the ODMHSAS funds an array of prevention and promotion services in Oklahoma addressing overdose, suicide, and youth/adult mental health outcomes as well as data collection, prevention training, and prevention workforce development & consultation services.

**Misuse of Prescription Drugs.** In the United States, prescription drugs are the second most commonly abused category of drugs, behind marijuana. Prescription drug misuse can have serious medical consequences. Increases in prescription drug misuse over the last 15 years are reflected in increased emergency room visits, overdose deaths associated with prescription drugs, and treatment admissions for prescription drug use disorders, the most severe form of which is an addiction. Drug overdose deaths in the US involving prescription opioids rose from 3,442 in 1999 to 17,029 in 2017. From 2017 to 2019, however, the number of deaths dropped to 14,139. Nearly 90% of drug overdose deaths in Oklahoma were unintentional.

- From 2008-2018, more than 4,700 Oklahomans died of an unintentional opioid overdose involving an opioid, including prescription and illicit opioids. At the height of the crisis, more than 500 Oklahomans died from an unintentional opioid overdose annually.

- Beginning in 2014, the number of unintentional opioid overdose fatalities began to decline suggesting Oklahoma’s comprehensive efforts to prevent overdoses have made an impact.

**Mental Health First Aid** is an eight-hour course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health
crisis. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand, and respond to signs of mental illness.\textsuperscript{75}

Mental Health First Aid is an international training program proven to be effective. Peer-reviewed studies show that individuals trained in the program:

- Grow their knowledge of signs, symptoms and risk factors of mental illnesses and addictions.\textsuperscript{76}
- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.\textsuperscript{76}
- Increase their confidence in and likelihood to help an individual in distress.\textsuperscript{76}
- Show increased mental wellness themselves.\textsuperscript{76}

\textbf{Use of Peer Recovery Support Specialists.} It is evident in Oklahoma that persons in recovery from a mental illness and/or substance use disorder, who are trained to work with others on their individual roads to recovery, fulfill unique roles in the service system. Peer Recovery Support Specialists (PRSSs) offer the advantage of lived experience from serious mental illness and/or substance abuse. They know the journey to recovery is real and attainable, because they have traveled the path.

Mental Health America compiled a meta-analysis of studies researching the effectiveness of PRSS services.\textsuperscript{79} Both quantitative and qualitative evidence indicate that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services, increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management.

The ODMHSAS has promoted the use of PRSS through its certification process and through an incentive program. In FY2021 there were 1,082 individuals trained as a PRSS or in a specialty. Below are the specialized PRSS supplemental training and the number trained in each category.

<table>
<thead>
<tr>
<th>PRSS Ethics</th>
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<tr>
<td>PRSS Older Adult</td>
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<td>PRSS-Methamphetamine</td>
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<tr>
<td>PRSS-Group Facilitation</td>
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</table>
**Composition of the State Epidemiological Outcomes Workgroup.** The mission of the State and Tribal Epidemiological Outcomes Workgroup (STEOW) is to improve prevention assessment, planning, implementation, and monitoring efforts through the application of systematic, analytical thinking about the causes and consequences of substance use disorders. The STEOW is composed of representatives from tribes, tribal organizations, government agencies, and non-profit organizations, and is co-facilitated by Cherokee Nation, Southern Plains Tribal Health Board and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). The STEOW consists of the overall workgroup and three teams: the Data Analysis and Reporting Team (DART), the Quality Improvement Team (QIT), and the Strategic Action Team (STAT). These groups collaborate at times while still preserving their own identity and function.

<table>
<thead>
<tr>
<th>First Name</th>
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<th>Organization</th>
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<tbody>
<tr>
<td>Tom</td>
<td>Anderson</td>
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<tr>
<td>Ceciley</td>
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<td>Vi</td>
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<tr>
<td>Jeanette</td>
<td>Cosby</td>
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<tr>
<td>Paul</td>
<td>Harris</td>
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<tr>
<td>Claire</td>
<td>Nguyen</td>
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<tr>
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<td>Samuel</td>
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<td>Raffaella</td>
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### Step Two Summary

The data and discussion used in Step Two above do not represent what the State would consider complete in terms of a comprehensive gap analysis. Regardless, substantial data are available and have aided the State in this block grant planning process. In fact, use of those data has driven a process by which Oklahoma has identified priorities on which to focus this plan and application. Those priorities are listed in planning steps three and four and relate to the areas of health promotion, improved access, reduced disparities, service accountability, criminal justice concerns, prevention of substance misuse and mental health disorders, and public awareness.

### References Utilized in Step Two

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   https://stateofstateshealth.ok.gov/Data/Demographic
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**Planning Tables**

Table 1 Priority Areas and Annual Performance Indicators

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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<tr>
<td>See Attached Table</td>
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<tr>
<td>Priority Area</td>
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</tbody>
</table>
| 1. Overall Health Promotion | Continue to integrate primary health care with behavioral health care | Improve health outcomes within CCBHCs | For adults with SMI and children with SED | Follow-up by physician after hospitalization for Mental Illness – 7 days after discharge | Year 1: Target- 55%  
Year 2: Target- 58%  
**Data Source:** Relias Population Health Management System  
**Description of Data:** Compiled from claims data through the Relias Population Health Management System  
**Data issues/caveats that affect outcome measures:** None |
| | | | | Presence of a fasting lipid profile within past 12 months for patients with diabetes | Year 1: Target- 46%  
Year 2: Target- 50%  
**Data Source:** Relias Population Health Management System  
**Description of Data:** Compiled from claims data through the Relias Population Health Management System  
**Data issues/caveats that affect outcome measures:** None |
## FFY2022/2023 BLOCK GRANT PLAN

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Target</th>
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</thead>
</table>
| 1. Overall Health Promotion-Continued | Improve the health status of behavioral health consumers with complex health needs | Increase the number served of persons who inject drugs and high risk persons with substance use disorders | Outreach for persons who inject drugs | Number of persons who inject drugs and high risk persons with substance use disorders served through outreach contracts | Year 1: Target- 8,000  
Year 2: Target- 8,500  
**Data Source:** Contractor invoices for services  
**Description of Data:** Contractor submits a monthly invoice with the number of individuals served that month. Invoices are audited for accuracy and congruence with clinical documentation.  
**Data issues/caveats that affect outcome measures:** Counts may be duplicated by month, i.e., the same individual may be seen in more than one month. |
| Increase a culture of wellness in behavioral health organizations | Increase the number of behavioral health serving organizations to adopt worksite wellness policies that address nutrition and physical activity for employees and consumers. | Provide Technical Assistance, Wellness Policy Templates, and Outreach to organizations. | Number of behavioral health organizations that adopt and/or adapt Wellness Policies. | **Year 1:** Target-5  
**Year 2:** Target-10  
**Data Source:** Wellness Division Data Set  
**Description of Data:** Smartsheet in partnership with TSET  
**Data issues/caveats that affect outcome measures:** None |
| Reduce the use of tobacco | Increase the number of online referrals made from behavioral health providers to the OK Tobacco Helpline | Promotion of OK Tobacco Helpline | Number of online referrals submitted from behavioral health providers to the OK Tobacco Helpline | **Year 1:** Target- 7,500  
**Year 2:** Target- 8,000  
**Data Source:** Ok Tobacco Helpline database  
**Description of Data:** The OK Tobacco Helpline keeps a database of where each online referral comes from (by agency) and provides monthly reports.  
**Data issues/caveats that affect outcome measures:** None |
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<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Target</th>
</tr>
</thead>
</table>
| **1. Overall Health Promotion Cont’d** | Continue to integrate primary health care with behavioral health care – Cont’d | Increase targeted interventions to those with high BMIs and their families | Establish a BMI data collection tool | Data collection tool | Year 1: Target- Develop BMI tool  
Year 2: Target- Implement BMI tool |  
**Data Source:** Designated ODMHSAS staff  
**Description of Data:** Completed tool, and then provider report of use  
**Data issues/caveats that affect outcome measures:** None |
| | | | | | |
| | Increase the number of credentialed Wellness Coaches trained in Youth Focused competencies | Train Wellness Coaches in Youth Focused competencies in behavioral health settings | Number of wellness coaches trained in Wellness Coach Youth e-learning | | Year 1: Target- 122  
Year 2: Target- 140 |  
**Data Source:** ODMHSAS Human Resources Development (HRD) database  
**Description of Data:** The ODMHSAS designated staff will report on training development and the ODMHSAS HRD maintains a database of individuals who complete training  
**Data issues/caveats that affect outcome measures:** None |
| | Increase the number of credentialed Wellness Coaches | Provide wellness coach training | Number of credentialed wellness coaches | | Year 1: Target- 1,000  
Year 2: Target- 1,200 |  
**Data Source:** ODMHSAS training records  
**Description of Data:** ODMHSAS will keep a record of those completing training  
**Data issues/caveats that affect outcome measures:** None |
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<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
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| 2. Improved Access and Reduced Disparities- Cont’d | Expand the integration of physical health interventions | Increase the number of services provided by Wellness Coaches | Expand use of the Wellness Coaches in substance use disorder and behavioral health settings | Number of services provided by Wellness Coaches | Year 1: Target- 150,000  
Year 2: Target- 200,000  
**Data Source:** Medicaid Management Information System (MMIS)  
**Description of Data:** Data are compiled through claims database and matched with staff IDs who are Wellness Coaches  
**Data Issues/caveats that affect outcome measures:** None |
| Expand services for American Indians (AIs) | Increase access to wraparound services for AI children and youth | Promotion of wraparound services for AI children and youth | Number of AI children and youth who received wraparound services | Year 1: Target- 1,500  
Year 2: Target- 1,550  
**Data Source:** Medicaid Management Information System (MMIS) & Youth Information System (YIS)  
**Description of Data:** Data are compiled through the claims database for outreach services and matched to the eligibility file containing race.  
**Data issues/caveats that affect outcome measures:** None |
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<th>Targets</th>
</tr>
</thead>
</table>
| 2. Improved Access and Reduced Disparities - Continued | Expand services for American Indians (AIs) - Continued | Increase access to substance use disorder treatment for AI | Outreach activities done through contracted providers | Number of AI who received substance use disorder services | Year 1: Target- 4,000  
Year 2: Target- 4,500  
**Data Source:**  
Medicaid Management Information System (MMIS)  
**Description of Data:**  
Data are compiled through the claims database for outreach services and matched to the eligibility file containing race.  
**Data issues/caveats that affect outcome measures:**  
None |
| Increase collaborative efforts with Tribes regarding AI Opioid use and treatment | Increase collaborative efforts between state agency, contracted agencies and tribes. | Conduct events together to educate the community or cross systems. | Number of collaborative events conducted together between state agency, contracted agencies and tribes regarding AI Opioid use and treatment | Year 1 Target- 2  
Year 2 Target- 2  
**Data Source:**  
ODMHSAS staff coordinating the events  
**Description of Data:**  
The ODMHSAS staff coordinating the events will provide the number of events held during the reporting period.  
**Data issues/caveats that affect outcome measures:**  
None |
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<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 2. Improved Access and Reduced Disparities - Continued | Improve access for military personnel and their families | Increase the number of veteran Peer Recovery Support Specialists (PRSS) certified through a Veteran specific PRSS training | Promotion of veteran specific PRSS training | Number of veterans certified through Veteran specific PRSS training | Year 1: Target- 25  
**Year 2:** Target- 30  
**Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database  
**Description of Data:** The number of veterans who acquire their ODMHSAS certification as a PRSS will be pulled from the ODMHSAS PRSS Certification database.  
**Data issues/caveats that affect outcome measures:** None |
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<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 2. Improved Access and Reduced Disparities - Continued | Expand services for individuals currently and previously active in the military | Increase the number of individuals currently and previously active in the military served in CMHCs and BHCs | Promotion of CMHC and BHCs to meet the service needs of individuals currently and previously active in the military | Number of individuals currently and previously active in the military served in CMHCs and BHCs | Year 1: Target- 1,400  
Year 2: Target- 1,500 |
| | Expand services for children with SED | Maintain the number of children with SED and/or co-occurring substance use disorders admitted to Systems of Care programs | Local systems of care and Wraparound sites | Number of children with SED and/or co-occurring substance use disorders admitted to Systems of Care programs | Year 1: Target- 2,800  
Year 2: Target- 2,800 |

**Data Source:** Medicaid Management Information System (MMIS)  
**Description of Data:** Data are compiled through the claims database for services provided by CMHCs, and matched to the eligibility file containing military status information.  
**Data issues/caveats that affect outcome measures:** None
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<tr>
<th>Priority Area</th>
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<th>Performance Indicators</th>
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<tbody>
<tr>
<td>2. Improved Access and Reduced Disparities - Continued</td>
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<td></td>
<td>Improved services for older adults</td>
<td>Increase the number of individuals who receive training in serving older adults from ODMHSAS each year</td>
<td>Develop and implement web-based training on serving older adults.</td>
<td>Number of individuals who have completed the web-based training on serving older adults.</td>
<td>Year 1: Target - Web-based training developed Year 2: Target - 50</td>
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<td>Increase access to EBPs specific to treatment of older persons within Health Homes and CCBHCs</td>
<td>Implement the Evidence-Based Practice of Cognitive Behavioral Therapy (CBT) to treat older persons within designated Health Homes and CCBHCs</td>
<td>Number of older adults in Health Homes or CCBHCs who receive Cognitive Behavioral Therapy (CBT)</td>
<td>Year 1: Target - 15 Year 2: Target - 20</td>
<td></td>
</tr>
</tbody>
</table>

Data Source: The ODMHSAS Clinical Support Manager and the ODMHSAS Human Resources Development (HRD) database

Description of Data: The ODMHSAS designated staff will report on training development and the ODMHSAS HRD maintains a database of individuals who complete training

Data issues/caveats that affect outcome measures: None

Data Source: Provider report to ODMHSAS Clinical Support Manager & Manager of Integrated Care

Description of Data: Designated Health Homes and CCBHCs will submit a monthly report reflecting the number of older adults served through the provision of CBT

Data issues/caveats that affect outcome measures: None
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<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
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</thead>
</table>
| 2. Improved Access and Reduced Disparities - Continued | Improved services for older adults | Increase access to EBPs specific to treatment of older persons with Substance Use Disorder | Implement the Evidence-Based Practice of Cognitive Behavioral Therapy (CBT) to treat older persons with substance use disorders | Number of older adults being treated for a Substance Use Disorder who receive Cognitive Behavioral Therapy (CBT) | Year 1: Target- 15  
Year 2: Target- 20  
**Data Source:** Provider report to ODMHSAS Clinical Support Manager  
**Description of Data:** Designated Substance Use Disorder treatment sites will submit a monthly report reflecting the number of older adults treated for SUD through the provision of CBT  
**Data issues/caveats that affect outcome measures:** None |
| | | | | | |
| | Implement Peer Recovery Support Specialist (PRSS) training specific to older persons | Promotion of older person’s peer specific trainings | Number of persons who become certified PRSS for older persons | | Year 1: Target- 25  
Year 2: Target- 30  
**Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database  
**Description of Data:** The number of persons who acquire their ODMHSAS certification as a PRSS for older persons will be pulled from the ODMHSAS PRSS Certification database.  
**Data issues/caveats that affect outcome measures:** None |
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<tr>
<th>Priority Area</th>
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<th>Strategies</th>
<th>Performance Indicators</th>
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</thead>
</table>
| 2. Improved Access and Reduced Disparities - Continued | Improve access to treatment for parents in substance use disorder treatment programs and their families | Increase the number of participants in Strengthening Families and Celebrating Families programs       | Strengthening Families and Celebrating Families – EBP family group counseling – for parents (and their children) in substance use disorder treatment programs and faith based organizations | Number of participants in Strengthening Families and Celebrating Families programs | **Year 1:**<br>Target- 1,000<br>**Year 2:**<br>Target- 1,200<br><br>**Data Source:**<br>Provider reports  
**Description of Data:**<br>The Manager of Adolescent and Family Co-occurring Services will poll providers, and maintain responses.  
**Data issues/caveats that affect outcome measures:**<br>None |
| Improve access to treatment for pregnant and parenting women | Maintain the average number of days pregnant women are on the waiting list before they are admitted to residential treatment | Priority admission to substance use disorder treatment services for pregnant and parenting women | Average number of days pregnant women were on a waiting list before they were admitted to residential treatment | **Year 1:**<br>Target- 15<br>**Year 2:**<br>Target- 15<br><br>**Data Source:**<br>Online waiting list maintained by ODMHSAS  
**Description of Data:**<br>Providers are required to report into database those clients needing residential services, and indicate if they are pregnant.  
**Data issues/caveats that affect outcome measures:**<br>None |
| Improve access to EBPs within residential substance use disorder (SUD) treatment for pregnant women, women and children | Provide and maintain EBPs within residential SUD treatment for pregnant women, women and children | Train residential SUD treatment providers for pregnant women, women and children in EBPs including Celebrating Families, Community Reinforcement Approach, Seeking Safety, and ABC infant model | Number of EBP trainings provided for residential SUD treatment providers for pregnant women, and women with children | **Year 1:**<br>Target- 3<br>**Year 2:**<br>Target- 4<br><br>**Data Source:**<br>ODMHSAS staff coordinating the trainings  
**Description of Data:**<br>The ODMHSAS staff coordinating the trainings will provide the number of EBP trainings held during the reporting period.  
**Data issues/caveats that affect outcome measures:**<br>None |
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<tbody>
<tr>
<td>2. Improved Access and Reduced Disparities - Continued</td>
<td>Increase access to an array of treatments for individuals with or at risk for OUDs, including those who are uninsured and underinsured, with emphasis on veterans, pregnant women, tribal, those coming out of jail and prisons.</td>
<td>Increase the number of individuals receiving opioid treatment and support services, including MAT.</td>
<td>Expand access to opioid treatment and support services</td>
<td>Number of individuals receiving opioid treatment and support services, including MAT services</td>
<td>Year 1: Target- 5,000 Year 2: Target- 5,500</td>
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<td>Ensure 100% of ODMHSAS contracted MAT providers utilize DATA waivered prescribers.</td>
<td>Increase DATA 2000 waiver trainings in collaboration with the Opioid Response Network.</td>
<td>Number of DATA 2000 waiver trainings provided</td>
<td></td>
<td>Year 1: Target- 4 Year 2: Target- 6</td>
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<td>Data Source: Agency surveys and billing Description of Data: Providers are required to report monthly on individuals receiving FDA approved MAT medications. ODMHSAS creates a quarterly report. Data issues/caveats that affect outcome measures: Only if providers are not accurately documenting or submitting required information.</td>
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<td>Priority Area</td>
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<td>Strategies</td>
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<tr>
<td>Access and Reduced Disparities - Continued</td>
<td>Increase access to an array of treatments for individuals with or at risk for OUDs, including those who are uninsured and underinsured, with emphasis on veterans, pregnant women, tribal, those coming out of jail and prisons.</td>
<td>Increase access to MAT for individuals in county jails</td>
<td>Expand access to MAT in county jails in collaboration with jail medical providers and partner pharmacy</td>
<td>Number of jail sites offering MAT</td>
<td>Year 1: Target- 23 Year 2: Target- 30 Data Source: Medication provider database Description of Data: ODMHSAS will receive regular reports from medication provider contractor Data issues/caveats that affect outcome measures: None</td>
</tr>
<tr>
<td>Improve access to treatment for the LGBT population</td>
<td>Increase the number of LGBT population receiving substance use disorder (SUD) treatment and supports</td>
<td>Provide specialized LGBT substance use disorder treatment and support services</td>
<td>Number of individuals receiving specialized LGBT SUD services</td>
<td>Year 1: Target- 75 Year 2: Target- 100 Data Source: Provider reporting to ODMHSAS staff Description of Data: Provider of specialized LGBT SUD treatment services submits regular reporting that include the number of individuals receiving these services. Data issues/caveats that affect outcome measures: None</td>
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</tr>
<tr>
<td>Implement Peer Recovery Support Specialist (PRSS) training specific LGBTQIA+ persons</td>
<td>Promotion of LGBTQIA+ persons peer specific trainings</td>
<td>Number of persons who become certified PRSS for LGBTQIA+ persons</td>
<td>Year 1: Target- 20 Year 2: Target- 25 Data Source: ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database Description of Data: The number of persons who acquire their ODMHSAS certification as a PRSS for older persons will be pulled from the ODMHSAS PRSS Certification database. Data issues/caveats that affect outcome measures: None</td>
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<td>Priority Area</td>
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<tr>
<td>2. Improved Access and Reduced Disparities - Continued</td>
<td>Improve access to treatment for the African American population</td>
<td>Increase the number of African Americans served in urban communities with a high percentage of African American population</td>
<td>Development and implementation of community/school partnership model for outreach, treatment and support</td>
<td>Number of partnerships developed in targeted communities</td>
<td>Year 1: Target- 2  Year 2: Target- 6  <strong>Data Source:</strong> OU Evaluation Team (E-Team)  <strong>Description of Data:</strong> Provider reports  <strong>Data issues/caveats that affect outcome measures:</strong> None</td>
</tr>
<tr>
<td></td>
<td>Expand access to specialized treatment services for children 0-5 and their families across Oklahoma, especially in rural and frontier counties.</td>
<td>Increase number of clinicians trained in EBP's appropriate for treatment of children 0-5, especially in rural and frontier counties.</td>
<td>Continue to offer training in assessment, diagnosis, and treatment of children 0-5 to include EBP's such as COS, CPP, and Infant Massage.</td>
<td>Number of attendees for IMH specific training annually</td>
<td>Year 1 - 100  Year 2 - 150  <strong>Data source:</strong> ODMHSAS Human Resources Development (HRD) database  <strong>Description of Data:</strong> ODMHSAS HRD maintains a database of individuals who complete training  <strong>Data issues/caveats that affect outcome measures:</strong> None</td>
</tr>
</tbody>
</table>
## FFY2022/2023 BLOCK GRANT PLAN

