Oklahoma

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/20/2019 3:34.04 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 2020
End Year 2021

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 Terri
Last Name White
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 405-248-9201
Fax
Email Address tlwhite@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 Terri
Last Name White
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 2020**

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

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**Title XIX, Part B, Subpart III of the Public Health Service Act**

| Section 1941 | Opportunity for Public Comment on State Plans                      | 42 USC § 300x-51         |
| Section 1942 | Requirement of Reports and Audits by States                        | 42 USC § 300x-52         |
| Section 1943 | Additional Requirements | 42 USC § 300x-53 |
| Section 1946 | Prohibition Regarding Receipt of Funds | 42 USC § 300x-56 |
| Section 1947 | Nondiscrimination | 42 USC § 300x-57 |
| Section 1953 | Continuation of Certain Programs | 42 USC § 300x-63 |
| Section 1955 | Services Provided by Nongovernmental Organizations | 42 USC § 300x-65 |
| Section 1956 | Services for Individuals with Co-Occurring Disorders | 42 USC § 300x-66 |
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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 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;

2. 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 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 other Certifications summarized above.

State: ________________________________

Name of Chief Executive Officer (CEO) or Designee: Terri L. White ________________________________

Signature of CEO or Designee¹: ________________________________

Title: Commissioner ________________________________ Date Signed: ________________________________

mm/dd/yyyy

1If 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:
### State Information

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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 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 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 designated 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 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: Terri White

Signature of CEO or Designee:

Title: Commissioner

Date Signed:

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

Footnotes:
## 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>Terri L. White</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>

**Signature:**

**Date:**

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

**Footnotes:**
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, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the 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 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. There are 21 Health Homes (HH) for adults with Serious Mental Illness (SMI) and 20 HH for children with Serious Emotional Disturbance (SED). Of these, 14 HH programs are provided by CMHCs. These HHs 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, and the Deputy Commissioner for Treatment and Recovery Services.

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 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).

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.

Prevention Services

The 17 Regional Prevention Coordinators (RPCs) serving all 77 counties in Oklahoma are the backbone of Oklahoma’s prevention service system. RPCs develop community level prevention work plans in partnership with community coalitions. 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 also administers 2Much2Lose (2M2L) as an overarching moniker of Oklahoma’s underage drinking prevention initiative. 2M2L initiatives include a youth leadership development program, delivery of AlcoholEdu in Oklahoma schools and the enforcement of underage drinking laws. 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 (which ended September 29, 2019) and SPF Rx programs funded by SAMHSA Center for Substance Abuse Prevention and state appropriated funds; the State Targeted Response to Opioids grant funded by SAHMSA Centers for Substance Abuse Prevention; the State Opioid Response grant funded by SAHMSA; the Prescription Drug Overdose project funded by SAHMSA Center for Substance Abuse Treatment; the First Responders CARA project funded by SAMHSAS; and Oklahoma’s Prescription For Change initiative supported by state appropriated funds. Two emerging prevention services include a partnership with the Oklahoma Department of Veterans Affairs to share a full-time employee for prevention and promotion services reaching veterans and military families;
and the development of Good Behavior Game (GBG) Support Center for Oklahoma schools.

**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.

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.
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
eventually 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 74 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 (OK) 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 by: 1) creating an improved crisis system for all children and families statewide that is standardized and sustainable; 2) implementing best practice outreach and engagement approaches for youth/young adults with first episode psychosis (FEP); and 3) building an early childhood SOC network, creating capacity and capability in local SOCs statewide to better serve the needs of infants, young children, and their families.

OK 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.

Drawing on best practices from our Now is the Time Initiative, 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). The goal is to engage youth into effective services and connect them with all needed supports early, thereby greatly increasing their chances of full recovery and a life of their choice.

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 accomplish all three 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; and building on an already robust regional training and infrastructure and university partnerships to ensure a workforce trained and prepared to deliver effective services.

The ODMHSAS currently has 21 Heath Homes in Oklahoma, 20 of which are Health Homes for children. Children’s Health Home programs use the Systems of Care philosophy and values, and use of the Wraparound process for those involved with multiple systems.

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. With the contracted FTC’s in the above mentioned counties as the demonstration sites, this initiative seeks to design programs appropriately implementing the provisions of CARA legislation. This initiative provides the platform for intentional strategic education and training around the importance of treating women prenatally and postnatally using plans of safe care. 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, and Kay. The
development of the FTC Best Practice Standards was a collaborative effort between national organizations, content experts, and federal agencies. Children and Family Futures (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.