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<thead>
<tr>
<th>Priority Area</th>
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<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
<th>Data Source</th>
<th>Description of Data</th>
<th>Data issues/caveats that affect outcome measures</th>
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<tbody>
<tr>
<td>2. Improved Access and Reduced Disparities - Continued</td>
<td>Improve access to evidenced-based practices for early interventions to address Early Serious Mental Illness (SMI)</td>
<td>Implement an EBP to address early intervention for Serious Mental Illness</td>
<td>Implement the Evidence-Based Practice of Cognitive Behavioral Therapy (CBT) to treat youth and young adults with Serious Mental Illness</td>
<td>Number of youth and young adults with early Serious Mental Illness who receive Cognitive Behavioral Therapy (CBT), including Recovery Oriented Cognitive Therapy (CT-R)</td>
<td>Year 1:</td>
<td>Target- 15</td>
<td>Outcome –</td>
<td>None</td>
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<td>Implement process for early identification and engagement of youth and young adults experiencing early SMI</td>
<td>Implement statewide eSMI Outreach to build collaborative relationships with local Higher Education and hospital to assist with early identification, engagement and intervention for youth and young adults experiencing early SMI</td>
<td>Number of youth and young adults with early Serious Mental Illness who are identified through eSMI Outreach and are connected with behavioral health EBP treatment services</td>
<td>Year 1:</td>
<td>Target- 15</td>
<td>Outcome –</td>
<td>None</td>
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<td>Data Source:</td>
<td>Provider report to ODMHSAS Clinical Support Manager</td>
<td>Designated eSMI CBT treatment sites will submit a monthly report reflecting the number of youth and young adults with early SMI treated through the provision of CBT or CT-R</td>
<td>Data issues/caveats that affect outcome measures:</td>
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<tr>
<td>Priority Area</td>
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<td>Strategies</td>
<td>Performance Indicators</td>
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</table>
| 2. Improved Access and Reduced Disparities - Continued | Improve access to treatment for the Latinx population. | Implement Peer Recovery Support Specialist (PRSS) training specific Latinx persons | Promotion of Latinx persons peer specific trainings | Number of persons who become certified PRSS for Latinx persons. | Year 1: Target- 20  
Year 2: Target- 25  
**Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database  
**Description of Data:** The number of persons who acquire their ODMHSAS certification as a PRSS for older persons will be pulled from the ODMHSAS PRSS Certification database.  
**Data issues/caveats that affect outcome measures:** None |
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<th>Performance Indicators</th>
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</thead>
</table>
| 3. Enhance Service Quality and Accountability | Expand use of recovery support services | Increase the number of PRSSs certified | Certification program for Peer Recovery Support Specialists (PRSS) | Number of PRSSs certified | Year 1: Target - 275  
Year 2: Target - 300  
Data Source: PRSS Certification Database  
Description of Data: ODMHSAS maintains a database of all certified PRSSs.  
Data issues/caveats that affect outcome measures: None |
| | Increase the number of services provided by PRSSs | Expand use of PRSSs in substance abuse and mental health settings | Number of services provided by PRSSs | | Year 1: Target - 210,000  
Year 2: Target - 225,000  
Data Source: Medicaid Management Information System (MMIS)  
Description of Data: Data are compiled through claims database and matched with staff IDs who are PRSSs.  
Data issues/caveats that affect outcome measures: None |
| Improve Crisis Education and Skills of PRSS Workforce | Implement Crisis Specific PRSS Trainings | Promote Crisis Specific PRSS Trainings | Number of Certified PRSS trained in Crisis Specific PRSS Trainings. | | Year 1: Target - 20  
Year 2: Target - 25  
Data Source: ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database  
Description of Data: The number of persons who complete the PRSS Crisis Training will be pulled from the ODMHSAS PRSS Certification database.  
Data issues/caveats that affect outcome measures: None |
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<tr>
<td></td>
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<td>Expand use of behavioral health case management services</td>
<td>Increase the number of case managers who are certified</td>
<td>Certification for Behavioral Health Case Managers</td>
<td>Number of Case Managers Certified</td>
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<tr>
<td></td>
<td></td>
<td>Increase the number of case managers who are certified</td>
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<td>Utilize evidence based practices for individuals impacted by trauma</td>
<td>Maintain the number of youth receiving CATS screening and follow-up with trauma-specific services</td>
<td>Require use of the Children and Adolescent Trauma Screening (CATS)</td>
<td>Number of youth receiving CATS screening and follow-up with trauma-specific services</td>
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<td>Year 1: Target- 150 Year 2: Target- 175</td>
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<td>3. Enhance Service Quality and Accountability - Continued</td>
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<td>Data Source: Case Management Data Base Description of Data: Data is collected using the application process and also using the CM system in ODMHSAS Access Control. Data issues/caveats that affect outcome measures: None</td>
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<tr>
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<td>Increase options for self-directed care</td>
<td>Increase the number of individuals receiving drop-in center services</td>
<td>Peer-run, drop-in centers as option for services and supports</td>
<td>Number of Peer-run drop-in services provided.</td>
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<td>Year 1: Target- 32,000 Year 2: Target- 34,000</td>
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<td>Data Source: Contractor invoices Description of Data: Contractors submit monthly invoices with the number of individuals served that month. Data issues/caveats that affect outcome measures: None</td>
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<td>Priority Area</td>
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</table>
| 3. Enhance Service Quality and Accountability - Continued | Increase access to training on Person-centered Planning | Increase the number of behavioral health providers trained on Person-centered Planning | Web-based training on Person-centered Planning | Number of persons who have completed the web-based Person-centered Planning training | Year 1: Target- 200  
Year 2: Target- 1250  
**Data Source:** ODMHSAS Human Resources Development (HRD) database.  
**Description of Data:** ODMHSAS HRD maintains a database of individuals who complete training.  
**Data issues/caveats that affect outcome measures:** None |
| | Leverage technology to improve access and quality of care for persons with SMI, SED or SUD living in rural areas | Increase the number of services provided through telehealth | Telehealth services for both substance use disorder (SUD) treatment and mental health services | Number of services provided through telehealth for persons with SMI, SED or SUD living in rural areas | Year 1: Target- 30,000  
Year 2: Target- 32,000  
**Data Source:** Medicaid Management Information System (MMIS)  
**Description of Data:** Data are compiled through the claims database. Telehealth services are identified in the claims system with a unique code modifier.  
**Data issues/caveats that affect outcome measures:** None |
<table>
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<tbody>
<tr>
<td>3. Enhance Service Quality and Accountability</td>
<td>Incentivize for more efficient use of resources and improved service outcomes</td>
<td>Maintain the percentage of time agencies meet the benchmark for the incentive payment as a result of indicators of improved care</td>
<td>Use of the Enhanced Tiered Payment System (ETPS)</td>
<td>Percent of time agencies meet the benchmark for the incentive payment</td>
<td>Year 1: Target- 92.5%</td>
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<td>Year 2: Target- 92.5%</td>
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<td>Data Source: Medicaid Management Information System (MMIS) and other administrative databases</td>
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<td>Description of Data: Data are compiled through the MMIS database, ODMHSAS PICIS database and telephone calls</td>
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<td>Data issues/caveats that affect outcome measures:</td>
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<td>None</td>
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<tr>
<td>Improve access to supported employment and</td>
<td>Increase the number of individuals trained in the EBP- Individual Placement and Supports (IPS)</td>
<td>Provide IPS training for providers and community stakeholders</td>
<td>Number of individuals trained in IPS</td>
<td>Year 1: Target- 50</td>
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<tr>
<td>education for individuals with SMI and SUD</td>
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<td>Year 2: Target- 75</td>
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<td>Data Source: The ODMHSAS Human Resources Development (HRD) databases</td>
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<td>Description of Data: The ODMHSAS HRD maintains a database of individuals who complete training.</td>
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<td>Data issues/caveats that affect outcome measures:</td>
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<td>None</td>
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<tr>
<td>3. Enhance Service Quality and Accountability - Continued</td>
<td>Improve access to supported employment and education for individuals with SMI and SUD - Continued</td>
<td>Increase the number of Individual Placement and Supports (IPS) service locations</td>
<td>Outreach and provide support to new locations to develop IPS services</td>
<td>Number of locations providing IPS services</td>
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<td></td>
<td>Increase the number of individuals with SMI and SUD that are competitively employed</td>
<td>Provide technical assistance to providers regarding successful implementation of the EBP-Individual Placement and Supports (IPS)</td>
<td>Percentage of individuals with SMI and SUD who are competitively employed through IPS</td>
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<td>Year 1:</td>
<td>Target- 60%</td>
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<td></td>
<td>Year 2:</td>
<td>Target- 65%</td>
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<td>Data Source:</td>
<td>IPS database</td>
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<td></td>
<td>Description of Data:</td>
<td>The lead IPS Trainer maintains a database of credentialed individuals and their sites for the IPS Learning Community.</td>
</tr>
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<td></td>
<td>Data issues/caveats that affect outcome measures:</td>
<td>None</td>
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<td></td>
<td>Year 1:</td>
<td>Target- 40%</td>
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<td>Year 2:</td>
<td>Target- 45%</td>
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<td>Data Source:</td>
<td>Provider report to ODMHSAS IPS staff</td>
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<td></td>
<td>Description of Data:</td>
<td>IPS launched teams submit a quarterly data report that includes the number of individuals served through IPS and the percentage of those individuals that competitively employed.</td>
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<td></td>
<td>Data issues/caveats that affect outcome measures:</td>
<td>None</td>
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<tr>
<td>Priority Area</td>
<td>Goals</td>
<td>Objectives</td>
<td>Strategies</td>
<td>Performance Indicators</td>
<td>Targets</td>
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</tbody>
</table>
| 3. Enhance Service Quality and Accountability - Continued | Increase evidence-based housing programming availability | Increase the number of certified recovery residences | Provide financial support for housing to become certified through the Oklahoma Association of Recovery Residences (OKARR) | Additional number of certified recovery houses | Year 1: Target - 50  
Year 2: Target - 65  
**Data Source:** OKARR certification  
**Description of Data:** The ODMHSAS will review the OKARR certification list  
**Data issues/caveats that affect outcome measures:** None |
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 4. Reduced Criminal Justice Involvement-Continued | Improve workforce capacity and skills in response to individuals with criminal justice/public safety involvement | Increase the number of police officers trained in CIT | Law enforcement training – Memphis Model Crisis Intervention Training (CIT) | Number of police officers trained in CIT | Year 1: Target- 350  
Year 2: Target- 400  
**Data Source:**  
Data maintained by ODMHSAS CIT trainer  
**Description of Data:**  
ODMHSAS staff maintain a roster of all individuals who complete the CIT course.  
**Data issues/caveats that affect outcome measures:**  
None |
| Improve workforce capacity and skills in response to individuals with criminal justice/public safety involvement | Increase law enforcement access to mental health experts | Provide ipads to CLEET commissioned officers in the state | Percentage of law enforcement officers with access to ipads to connect to mental health professionals | Year 1: Target- 100%  
Year 2: Target- 100%  
**Data Source:**  
ODMHSAS database  
**Description of Data:**  
ODMHSAS maintains databased in partnership with ipad vendor.  
**Data issues/caveats that affect outcome measures:**  
None |
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 5. Prevention of Mental Illness and Substance Use Disorders | Reduce rates of suicide | Develop 988 Call Center capacity | Develop 988 Call Center capacity in preparation for the launch of 988 as the national behavioral health crisis number | Launch of 988 Call Center | Year 1: Target- 1  Year 2: Target- 1  
**Data Source:** ODMHSAS contract  
**Description of Data:** ODMHSAS contract  
**Data issues/caveats that affect outcome measures:** None |
| | Reduce rates of suicide | Continue to increase suicide prevention among Oklahoma adults through education and outreach | Outreach and education to those receiving services from the Employment Security Commission and those reaching SMVF populations, and employers. | Treatment and prevention information available on Employment Security Commission website and veterans’ resources websites | Year 1: Target- 1  Year 2: Target- 1  
**Data Source:** Information available  
**Description of Data:** Information available on site  
**Data issues/caveats that affect outcome measures:** None |
| | Reduce substance use | Increase the number of evidenced-based prevention strategies reported | Community level strategies for substance abuse prevention | Number of evidenced-based prevention strategies reported | Year 1: Target- 32  Year 2: Target- 32  
**Data Source:** Oklahoma Prevention Reporting System (PRS)  
**Description of Data:** The ODMHSAS Prevention division analyzes data reported on OKPROS and identifies the specific number of EBP’s utilized in delivering community level strategies.  
**Data issues/caveats that affect outcome measures:** None |
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 5. Prevention of Mental Illness and Substance Use Disorders - Continued | Early identification and intervention of substance use problems | Increase use of SBIRT | Screening, brief intervention and referral to treatment (SBIRT) services within primary care and other community health/hospital settings | Number of SBIRT interactions provided in health/hospital setting | Year 1: Target- 350  
Year 2: Target- 400  
Data Source: SBIRT Registry  
Description of Data: The ODMHSAS SBIRT trainer maintains a database of individuals who complete the training. Numbers will be reflected as annual (not cumulative) counts.  
Data issues/caveats that affect outcome measures: None |
| | | Increase school-based primary substance use prevention services (Botvin Lifeskills, AlcoholEdu, PAX Good Behavior Games) | Utilizing Multi-Tiered System of Supports approach to preventing/treating mental, emotional, and behavioral (MEB) problems among youth. | Number of school-based primary substance use prevention services and number of schools | Year 1: Target- 25 and 25%  
Year 2: Target- 25 and 25%  
Data Source: ODMHSAS database  
Description of Data: ODMHSAS database  
Data issues/caveats that affect outcome measures: None |
### FFY2022/2023 BLOCK GRANT PLAN

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 5. Prevention of Mental Illness and Substance Use Disorders - Continued | Reduce underage drinking | Decrease the prevalence of underage drinking | Consistent and highly visible enforcement of state and local laws related to underage and high risk drinking | Percentage of individuals age 12-20 who used alcohol in the past month | Year 1: Target- 17.3%  
Year 2: Target- 16.9%  
**Data Source:** National Survey on Drug Use and Health (NSDUH)  
**Description of Data:** State level data are obtained through NSDUH.  
**Data issues/caveats that affect outcome measures:** NSDUH may run a few years behind on state-specific data, and data is often reflected as a rolling average. |
| | | Increase the number trained in enforcement of youth access to alcohol laws | | Number trained in enforcement of youth access to alcohol laws | Year 1: Target- 75  
Year 2: Target- 80  
**Data Source:** Prevention division database  
**Description of Data:** Prevention division staff maintain a database of all who have received the training.  
**Data issues/caveats that affect outcome measures:** None |
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Prevention of Mental Illness and Substance Use Disorders - Continued</td>
<td>Reduce underage drinking – Continued</td>
<td>Increase the number of persons trained in Responsible Beverage Sales and Service training</td>
<td>Consistent and highly visible enforcement of state and local laws related to underage and high risk drinking – Continued</td>
<td>Number trained in Responsible Beverage Sales and Service training</td>
<td>Year 1: Target- 1,500 Year 2: Target- 2,000</td>
</tr>
<tr>
<td></td>
<td>Reduce misuse of prescription drugs</td>
<td>Decrease number of individuals 18-25 reporting past year non-medical prescription pain reliever use</td>
<td>Increase state and community level prevention strategies to prevent non-medical use of prescription drugs</td>
<td>Number of individuals 18-25 reporting past year prescription pain reliever misuse</td>
<td>Year 1: Target- 28,000 Year 2: Target- 27,000</td>
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<td>Data Source: National Survey on Drug Use and Health (NSDUH) Data Source: National Survey on Drug Use and Health (NSDUH) Description of Data: State level data are obtained through NSDUH. Data issues/caveats that affect outcome measures: The NSDUH may lag in annual reporting of state-specific data, and often reflect rolling averages. The results for current efforts will not be known for several years.</td>
</tr>
<tr>
<td>Priority Area</td>
<td>Goals</td>
<td>Objectives</td>
<td>Strategies</td>
<td>Performance Indicators</td>
<td>Targets</td>
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<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 5. Prevention of Mental Illness and Substance Use | Reduce misuse of prescription drugs – **Continued** | Decrease number of individuals 26 and older reporting past year non-medical prescription pain reliever use | Increase state and community level prevention strategies to prevent non-medical use of prescription drugs - **Continued** | Number of individuals 26 and older reporting past year prescription pain reliever misuse | Year 1: Target- 87,000  
Year 2: Target- 86,000  
**Data Source:** National Survey on Drug Use and Health (NSDUH)  
**Description of Data:** The NSDUH may run a few years behind with state specific data, and may reflect rolling averages.  
**Data issues/caveats that affect outcome measures:** The NSDUH may run a few years behind with state specific data, and may reflect rolling averages. |
|                                                   |                                                 |                                                                             |                                                                                             |                                                                                        |                                                                         |
|                                                   |                                                 | Increase the number of persons trained in Naloxone administration | Increase opioid overdose prevention training and access to naloxone | Number trained in Naloxone administration | Year 1: Target- 2,400  
Year 2: Target- 2,600  
**Data Source:** Prevention division database  
**Description of Data:** Prevention division staff maintain a database reflecting individuals who have received the training.  
**Data issues/caveats that affect outcome measures:** None |
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Prevention of Mental Illness</td>
<td>Reduce misuse of prescription drugs – Continued</td>
<td>Increase the number of Naloxone administrations</td>
<td>Increase opioid overdose prevention training and access to naloxone - Continued</td>
<td>Number of Naloxone administrations</td>
<td>Year 1: Target-120</td>
</tr>
<tr>
<td>and Substance Use Disorders -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 2: Target- 140</td>
</tr>
<tr>
<td>Continued</td>
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<td></td>
<td>Data Source: Prevention division database</td>
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<td></td>
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<td></td>
<td>Data issues/caveats that affect outcome measures: Rely on submission of report-back forms from law enforcement, or members of the public getting refills.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/a</td>
</tr>
<tr>
<td>5. Prevention of Mental Illness</td>
<td>Reduce misuse of prescription drugs – Continued</td>
<td>Implement substance abuse prevention plans and services</td>
<td>Implement Prevention Works community coalitions</td>
<td>Number of Prevention Works community coalitions</td>
<td>Year 1: Target-30</td>
</tr>
<tr>
<td>and Substance Use Disorders -</td>
<td></td>
<td></td>
<td></td>
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<td>Year 2: Target- 35</td>
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<tr>
<td>Continued</td>
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<td>Data Source: Prevention division database</td>
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<td></td>
<td>Data issues/caveats that affect outcome measures: N/a</td>
</tr>
</tbody>
</table>

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### FFY2022/2023 BLOCK GRANT PLAN

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Performance Indicators</th>
<th>Targets</th>
</tr>
</thead>
</table>
| 6. Public Awareness | Utilize social media to provide awareness around behavioral health issues such as stigma and access to care | Increase public reach of treatment and prevention information              | Rebrand the OK I’m Ready substance abuse and prevention campaign             | Percentage of Oklahomans reached                                                     | Year 1: Target- 50%  
Year 2: Target- 60%  
Data Source: ODMHSAS Prevention and Communications division  
**Description of Data:** Counters are used to record the number of hits.  
**Data issues/caveats that affect outcome measures:** User preference and available social media platforms are difficult to predict. |
|                     | Provide public information for improved access to services             | Provide public information for improved access to services                 | Increase the number of informational materials disseminated                 | Provide information outreach                                                            | Year 1: Target- 50,000  
Year 2: Target- 55,000  
Data Source: Prevention division database  
**Description of Data:** Prevention division staff manage and track the dissemination of materials.  
**Data issues/caveats that affect outcome measures:** None |
## Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.  