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 300 licensed behavioral health disaster volunteers.

Per FEMA, Oklahoma has the 3rd highest per capita 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. 680 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. Since 2002, ODMHSAS and all supporting CIT partners, have trained around 1,200 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.

- **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, approximately 30,000 screens have been completed and 26,500 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 95.4 percent drop in unemployment, a 119.3 percent jump in monthly income, a 116.7 percent increase in participants with private health insurance and better than 81 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). There are approximately 4,000 drug court slots statewide.

- **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 60 percent drop in unemployment, a 97 percent decrease in arrests and an 89 percent decrease in the number of days spent in jail. Graduates of the program also show a 63 percent decrease in the number of needed inpatient hospital days. There are currently mental health courts in 19 Oklahoma counties with an additional 7 counties being planned. Appropriated state funding currently allows for approximately 700 mental health court slots statewide.

- **Misdemeanor 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 7 counties operating misdemeanor diversion programs, with an additional 9 in planning stages.

- **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. 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.

- **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 three 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. Three co-occurring treatment specialists, also employed by the ODMHSAS, are assigned to prisons and community corrections facilities to provide co-occurring treatment to inmates who need integrated treatment for mental health and addiction issues.
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 FY2019, a total of 77,033 children under age 18 were served in the ODMHSAS system by both mental health and substance use disorder providers; 14,993 children with SED. Additional information is provided below to address specific MHSBG requirements.

- **Mental Health and Rehabilitation Services for Children with SED.** CMHCs, Health Homes and SOCs (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.
  
  - Home-based services
  - Family therapy
  - Diagnosis-related education
  - Client advocacy
  - Outreach
  - Peer family support
  - Family self-sufficiency (housing)
  - Socialization
  - School-based services
  - Wraparound/flexible funds
  - 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 and SOC sites are developing collaborations with Federally Qualified Health Centers (FQHCs), tribal health services, clinics, homeless clinics and county health departments. Oklahoma currently has 21 behavioral Health Homes, 20 of which serve children. In FY2019 11,017 children with SED were served in HHs. Health Homes, 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 twelve teams serving 23 counties across the state of Oklahoma funded through various different grants, including the Mental Health Block Grant; State Opioid Response grant, Oklahoma Now is the Time grant, and the Assisted Outpatient Treatment 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.** The Now Is The Time – Healthy Transitions (NITT-HT) grant, referred to in Oklahoma as the Oklahoma Now Is The Time (ONIT) grant, focuses on integrated services and supports for youth and young adults ages 16 through 25 with serious mental health conditions and their families. ONIT’s developmentally-appropriate and effective youth-guided local Systems of Care have been designed to improve outcomes in education, employment, housing, mental health and co-occurring disorders, and decrease contact with the juvenile and criminal justice systems. ONIT programs focus on a blended model of Wraparound and Transition to Independence Process (TIP). Currently ONIT has five lab sites; three in Oklahoma County, one in Okmulgee County and one in Washington County. During FY17, 693 youth and young adults were outreached; 948 were screening for behavioral health needs; and 320 were referred to services.

- **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 2018 Children’s conference theme was Building on 25 years of coming together to share, learn and grow. The conference happened on May 1-3rd, at the Embassy suites Conference Center in Norman. The keynotes that year were Julian Ford, Ph.D. Alton Carter, Tracy Spears, and a transition aged youth panel. The format of the conference included a day of institutes and two days of workshops. We also had a youth track for youth 6-12 years of age and for youth aged 13-18 years of age.

The 2019 Children’s Behavioral Health Conference theme was Connecting the Dots. It happened on May 14-16th at the Embassy Suites Conference Center in Norman. The keynotes that year were Mike Veny and a professional culture panel made up of Dr. Raul Font, Courtney Yarholar, and Brittany Couch. This year our Ethics sessions were held during lunch in the grand ballroom so that everyone could take part in the session. The format of the conference included a day of institutes and two days of workshops. We also had a youth track for youth aged 6-12 years and for youth aged 13-18 years of age. This was the first time in many years that we had a specialized Family training and a Family Support Provider training as part of the conference as well as a specialized session for law enforcement on Drug Trends.

- 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 twelve teams serving 23 counties across the state of Oklahoma funded through various different grants, including the Mental Health Block Grant; State Opioid Response grant, Oklahoma Now is the Time grant, and the Assisted Outpatient Treatment 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.** 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 currently has 21 behavioral Health Homes. In FY2019, 10,791 adults with SMI were served in HHs. Health Homes, for adults with SMI, 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.

- **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 publically 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 29 minute stabilization services. Other modalities, such as Crisis Intervention Training (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. As of October 1, 2016 the ODMHSAS 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 continues to provide 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.

- **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.

• **Health Homes in Rural Areas.** There are currently 21 Health Homes (HH) for adults with SMI and children with SED were established. Of these 21 HHs, 17 provide HH services to rural communities.

• **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 (Cisco Jabber) 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 provide 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.** Pregnant women have priority status in Oklahoma. 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, through use of the Oklahoma Determination of ASAM Service Level (ODASL). 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. 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. Individuals meeting criteria will be considered standard population. There are 5 special populations that have enhanced
rates. Special population 1 SMI or co-occurring; Special population 2 SED or co-occurring; Special population 3 ASAM Level of Care 2.1: Intensive Outpatient Services [Age 18 and over]; Special population 4 ASAM Level of Care 2.1: Intensive Outpatient Services [Age 12 through 17]; Special population 5 Chronic Homeless or First Time Psychosis Episode for Children and Adults.

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.

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 include three Community Mental Health Agencies that cover 21 counties two urban and 19 rural. 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 waivered 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

Children and Youth who are At Risk for Mental, Emotional and Behavioral Disorders, including, but not limited to Addiction, Conduct Disorder and Depression.

The ODMHSAS is building the infrastructure using the Strategic Prevention Framework to provide a foundation for the prevention of mental, emotional, and behavioral disorders. Many of these have the same risk and causal factors in common and could benefit from shared prevention interventions. Oklahoma supports a broadened focus on multi-sector prevention systems development to expand interventions using shared strategies to serve the same or similar populations. In FY 11, the ODMHSAS embarked on Step 1 (Assessment) of the Strategic Prevention Framework to assess the nature, extent and driving factors of mental illness in the state. Oklahoma now administers the Adverse Childhood Experience module in the Behavioral Risk Factor Surveillance Survey as a strategy to fill data gaps identified during the assessment phase. A rigorous application of the SPF has followed to develop a state strategic prevention plan that incorporates mental illness prevention and mental health promotion. As a result, the ODMHSAS has initiated a contract with Oklahoma State University to develop and sustain a statewide support center for the implementation of Good Behavior Game in schools. Currently the State Targeted Response (STR) grant for the opioid crisis has targeted 40 high need classrooms in Oklahoma to implement this program. Additionally, the Office of Suicide Prevention has increased services for adults in community, emergency room, and behavioral health clinical settings.

Targeted Services for Community Populations for Environmental Prevention Activities. Oklahoma’s public health approach for substance abuse prevention services utilizes the Strategic Prevention Framework and focuses on decreasing risk and casual factors, such as the availability of alcohol and drugs, community norms regarding the acceptability of high-risk behaviors, the promotion of alcohol products, reducing family conflict, and youth rebelliousness. The ODMHSAS contracts with local agencies to plan and implement a public health based prevention strategy in multiple targeted communities on data-driven alcohol and other drug priorities. The funded entities build local prevention infrastructures that can support the implementation of a broad array of practices in targeted communities identified through a needs assessment process.
achieve population-level outcomes, evidence-based prevention strategies are implemented and include policies or practices that create a community or cultural environment that supports healthy and safe behavior.

The ODMHSAS continues to broaden prevention activities across the behavioral health spectrum and within the broader view of overall health status. Prevention staff members work across other divisions within the ODMHSAS and train at the community level to ensure that prevention activities are based on the following elements:

- Valid estimate(s) of communities' prevention needs using epidemiological data
- Community prevention capacity building focus
- Strategic plan(s)
- Evidence-based policies, practices, and programs implemented with fidelity
- Evaluation of outcomes

Local prevention service agencies are the direct recipients of prevention block grant funds. Statements of work with these entities stipulate that prevention services must be implemented in partnership between these agencies, coalitions and communities. Contracted providers have two explicit roles at the community level. First they must provide expertise and guidance through training and technical assistance to communities and community coalitions to build substance abuse prevention capacity. Secondly, they are required to strategically coordinate the implementation of prevention services at the local level in partnership with community stakeholders.

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.