ONLY include funds expended by the executive branch agency administering the SABG.

### Planning Tables

**Planning Period Start Date: 7/1/2021**  
**Planning Period End Date: 6/30/2023**

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
<th>H. COVID-19 Relief Funds (MHBG)(^{a})</th>
<th>I. COVID-19 Relief Funds (SABG)(^{a})</th>
<th>J. ARP Funds (SABG)(^{b})</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention(^{c}) and Treatment</td>
<td>$25,726,456.00</td>
<td>$2,098,383.00</td>
<td>$24,629,401.00</td>
<td>$51,007,184.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$12,056,198.00</td>
<td>$11,105,822.00</td>
<td></td>
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</tr>
<tr>
<td>(\text{a. Pregnant Women and Women with Dependent Children})(^{d})</td>
<td>$13,611,028.00</td>
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<tr>
<td>(\text{b. All Other})</td>
<td>$12,115,428.00</td>
<td>$2,098,383.00</td>
<td>$24,629,401.00</td>
<td>$51,007,184.00</td>
<td></td>
<td></td>
<td>$9,292,450.00</td>
<td>$11,105,822.00</td>
<td></td>
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<tr>
<td>2. Primary Prevention(^{d})</td>
<td>$6,860,388.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$6,552,496.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$3,214,848.00</td>
<td>$2,776,455.00</td>
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</tr>
<tr>
<td>(\text{a. Substance Abuse Primary Prevention})</td>
<td>$6,860,388.00</td>
<td></td>
<td></td>
<td>$6,552,496.00</td>
<td></td>
<td></td>
<td>$3,214,848.00</td>
<td>$2,776,455.00</td>
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<tr>
<td>(\text{b. Mental Health Primary Prevention})</td>
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<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
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<td>4. Tuberculosis Services</td>
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<td>5. Early Intervention Services for HIV</td>
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<tr>
<td>6. State Hospital</td>
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<td>7. Other 24-Hour Care</td>
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<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
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</tr>
<tr>
<td>9. Administration (excluding program/provider level) MHBG and SABG must be reported separately</td>
<td>$1,715,098.00</td>
<td></td>
<td></td>
<td>$5,528,369.00</td>
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<td></td>
<td>$803,170.00</td>
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<tr>
<td>10. Crisis Services (5 percent set-aside)</td>
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<td></td>
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</tr>
<tr>
<td>11. Total</td>
<td>$34,301,942.00</td>
<td>$0.00</td>
<td>$2,098,383.00</td>
<td>$24,629,401.00</td>
<td>$68,088,049.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$16,074,216.00</td>
<td>$13,882,277.00</td>
<td></td>
</tr>
</tbody>
</table>

\(^{a}\) The 24-month expenditure period for the COVID-19 Relief Supplemental funding is March 15, 2021 – March 14, 2023, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.  

\(^{b}\) The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – September 30, 2025, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.  

\(^{c}\) Prevention other than primary prevention  

\(^{d}\) The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse  

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### Footnotes:

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Table 2 State Agency Planned Expenditures (MH)
States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>Source of Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Substance Abuse Block Grant</td>
</tr>
<tr>
<td></td>
<td>B. Mental Health Block Grant</td>
</tr>
<tr>
<td></td>
<td>C. Medicaid (Federal, State, and Local)</td>
</tr>
<tr>
<td></td>
<td>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</td>
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<tr>
<td></td>
<td>E. State Funds</td>
</tr>
<tr>
<td></td>
<td>F. Local Funds (excluding local Medicaid)</td>
</tr>
<tr>
<td></td>
<td>G. Other</td>
</tr>
<tr>
<td></td>
<td>H. COVID-19 Relief Funds (MHBG)</td>
</tr>
<tr>
<td></td>
<td>I. COVID-19 Relief Funds (SABG)</td>
</tr>
<tr>
<td></td>
<td>J. ARP Funds (MHBG)</td>
</tr>
</tbody>
</table>

|          | 1. Substance Abuse Prevention and Treatment |
|          | a. Pregnant Women and Women with Dependent Children |
|          | b. All Other |
|          | 2. Primary Prevention |
|          | a. Substance Abuse Primary Prevention |
|          | b. Mental Health Primary Prevention |
|          | 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) |
|          | 4. Tuberculosis Services |
|          | 5. Early Intervention Services for HIV |
|          | 6. State Hospital |
|          | 7. Other 24-Hour Care |
|          | 8. Ambulatory/Community Non-24 Hour Care |
|          | 9. Administration (excluding program/provider level) |
|          | MHBG and SABG must be reported separately |
|          | 10. Crisis Services (5 percent set-aside) |
|          | 11. Total |

|          | $791,316.00 |
|          | $909,414.00 |
|          | $1,570,806.00 |
|          | $6,330,527.00 |
|          | $92,969,972.00 |
|          | $9,635,811.00 |
|          | $265,288,198.00 |
|          | $7,275,308.00 |
|          | $13,351,843.00 |
|          | $395,658.00 |
|          | $454,707.00 |
|          | $15,708,052.00 |

|          | $9,094,136.00 |

---

Footnotes:

a The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 - September 30, 2025, which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states.

c Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

d While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

e Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

f Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>4,298</td>
<td>773</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>24,462</td>
<td>20,245</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>119,465</td>
<td>5,009</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>102,881</td>
<td>5,515</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>7,888</td>
<td>6,196</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the state does not have a data source. Not applicable

Footnotes:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021   Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY Grant Award</th>
<th>2022 SA Block Grant Award</th>
<th>COVID-19 Award</th>
<th>ARP Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Use Disorder Prevention and Treatment³</td>
<td></td>
<td></td>
<td>$12,055,657.00</td>
<td>$11,105,822.00</td>
</tr>
<tr>
<td>2. Primary Substance Use Disorder Prevention</td>
<td></td>
<td>$3,430,194.00</td>
<td>$3,214,848.00</td>
<td>$2,776,455.00</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV⁴</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$857,549.00</td>
<td></td>
<td>$803,711.00</td>
<td></td>
</tr>
<tr>
<td>6. Total</td>
<td>$17,150,971.00</td>
<td>$16,074,216.00</td>
<td>$13,882,277.00</td>
<td></td>
</tr>
</tbody>
</table>

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

³Prevention other than Primary Prevention
For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:
### Table 5a SABG Primary Prevention Planned Expenditures

**Planning Period Start Date:** 10/1/2021  
**Planning Period End Date:** 9/30/2023

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>A</th>
<th>B</th>
<th>COVID-19</th>
<th>ARP²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SA Block Grant Award</td>
<td>FFY 2022</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td>Universal</td>
<td>$857,514</td>
<td>$405,000</td>
<td>$516,811</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
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<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$857,514</td>
<td>$405,000</td>
<td>$516,811</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
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<tr>
<td></td>
<td>Indicated</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Education</td>
<td>Universal</td>
<td>$343,005</td>
<td>$650,000</td>
<td>$836,546</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Indicated</td>
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<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$343,005</td>
<td>$650,000</td>
<td>$836,546</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>Indicated</td>
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<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Alternatives</td>
<td>Universal</td>
<td>$20,580</td>
<td>$19,289</td>
<td>$16,659</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$20,580</td>
<td>$19,289</td>
<td>$16,659</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td>Universal</td>
<td>$3,430</td>
<td>$700,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$3,430</td>
<td>$700,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Community-Based Process</td>
<td>Selective</td>
<td>Indicated</td>
<td>Unspecified</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
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<td>-----------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Environmental</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>7. Section 1926 Tobacco</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8. Other</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
</table>

| Total Prevention Expenditures | $3,430,194 | $3,214,843 | $2,776,455 |
| Total SABG Award | $17,150,971 | $16,074,216 | $13,882,277 |
| Planned Primary Prevention Percentage | 54.93 % | 58.61 % | 67.87 % |

1The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

2The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 - September 30, 2025, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

3Total SABG Award is populated from Table 4 - SABG Planned Expenditures.
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021  Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 SA Block Grant Award</th>
<th>COVID-19 Award(^1)</th>
<th>ARP Award(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal Indirect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total SABG Award(^3)</strong></td>
<td><strong>$17,150,971</strong></td>
<td><strong>$16,074,216</strong></td>
<td><strong>$13,882,277</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td>0.00 %</td>
<td>0.00 %</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>

\(^1\)The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

\(^2\)The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

\(^3\)Total SABG Award is populated from Table 4 - SABG Planned Expenditures

---

**Footnotes:**

Not applicable - completed Table 5a
## Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

<table>
<thead>
<tr>
<th>Planning Period Start Date: 10/1/2021</th>
<th>Planning Period End Date: 9/30/2023</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SABG Award</td>
</tr>
<tr>
<td><strong>Targeted Substances</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>✔</td>
</tr>
<tr>
<td>Tobacco</td>
<td>✔</td>
</tr>
<tr>
<td>Marijuana</td>
<td>✔</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>✔</td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>✔</td>
</tr>
<tr>
<td>Inhalants</td>
<td>✔</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>✔</td>
</tr>
<tr>
<td>Bath salts, Spice, K2)</td>
<td></td>
</tr>
<tr>
<td><strong>Targeted Populations</strong></td>
<td></td>
</tr>
<tr>
<td>Students in College</td>
<td>✔</td>
</tr>
<tr>
<td>Military Families</td>
<td>✔</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>✔</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>✔</td>
</tr>
<tr>
<td>African American</td>
<td>✔</td>
</tr>
<tr>
<td>Hispanic</td>
<td>✔</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>✔</td>
</tr>
<tr>
<td>Asian</td>
<td>✔</td>
</tr>
<tr>
<td>Rural</td>
<td>✔</td>
</tr>
</tbody>
</table>
The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

**Footnotes:**
### Planning Tables

#### Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021       Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Integrated&lt;sup&gt;1&lt;/sup&gt;</th>
<th>D. COVID-19&lt;sup&gt;2&lt;/sup&gt;</th>
<th>E. ARP&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$0.00</strong></td>
</tr>
</tbody>
</table>

<sup>1</sup>Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.
The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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**Footnotes:**

No non-direct services/system development
## Planning Tables

### Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2021  
MHBG Planning Period End Date: 06/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 Block Grant</th>
<th>FFY 2022¹ COVID Funds</th>
<th>FFY 2022² ARP Funds</th>
<th>FFY 2023 Block Grant</th>
<th>FFY 2023¹ COVID Funds</th>
<th>FFY 2023² ARP Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$100,000.00</td>
<td></td>
<td></td>
<td>$100,000.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td></td>
<td></td>
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¹ The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the “standard” SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

² The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the “standard” MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

### Footnotes:

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.\(^{22}\) Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.\(^{23}\) It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.\(^{24}\)

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.\(^{25}\) SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.\(^{26}\) For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.\(^{27}\)

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.\(^{28}\)

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.\(^{29}\) The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.\(^{30}\) Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.\(^{33}\) Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.\(^{34}\)

One key population of concern is persons who are dually eligible for Medicare and Medicaid.\(^{35}\) Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.\(^{36}\) SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.\(^{37}\) Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.\(^{38}\) SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with...
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


4. [https://www.ahqr.gov/workingforquality/about.htm](https://www.ahqr.gov/workingforquality/about.htm)
41. [http://uscompact.org/about/cofa.php](http://uscompact.org/about/cofa.php)

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   Oklahoma has 6 CCBHCs operating statewide for persons with SMI/SED. This includes individuals with co-occurring substance use disorders. Oklahoma CCBHCs coordinates care with primary care physicians utilizing MOUs to ensure all necessary services are provided. A CCBHC must have the capacity to provide all of the following services, as appropriate, based on members' changing needs: screening; assessment; diagnosis; comprehensive care management; care coordination; health promotion; integrated care; crisis services; primary care screening and monitoring; outpatient mental health services, outpatient substance use services, outreach, case management, psychiatric rehabilitation; housing services; employment services; peer support services; family support services; and veterans services.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

   Systems of Care is a comprehensive spectrum of mental health and other support services that are organized into coordinated networks to meet the multiple and changing needs of children, adolescents and their families with a SED. This includes children and adolescents with co-occurring substance use disorders. Systems of Care provides community based, family driven, youth guided, and culturally competent services statewide. Wraparound is a way to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than services. In addition to addressing the needs of the identified youth, Wraparound plans are designed to meet the needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people’s social support network.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? [Yes] [No]

   b) and Medicaid? [Yes] [No]

4. Who is responsible for monitoring access to M/SUD services provided by the QHP? The Oklahoma Department of Mental Health and Substance Abuse Services

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? [Yes] [No]
6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education
   b) Health risks such as
      ii) heart disease
      iii) hypertension
      iv) high cholesterol
      v) diabetes
   c) Recovery supports

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
   Oklahoma is part of a SAMHSA technical assistance process to look at parity and has formed a coalition that includes ODMHSAS, the State Insurance Commission and other stakeholders to further address opportunities. ODMHSAS along with the Insurance Commission have participated in public outreach and education. A challenge beyond parity compliance is the number of Oklahomans employed through small business (exempt), low provider rates and a growing number of professionals who do not accept insurance.

10. Does the state have any activities related to this section that you would like to highlight?
    Oklahoma was awarded SAMHSA's CCBHC Planning Grant in 2016 and was then selected as one of 8 states for the CCBHC demonstration program to improve access to high quality behavioral health services. Oklahoma CCBHC's began operating as a CCBHC under SAMHS'S Demonstration grant in April of 2017. Oklahoma obtained a CMS State Plan Amendment for CCBHC in 2019. Oklahoma currently has 6 total CCBHCs, serving in 77 individual locations; 3 Demonstration site CCBHCs and 3 SPA CCBHCs. The purpose of Oklahoma CCBHCs is to: provide access to integrated services for all individuals regardless of pay source or ability to pay; provide a full array of mental health and substance use disorder services available in every certified location, and provide, or coordinate with, primary care services; provide quality driven services as demonstrated through data reports and outcomes reports generated by the ODMHSAS or its contractor; and provide enhanced integration and coordination of mental health, primary, and substance use disorder services and supports for persons across the lifespan. Services and supports will be delivered utilizing an interdisciplinary, team-based approach.
    To ensure enhancement of current behavioral health services and integrated care services, CCBHCs must provide the following services. Care coordination and collaboration guide all aspects of treatment. Services must be integrated and address both physical and behavioral health needs of consumers. Services must also be data driven. CCBHCs must use data to determine outcomes, monitor performance, and promote health and wellbeing.
    Please indicate areas of technical assistance needed related to this section

   None Needed

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities\textsuperscript{42}, Healthy People, 2020\textsuperscript{43}, National Stakeholder Strategy for Achieving Health Equity\textsuperscript{44}, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)\textsuperscript{45}.

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

The HHS Secretary's top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”\textsuperscript{46}

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status\textsuperscript{47}. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations\textsuperscript{48}. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

\textsuperscript{42} http://www.minorityhealth.hhs.gov/npha/files/Plans/HHS/HHS_Plan_complete.pdf

\textsuperscript{43} http://www.healthypeople.gov/2020/default.aspx

\textsuperscript{44} http://www.minorityhealth.hhs.gov/npha/files/Plans/NSS/NSS_07_Section3.pdf

\textsuperscript{45} http://www.ThinkCulturalHealth.hhs.gov
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   
   a) Race  
   b) Ethnicity  
   c) Gender  
   d) Sexual orientation  
   e) Gender identity  
   f) Age

   ![Yes/No]

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

   ![Yes/No]

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

   ![Yes/No]

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

   ![Yes/No]

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

   ![Yes/No]

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?

   ![Yes/No]

7. Does the state have any activities related to this section that you would like to highlight?

   The ODMHSAS is one of eight states participating in the SAMHSA Certified Community Behavioral Health Center Demonstration Project. As part of the planning process, the ODMHSAS conducted an extensive needs assessment to determine gaps in services, underserved populations, and other disparities occurring in the service delivery system. From February through September, 2016, 23 different events were held across the State to gather meaningful stakeholder input. These included listening sessions, surveys, and focus groups with participants comprised of youth and adult clients, family members, military groups, tribes, and community and state organizations. The CCBHCs as well as ODMHSAS staff were able to hear this input loud and clear and take action to improve care. In addition, data analysis was conducted utilizing several sources for the needs assessments. County-level census data was heavily employed to compare the general population’s demographics to persons currently served and also to the staff. Examples of demographic and cultural variables include race, ethnicity, language, disability, and military status. Multiple tables were produced to display data by agency locations so weaknesses at the site or agency level could be addressed. In addition, a staff survey was administered by the ODMHSAS to determine distribution of sexual orientation, disability, lived experience/family member, race, age, gender, languages spoken, length in the MH system and at agency, license/certificate/credential held, EBPs trained in, and primary age group of clients seen. Agencies also conducted “walk-throughs” to access handicap accessibility, and culturally inclusive signage, paperwork, and art work. Through this process, the ODMHSAS has gained valuable insight into the health disparities occurring and is working on identification and management of serious chronic diseases and health conditions such as diabetes, hypertension and heart disease. In 2020 the CCBHCs conducted another round of needs assessments to address any new disparities. The remaining CMHCs have all received SAMHSA expansion grants and have or are currently conducting needs assessments to address health disparities.

   Please indicate areas of technical assistance needed related to this section
   
   Not Needed

Footnotes:


Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question
While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, \( V = \frac{Q}{C} \)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,\(^49\) The New Freedom Commission on Mental Health,\(^50\) the IOM,\(^51\) NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).\(^52\) The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”\(^53\) SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS)\(^54\) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT)\(^55\) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.


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


53 http://psychiatryonline.org/

54 http://store.samhsa.gov

55 https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☑ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☑ Quality measures focused on consumer outcomes rather than care processes.
   g) ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
   h) ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Through a collaborative process with the Community Mental Health Center (CMHC) provider community, the Oklahoma Health Care Authority (OHCA), and the state’s Medicaid agency, ODMHSAS was able to accomplish something that many cash-strapped state agencies are seeking to do; that is, improve quality of care, increase provider payments, and serve more people in need (https://www.nasmhpd.org/sites/default/files/The%20Oklahoma%20Enhanced%20Tier%20Payment%20System%20Final.pdf). Twelve measures make up the pay-for-performance program, called the Enhanced Tier Payment System (ETPS). Additional payments are made to the CMHCs based on the data outcomes of these twelve measures. The outcomes are based on how close to the benchmarks each CMHC comes for each of the 12 measures, with the goal to improve consumer outcomes.

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

None Needed

Oklahoma

Footnotes:
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset.*

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - Yes • Yes
   - No • No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes • Yes
   - No • No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

EBP: RAISE NAVIGATE
- Family and Children's Services is a CMHC with a full array of services available. They are located in Tulsa and serve all of Tulsa County. Tulsa is one of the two urban areas in Oklahoma that have a population large enough to support a full RAISE NAVIGATE Early Treatment Program and Family and Children's
- Red Rock Behavioral Health recently became a CCBHC as of April 1 2017. Red Rock is one of two large Community Mental Health Centers in Oklahoma County. This agency services the entire county and has the resources to provide and support this EBP.

EBP: Individual Placement Services (IPS)
IPS is being implemented statewide.

EBP:
Cognitive Behavioral Therapy (CBT) and Recovery Oriented Cognitive Therapy (CT-R) - currently in the process of implementation at all 13 Community Mental Health Centers.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
   Through frequent trainings offered both independently and through our Annual statewide conferences. Through contracting statewide for eSMI Outreach and engagement with eSMI EBPs.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?
   Yes
   No

5. Does the state collect data specifically related to ESMI?
   Yes
   No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?
   Yes
   No

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.
   RA1SE NAVIGATE is a Coordinated Specialty Care model that is a collaborative, recovery oriented approach involving clients, treatment team members, and when appropriate, family, as active participants. This comprehensive early treatment model is focused on helping young people age 16-30 who have experienced their first episode of psychosis within the last two years to help them be more successful in their homes and in their communities. The team of providers consists of: Individual Therapist/IRT Specialist, Family Clinician, Supported Education and Employment (SEE) Specialist, and a Psychiatrist. A Case Manager and Peer Recovery Support Specialist are recommended but not required by the model.

   Cognitive Behavioral Therapy (CBT) and Recovery Oriented Cognitive Therapy (CT-R)

   Individual Placement Services (IPS)

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state’s ESMI programs including psychosis?
   Over the next two FFY’s we plan to:
   • Identify tools to effectively measure data specifically related to FEP/NAVIGATE outcomes
   • Work with RA1SE NAVIGATE Training Team ((which consists of Susan Gingerich, Shirley Glynn, Dr. Piper Meyer-Kalos, and Dr. Delbert Robinson) to implement fidelity measures for the RA1SE NAVIGATE model.
   • Fully implement CBT and CT-R specific to eSMI within all CMHCs
   • Implement First Episode Psychosis Crisis Care program in Oklahoma City
   • Further develop statewide outreach efforts for early identification and intervention for SMI

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.
   Currently the NAVIGATE sites have been collecting and reporting data related to the young person’s problems, functioning, and hopefulness (based on self-reports of the young person and an assigned staff member) throughout the time that a young person is enrolled in NAVIGATE Services.

10. Please list the diagnostic categories identified for your state’s ESMI programs.
    Our two NAVIGATE programs are serving those age 16 – 30 who are newly diagnosed (in the past two years) with a Schizophrenia-Spectrum Disorder (Schizophreniform Disorder, Schizophrenia, or Schizoaffective Disorder).

    Our eSMI serving programs for non-FEP are serving those age 16-30 who are newly diagnosed with a mental illness and meet criteria for Serious Mental Illness.

    Please indicate areas of technical assistance needed related to this section.
    None Needed

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Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?  Yes  No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
   N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
   The state has policy in place that requires service providers to actively engage consumers, and their caregivers when applicable, in the development and update of their plan of service. The ODMHSAS offers training to assist service providers with successful engagement and communication.

4. Describe the person-centered planning process in your state.
   The ODMHSAS encourages providers to use person-centered planning. The ODMHSAS offers a comprehensive training that assists service providers with understanding how to more fully implement person-centered planning in all aspects of the service process (from assessment, to plan development, to the provision of services, to on-going evaluation of progress). The training also addresses how this process translates to clinical documentation (in a way that is collaborative with the person served and conducive to self-direction). A web-based version of this comprehensive training has recently gone live; greatly increasing provider access and ultimately improving the person-centered planning process in Oklahoma.

   To further reinforce the person-centered planning process, the ODMHSAS and OHCA requirements for clinical progress notes allow for time spent by the service provider and the consumer completing a treatment progress note together to be compensable. Time spent by the service provider completing the progress note without the consumer is not compensable.

   The Oklahoma Administrative Code (OAC 450:15) assures that each consumer is informed of their right to designate a family member or other concerned individual as their treatment advocate, to participate in consumer treatment planning and discharge planning to the extent consented to by the consumer.

   Person centered and strengths based service planning are required in all state funded and certified programs. Training events referenced earlier, provide on-going staff development to further expand skills and awareness in this area. In addition, training opportunities with regard to strengths-based case management also help with continued development. The increased presence of Peer Recovery Support Specialists within ODMHSAS funded organizations assists with promoting and supporting shared-decision making. As previously mentioned, consumers are able to name a treatment advocate to help with making sure their wishes are known and addressed. In addition, consumers are afforded full access to the Office of Consumer Advocacy to assure that their voices and concerns are addressed on a timely and individualized basis.

   Person centered and strengths based service planning are required in all state funded and certified programs. Training events referenced earlier, provide on-going staff development to further expand skills and awareness in this area. In addition, training opportunities with regard to strengths-based case management also help with continued development. The increased presence of Peer Recovery Support Specialists within ODMHSAS funded organizations assists with promoting and supporting shared-decision making. As previously mentioned, consumers are able to name a treatment advocate to help with making sure their wishes are known and addressed. In addition, consumers are afforded full access to the Office of Consumer Advocacy to assure that their voices and concerns are addressed on a timely and individualized basis.

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

None Needed
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: [http://www.samhsa.gov/sites/default/files(grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf]. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
   - Yes ☐ No ☑

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
   - Yes ☐ No ☑

3. Does the state have any activities related to this section that you would like to highlight?
   - The ODMHSAS utilizes multiple programs and staff to assure compliance and appropriateness related to the SABG and MHBG programs. The following functions are included within the ODMHSAS approach to program integrity and compliance monitoring.
     - The Director of Provider Compliance and Assistance reports directly to the Deputy Commissioner for Treatment and Recovery Services. This function monitors contract compliance and performance for provisions related to SABG and MHBG funded treatment services.
   - Please indicate areas of technical assistance needed related to this section
   - None Needed

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Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

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

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
   The Oklahoma Department of Mental Health and Substance Abuse conducted two formal tribal state consultations last year.

2. What specific concerns were raised during the consultation session(s) noted above?
   Priorities brought up during consultation included:
   a) Collaboration with tribal opioid response grants to address the Opioid crisis together
   b) Follow-up meetings and continued discussion between the tribes and ODMHSAS
   c) Development and establishment of Tribal Behavioral Health Association
   d) Provision of insight into specific processes of services
   e) Continued partnerships, especially for state and tribal grants to address priorities together

3. Does the state have any activities related to this section that you would like to highlight?
   The Oklahoma Department of Mental Health and Substance Abuse continues to actively develop partnerships with tribal governments and other tribal serving organizations to ensure maximum and effective prevention and treatment efforts within communities. These efforts are made available through all of our departments and tribal liaison in the following: training, technical assistance, data provision, data collection, and meetings of collaboration and consultation.
   Activities for the last year include formal consultations, collaborations, and partnerships with the 39 tribes located in the state of Oklahoma. The tribal liaison for the department attended community meetings, tribal grant advisory councils, tribal consortiums, tribal state workgroups, and responded to technical assistance requests from tribal governments, tribal organizations and state contracted agencies. Topics addressed during these activities included prevention, substance abuse treatment, drug court, opioid crisis, reentry programs and cultural competence.
   Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

**Assessment**

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   - Yes
   - No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)
   - Data on consequences of substance-using behaviors
   - Substance-using behaviors
   - Intervening variables (including risk and protective factors)
   - Other (please list)
   - Capacity Assessment, Community Readiness Survey, Coalition Readiness Assessment, Organizational Capacity Assessment.

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
   - Cultural/ethnic minorities
   - Sexual/gender minorities
   - Rural communities
   - Others (please list)

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)

Prescription opioid overdose-related deaths (number and rate) (Sources: National Vital Statistics System, Oklahoma Fatal Unintentional Poisoning Surveillance System)

Alcohol poisoning-related deaths (number and rate) (Source: National Vital Statistics System, Oklahoma Fatal Unintentional Poisoning Surveillance System)

Chronic liver disease deaths (number and rate) (Source: National Vital Statistics System)

Drug overdose-related hospitalizations (number and rate) (Source: Oklahoma Inpatient Hospital Discharge Data) Prescription opioid-related hospitalizations (number and rate) (Source: Oklahoma Inpatient Hospital Discharge Data)

Alcohol-related motor vehicle crash fatalities (number and rate) (Source: National Highway Safety Administration, Fatal Analysis Reporting System)

Alcohol-related motor vehicle crashes (number and rate) (Source: Oklahoma Highway Safety Office) Alcohol-related arrests (number and rate) (Source: Oklahoma State Bureau of Investigation)

Drug-related arrests (number and rate) (Source: Oklahoma State Bureau of Investigation)

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

Prescription Drug Monitoring Program data

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?  
   - Yes  
   - No

If yes, (please explain)

The ODMHSAS utilizes needs assessment data, epidemiological and capacity indicators, to make decisions about the allocation of SABG primary prevention funds. The State Tribal Epidemiological Outcomes Workgroup (STEOW) and the staff epidemiologist are tasked with analyzing the state epidemiological data to determine problem or emerging alcohol, tobacco, and other drug consumption and consequence patterns using CSAP data recommendations – national source, state level, validity, trend, consistency, and sensitivity. The STEOW determines a score for each substance with consequence indicators. Time trends are analyzed, and regression analysis performed for each indicator. The constructs/indicators identified by this process are prioritized for SABG funding, and resources are allocated to Community Based Prevention Service providers for prevention services.

Prevention sub-recipients are required conduct local data collection and analysis to identify which of the state-issued priorities will be their focus and to identify populations of focus. In addition to epidemiological data, the ODMHSAS conducts state and community level needs assessments in the areas of coalition capacity, community readiness, workforce training and technical assistance needs, public health competencies, and infrastructure capacity.

If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Capacity Building**

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  
   - Yes ☑️ No ☐

   If yes, please describe
   The Oklahoma Drug and Alcohol Professional Counselor Association (ODAPCA) is the certifying body in Oklahoma for Certified Prevention Specialist (CPS) and Associate Prevention Specialist (APS), which is recognized by the International Certification and Reciprocity Consortium. All individuals working under sub-recipient contracts of the SABG for prevention in Oklahoma are required to be CPS or APS within 18 months of employment. The ODMHSAS provides prevention workforce training and technical assistance to the substance abuse prevention workforce, including Prevention Ethics, Substance Abuse Prevention Specialist Training, and a myriad of SPF and evidence-based strategy related training.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  
   - Yes ☑️ No ☐

   If yes, please describe mechanism used
   The ODMHSAS routinely conducts assessment of workforce needs. A comprehensive plan has been developed to address needs identified. The plan contains priorities in the areas of: data collection, analysis and reporting; coordination of services; training and technical assistance; and performance and evaluation. Areas of need related to training and technical assistance included:
   1. The infrastructure to gather, assess, and disseminate available data on substance abuse and its contributing factors and impacts in communities
   2. A common training and technical assistance (TTA) program
   3. TTA related to culturally appropriate prevention programs
   4. Linking and coordinating the Substance Abuse Prevention Strategic Plan with state and local prevention initiatives
   5. Planning strategic prevention initiatives at the community level that are comprehensive, community specific, evidence-based, and data-driven
   6. Ongoing technical assistance that promotes the collection of valid outcome data.

   The ODMHSAS will continue to pursue strategies to build the capacity of its prevention system in several key ways, including formalizing prevention standards, standardizing the delivery and monitoring of prevention training and technical assistance, and providing increased training and consultation at the community level. To this end, the ODMHSAS has partnered with the Oklahoma State Department of Health and Oklahoma Tobacco Settlement Endowment Trust to develop the Public Health Academy of Oklahoma (PHAO). The PHAO project will (1) plan and deliver a regular Public Health Institute to improve public health core competencies among the prevention workforce; (2) offer an online Learning Management System (LMS) to conduct regular, distance learning opportunities for Oklahoma’s diverse workforce; and (3) provide an Online Learning Community to increase linkages at the local-local and state-local levels among community-based prevention providers. The PHAO represents a significant step forward in building the capacity of Oklahoma’s prevention workforce and leverages resources to unite public health systems in the state around shared workforce needs. Additionally, the ODMHSAS prevention system is integrated, meaning the SABG is
intentionally aligned with the SPF and shares an infrastructure with Oklahoma’s SPF PFS initiative. Oklahoma will continue to work collaboratively with the PTTC system on additional training needs through regular capacity planning. Capacity planning and TTA development is conducted in partnership with the Cherokee Nation (a tribal PFS grantee) and Southern Plains Tribal Health Board (SPTHB) and made available to the full prevention workforce, including Drug Free Communities grantees.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  
   
   If yes, please describe mechanism used
   Subrecipients are required to conduct community readiness assessments within the first year and routinely thereafter. Prevention contractors report community readiness outcomes and progress toward improvement to the ODMHSAS.
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Planning**

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan. 

   See attached

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)
   - Yes
   - No
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   
   a) ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) ☐ Timelines
   c) ☐ Roles and responsibilities
   d) ☐ Process indicators
   e) ☐ Outcome indicators
   f) ☑ Cultural competence component
   g) ☑ Sustainability component
   h) ☑ Other (please list):

   - Evidence- Based Strategies; Logic Model; Workforce Structure
   i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  
   - Yes  
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  
   - Yes  
   - No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.

The Evidence Based Practices Workgroup was established in 2011 and actively supports subrecipients’ implementation of the SPF for the SABG priorities. The Workgroup includes academic researchers, prevention professionals, tribal government representatives, prevention evaluators, and key state agency representatives. The EBP Workgroup conducts reviews of subrecipient workplans, develops evidence-based intervention matrices and guidance documents, and advises subrecipients in selection, adaptions, and fidelity issues. Plans to sustain the EBP Workgroup include a review of existing evidence-based matrices on prescription drug abuse prevention interventions, intervention cost/benefit evaluation, expanded application to other...
prevention fields, and ongoing membership evaluation and recruitment.
6. Information Dissemination providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

2. Education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. Alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. Problem Identification and referral that aims at identification of those who have indulged in illegal or age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. Community-based Process that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. Environmental Strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Implementation**

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) SSA staff directly implements primary prevention programs and strategies.
   b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) The SSA funds regional entities that provide training and technical assistance.
   e) The SSA funds regional entities to provide prevention services.
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   g) The SSA funds community coalitions to provide prevention services.
   h) The SSA funds individual programs that are not part of a larger community effort.
   i) The SSA directly funds other state agency prevention programs.
   j) Other (please describe)

   Funded Oklahoma Conference of Churches.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

      The ODMHSAS supports a state-level prevention “Ok, I’m Ready” campaign which serves as a resource for print and electronic materials. Making extensive use of private and public resources, the “Ok, I’m Ready” campaign provides materials to all Community Based Prevention Service (CBPS) providers and to other prevention and treatment programs in the state, public and private schools, faith organizations, public and private agencies, state and local governmental officials, and private citizens within the State. The Prevention Resource Center also researches, plans, executes, and evaluates strategic community outreach efforts at large scale Oklahoma venues reaching defined populations related to the State’s data driven prevention priorities. In addition, CBPS providers utilize specific local materials and create print materials specific to their communities needs however new materials must be reviewed and approved by ODMHSAS.

   b) Education:

      The ODMHSAS and its prevention contractors are the single largest deliverer of substance abuse prevention education in the State. At the state level, the ODMHSAS offers training in public health competencies (SPF), prevention ethics, Substance Abuse Prevention Skills Training (SAPST), community and law enforcement youth access to alcohol training, youth leadership development, and numerous trainings on evidence-based prevention practices. Statewide, the Alcohol Beverage Law Enforcement (ABLE) Commission and the Responsible Beverage Sales and Service (RBSS) training provider
conduct skill-based community and coalition trainings to build local capacity on topics such as public health principles, identifying signs and symptoms of behavioral health problems, coalition development, collection and use of risk and protective factor data, and evidence-based prevention approaches. Additionally, the CBPS providers conduct opioid overdose prevention education and prescribing guidelines to communities and local organizations.

c) Alternatives:

Prevention providers with youth leadership coalitions on the prevention of underage drinking and provide support to these groups for alcohol and drug-free youth activities and drug-free community events/venues. Funded CBPS providers work with local event organizers to establish written agreements to offer alcohol and drug-free activities within the communities they serve.

d) Problem Identification and Referral:

Printed information about resources in local service areas and throughout the State are provided to Oklahomans who asked about referrals for alcohol, tobacco, or drug addiction. The ODMHSAS distributes referral information for statewide prevention agencies, substance abuse treatment programs, and mental health programs that were at least partially supported by the Department. The ODMHSAS offers training to prevention providers and their partners in Mental Health First Aid and Psychological First Aid for post disaster response to build local capacity to respond to emergent referral needs in the course of their primary prevention work. SABG prevention agencies provided no screening or intervention services.

e) Community-Based Processes:

The ODMHSAS continues to focus the efforts of prevention services on coalition development and community mobilization. By spending time promoting and supporting coalitions, CBPS providers will work to increase community engagement in the promotion and implementation of primary prevention ideas, norms, and evidence based public health practices and activities. CBPS will educate local communities on prevention concepts such as community planning, utilizing the Strategic Prevention Framework model, evidence-based practices, and community mobilization. The CBPS provider support a network of community coalitions throughout the state and inform priority communities to develop and implement strategic prevention plans. Additionally, CBPS providers help recruit participants in survey collection such as Oklahoma Prevention Needs Assessment (OPNA) and Adult Prevention Needs Assessment (APNA) while analyzing other social indicator data as needed. This information and other local data allow the coalitions to assess the prevention needs in their area and set priorities, as well as identify and implement programs to target those needs. Coalition development and community-based activities continue to be major components of Oklahoma’s prevention efforts.

f) Environmental:

The ODMHSAS continues to invest in public health, community-level change interventions to impact and sustain population health outcomes. The CBPS providers, in partnership with community coalitions, plan, implement, and evaluate environmental prevention strategies required to incorporate a comprehensive compliment of policy, media advocacy/communication, and community organizing strategies. CBPS providers are required to develop and support the implementation of youth access and other high-risk alcohol prevention efforts in coordination with local and state law enforcement. No SABG funds will be used for actual enforcement.

Environmental prevention strategies implemented in Oklahoma consist of local and state-level prevention policy development, law enforcement, media advocacy, and community organizing methods that limit access to substances and change social norms that are accepting and permissive of substance abuse. Specific evidence-based strategies include alcohol retail training and enforcement of youth access to alcohol, tobacco and other drugs.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

   Yes  No

If yes, please describe

The ODMHSAS carefully plans and coordinates allocation of resources from the SABG, state appropriations, and federal discretionary grants in order to meet state and federal requirements. The ODMHSAS staff monitors providers for compliance and review and approve local plans prior to implementation. Each ODMHSAS Field Representative is assigned provider agencies to monitor each fiscal year. Monitoring includes an annual site visit in addition to ongoing contacts with the agencies throughout the year to stay up-to-date on the agencies’ needs, performance data, and to assess/deliver technical assistance. The annual site visit consists of a review of records, policies and procedures, staff credentials and training, billing, and other information gathering to insure all block grant requirements is adhered to as required. The ODMHSAS also reviews records and provides training to contractors on the appropriate use of SABG primary prevention funds.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Evaluation**

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No
   
   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - [ ] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - [ ] Includes evaluation information from sub-recipients
   - [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - [ ] Establishes a process for providing timely evaluation information to stakeholders
   - [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - [ ] Other (please list:)
   - [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - [ ] Numbers served
   - [ ] Implementation fidelity
   - [ ] Participant satisfaction
   - [ ] Number of evidence based programs/practices/policies implemented
   - [ ] Attendance
   - [ ] Demographic information
   - [ ] Other (please describe:)

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - [ ] 30-day use of alcohol, tobacco, prescription drugs, etc
   - [ ] Heavy use
   - [ ] Binge use
   - [ ] Perception of harm
c) ✓ Disapproval of use

d) ✓ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) Other (please describe):
PREVENTING
Mental, Emotional
& Behavioral Disorders
OKLAHOMA STRATEGIC PLAN
Our Vision
The Strategic Plan provides a vision for Oklahoma in which everyone is provided the opportunity to achieve a state of health and well-being free from problems related to mental, emotional, and behavioral disorders.

Our Mission
The mission of this Strategic Plan is to:

- Implement effective prevention strategies that are evidence-based and accountable to the people of Oklahoma.
- Leverage the power of community leadership.
- Enhance the capacity of communities, schools, healthcare providers, workplaces, and families to forever practice prevention.