**Targeted Services in Community Settings for Indicated Prevention Interventions.** Oklahoma will continue funding primary prevention services with the SAPTBG but the ODMHSAS will also continue to examine community needs and the impact of providing other prevention services, utilizing available resources. Many of the targeted services and system components described throughout this section include public awareness and preventive supports within the contexts of providing those other direct services. Those often are targeted to specific community settings and groups closely affiliated with the recipients of targeted treatment and support 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 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. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

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

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 included 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 2018 Census population estimates, Oklahoma has a population of 3,943,079 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 74.2% of the population is White; 7.8 percent is Black; 9.3% is American Indian/Alaska Native; 2.3% is Asian; 0.2% percent is Native Hawaiian and Other Pacific Islander; and 6.2% are of two or more races. Oklahoma also has a Hispanic/Latino population of 10.9%. 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 2013-2017 is $49,767 compared to the US median income of $57,652. The percentage of persons below poverty level is 15.8% which is higher than the national
percentage of 12.3%\(^1\).

**Health Status for Behavioral Health Consumers with Complex Health Needs.** According to the America's Health Rankings® 2018, Oklahoma ranks 47th for overall health status and had the largest rank decline from 2017 due mostly to increases in obesity and physical inactivity.\(^2\) The state ranked 43rd for diabetes, 48th for obesity, 39th on tobacco use, 45th for cancer deaths, 34th for drug deaths, 49th on lack of insurance, 47th on physical inactivity, 40th on infectious disease, 45th for immunizations for adolescents, 43rd for immunizations for children, 44th of preventable hospitalizations, 48th for cardiovascular deaths, and 44th on premature death. The 2019 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance, with the state in the bottom quartile on access and affordability, avoidable hospital use and costs, healthy lives, and disparity.\(^3\) 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.\(^4\)

- The State’s chronic lower respiratory disease is ranked second compared to other state rates in 2017.\(^4\)

- 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.\(^4\)

- Oklahoma is ranked fifth for chronic liver disease/cirrhosis, resulting in 670 deaths in 2017.\(^4\) 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.\(^5\)

**Tobacco Use**

- In 2017, 20.2% of adult Oklahomans smoked. Nationally, the rate was 17.1%.\(^6\)
- 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%.\(^7\)
- In 2017, 7.1% of adults used e-cigarettes and 7.4% used smokeless tobacco.\(^8\)
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%. 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%.

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

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 Emotional Disturbance. All 14 CMHCs and nine private mental health facilities are designated as HHs, providing statewide coverage with over 120 different HH locations.

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 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 SFY2018, 73,645 persons with the SMI designation was served through the Oklahoma publically funded behavioral health system. This represents 70.2% of the 104,839 adults served.
• According to the NSDUH 2016-2017 Report, Oklahoma is ranked 15th for serious mental illness in the past year, with a rate of 4.99% compared to the national rate of 4.38%.10

• While 14.52% received mental health services in the past year in Oklahoma, the State rank is 36th.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, 20.02%, 18.57%, respectively. Oklahoma has the 14th highest rate in the nation.10

• The State is ranked 13th in the nation for “major depressive episode” in the past year and has a higher rate at 7.75% vs. 6.89%.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 FY2018, the total number of children 0-18 served was 89,566. The total number of children 0-18 years with an SED designation served was 41,992 (46.8%).9

The 14 CMHC are participate 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 disorder in the past year* for persons 12 years and older was 2.77, compared to the US rate of 2.76.\textsuperscript{10}

• *Pain Reliever Use Disorder in the Past Year* for person 12 years and older the Oklahoma rate was .69 versus the national rate of .63.\textsuperscript{10}

• *Alcohol Use Disorder in the Past Year* for person 12 years and older the State rate was 5.9 compared to the national rate of 5.82.\textsuperscript{10}

• *Substance Use Disorder in the Past Year* for person 12 years and older the Oklahoma rate was 7.44 versus the US rate of 7.35; for persons 18 years and older the State rate was 7.88 versus the US rate of 7.72.\textsuperscript{10}

• *Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use in the Past Year* for person 12 years and older the Oklahoma rate was 2.23 compared to the national rate of 2.45; for persons 18 years and older the State rate is 2.13versys the US rate of 2.4.\textsuperscript{10}

• *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 5.28 compared to the US rate of 5.22; for persons 18 years and older the Oklahoma rate was 5.66 versus the national rate of 5.5.\textsuperscript{10}

• *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 6.83 compared to US rate of 6.82; for persons 18 years and older the State rate was 7.12 versus the US rate of 7.11.\textsuperscript{10}

The substance use disorder (SUD) treatment and recovery services network is comprised of 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. 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.