Overview of Prevention & Promotion
Prevention takes many forms, but can be defined as, “Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder.” Mental health promotion is defined as, “Interventions that aim to enhance the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity.” (Institute of Medicine, Preventing Mental, Emotional and Behavioral Disorders Among Young People)

Visually depicted, prevention is an array of interventions necessary to support and promote healthy mental, emotional, and behavioral development. Often referred to as “the continuum”, the figure above is meant to convey the interconnectedness between prevention and treatment interventions as well as to distinguish each stage in the spectrum. Updated in 2019, the National Academy of Sciences modified the continuum to highlight the need for active promotion of healthy development across the entire population, significantly increasing the scope of promotion and prevention to reflect their importance.
Prevention Service Standards

The ODMHSAS Prevention Services Division develops, funds, and oversees a portfolio of services to prevent the onset and progression of mental, emotional, and behavioral problems. To maintain the highest quality and most effective prevention system, it is essential that Oklahoma’s prevention workforce deliver services aligned with the following standards.

Guiding Principle #1: Our services are rooted in prevention science.

1. Mental, emotional, and behavioral problems are preventable. Prevention exists on a continuum that includes primary, secondary, and tertiary as well as interventions that promote overall wellbeing.

2. Mental, emotional, and behavioral problems are developmental, and opportunities for preventive intervention exist beginning at pre-conception and throughout the lifespan, with a particular focus on children, youth, and young adults.

3. How people develop is a function of complex interactions of biopsychosocial processes. Individuals exist within complex systems such as neighborhoods, families and schools that are, in turn, nested within a larger community and culture. Prevention strategies are required at the individual and population levels.

4. Prevention science has identified risk factors at the biological, psychological, family, community, and cultural levels that precede the development of problem outcomes. Conversely, protective factors can reduce or buffer against risk for future problems. Research continues to build upon this framework, including the integration of Adverse Childhood Experiences (ACEs) and trauma, to further understanding of how substance use and mental health problems develop. Prevention practices aim to identify and decrease risk and increase protection.

5. Risk for the development of many common mental, emotional, and behavioral problems is strongly associated with underlying conditions known as social determinants of health. These include poverty, education, healthcare, and discrimination. The accumulation of advantage and disadvantage leads to social and economic inequities and consequently to inequitable mental and physical health outcomes.

Guiding Principle #2: We use a comprehensive planning & implementation framework.

Prevention planners are pressed to put in place solutions to urgent problems facing communities. But research and experience have shown that prevention must begin with an understanding of these complex behavioral health problems within their environmental contexts; only then can communities establish and implement effective plans.

To facilitate this understanding, SAMHSA developed the Strategic Prevention Framework (SPF). The five steps and two guiding principles of the SPF offer preventionists a comprehensive approach to understand and address behavioral health problems facing their communities. Similarly, schools undertaking comprehensive planning for the prevention and treatment of mental, emotional, behavioral problems utilize frameworks such as Multi-Tiered Systems of Support (MTSS) and Interconnected Systems Framework (ISF), which can be successfully guided by the SPF.

The SPF includes these five sequential steps:

1. Assessment: Identify prevention needs based on data (e.g., What is the problem?)
2. Capacity: Build resources and readiness to address prevention needs (e.g., What do you have to work with?)
3. Planning: Find out what works to address prevention needs and how to do it well (e.g., What should you do and how should you do it?)
4. Implementation: Deliver evidence-based programs and practices as intended (e.g., How can you put your plan into action?)
5. Evaluation: Examine the process and outcomes of programs and practices (e.g., Is your plan succeeding?)

The SPF is also guided by two essential cross-cutting principles that should be integrated into each of the steps:

1. Cultural competence. The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.
2. Sustainability. The process of building an adaptive and effective system that achieves and maintains desired long-term results.
Guiding Principle #3: We utilize evidence-informed interventions.

To ensure publicly-funded prevention services are effective, the ODMHSAS supports programs and practices that meet the following criteria established by the SAMHSA and further refined by the Oklahoma Evidence Based Practices Workgroup:

Tier 1) Documented on a national registry of evidence based practices as identified by the ODMHSAS;
Tier 2) Documented in a peer-reviewed publication that demonstrates positive effects based on the evaluation of the targeted causal or contributing factor(s); or
Tier 3) Documentation that illustrates the strategy has been effectively implemented in the past, multiple times, with results that show a consistent pattern of positive effects.

Prevention approaches not meeting these standards are carefully examined prior to selection and monitored. All evidence-informed prevention interventions are also assessed for fit (matches population of focus, prioritized problems/issue), feasibility (matches resources, timeline) and potential negative effects or risks.

Guiding Principle #4: Our services are inclusive, culturally informed, and seek to maximize health for all.

The ODMHSAS recognizes that health disparities and health equity are essential in the planning and delivery of prevention services. Health disparity arises from social, economic, or environmental disadvantage resulting in someone’s relative position socially—an order in which individuals or groups can be separated by their economic resources, as well as by race, ethnicity, religion, gender, sexual orientation, and disability. Use of the Culturally and Linguistically Appropriate Services (CLAS) standards includes effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, and health literacy.
Guiding Principle #5: We are a hopeful, capable, and accountable prevention workforce.

The practice of prevention is both an art and a science. Therefore successful professionals in this field seek to develop a breadth and depth of experience in both. Due to our belief in the change process, change theory, and our role as change leaders, our goal is to hone our practice toward the ends of solving social problems and pursuing increased wellness and benefit. The public entrusts us with these duties as well as resources to carry them out, therefore we maintain a high sense of accountability to those we serve.

The science of prevention relates to continually educating oneself and engaging in the process of on-going evaluation and research towards our goals. We constantly seek knowledge in our field as well as related fields. We thoughtfully and strategically document and learn from our own work. We are committed to continual improvement of process and outcomes. Our problem-solving and decision-making is informed by the best evidence.

The art of prevention concerns developing our personal strengths and talents as well as the strength and talents of our colleagues and the systems in which we work towards a more prevention-oriented way of being and operating. We adapt and apply the research to the specific needs and cultures of those we serve. We learn to put the science into practice in a way that fits into the lives, capacity, and readiness of those we serve. We operate from a sense of ethics, integrity, and transparency. We acknowledge the rights of those we serve and develop plans and strategies in partnership with those we serve. We are adaptive, strategic, holistic thinkers. We are leaders in helping our communities envision a more prevention-oriented world.

Strategic Priorities

Epidemiological data identify problems, help determine what areas and who are affected by problems—knowledge that is essential for effective intervention—and measure the success of interventions aimed at preventing or reducing these problems. Engagement in careful assessment of needs, resources, capacity, readiness, and contextual conditions—prior to selecting strategies—is essential to successful prevention efforts.

This data focus—collection, analysis, and use—is entrenched in each step of the SPF and continually informs the prevention process. The formal assessment of contextual conditions, needs, resources, readiness, and capacity is used to identify priorities in Step 1. In Step 2, data are shared to generate awareness, spur mobilization, and leverage resources. In Step 3, assessment data are used to drive the development of a strategic plan and guide the selection of evidence-based strategies. Data are used in Step 4 to inform (and, if necessary, revise) the implementation plan. And finally, data are collected to monitor progress toward outcomes, and findings are used to make adjustments and develop sustainable prevention efforts.

The ODMHSAS Prevention Services reviewed epidemiological data to identify strategic directions over the next five years. The assessment identified the following prevention priority areas (listed in alphabetical order):

- Alcohol Use
- Depression & Psychological Distress
- Marijuana Use
- Opioid Use
- Stimulant Use
- Suicide
- Tobacco Use
**Consequence**

These negative Outcomes...

- Suicide Attempt and Death
- Drug Overdose Injury and Death
- Chronic Diseases/Disorders, Including Substance Use Disorder, Mental Health Disorder
- Child Maltreatment
- Academic Failure
- Fatalities & Serious Injury from Traffic Crashes

**Problem Areas**

Result from these types of problem areas...

- Youth alcohol, marijuana, prescription opioid, and tobacco use
- Youth depression and psychological distress
- Adult problem alcohol, marijuana, opioid, stimulant, and tobacco use
- Adult depression

**Intervening Variables**

Driven by these common factors...

- Access to substances
- Favorable attitudes to substance use
- Peer norms and low perception of disapproval
- Early initiation of use; intention to use
- Favorable parental attitudes to substance use
- Family conflict
- Poor parent communication
- Low commitment to school
- Low perception of risk
- Low neighborhood attachment
- Rebelliousness
- Depressive symptoms
- Adverse childhood experiences
- Unemployment
- Depression, anxiety
- Mental health/substance use disorders
- Loneliness, social support
- Access to lethal means
- Socio-economic status
- Incarceration

**Strategies**

...Can be addressed by installing these prevention services within and between sectors.

- Schools
  - MTSS, Multi-Tiered Systems of Support Development
  - School-Based Primary & Secondary Prevention Programs
  - Nurturing Practices
- Communities
  - Community Coalition Organizing, Problem Solving & Community Design
  - Outreach & Education Services
  - Safety Planning
  - Action-Oriented Prevention Communication Campaigns
- Healthcare
  - Screening and Brief Intervention
  - Care Management and Referral
  - Safety Planning
  - Prescribing Guidelines
  - Prevention Education
- Employers
  - Mental Health Literacy
  - Workplace Suicide Prevention and Mental Health Promotion
  - Responsible Alcohol & Tobacco Sales, Training & Enforcement
- Families
  - Parent Supports
  - Family-Based Prevention Programs
  - Home Safety

Oklahoma's outcome-driven logic model visually depicts the prevention system change process. Priorities are elevated at the state-level to identify key areas for improvement. The model presents a roadmap of cause-effect relationships and preventive actions to be taken.

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**PREVENTING Mental, Emotional & Behavioral Disorders**

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Prevention System Infrastructure

An effective state prevention system requires a strong infrastructure that supports high-quality service delivery. The ODMHSAS Prevention Services will strive to advance the following infrastructure priorities:

Partnerships

- Build upon the success and aid in the future development of existing state-level prevention organizing bodies through continued ODMHSAS leadership or support such as the Oklahoma Rx Workgroup, Oklahoma Suicide Prevention Council, and the SBIRT-OK Collaborative.

- Support the State Epidemiological Outcomes Workgroup and Evidence-Based Practices Workgroup to provide the ODMHSAS prevention system with critical, guiding expert consultation for data and best practice implementation.

- Maximize interagency state partnerships, including focused prevention endeavors with the Oklahoma State Department of Education, Oklahoma Department of Veterans Affairs, Oklahoma Regents for Higher Education, Oklahoma State Department of Health, Oklahoma Juvenile Affairs, and Oklahoma Department of Human Services.

- Develop an ODMHSAS prevention ‘Collaboratory’ comprised of contracted service providers, consumer groups, and other key prevention stakeholders to regularly convene for cross-sector learning, peer sharing, and state system planning.

- Understand and help elevate policy or other systemic solutions that can improve prevention outcomes in the state; maintain connection to prevention-related policy committees.

Workforce

- Continue to support the development of certified prevention specialists while cultivating a diverse workforce of laypersons and professionals in other fields who can serve as preventionists.

- Provide high-quality prevention training opportunities, including a regular Prevention Academy and Prevention Grand Rounds.

- Provide high-quality consultation and technical assistance to the prevention workforce through capable, customer-service oriented staff who serve assigned providers, constituents, and communities.

- Utilize practice dissemination models – structured processes of teaching and installing research-based practices - to widely disseminate and sustain evidence-based prevention.

Data

- Develop the ODMHSAS capacity to support prevention data collection, analysis, and utilization under the leadership of dedicated epidemiologists and data specialists.

- Provide high utility data products to the Oklahoma prevention system, including web-based dashboards and query systems as well as custom products for communities, population groups, and issue-based reports.

- Develop a centralized, uniform reporting system for improved ODMHSAS prevention performance monitoring.

- Actively seek solutions to address identified data gaps that create barriers to understanding and measuring prevention needs.

Resources

- Allocate resources to the sectors best positioned to influence and install prevention; diversify prevention funding allocations to include schools, communities, faith, families, healthcare, and business/workplaces.

- Actively seek funding for Oklahoma to support the advancement of this plan’s strategic priorities.

- Actively support local and state-level organizations in successfully applying for available prevention funds.

- Maintain Oklahoma’s role in the national and regional prevention agenda through active roles with the PTTC, National Prevention Network, SAMHSA, and other key organizations.
Sector Based Prevention System

A sector-based prevention system aims to integrate prevention services within the domains of Oklahomans’ everyday living and experiences. This approach recognizes that Oklahoma cultural norms, influences, and experiences are shaped by several key sectors of living: the family, the educational system, workplaces, neighborhoods and communities at large, the healthcare delivery system, faith communities, and media. Each of these sectors presents opportunities for:

- The delivery of direct prevention services and programs;
- Communication and reinforcement of healthy behaviors and resources;
- Sector leader influence and modeling of healthy behaviors; and
- Policies and practices that shape norms – expectations, attitudes, behaviors.

Investments in a prevention system with specific aims in each of these sectors of everyday living will improve Oklahoman’s wellbeing, reduce risk, and shape new norms related to positive mental, emotional, and behavioral health. This approach relies on a prevention workforce made up of: (1) certified prevention professionals, (2) sector leaders such as physicians, school principals, or business owners who take on prevention responsibilities, and (3) laypersons who adopt, reinforce, and lead prevention-oriented beliefs and practices.

Prevention science helps organize factors that predict (or protect from) the development of mental, emotional, and behavioral problems. These factors, known as risk and protective factors (or intervening variables) can be more easily understood when grouped into domains - typically individual, peer, school, family, and community. The ODMHSAS will organize the state’s prevention service delivery system in the following Oklahoma sectors:

Education
- Common and higher education settings are powerfully formative and important venues for the delivery of direct and indirect prevention services to young people. As employers, education systems also impact the lives and wellbeing of Oklahoma adults. The ODMHSAS will continue to provide leadership in planning and implementing best practice prevention services in schools and college campuses. State-level tools to help education adopt MTSS frameworks will be provided, and prevention programs such as the Pax Good Behavior Game and Botvin LifeSkills will be disseminated.

Families
- Family experiences, circumstances, and relationships are powerful. Family-based risk factors are highly predictive of future mental, emotional, and behavioral problems; in turn, families can offer high levels of protection from problems. The ODMHSAS will offer effective family sector prevention services such as Strengthening Families Program, parent education, and support.

Communities
- Communities are an effective organizing force for bringing evidence-based policies and programs to scale. With the understanding that local issues need local solutions and local leadership, the ODMHSAS will support community and neighborhood-level prevention coalitions across the state to provide community-based prevention services with local partners such as county/municipal governments, school districts, faith communities, and businesses.

Healthcare
- The encounters between healthcare providers and patients are critically important in shaping health behaviors. Screening, education, and planning between healthcare staff and their patients can effectively prevent mental health and substance use problems. The ODMHSAS will support statewide efforts to disseminate best practices in primary care, specialty care, and emergency department settings. Key partnerships with providers, practices, associations/boards, and payors will help embed these approaches in Oklahoman’s routine experience at their doctors’ offices.
Business/Employer
Oklahoma businesses have the high potential to boost employee wellness to protect from the harms of substance use or mental health problems. As gatekeepers in the community, certain Oklahoma businesses such as alcohol retailers, can help guard against harmful consequences by practicing prevention while at work. The ODMHSAS will build upon its prevention investment in the business/employer sector with increased efforts to educate employees, connect them to needed services, and adopt preventive business practices.

Faith:
The ODMHSAS will support faith-based communities across the state to provide prevention services to their congregations and communities. Faith-based sector providers will deliver direct prevention services, link faith-based organizations with community resources, and build relationships between groups at risk in the community.

These sectors will work with the ODMHSAS to uptake prevention within their spheres of influence. The ODMHSAS will seek ways to stimulate collaboration across the sectors in direct and indirect ways. Certain sectors will work directly together to deliver prevention services, other sectors will focus within their own community or organization. Underlying the sector-based prevention work will be a communications plan to broadcast prevention education messages and resources to Oklahomans.
SABG Prevention Evaluation Plan

The ODMHSAS monitors and conducts evaluation on the state and community level in order to assess the level of change on important indicators and gauge strategy effectiveness.

State-Level Evaluation

- The Oklahoma State and Tribal Epidemiological Outcomes Workgroup monitors important alcohol, tobacco, and other drug consequence and consumption indicators on the state as well as when they are significantly related to identified populations of note. The results of this evaluation are reported in the Oklahoma Epidemiological Profile.

Sample Measures

<table>
<thead>
<tr>
<th>Construct</th>
<th>Indicator/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underage Drinking</td>
<td>Current, 30-day alcohol use among youth under age 21</td>
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<tr>
<td></td>
<td>Current, 30-day binge drinking among youth under age 21</td>
</tr>
<tr>
<td></td>
<td>Current, 30-day drinking and driving among youth under age 21</td>
</tr>
<tr>
<td>Adult Binge Drinking</td>
<td>Current, 30-day binge drinking among adults age 18 and older</td>
</tr>
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<td></td>
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</tr>
<tr>
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<td>Adults &gt; 18 years old use of prescription drugs without a prescription in their lifetime</td>
</tr>
<tr>
<td></td>
<td>Adults &gt; 18 years old non-medical use of prescription drugs in the past 30 days</td>
</tr>
<tr>
<td></td>
<td>Current, 30-day use of prescription drugs among 6, 8, 10, and 12 graders</td>
</tr>
<tr>
<td>Methamphetamine Use</td>
<td>Current, 30-day methamphetamine use among 6, 8, 10 and 12 graders</td>
</tr>
<tr>
<td>Marijuana Use</td>
<td>Current 30-day marijuana use among 6, 8, 10 and 12 graders</td>
</tr>
<tr>
<td></td>
<td>Current, 30-day marijuana use among adults age 18-25 and &gt; 26 years old</td>
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<tr>
<td>Alcohol Use During Pregnancy</td>
<td>Any alcoholic drinks during last 3 months of pregnancy, Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Alcohol use during pregnancy</td>
</tr>
</tbody>
</table>

- In addition, the ODMHSAS evaluates the aggregate effectiveness of Core Prevention Services across the state including Responsible Beverage Sales and Service Training (RBSS), 2 Much 2 Lose (2M2L) Law Enforcement Training, and the aggregate effect of local strategies when applicable (e.g. enforcement strategies including alcohol compliance checks.)
Sample Measure

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<tr>
<td></td>
<td>Alcohol-Related Mortality</td>
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<tr>
<td></td>
<td>Alcohol Poisoning Deaths</td>
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</tr>
<tr>
<td>Non-Medical Use of Prescription Drugs</td>
<td>Opioid Overdose Deaths</td>
</tr>
</tbody>
</table>

Local-Level Evaluation

The ODMHSAS utilizes a public health approach termed hereafter as the Strategic Prevention Framework (SPF). The SPF is a community-based approach to prevention and a series of implementation principles intended to produce population-level outcomes. The state invests in Community Based Prevention Services (CBPS) in order to plan and implement alcohol and other drug prevention services. Each CBPS provider is required to develop an approved evaluation plan which includes the following components as they relate to their high need communities:

- National Outcome Measures (NOMs)
- Participation in any other ODMHSAS or SAMHSA required evaluations
- Consequence Data

Sample Measures

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</tr>
<tr>
<td>Youth</td>
<td>Current, 30-day binge drinking among youth under age 21</td>
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<tr>
<td>-------</td>
<td>------------------------------------------------------</td>
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<td>Any alcoholic drinks during last 3 months of pregnancy, Pregnancy</td>
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</table>

- **Intervening Variable Data**

  **Sample Measures**

  Indicator/Measure
  - Retail Access
  - Social Access
  - Visible and Consistent Enforcement of Laws
  - Perception of Risk
  - Perception of Harm
  - Community Norms favorable to use
  - Promotion

- **Process and Outcome Data**

  **Sample Measures**

  - # of Law Enforcement Trainings
  - # Policies Passed / Reach
  - # Practices Changed / Reach
  - # of Media Outputs / Media Reach
  - # of Trainings
  - # of Risk Assessments
- Changes in Community Readiness
  Sample Measures

  Tri-Ethnic Center - Change in Community Readiness Level

- Changes in Coalition Capacity
- Changes in Organizational Readiness
- Other Capacity or Readiness Measures (as needed)
- Oklahoma Prevention Needs Assessment (OPNA)
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The statewide network of CMHCs is primarily responsible for comprehensive services for adults with serious mental illness (SMI). In recent years, this system has also intentionally expanded to proactively support diversion from the criminal justice system. Initiatives within this realm include 13 mental health courts that serve a total of 16 counties, a day reporting center in Oklahoma City, jail-based screenings in both Tulsa and Oklahoma City, statewide training in the Memphis Model Crisis Intervention Training (CIT) program, prison-based treatment for co-occurring mental health and substance use disorders, prison-based discharge planners, and community-based re-entry intensive care coordination teams. In addition, efforts toward integrated care have resulted in the implementation of 21 Health Homes; making primary health care more readily available.

CMHCs, by regulation, must provide the following basic services: Crisis Intervention; Medication and psychiatric services; Case Management; Evaluation and treatment planning; Therapy services; and Psychosocial rehabilitation. In addition, the following services are also made available: Employment services; Housing services; Educational services; Substance Use Disorder services within CMHCs including services for Persons with Co-Occurring Disorders; Medical, Vision and Dental services; Support services (ex: Peer Support services, including Peer Run Drop-In Centers); and Psychiatric Rehabilitation (ex: Clubhouse International Certified Clubhouses). Additional services for children and their families include: Home-based services; Family therapy; Diagnosis-related education; Client advocacy; Outreach; Peer family support; Family self-sufficiency (housing); Socialization; School-based services; and Wraparound.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

   a) Physical Health  [Yes □ No □]
   b) Mental Health   [Yes □ No □]
   c) Rehabilitation services [Yes □ No □]
   d) Employment services   [Yes □ No □]
   e) Housing services    [Yes □ No □]
   f) Educational Services [Yes □ No □]
   g) Substance misuse prevention and SUD treatment services [Yes □ No □]
   h) Medical and dental services [Yes □ No □]
   i) Support services   [Yes □ No □]
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) [Yes □ No □]
   k) Services for persons with co-occurring M/SUDs [Yes □ No □]

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)
3. Describe your state’s case management services

Case management is funded both by the ODMHSAS and the Medicaid program. Since the mid-1990s the ODMHSAS has promulgated the strengths based, person centered case management model to support case management activities in all community and facility settings. Case management services follow a plan approved by the service recipient and qualified staff. Billable activities include referral, linkage, advocacy and follow-up support provided in partnership with the consumer to assist with self-sufficiency and successful integration into community life. All staff that provides publicly funded behavioral case management services are statutorily required to be certified by the ODMHSAS, or possess Oklahoma certification as an Alcohol and Drug Counselor (CADC), or possess Oklahoma licensure as a Behavioral Health Professional (or under state supervision). For ODMHSAS Certification as a Behavioral Health Case Manager, applicants must complete a specified curriculum and examination to be eligible. A dedicated website (http://www.ok.gov/odmhsas/Mental_Health/Behavioral_Health_Case_Management/index.html) provides access to the ODMHSAS certification information for case managers. Multiple entry points are available to attain certification. The ODMHSAS provides options for on-line training of specific elements as well as the ability to test at numerous locations statewide to qualify as reimbursable case managers. The ODMHSAS also recognizes the value of potential workforce members who have case management life experience and maintains a certification option for applicants with 60 college credit hours or a high school diploma with 36 total months of experience working with persons who have a mental illness, additional to those who have completed traditional degree-based programs.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Oklahoma’s service culture embraces a strengths-based and person-centered approach which begins with a thorough assessment of consumer interest, strengths and needs, and the formation of a plan to assist the consumer with successfully achieving their identified goals. The resources and supports necessary for community success are identified and facilitated through collaborative efforts among the consumer, their support systems, and the service provider. This level of focus helps to reduce the use of hospital or other institutional based resources. CMHCs are monitored to assure that services include cooperative discharge planning with inpatient programs and crisis units, early response and crisis intervention programs, and community partnerships with law enforcement. Community Based Structured Crisis Centers provide short term stays and stabilization in lieu of placement in inpatient facilities. Urgent Care Centers in four locations, offer 23 hour 29 minute stabilization services. Other modalities, such as Crisis Intervention Team (CIT) and Program of Assertive Community Treatment (PACT), provide intervention, coordinated care, and successful community integration. Enhancements of early intervention and transitional services for individuals who interface with the criminal justice system also prevent the use of hospitalization as well as incarceration. Further, the Enhanced Tier Payment System (ETPS) discussed elsewhere in this application provides an enhanced payment based, in part, on meeting lower inpatient utilization targets.

The ODMHSAS has also implemented Oklahoma’s Pathway To Recovery Assisted Outpatient Treatment (PTR AOT) program in Oklahoma’s two most heavily-populated counties, Oklahoma and Tulsa, and in four rural counties in Northeast Oklahoma, Rogers, Washington, Ottawa, and Delaware. Oklahoma’s PTR AOT program provides a strengths-based, non-threatening process for ensuring that adults with serious mental illness (SMI), who do not yet recognize the need for treatment, access and participate in effective treatment to safely and successfully achieve an independent life in the community of their choice with hope for the future. A high priority is placed on preventing a need for psychiatric hospitalization or incarceration due to SMI.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>241,864</td>
<td>68,383</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>85,064</td>
<td>28,810</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

2. Oklahoma Department of Mental Health and Substance Abuse Services, data query accessed August 17, 2021
4. Oklahoma Department of Mental Health and Substance Abuse Services, data query accessed August 17, 2021
Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services
  - Yes
  - No

- b) Educational services, including services provided under IDEA
  - Yes
  - No

- c) Juvenile justice services
  - Yes
  - No

- d) Substance misuse prevention and SUD treatment services
  - Yes
  - No

- e) Health and mental health services
  - Yes
  - No

- f) Establishes defined geographic area for the provision of services of such system
  - Yes
  - No
Describe your state’s targeted services to rural population.

Individuals in rural areas generally have access to overall treatment and support systems described in earlier portions of the section. However, 59 of Oklahoma’s 77 counties are considered rural or frontier and the ODMHSAS continues to focus on improved access and providing services in more effective ways for adults and children in rural areas. Examples are discussed below.

• Children and their Families in Rural Areas. All rural CMHCs provide case management services to children. Most of the treatment is provided in the child’s home or a community based location. Transportation continues to be a problem in rural areas of the state. Of the state’s 74 Systems of Care counties, 71 are located within rural settings. These sites engage a broad stakeholder base to coordinate care, leverage resources, and improve services to children and their families in rural settings.

• Adults Accessing Mental Health Services in Rural Areas. Ten CMHCs serve the rural areas of the state. All offer the required mental health services and also purchase or provide local acute inpatient treatment or crisis services to stabilize individuals on emergency orders of detention. Case management services and flexible funds for case managers in rural areas provide in-home support for isolated individuals and assist in purchasing needed goods and services not otherwise available. Most ODMHSAS certified residential care facilities are located in rural counties in the far northeast corner of the state. CMHCs target additional services to these facilities including general psychosocial rehabilitation day programs, social skills training, case management, and medication clinics.

• Substance Use Disorder Treatment and Supports in Rural Areas. ODMHSAS Telehealth Services now include mental health treatment and follow ups for adults, children and families, substance use disorder services, telecourt, drug court and family drug court for all Oklahoman’s in need. Beginning in SFY 2011, Oklahoma’s telehealth initiative expanded to target specific rural based substance use disorder treatment facilities by adding units in seven facilities. Today ODMHSAS Telehealth Service provides access in most substance use disorder treatment facilities.

• Technology Supports in Rural Areas. The ODMHSAS maintains a statewide telemedicine network. This network increases access to services and information including medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. The ODMHSAS has partnered with a software vendor, MyCare, to provide simple, cost effective, telehealth connectively to the “most remote” areas of Oklahoma.

Targeted Services for Individuals who are Homeless

• Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH). The PATH allocation for Oklahoma for grant year 09/01/2016 – 08/31/2017 is $452,678. PATH programs are located in areas with the highest numbers of people who are homeless: Oklahoma City and Tulsa, and in the rural communities of Tahlequah (located in northeast Oklahoma) and McAlester (located in southeast Oklahoma). Services primarily focus on outreach and case management (including referrals for primary health services, job training, educational services and relevant housing services) but also include screening and diagnostic treatment services, community mental health services, habilitation and rehabilitation services, alcohol and drug treatment, staff training and housing services. Individuals who are identified as homeless and having a serious mental illness are engaged in treatment and support services with efforts made to integrate them into services.

• The Tulsa Day Center for the Homeless. This urban program provides linkages with needed mental health and community services on behalf of adults and children who present at their site, including assistance with accessing housing. In addition, they provide supportive services to people who leave the shelter and become housed to help ensure transition success and reduce recidivism. The goal of the Tulsa Day Center for the Homeless is to provide clients with homeless programs that will lead to successful re-housing and self-sufficiency.

• HUD Continuum of Care (CoC) Projects. These sites are operated by two CMHCs, Central Oklahoma Community Mental Health Center (McClain County and Norman Permanent Housing) and Hope Community Services (Balance of State). Each facilitates HUD permanent supportive housing projects that provide rental assistance to homeless persons with mental illness or co-occurring mental illness and substance use disorders. These projects assist participants with accessing and maintaining permanent housing. In addition to rental assistance, the projects also provide supportive services to help individuals achieve a sustained level of self-sufficiency. Other CMHCs also participate in local Continuums of Care.

• Discharge Planning Bridge Subsidy Program. The ODMHSAS provides targeted funds to assist very low-income individuals (age 18 and older) with mental illness or co-occurring mental illness and substance use disorders who are homeless or at risk of becoming homeless, as they discharge from psychiatric inpatient care, DOC, or age out of the foster care system. The primary focus
is to access decent, safe, sanitary, and affordable housing. The funds assist with housing costs such as rent, utility costs, rent deposits and utility deposits. This program will make sure that each eligible person has the option to receive any supports or services he or she needs. This assistance can be accessed statewide.

• Safe Havens. Safe havens emphasize a housing first approach and allow individuals to remain in that housing even if they do not want to seek treatment. Oklahoma will continue to utilize MHBG funds for safe haven housing in state FY2016 and FY2017. Safe Haven services assist homeless persons in building relationships with mental health service providers, access community programs, and facilitate the eventual transition to permanent housing. Current safe haven programs are in Tulsa and are operated by the Mental Health Association of Oklahoma.

• Home, Honor, and Health (H3OK) – Home, Honor, and Health for Oklahomans (H3OK) is a housing first coordinated case management project which integrates an array of needed services and supports for veterans and others who are homeless or chronically homeless in Oklahoma City and Tulsa. H3OK aligns necessary resources for those who are challenged with a serious mental illness, substance use disorder, or co-occurring disorder who are experiencing homelessness to achieve and maintain permanent safe housing through evidenced-based models—Housing First, Pathways Case Management, Seeking Safety, Motivational Interviewing, SOAR and Individual Placement and Support. All of these best practices follow key principles of participant choice, recovery, and harm-reduction.

Services for Older Adults

Services to older Oklahomans are available at CMHCs through the general array of adult program services, but specific services targeting older adults and designated older adult staff are limited. Limited resources have prevented expansion of these efforts, however, in the FFY2018/FFY2019 Block Grant period there are plans to identify and implement EBPs specific to older person’s both within Health Home settings, and substance use disorder treatment settings. In addition, there are planned efforts for the development of older adult specific curriculum for Peer Recovery Support Specialist training. The ODMHSAS continues to collaborate with stakeholders from the Aging community to offer training on the unique considerations regarding mental health and older adults. In addition, the ODMHSAS is an active participant in the Oklahoma Mental Health and Aging Coalition, which provides a forum where a variety of stakeholders advocate for increased, accessible and culturally appropriate services for older Oklahomans. Additionally, the Coalition provides statewide mental health, substance use, prevention and treatment education and advocacy, and partners with other networks that provide services to older adults to integrate and cross-train networks.

b. Describe your state’s targeted services to the homeless population.

Some of the treatment and supports for adults and children who are homeless are described elsewhere in this application. Additional services targeted for individuals who are homeless are described below.

• Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH). The PATH allocation for Oklahoma for grant year 09/01/2018 – 08/31/2019 is $452,820. PATH programs are located in areas with the highest numbers of people who are homeless: Oklahoma City and Tulsa, and in the rural communities of Tahlequah (located in northeast Oklahoma) and McAlester (located in southeast Oklahoma). Services primarily focus on outreach and case management (including referrals for primary health services, job training, educational services and relevant housing services) but also include screening and diagnostic treatment services, community mental health services, habilitation and rehabilitation services, alcohol and drug treatment, staff training and housing services. Individuals who are identified as homeless and having a serious mental illness are engaged in treatment and support services with efforts made to integrate them into services.

• Substance Use Disorder Outreach. The ODMHSAS also provides support to two urban-based substance use disorder treatment programs for outreach activities. Outreach activities target high-risk drug using individuals, many of whom are homeless and impacted by both mental illness and addiction problems. The outreach workers gain their trust, educate them about HIV/AIDS, communicable diseases, and the harm caused by IV drug use, provide tests for HIV if requested, and assist with linkages to treatment programs.

• The Tulsa Day Center for the Homeless. This urban program provides linkages with needed mental health and community services on behalf of adults and children who present at their site, including assistance with accessing housing. In addition, they provide supportive services to people who leave the shelter and become housed to help ensure transition success and reduce recidivism. The goal of the Tulsa Day Center for the Homeless is to provide clients with homeless programs that will lead to successful re-housing and self-sufficiency.

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becoming homeless, as they discharge from psychiatric inpatient care, DOC, or age out of the foster care system. The primary focus is to access decent, safe, sanitary, and affordable housing. The funds assist with housing costs such as rent, utility costs, rent deposits and utility deposits. This program will make sure that each eligible person has the option to receive any supports or services he or she needs. This assistance can be accessed statewide.

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c. Describe your state’s targeted services to the older adult population.

Services to older Oklahomans are available at CMHCs through the general array of adult program services, but specific services targeting older adults and designated older adult staff are limited. Limited resources have prevented expansion of these efforts, however, over the last 2-year period we have been able to implement several older adult specific initiatives. During each of the last 2 years, the ODMHSAS has partnered with the Oklahoma Mental Health and Aging Coalition, the Oklahoma Healthy Aging Initiative, the Fran and Earl Ziegler College of Nursing at the University of Oklahoma, and the Anne and Henry Zarrow School of Social Work at the University of Oklahoma to facilitate a Positive Aging Institute to help increase provider and community knowledge regarding the unique considerations when serving older adults. In summer of 2018, the ODMHSAS held the first day-long older adult specialty training for Peer Recovery Support Specialists (PRSS). In fall of 2018, the ODMHSAS held the first Mental Health First Aid for Older Adults training. Just recently the ODMHSAS has provided intensive training and follow-up consultation on the evidence-based practice of Cognitive Behavioral Therapy (CBT) in the treatment of older adults for 6 designated older adult specific pilot project sites: 3 within Health Home settings, and 3 within substance use disorder treatment settings. The ODMHSAS continues to collaborate with stakeholders from the Aging community to offer training on the unique considerations regarding mental health and older adults. In addition, the ODMHSAS is an active participant in the Oklahoma Mental Health and Aging Coalition, which provides a forum where a variety of stakeholders advocate for increased, accessible and culturally appropriate services for older Oklahomans. Additionally, the Coalition provides statewide mental health, substance use, prevention and treatment education and advocacy, and partners with other networks that provide services to older adults to integrate and cross-train networks.
Describe your state’s management systems.

As the Single State Agency for Substance Abuse and the State Mental Health Authority, the ODMHSAS fulfills state level responsibilities as regulator and purchaser of services. In some areas of the state, and with specific levels of care, the ODMHSAS also operates as a direct provider of services. Other state agencies collaborate with the ODMHSAS to fulfill similar roles within their authority. Regional and local responsibilities are typically carried out by specific organizations with which the ODMHSAS contracts.

Licensure of most treatment and support service organizations is statutorily required and administered through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Provider Certification Division. The ODMHSAS also supervises mandated certifications for Behavioral Health Case Managers and Peer Recovery Support Specialists, and the Alcohol and Drug Substance Abuse Course process (organizations, individual assessors and course facilitators, related to drivers’ licenses administrative law reinstatement). The ODMHSAS Central Office in Oklahoma City provides planning, training, technical assistance, oversight, fiscal and accountability support for the entire system. Key Central Office functions include Support for Treatment and Recovery Services, Decision Support Services, Information Technology Services, Consumer Advocacy and Wellness, the Inspector General, Human Resources Management and Development, Finance, Legal, Grants Management, and Provider Certification. All leadership and management structures are organized under the ODMHSAS Commissioner and her executive staff including the Chief Operating Officer, and the Deputy Commissioner for Treatment and Recovery Services.

On a daily basis, approximately 2,314 behavioral health staff provide outpatient and other community based services to children, youth and adult consumers statewide. The majority of these are employed as case managers, counselors, social workers, psychologists, nurses and psychiatrists at the CMHCs. However, other providers are represented in this workforce including Recovery Support Specialists, Family Support Providers, and residential support staff. The ODMHSAS provides ongoing training and performance improvement opportunities to all providers throughout the system, including employees of the ODMHSAS and staff from partnering organizations. The ODMHSAS Human Resources Development training programs recorded combined audiences of over 17,899 participants from all areas of Oklahoma in state fiscal year 2017. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce.

With regard to emergency service provider training, the ODMHSAS provides numerous training opportunities for staff member development throughout the year to enhance skills needed when they encounter adults with SMI. The training announcements are distributed to individuals and organizations statewide, including emergency health workers. Many participants work in first response settings, including emergency rooms, ambulance services and law enforcement. Law enforcement jurisdictions also collaborate with the ODMHSAS to cross train staff in diversionary and proactive responses with people who may be experiencing mental illness or addiction symptoms. The Memphis Model Crisis Intervention Training (CIT) is widely utilized. The ODMHSAS staff also provides training in various suicide intervention and crisis techniques to emergency room and other health personnel. The state has expanded training offerings of Practical Front Line Assistance and Support for Healing (PFLASH), Psychological First Aid (PFA), Question, Persuade and Refer (QPR), and other early intervention response techniques to non-mental health professionals, including first responders.
Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question
Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

   a) A full continuum of services
      i) Screening
      ii) Education
      iii) Brief Intervention
      iv) Assessment
      v) Detox (inpatient/social)
      vi) Outpatient
      vii) Intensive Outpatient
      viii) Inpatient/Residential
      ix) Aftercare; Recovery support

   b) Services for special populations:
      Targeted services for veterans?
      Adolescents?
      Other Adults?
      Medication-Assisted Treatment (MAT)?
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention-Required SABG.
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes  
   - No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   - Yes  
   - No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes  
   - No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes  
   - No

5. Has your state identified a need for any of the following:  
   a) Open assessment and intake scheduling  
      - Yes  
      - No
   b) Establishment of an electronic system to identify available treatment slots  
      - Yes  
      - No
   c) Expanded community network for supportive services and healthcare  
      - Yes  
      - No
   d) Inclusion of recovery support services  
      - Yes  
      - No
   e) Health navigators to assist clients with community linkages  
      - Yes  
      - No
   f) Expanded capability for family services, relationship restoration, and custody issues?  
      - Yes  
      - No
   g) Providing employment assistance  
      - Yes  
      - No
   h) Providing transportation to and from services  
      - Yes  
      - No
   i) Educational assistance  
      - Yes  
      - No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Program monitoring and compliance division reviews each agency separately for compliance with stated requirements of the contract. Review personnel from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) are assigned specific programs and with specific contracts. The review process is divided into two elements, personnel which includes qualifications and training, and a clinical review which includes a review of the clinical record for consumers in the provider’s program.
**Criterion 4, 5 & 6**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement
   b) 14-120 day performance requirement with provision of interim services
   c) Outreach activities
   d) Syringe services programs, if applicable
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Has your state identified a need for any of the following:
   a) Electronic system with alert when 90 percent capacity is reached
   b) Automatic reminder system associated with 14-120 day performance requirement
   c) Use of peer recovery supports to maintain contact and support
   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers
   b) Cooperative agreement/MOU with public health entity for testing and treatment
   c) Established co-located SUD professionals within FQHCs

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

**Early Intervention Services for HIV (for "Designated States" Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?

2. Has your state identified a need for any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas
   b) Establishment or expansion of tele-health and social media support services
c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

Yes ☐ No ☐

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C§ 300x-31(a)(1)F)?