**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. 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.

- I 2017 there were 388 overdose deaths involving opioids in Oklahoma—a rate of 10.2 deaths per 100,000 persons, compared to the national rate of 14.6 deaths per 100,000 persons.21

- The most significant decline occurred among deaths involving prescription opioids, from 444 deaths in 2012 to 251 deaths in 2017. Deaths involving synthetic opioids (mainly fentanyl) have remained steady since 2010 with 102 deaths reported in 2017. 21

- Those involving heroin have increased threefold since 2011 from 17 deaths to 61 deaths in 2017.21

- In 2017, Oklahoma providers wrote 88.1 opioid prescriptions for every 100 persons (a 30 percent decline since 2012, when the rate was 127 opioid prescriptions per 100 persons).22

From January 2015 through December 2017, researchers looked at opioid overdose mortality rates and public access to three types of medicine used to treat opioid use disorder in more than 3,000 counties nationwide. Counties which ranked below average in both of these categories were deemed to be at high risk in the opioid crisis.23

- Oklahoma ranked within the Top 10 of states with the greatest percentage of high-risk counties.23

- Eighteen of its 77 counties are at least twice as likely to be at high risk for opioid overdose deaths and to lack providers who can deliver medications to treat opioid use disorder.23

To combat opioid abuse, the ODMHSAS is focused on increasing access to medication-assisted treatment (MAT), reducing unmet needs and overdose related deaths through the provision of prevention, treatment, and recovery activities. In addition, the Department 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 that affect their bodies and their overall health. These risks
include HIV and Hepatitis C. And because of the illegal status of most drugs that are injected and the perceived stigma of injection drug use, many PPWIDs do not seek medical attention.

- In 2016, 9 percent (3,480) of the 39,589 new diagnoses of HIV in the United States were attributed to injecting drug use. Among males, 6.3 percent (2,530) of new cases were transmitted via injecting drug use or male-to-male contact and injecting drug use. Among females, 2.3 percent (950) were transmitted via injecting drug use.  

- Of the new HIV cases in 2016, 293 occurred in Oklahoma. Among males, 16.6 percent of new HIV cases were attributed to injecting drug use or male-to-male contact and injecting drug use. Among females, 13.5 percent of new HIV cases were attributed to injecting drug use. 

- In 2016, 991,447 Americans were living with a diagnosed HIV infection—a rate of 306.6 cases per 100,000 persons. Among males, 19.9 percent (150,466) contracted HIV from injecting drug use or male-to-male contact and injecting drug use while 21 percent (50,154) of females were living with HIV attributed to injecting drug use.

- In 2015, an estimated 5,774 persons were living with a diagnosed HIV infection in Oklahoma—a rate of 179 cases per 100,000 persons. Of those, 18.6 percent of male cases were attributed to injecting drug use or male-to-male contact and injecting drug use. Among females, 26.3 percent were living with HIV attributed to injecting drug use.

- In 2016, there were an estimated 41,200 new cases of acute Hepatitis C (HCV)(CDC). Among case reports that contain information about injecting drug use, 68.6 percent indicated use of injection drugs.

- In 2016, 32 cases of acute HCV (0.8 cases per 100,000 persons) were reported in Oklahoma. Among those, 62.5 percent reported injecting drug use.

- 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.
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., *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.

**Persons at Risk for Tuberculosis.** While the national rate of tuberculosis in the US was 2.8 per 100,000 population in 2017, the rate in Oklahoma was 1.4, down 30.9 percent from 2016. In 2017, 54 cases were reported in Oklahoma, down 30.8 percent from 2016. Oklahoma ties two other states for the 14th lower rate in the nation.²⁴

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**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 366,706, comprising 9.3 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.\textsuperscript{27,28}

• Lung cancer is the leading cause of cancer deaths among AI/AN.\textsuperscript{25,27,28,29}

• Diabetes is the fourth leading cause of death among AI/AN.\textsuperscript{27,28} The risk of developing diabetes is 30–40% higher for smokers than nonsmokers.\textsuperscript{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.\textsuperscript{31}

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

Suicide rates are higher with AI youth as well. A study using data from the National Violent Death Reporting System compared non-Hispanic AI/AN and non–Hispanic white decedents from 2003-2014.\textsuperscript{32}

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

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

The CCBHCs 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 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.