Yes ☐ No ☐

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

Yes ☐ No ☐

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

Yes ☐ No ☐

If yes, please provide a brief description of the elements and the arrangement.
Criterion 8, 9, and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement?  
   - Yes ☑️ No

2. Has your state identified a need for any of the following:
   
   a) Workforce development efforts to expand service access  
      - Yes ☑️ No
   
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  
      - Yes ☑️ No
   
   c) Establish a peer recovery support network to assist in filling the gaps  
      - Yes ☑️ No
   
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  
      - Yes ☑️ No
   
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  
      - Yes ☑️ No
   
   f) Explore expansion of services for:
      i) MAT  
         - Yes ☑️ No
      ii) Tele-Health  
         - Yes ☑️ No
      iii) Social Media Outreach  
         - Yes ☑️ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  
   - Yes ☑️ No

2. Has your state identified a need for any of the following:
   
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  
      - Yes ☑️ No
   
   b) Establish a program to provide trauma-informed care  
      - Yes ☑️ No
   
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  
      - Yes ☑️ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  
   - Yes ☑️ No

2. Does your state provide any of the following:
   
   a) Notice to Program Beneficiaries  
      - Yes ☑️ No
   
   b) An organized referral system to identify alternative providers?  
      - Yes ☑️ No
   
   c) A system to maintain a list of referrals made by religious organizations?  
      - Yes ☑️ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  
   - Yes ☑️ No

2. Has your state identified a need for any of the following:
   
   a) Review and update of screening and assessment instruments  
      - Yes ☑️ No
   
   b) Review of current levels of care to determine changes or additions  
      - Yes ☑️ No
   
   c) Identify workforce needs to expand service capabilities  
      - Yes ☑️ No
Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Patient Records
1. Does your state have an agreement to ensure the protection of client records?
   - Yes ☑️ No ☐

2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements
      - Yes ☑️ No ☐
   b) Training on responding to requests asking for acknowledgement of the presence of clients
      - Yes ☑️ No ☐
   c) Updating written procedures which regulate and control access to records
      - Yes ☑️ No ☐
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure:
      - Yes ☑️ No ☐

Independent Peer Review
1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
   - Yes ☑️ No ☐

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
   It is estimated that twenty-two (22) providers will participate in the Independent Peer Review process during FFY2022/2023; approximately eleven (11) providers each year.

3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan
      - Yes ☑️ No ☐
   b) Establishment of policies and procedures related to independent peer review
      - Yes ☑️ No ☐
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations
      - Yes ☑️ No ☐

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
   - Yes ☑️ No ☐

   If Yes, please identify the accreditation organization(s)
   i) ☐ Commission on the Accreditation of Rehabilitation Facilities
   ii) ☐ The Joint Commission
   iii) ☑ Other (please specify)

   The ODMHSAS certifies sub-recipients based on the Administrative Rules/Standards relative to the services they are providing. The ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children, Inc. (COA), or the American Osteopathic Association (AOA) as compliance with certain specific ODMHSAS standards.
Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ○ No

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ○ No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ○ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state ○ Yes ○ No
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ○ Yes ○ No
   c) Performance-based accountability: ○ Yes ○ No
   d) Data collection and reporting requirements ○ Yes ○ No

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ○ No
   b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ○ No
   c) Collaborative training sessions for employees and community agencies’ staff to coordinate and increase integrated services ○ Yes ○ No
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC? ○ Yes ○ No
   b) Mental Health TTC? ○ Yes ○ No
   c) Addiction TTC? ○ Yes ○ No
   d) State Targeted Response TTC? ○ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women ○ Yes ○ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis ○ Yes ○ No
   b) Early Intervention Services Regarding HIV ○ Yes ○ No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ○ No
   b) Professional Development ○ Yes ○ No
c) Coordination of Various Activities and Services

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Footnotes:
Oklahoma is not an HIV designated state.
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021?
   - Yes
   - No

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

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Footnotes:
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

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

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing business as usual. These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

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

58 Ibid

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?
   - Yes ☑️ 
   - No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?
   - Yes ☑️ 
   - No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?
   - Yes ☑️ 
   - No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   - Yes ☑️ 
   - No

5. Does the state have any activities related to this section that you would like to highlight.

Oklahoma has state-wide trauma screening system. For adults we utilize the PCL-5 and for children and youth 3-17 we use the CATS Child and Adolescent trauma screening. Both measures are public domain which made them both sustainable and spreadable. They are reimbursable my Medicaid to encourage non-CMHC providers to use them. And July 1st, 2016 the CDC was changed so that overall severity scores can be reported and tracked for data driven planning and feedback.

Oklahoma has a state wide TFCBT program for out CMHCs and it is in contract how each agency must have staffed trained to provide this service.
We believe peers are vital to any trauma informed agency. In our PRSS certification process, peers are trained in how to help someone complete the PCL-5, as having a peer assist you with a trauma screen makes it easier. In addition, we have a new track with peers go through the training and receive consultation in Seeking Safety. Our plan is to have peer led Seeking Safety groups in all our centers.

Oklahoma has a 3 hour trauma-informed 101 eLearning and a 1 hour self-care eLearning so that all levels of staff can be trained on site.

Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question
More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60 A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

60 http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  
   Yes ☐ No ☐

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  
   Yes ☐ No ☐

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  
   Yes ☐ No ☐

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  
   Yes ☐ No ☐

5. Does the state have any activities related to this section that you would like to highlight?

The ODMHSAS provides programs and services that address diversion at each steps of the Sequential Intercept Model. Crisis Intervention Training (CIT) is provided to CLEET commissioned law enforcement officers throughout the state through partnerships with multiple law enforcement agencies. After successfully piloting with community-based providers the use of officer ipads that connect directly to mental health staff, the ODMHSAS received state appropriations in FY22 to equip all approximately 6,000 officers in the state with ipads. Additionally, the ODMHSAS has implemented a pre-sentence criminogenic risk and needs assessment program to provide courts with information about evidence based diversion sentencing recommendations which best meet the defendants' individualized needs. With tens of thousands of felony defendants screened to date, this program has resulted in fewer jail days between arrest and case disposition. Oklahoma continues to have a strong drug and mental health court system which follow the latest best practice standards published by the National Drug Court Institute and demonstrate a tremendous amount of success through outcomes such as reduction in recidivism, increase in employment and education, decrease in arrests and jail days, and increase in child custody. The success of these programs has led to the development of additional court-based diversion opportunities including early/misdemeanor diversion and pretrial services. Lastly, through collaboration with the Department of Corrections, the ODMHSAS has seven prison-embedded reentry staff supporting the
treatment reentry needs of individuals discharging from prison whom have behavioral health treatment needs.

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

None Needed

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Footnotes:
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49[4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.


Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   - Yes  -  No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  
   - Yes  -  No

3. Does the state purchase any of the following medication with block grant funds?  
   - Yes  -  No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?  
   - Yes  -  No

5. Does the state have any activities related to this section that you would like to highlight?
   STR/SOR is supporting proactive engagement strategies to overcome barriers, ensure open and accessible services and support treatment compliance. Strategies include: ensuring all contracted treatment providers have been allotted funds to assist with co-pays and deductibles; transportation assistance (vouchers, bus tokens and/or fuel cards); one-time emergency funds for a crisis that would prevent a person from obtaining treatment when the individual has a plan to advert future crisis; and implementing an evidence-based contingency management program within all MAT programs.
The Oklahoma initiative has engaged providers to assure expansion of services, including early intervention initiatives for OUD dependence and addiction, ambulatory withdrawal management, outpatient and intensive outpatient services, MAT, and residential care. All services have been expanded beyond initial capacity to approximately 54 counties. Some providers have expanded prescribers to satellite offices to reduce patient travel burden and eliminate potential barriers to treatment, while others have utilized telemedicine after induction to provide the ongoing support and some therapeutic services.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises, “Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.”

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

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) Psychiatric Advance Directives
   c) Family Engagement
   d) Safety Planning
   e) Peer-Operated Warm Lines
   f) Peer-Run Crisis Respite Programs
   g) Suicide Prevention

2. Crisis Intervention/Stabilization
   a) Assessment/Triage (Living Room Model)
   b) Open Dialogue
   c) Crisis Residential/Respite
   d) Crisis Intervention Team/Law Enforcement
   e) Mobile Crisis Outreach
   f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) Peer Support/Peer Bridgers
   b) Follow-up Outreach and Support
   c) Family-to-Family Engagement
   d) Connection to care coordination and follow-up clinical care for individuals in crisis
   e) Follow-up crisis engagement with families and involved community members

4. Does the state have any activities related to this section that you would like to highlight?

The ODMHSAS is leading the state’s efforts to develop a comprehensive behavioral health crisis response system. While some components of the system are already in place, including some strategically placed urgent recovery and crisis centers, ODMHSAS is preparing the network of care to be ready to best respond to service needs during the roll out of 988. The Comprehensive Crisis Response plan describes the system of responses which ODMHSAS is rolling out during FY22-23 fiscal year. Starting with a 988 call center, the ODMHSAS has engaged a coalition of state leaders from 911 PSAPs, tribes, state behavioral health contractors, current NSPLs, and individuals with lived experience to provide information into the development of call center needs. The ODMHSAS has also been actively engaged Vibrant and SAMHSA to ensure state and federal plans align with 988 intent. Additionally, while ODMHSAS has operated statewide Children’s Mobile Crisis Teams for several years, Adult Mobile Crisis Teams will be launched during the upcoming year to respond in the community to situations which are not deescalated by the 988 call center. Lastly, the network of urgent recovery and crisis centers is expanding as a result of new state appropriated investments to provide respite and observation in order to divert persons as indicated from inpatient services. The launch of the call center, adult mobile crisis teams, and expansion of urgent recovery and crisis centers will ensure Oklahomans in crisis will always have someone to talk to, someone to respond, and somewhere to go to support their immediate needs.

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

None Needed

Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](https://www.samhsa.gov/). States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

**Please respond to the following:**

1. Does the state support recovery through any of the following:
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The ODMHSAS promotes a recovery-focused service system with a focus on improving access to quality health and behavioral health treatment; incorporating peer, family, and other community supports; emphasis on person-centered care that includes shared decision-making; and continued efforts to try to improve access to housing, employment, education, and related supports.

The ODMHSAS defines recovery in the Oklahoma Administrative Code (OAC) 450:53.

"Recovery is a "...journey of healing and transformation enabling a person with a mental health or substance abuse diagnosis to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential. The process of recovery leads individuals to the highest level of autonomy of which they are capable. Key characteristics of recovery include:

- Recovery is self-directed, personal, and individualized;
- Recovery is holistic;
- Recovery moves beyond symptom reduction and relief;
- Recovery is a process of healing and discovery;
- Recovery encompasses the possibility of individuals to test, make mistakes and try again; and
- Recovery can occur within or outside the context of professionally directed treatment."

Consumer and family education is offered throughout the state on an ongoing basis by multiple advocacy organizations including those that have more experience working specifically with individuals with SMI or SED, such as the National Alliance on Mental Illness, the Mental Health Association of Oklahoma, the Oklahoma Federation of Families (OFF) and the Evolution Foundation.

Oklahoma provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services. ODMHSAS’ annual Recovery and Prevention Conference, Justice and Recovery Conference, and Children’s Behavioral Health Conference provide a forum for presentations on recovery principles and practices and the role of peer providers. Staff in recovery and national leaders in recovery support services have presented at these annual conferences.

The following are examples of exemplary activities related to recovery support services:

- The ODMHSAS’ Enhanced Tier Payment System (ETPS) provides additional funding to providers who increase recovery support services to consumers. This system encourages providers to hire recovery support staff and to deliver recovery support services.

- ODMHSAS’ Behavioral Health System has evolved its Community Mental Health Centers into Certified Community Behavioral Health Centers (CCBHCs). CCBHCs require and promote peer recovery support in its model which has increased the hiring and integration of Certified Peer Recovery Support Specialists. Currently there are over 1000 actively certified Peer Recovery Support Specialists working across programs and providers.

- Expansion of the peer support services has helped increase engagement of special populations. Currently, there are tracts for Peers to specialize in youth and young adults, veterans, forensic/criminal justice, medication assisted recovery, older adults, gambling, Latinx, and peer administration/leadership/supervision. Expansion of the peer’s role and the workforce will continue this next fiscal year as we develop tracts for populations with experience in Crisis Care and the LGBTQIA+ community.

- The ODMHSAS hires people in recovery in leadership roles and throughout the system. The ODMHSAS Supporting Treatment and Recovery Services (STARS) Division has staff that are self-identified consumers working in the division. The ODMHSAS Peer Division Trainers of the Peer Certification self-identify as peers in recovery and are certified as Peer Recovery Support Specialists. ODMHSAS’ Chief Communications Officer, Director of Recovery Supports, and Program Manager of the state’s Employee Assistance Program identify as individuals in recovery and are certified as Peer Recovery Support Specialists. The current CEO of one of the largest providers in Oklahoma identifies as an individual in recovery and is currently certified as a Peer Recovery Support Specialist in Oklahoma. This is also the case for much of the organization’s leadership team.

- The ODMHSAS encourages providers to use person-centered planning. The ODMHSAS offers a comprehensive training that assists service providers with understanding how to implement person-centered planning in all aspects of the service process (from assessment, to plan development, to the provision of services, to on-going evaluation of progress). The training also

2. Does the state measure the impact of your consumer and recovery community outreach activity?

- Yes
- No
addresses how this process translates to clinical documentation (in a way that is collaborative with the person served and conducive to self-direction). To further reinforce this process, the ODMHSAS and OHCA requirements for clinical progress notes allow for time spent by the service provider and the consumer completing a treatment progress note together to be compensable. Time spent by the service provider completing the progress note without the consumer is not compensable.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The ODMHSAS promotes a recovery-focused service system with focus on improving access to quality health and behavioral health treatment; incorporating peer, family and other community supports; emphasis on person-centered care that includes shared decision-making; and continued efforts to try to improve access to housing, employment, education and related supports.

The ODMHSAS defines recovery in the Oklahoma Administrative Code (OAC) 450:53.

"Recovery is a "...journey of healing and transformation enabling a person with a mental health or substance abuse diagnosis to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential. The process of recovery leads individuals to the highest level of autonomy of which they are capable. Key characteristics of recovery include:

• Recovery is self-directed, personal and individualized;
• Recovery is holistic;
• Recovery moves beyond symptom reduction and relief;
• Recovery is a process of healing and discovery;
• Recovery encompasses the possibility of individuals to test, make mistakes and try again; and
• Recovery can occur within or outside the context of professionally directed treatment."

Consumer and family education is offered throughout the state on an ongoing basis by multiple advocacy organizations including some that have more experience working specifically with individuals with substance use disorders, which include the National Association of Black Veterans (NABVETS), the Oklahoma Citizen Advocates for Alcohol Recovery and Transformation Association (OCARTA), and Parent’s Helping Parents (PHP).

Oklahoma provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services. ODMHSAS’ annual Recovery and Prevention Conference, Justice and Recovery Conference, and Children’s Behavioral Health Conference provide a forum for presentations on recovery principles and practices and the role of peer providers. Staff in recovery and national leaders in recovery support services have presented at these annual conferences.

The following are examples of exemplary activities related to recovery support services:

• The Oklahoma Association for Recovery Residences (OKARR) is the Oklahoma state affiliate of the National Alliance for Recovery Residences (NARR). OKARR: links individuals seeking and sustaining recovery from substance use issues with quality recovery housing, promotes the quality of recovery housing by offering training and resources to recovery housing providers and workforce, and certifies recovery housing that meets national best practice. ODMHSAS provides Peer Recovery Support Specialist certification training to all appropriate and qualified staff of the OKARR certified Recovery Residence to promote and provide recovery support to their residents.

• The expansion of peer support services has helped increase engagement of special populations. Currently, there are tracts for Peers to specialize in youth and young adults, veterans, forensic/criminal justice, medication assisted recovery, methamphetamine use, older adults, gambling, Latinx, and peer administration/leadership/supervision. Expansion of the peer’s role and the workforce will continue this next fiscal year as we develop tracts for populations with experience in Crisis Care and the LGBTQIA+ community.

• Particular focus, as it relates to tobacco cessation within the system has been a primary recovery support for both the SMI and SUD populations. However, particular to the SUD population has been a focus to better incorporate recovery support services as a whole health initiative. Specifically, the ODMHSAS has partnered with Residential Treatment Providers (RTP) to integrate peer staff in roles to facilitate cessation support groups and establish coordinated referrals to community resources such as the Oklahoma Tobacco Helpline. This project was piloted with three RTPs and proved to be successful. That is, a total of 390 residents at RTPs were connected to the Oklahoma Tobacco Helpline and 30% of these individuals have stayed quit at 7-month follow up. This project has since expanded and now includes 10 crisis units, 10 RTPs, 8 outpatient providers, and 4 inpatient providers.

• The ODMHSAS hires people in recovery in leadership roles and throughout the system. The ODMHSAS Supporting Treatment and Recovery Services (STARS) Division has staff that are self-identified consumers working in the division. The ODMHSAS Peer Division Trainers of the Peer Certification self-identify as peers in recovery and are certified as Peer Recovery Support Specialists. ODMHSAS’ Chief Communications Officer, Director of Recovery Supports, and Program Manager of the state’s Employee Assistance Program identify as individuals in recovery and are certified as Peer Recovery Support Specialists. The current CEO of one of the largest providers in Oklahoma identifies as an individual in recovery and is currently certified as a Peer Recovery Support Specialist in Oklahoma. This is also the case for much of the organization’s leadership team.
• The ODMHSAS encourages providers to use person-centered planning. The ODMHSAS offers a comprehensive training that assists service providers with understanding how to implement person-centered planning in all aspects of the service process (from assessment, to plan development, to the provision of services, to on-going evaluation of progress). The training also addresses how this process translates to clinical documentation (in a way that is collaborative with the person served and conducive to self-direction). To further reinforce this process, the ODMHSAS and OHCA requirements for clinical progress notes allow for time spent by the service provider and the consumer completing a treatment progress note together to be compensable. Time spent by the service provider completing the progress note without the consumer is not compensable.

5. Does the state have any activities that it would like to highlight?

• ODMHSAS currently trains and certifies Oklahoma’s Peer Recovery Support Specialist work force. In order to ensure a well-equipped and quality workforce, ODMHSAS provides specialty tracts that enhance knowledge, skills, and competency in a variety of areas and populations served. Currently specialty tracts are provided for transitional age youth, older adults, veterans, methamphetamine use, forensic/criminal justice, medication assisted treatment, gambling, group facilitation skills and Latinx. ODMHSAS provides e-learnings on self-care to help ensure the wellbeing of the peer workforce and provide skills they can teach and role model to their clients. ODMHSAS is currently developing a Crisis Tract and LGBTQA+ tract. With the role out of 988 and the expansion of crisis services in the state, we felt a crisis tract was a necessity. ODMHSAS believes that Peer Recovery Support Staff also need support and provides virtual monthly support meeting for the peer workforce and a special support call for peers that work in crisis services. ODMHSAS believes that ensuring quality peer support requires quality supervision. ODMHSAS provides a Peer Recovery Support Supervisory Training for all those that supervise Peer Recovery Support Specialists. It is a contractual requirement for providers to ensure those supervising peer support staff receive the supervisory training.

• In order to ensure quality and accountability ODMHSAS’ Peer Division has established a Peer Advisory Board consisting of a variety of individuals in recovery working in a variety of organizations. The Peer Advisory Board this fiscal year has established by-laws as well as voted in a Chair and Vice-Chair with technical assistance from the ODMHSAS Peer Division.

• The Oklahoma Recovery Alliance, which consists of many community partners that are Recovery Community and Advocacy Organizations have recently adopted by-laws and voted on a Chair, Vice Chair, and Treasurer with the technical assistance of the ODMHSAS Peer Division. The by-laws will provide needed structure for the alliance. The Oklahoma Recovery Alliance provides a monthly arena for the members to exchange ideas, information, and joint efforts to promote recovery for Oklahomans.

• ODMHSAS understands that tobacco cessation efforts are vital to the quality of life and longevity of life for those seeking services in behavioral health. Peer Recovery Support Specialists are leading the way in these efforts. ODMHSAS has included within provider contracts the use of Peer Support as an intervention for Tobacco Cessation. Trainings to help staff provide these interventions is provided through ODMHSAS. Peers lead out tobacco cessation intervention efforts and have helped decrease tobacco prevalence rates from 74% to 47% on average. ODMHSAS providers made over 10,000 referrals to the Oklahoma Tobacco Helpline in FY20, accounting for 56% of all referrals statewide; it’s estimated that the program has averted 29 deaths and saved nearly $3 million in medical costs.

• ODMHSAS believes in preventing gaps in treatment and between levels of care. The integration of Peer Support is a vital part of closing those gaps and providing “warm hand offs” between levels of care. Within ODMHSAS’ behavioral health system, in fiscal year 2020, those discharging from inpatient or crisis services: 83% had follow up within 7 days, 78% did not re-admit to inpatient/crisis within 6 months and 81% were engaged in treatment within 45 days.

Please indicate areas of technical assistance needed related to this section.
None Needed
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

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

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

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

**Please respond to the following items**

1. Does the state's Olmstead plan include:
   - Housing services provided. [Yes] [No]
   - Home and community based services. [Yes] [No]
   - Peer support services. [Yes] [No]
   - Employment services. [Yes] [No]

2. Does the state have a plan to transition individuals from hospital to community settings?
   - None Needed

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question
MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.63. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.64. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.65.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.66. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.67.

According to data from the 2015 Report to Congress on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED? [ ] Yes [ ] No
   b) The recovery and resilience of children and youth with SUD? [ ] Yes [ ] No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare? [ ] Yes [ ] No
   b) Juvenile justice? [ ] Yes [ ] No
   c) Education? [ ] Yes [ ] No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization? [ ] Yes [ ] No
   b) Costs? [ ] Yes [ ] No
   c) Outcomes for children and youth services? [ ] Yes [ ] No

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? [ ] Yes [ ] No
   b) Mental health treatment and recovery services for children/adolescents and their families? [ ] Yes [ ] No

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system? [ ] Yes [ ] No
   b) for youth in foster care? [ ] Yes [ ] No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Currently Oklahoma treatment providers within systems of care provide integrated services in the following ways:

A. OKSOC uses a Wraparound model that is able to serve anyone 0 up to 25 with mental health or substance use disorder regardless of system involvement. This model is primary for youth who are identified as SED who may or may not have a co-occurring disorder.

B. ODMHSAS currently has several partnerships involving OSDE to include the BISS model and quarterly Leadership meetings to identify partnership opportunities for school systems in Oklahoma. School-based services is looking to establish new BISS provider networks throughout the remaining 200+ school district in Oklahoma.

C. ODMHSAS and OKDHS has several partnerships around access to treatment for youth in the child welfare system. One partnership that is currently being implemented is the Enhanced Foster Care program. ODMHSAS facilitate consultation calls with DHS staff and mental health service providers to establish and monitor mental health services.

A. The local SOC community partnership around creating community connections for youth and families and family support options connecting families to the Children’s Behavioral Health Network.
B. ODMHSAS and OJA are continuing to partner around juvenile reentry. The identification of juveniles who are discharge at an OJA institution for the purpose of coordinating the behavioral health treatment for those identifies with and MH or SU disorder.

7. Does the state have any activities related to this section that you would like to highlight?

A. All mental health and substance use providers have been offered training for Motivational Interviewing (MI) and Advanced Motivational Interviewing Training, Seeking Safety and Advanced Seeking Safety training, Transition to Independence process training (geared towards working with young adults in services), Foundations of Infant Mental Health Part 1 &2 that is appropriate for all levels of staff to attend, DC 0-5 training, Specialized CBT training for specific treatment providers, TF-CBT training.

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

a. Urgent Recovery Centers (URC): Family style model crisis intervention diversion and de-escalation for families. Any TA around this Family style model
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  
   - Yes  
   - No

2. Describe activities intended to reduce incidents of suicide in your state.
   The State of Oklahoma continues to use the best practices applications for specific treatment of suicidality under the guise of Collaborative Assessment and Management of Suicide Training/Treatment. All State Operated and State-Contracted Mental Health Agencies is required to use a suicide specific screening tool at all intakes and admission to Inpatient Hospitalization or Outpatient facilities by using the (Columbia Suicide Severity Rating Scale (CSSRS) and or the Patient Health Questionnaire #9 (PHQ-9). The applied suicide screening assessment to include reapplication of the assessments according to severity/incidence of suicidality. Consultation provided to CMHCs, Outpatient Health (and Mental Health), Hospitals and Community entities to adopt/design/implement/apply similar plans. Design/Implementation of infrastructure to maintain training and system sustainability.

3. Have you incorporated any strategies supportive of Zero Suicide?  
   - Yes  
   - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   - Yes  
   - No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted?  
   - Yes  
   - No

If so, please describe the population targeted.

Have targeted all private and nonprofit as well as all State Operated and State Contracted Mental Health agencies that provide mental health services to individuals who may be suicidal or has tried to die by suicide in their communities. Due to the COVID 19 Pandemic, Colleges and Universities has expressed more interest in our system/training and consultations to provide treatment for their more specific demographic groups of student population in their college counseling programs for treatment of suicidal and substance abuse issues.

Oklahoma continues to lead the Nation in instituting this life-saving evidenced based technique of Collaborative Assessment and Management of Suicidality (CAMS) in all 77 counties, providing better understanding and decrease suicidality. At this present time, we have trained 1929 clinicians in CAMS. ODMHSAS plans to continue to offering CAMS training during the next Block Grant period.

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

None Needed

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Footnotes:
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

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

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

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  ○ Yes  ○ No

2. Has your state identified the need to develop new partnerships that you did not have in place?  ○ Yes  ○ No

   If yes, with whom?

   N/A

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

   None Needed

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

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

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Oklahoma State Planning and Advisory Council’s purpose is to (1) Review plans, including the Federal Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant Plan, provided to the Council, and to submit to the state any recommendations of the Council for modifications to the plans; (2) Serve as an advocate in promoting quality of life for all adults with SMI and/or addictions, children with SED and their families, and other individuals with mental illness, emotional issues and/or addictions; (3) Serve as an advocate for promotion of prevention of these disorders; (4) Monitor, review and evaluate not less than once each year, the allocation and adequacy of mental health, substance use disorder and prevention services within the State; and (5) Exchange information and develop, evaluate and communicate ideas about mental health, substance use disorder and prevention planning and services.

The Council consists of 40 members. The Council is made up of residents of the State of Oklahoma and include representatives of 1) the principal State agencies involved in mental health, substance abuse and prevention and related support services; 2) public and private entities concerned with the need, planning, operation, funding and use of mental health, substance abuse and prevention services and related support activities; 3) adults with serious mental illnesses and/or addictions who are receiving (or have received) services; 4) the families of such adults; 5) youth with serious emotional disturbances and/or addictions who are receiving (or have received) services; and, 6) the families of children with serious emotional disturbances and/or addictions.
Council membership includes several members who either coordinate or serve on local and statewide advocacy Councils and committees. They keep the PAC informed and engaged regarding state and local advocacy issues and initiatives.

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

None Needed

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.70

70There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:
Letter of Support from the PAC is attached.
August 24, 2021

Formula Grants Branch
Division of Grant Management, OFR, SAMHSA
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

To Whom it May Concern,

As Vice Chair of the Planning and Advisory Council to the Oklahoma Department of Mental Health and Substance Abuse Services, I am submitting this letter of support for Oklahoma’s Block Grant Application for FFY2022/2023.

The Planning and Advisory Council reviewed and approved the Block Grant Application at our August 19th, 2021 meeting.

Years of advocacy have resulted in the July 2021 expansion of Medicaid in Oklahoma and a solid step in changing our status as one of the unhealthiest, both mentally and physically, States in the Nation. The mental and physical exhaustion of COVID continues, with unknown outcomes, but with some silver linings such as the increased use of technology and increased focus on mental health issues, isolation and loneliness.

While Oklahoma has phased out Behavioral Health Homes, our CCBHs are thriving and have expanded. In our current political environment of no mask mandates in schools and banned teaching of critical race theory, a law was signed mandating suicide prevention trainings in our schools. Currently criminal justice reform appears to be stalled. Our Peer Support program and Peer Support specialties continue to flourish. COVID's impact on suicides, addiction, and wellness is yet to be determined, but we are preparing for anticipated challenges.

Our Block Grant Plan continues to address disparities for Veterans, Older Adults, Tribes and individuals involved in the Criminal Justice System. The following is a list of several measures that have been added to the Plan: Youth Wellness Coaches, Opioid treatment and support, Housing programming, Law Enforcement access to mental health professionals through IPads, Call Center capacity in anticipation of 988, Suicide Prevention education and outreach, School based prevention services, Prevention Works Community Coalitions, and Re-branding the Public Awareness campaign.

We are encouraged and hopeful while remaining persistent and relentless.

Sincerely,

Karen Orsi, Vice Chair
Planning and Advisory Council to the
Oklahoma Department of Mental Health
And Substance Abuse Services
**Environmental Factors and Plan**

**Advisory Council Members**
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

- State Education Agency
- State Vocational Rehabilitation Agency
- State Criminal Justice Agency
- State Housing Agency
- State Social Services Agency
- State Health (MH) Agency

**Start Year:** 2022  **End Year:** 2023

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janelle Bretten</td>
<td>State Employees</td>
<td>Oklahoma Office of Juvenile Affairs</td>
<td>3812 N 36th St. OK, 73118</td>
<td><a href="mailto:Janelle.Bretten@oja.ok.gov">Janelle.Bretten@oja.ok.gov</a></td>
</tr>
<tr>
<td>John Brewer</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td></td>
<td><a href="mailto:johnb@jnbrewer.com">johnb@jnbrewer.com</a></td>
</tr>
<tr>
<td>Melinda Bunch</td>
<td>State Employees</td>
<td>Oklahoma Department of Rehabilitation</td>
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<tr>
<td>Cathy Costello</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td></td>
<td><a href="mailto:Momcostello@yahoo.com">Momcostello@yahoo.com</a></td>
</tr>
<tr>
<td>George Crooks</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>3000 United Founders Bldg, Suite 104 OKC, 73112</td>
<td>PH: 405-413-7778</td>
<td><a href="mailto:geoman47@hotmail.com">geoman47@hotmail.com</a></td>
</tr>
<tr>
<td>Bryan Day</td>
<td>Providers</td>
<td>12 &amp; 12 Inc.</td>
<td>12 E. 12th Street, Tulsa OK, 74119</td>
<td><a href="mailto:bryan.day@12and12.org">bryan.day@12and12.org</a></td>
</tr>
<tr>
<td>Jeni Dolan</td>
<td>Providers</td>
<td>Operation Aware of Oklahoma</td>
<td>10021 South Yale Avenue Suite 105, Tulsa OK, 74137</td>
<td><a href="mailto:jdolan@operationaware.org">jdolan@operationaware.org</a></td>
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<tr>
<td>Darlene Drew</td>
<td>State Employees</td>
<td>Oklahoma Housing Finance Agency</td>
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<td>Jessica Hawkins</td>
<td>State Employees</td>
<td>ODMHSAS - Prevention Representative</td>
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<tr>
<td>Brett Hayes</td>
<td>State Employees</td>
<td>Oklahoma Department of Human Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julia Jernigan</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>PO Box 7328, Edmond OK, 73083</td>
<td>PH: 405-471-2499</td>
<td><a href="mailto:julia@okbha.org">julia@okbha.org</a></td>
</tr>
<tr>
<td>Alesha Lily</td>
<td>State Employees</td>
<td>Oklahoma State Department of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amber Martinez</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>916 NW 35th OKC, OK, 73118</td>
<td>PH: 405-408-8742</td>
<td><a href="mailto:onlyamberm@gmail.com">onlyamberm@gmail.com</a></td>
</tr>
<tr>
<td>Matt Mashore</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>4400 N. Lincoln Blvd. OKC OK, 73105 PH: 405-590-9742</td>
<td><a href="mailto:mattherm@red-rock.com">mattherm@red-rock.com</a></td>
<td></td>
</tr>
<tr>
<td>Kimrey McGinnis</td>
<td>State Employees</td>
<td>Oklahoma Health Care Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Janna Morgan</td>
<td>State Employees</td>
<td>Oklahoma Department of Corrections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edie Nayfa</td>
<td>Providers</td>
<td>Catalyst Behavioral Services</td>
<td>3033 N. Walnut Avenue OKC OK, 73105</td>
<td><a href="mailto:enayfa@catalystok.org">enayfa@catalystok.org</a></td>
</tr>
<tr>
<td>Karen Orsi</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>13405 Golden Eagle Drive Edmond OK, 73103</td>
<td><a href="mailto:kareno@northcare.com">kareno@northcare.com</a></td>
<td></td>
</tr>
<tr>
<td>Kelli Reid</td>
<td>State Employees</td>
<td>ODMHSAS - Substance Use Representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lyndsey Roberts</td>
<td>Providers</td>
<td>Neighbors Building Neighborhoods</td>
<td>207 N 2nd Street Muskogee OK, 74401</td>
<td><a href="mailto:lroberts@nbn-nrc.org">lroberts@nbn-nrc.org</a></td>
</tr>
<tr>
<td>Catherine Robertson</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>15676 CR 3540 Ada OK, 74820</td>
<td><a href="mailto:Catherine.Barnhill@chickasaw.net">Catherine.Barnhill@chickasaw.net</a></td>
<td></td>
</tr>
<tr>
<td>Lyndi Seabolt</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>OKC OK,</td>
<td><a href="mailto:LSeabolt@spthb.org">LSeabolt@spthb.org</a></td>
<td></td>
</tr>
<tr>
<td>Michelle Sutherlin</td>
<td>State Employees</td>
<td>Oklahoma State Department of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheamekah Williams</td>
<td>State Employees</td>
<td>ODMHSAS Mental Health Representative</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes:
Environmental Factors and Plan

Advisory Council Composition by Member Type

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>have received, mental health services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>adults with SMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>22</td>
<td>55.00%</td>
</tr>
<tr>
<td>State Employees</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>18</td>
<td>45.00%</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>people)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Council was sent the application, and the application was reviewed in detail with Council members at the regularly scheduled Council meeting on Thursday, August 19th. Council members were in support of the application and voted to provide a letter of support for the application. There were no recommended modifications.

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Footnotes:
You will note that we have many vacancies. We had many Council members term out at the end of 2019, and COVID continues to slow our process of recruitment for new members. The Council and its Membership Committee continue to try to identify and recruit members to fill the additional vacant positions on the Council (including targeted positions for parents of children with SED). A deadline for filling those positions is uncertain at this time due to COVID, however, the Council is motivated to fill the positions as soon as possible.
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

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

Please respond to the following items:
1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?  Yes  No
   b) Posting of the plan on the web for public comment?
      If yes, provide URL: https://www.ok.gov/odmhsas/
      Yes  No
   c) Other (e.g. public service announcements, print media)  Yes  No

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Footnotes:
Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the Consolidated Appropriations Act, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018.

Section 520. Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, intravenous drug user (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, persons who inject drugs (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs: These documents can be found on the Hiv.gov website: https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs.


Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC

- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below

- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.
End Notes

1 Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds only and is consistent with guidance issued by SAMHSA.

2 Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

3 Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

4 Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receive SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires “designated states” as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

5 Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016 describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

• Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
• HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
• Provision of naloxone (Narcan?) to reverse opiate overdoses;
• Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
• Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
• Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a description of the elements of an SSP that can be supported with federal funds.

• Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
• Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
• Testing kits for HCV and HIV;
• Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
• Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;
• Provision of naloxone to reverse opioid overdoses

• Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;

• Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;

• Communication and outreach activities; and

• Planning and non-research evaluation activities.

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Footnotes:
Block Grant/Harm Reduction Proposal

1. The ODMHSAS will purchase naloxone and fentanyl test strips for distribution by SSPs to people who inject drugs (PWID). The ODMHSAS will partner with the Oklahoma State Department of Health Sexual Health and Harm Reduction Service (OSDH SHHR) to identify SSPs, disburse naloxone and fentanyl test strips to eligible SSPs, and provide training and technical assistance on best practices.

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Months from award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish purchase order for injectable naloxone and fentanyl tests strips</td>
<td>1 month, annually</td>
</tr>
<tr>
<td>Identify SSP programs from OSDH SHHR registry</td>
<td>3 mos, quarterly</td>
</tr>
<tr>
<td>Conduct training for SSP staff on ODMHSAS data collection and evaluation</td>
<td>4 mos, quarterly</td>
</tr>
<tr>
<td>Begin distribution of naloxone and fentanyl test strips to SSPs</td>
<td>4 mos, ongoing</td>
</tr>
</tbody>
</table>

2. Needle disposal services have been identified as highly needed across the state. The ODMHSAS will establish a contract to provide collection sites and disposal services in high need geographic areas. The ODMHSAS will collaborate with SSPs and OSDH SHHR services to identify the allocation plan for disposal services in community settings.

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Months from award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct survey/focus groups to identify high need areas</td>
<td>1 month, annually</td>
</tr>
<tr>
<td>Establish contract with state approved vendor</td>
<td>3 mos, annually</td>
</tr>
<tr>
<td>Project implementation begins</td>
<td>3 mos</td>
</tr>
</tbody>
</table>

Budget:

3. The ODMHSAS will ensure that PWID are connected to appropriate behavioral healthcare by embedding staff from CCBHCs to serve as liaisons/client navigators for PWID who enter the system through referrals from OSDH SHHR staff, SSPs, or other community organizations working with PWID. Specially trained peer recovery support specialists will partner with SSP staff and volunteers, OSDH SHHR Disease Intervention Specialists and nurse practitioners, and other community agencies to promote access to behavioral health services, provide warm hand-offs, and provide training and technical assistance to incorporate best practices.

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Months from award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish contracts for peer staff</td>
<td>1 month, annually</td>
</tr>
<tr>
<td>CCBHC policies developed for SSP collaboration and warm handoffs</td>
<td>2 mos</td>
</tr>
<tr>
<td>Peer staff hired</td>
<td>3 mos</td>
</tr>
<tr>
<td>Partner with ODMHSAS Recovery Services to develop training</td>
<td>3 mos</td>
</tr>
<tr>
<td>Conduct PRSS training</td>
<td>4 mos, ongoing</td>
</tr>
<tr>
<td>Project implementation</td>
<td>4 mos, ongoing</td>
</tr>
</tbody>
</table>

4. The ODMHSAS will support workforce development for SSPs by collaborating with the Oklahoma Harm Reduction Alliance (OKHRA) and OSDH SHHR to provide evidence-based and evidence-informed training to the SSP workforce. The ODMHSAS will work with partners to identify SSP
workforce training and technical assistance needs, identify appropriate trainers, and conduct virtual and in-person trainings, including co-location of training opportunities between the SSP and behavioral health workforce communities. A minimum of three (3) trainings will be conducted annually.

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Months from award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training needs assessment survey and focus groups</td>
<td>1 month, annually</td>
</tr>
<tr>
<td>Workforce development training plan developed</td>
<td>2 mos, annually</td>
</tr>
<tr>
<td>Training project implementation begins</td>
<td>3 mos, ongoing</td>
</tr>
</tbody>
</table>

Budget Summary:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity/cost per unit</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naloxone (IM)</td>
<td>$25/2000</td>
<td>50,000</td>
</tr>
<tr>
<td>Fentanyl test strips</td>
<td>$1/100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Sharps Disposal*</td>
<td>$250 (30 gallon container)/560</td>
<td>140,000</td>
</tr>
<tr>
<td>Regional Peer Navigator</td>
<td>$40,000/5</td>
<td>$200,000</td>
</tr>
<tr>
<td>Training contracts</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

*Based on average cost of $70,000 per year per SSP from $12,500 for very small to $250,000 for very large SSPs.
Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A
If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

<table>
<thead>
<tr>
<th>Syringe Services Program SSP Agency Name</th>
<th>Main Address of SSP</th>
<th>Planned Dollar Amount of SABG Funds Expended for SSP</th>
<th>SUD Treatment Provider (Yes or No)</th>
<th># Of Locations (include mobile if any)</th>
<th>Narcan Provider (Yes or No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Data Available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes:
Not Applicable as we have no SSP providers yet.

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