- Black preschoolers in Oklahoma receive 2 in 10 out-of-school suspensions, despite making up only 1 in 10 students.\(^8^9\)
- 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.\(^9^0\)
- Black youth were arrested at a rate three times greater than their white peers in FY 2013 in the State.\(^9^1\)
- 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.\(^9^2\)

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.\(^9^3\) Black children made 37 percent fewer visits to psychiatrists, and 47 percent fewer visits to any mental health professional, than white children. The authors commented, “Minority kids don’t get help when they’re in trouble. Instead they get expelled or jailed.”

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.\(^3^3\)

- In state prisons, 73 percent of women and 55 percent of men have at least one mental health problem.\(^3^4\)
- In federal prisons, 61 percent of women and 44 percent of men have at least one mental health problem.\(^3^4\)
- In local jails, 75 percent of women and 63 percent of men have at least one mental health problem.\(^3^4\)

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, 2019, Oklahoma has 26,009 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 2018 there were 17,798 adults arrested for drug-related crimes and 22,732 arrested for alcohol-related crimes, resulting in 39 percent of arrests being alcohol or drug-related.\(^3^6\) This does 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 Discharge Planners and Co-occurring Treatment Specialists at three targeted correctional facilities.

The ODMHSAS is providing training on Statewide Moral Reconation Therapy (MRT), an evidence based curriculum designed to reduce criminogenic behavior. In addition, 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. Drugs courts are now available in 76 of the 77 counties.
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.\(^{42}\)

- 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.\(^{42}\)
- 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.\(^{42}\)
- 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).\(^{42}\)
- 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.\(^{42}\)

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.\(^{43}\)

- 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.\(^{43}\)
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.

**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.  

- Compared to people that identify as straight, LBGT individuals are 3 times more likely to experience a mental health condition.  

- LBGT youth are 4 times more likely to attempt suicide, experience suicidal thoughts, and engage in self-harm, as compared to youths that are straight.

- For transgender individuals, 38-65% experience suicidal ideation.

- An estimated 20-30% of LGBT individuals abuse substance, compared to about 9% of the general population.

- 25% of LGBT individuals abuse alcohol, compared to 5-10% of the general population.

- LBGT individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse.

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.

- SUD rates among people older than 50 years are projected to increase from about 2.8 million in 2006 to 5.7 million in 2020.\(^52\)

- 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.\textsuperscript{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.

<table>
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<th>ICD-10 Code</th>
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<td><strong>Total</strong></td>
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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.\textsuperscript{62}

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 the most NSDUH data available, 8.3% of children under the age of 18 years are living with a parent who abused alcohol or an illicit drug in the last year. Another 10.3% lived with a parent who was dependent on or abused alcohol and 3% lived with a parent who was dependent on or abused illicit drugs.63

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.

As stated above, the ODMHSAS has implemented an electronic wait list with priority given to 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. 1 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. 1 in heart-disease mortality
- No. 2 in male incarceration rates
- No. 3 in divorce with 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. 5 in cancer deaths per capita, according to the U.S. Centers for Disease Control and Prevention.
- No. 5 in teen smoking with an estimated 12.5% of teens, according to CDC data.
- No. 9 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.
- Oklahoma and Montana were tied 17 percent for children with three or more, the highest rate in the nation.
- In fact, 38% of Oklahoma children in the survey had one or two ACEs and 17% had three or more Aces.
- Oklahoma’s most common ACEs were attributed to economic hardship (30%),
divorce (30%), alcohol (17%), violence (13%), and mental illness (12%).

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.
- Psychosis often begins when a person is in their late teens to mid-twenties.
- Three out of 100 people will experience psychosis at some time in their lives.

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 2017 was $44,376, although rural per capita income lagged at $37,256. The ERS reports that the poverty rate in rural Oklahoma is 18.9%, compared with 14.4% in urban areas of the state. Of the rural population, 14.3% has not completed high school, while 11.5% of the urban population lacks a high school diploma. The unemployment rate in rural Oklahoma is 3.5%, while in urban Oklahoma, it is 3.3.

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 2019, 11,126 Oklahomans were given behavioral health care services via Telehealth.
- For this same year, 27,061 services were delivered via telehealth.

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. Department of Housing and Urban Development 2017 Annual Homeless Assessment Report, Oklahoma has a homeless population of 5,854. 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 2,692 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.\textsuperscript{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 2.8 per 100,000 population in 2017, the rate in Oklahoma was 1.4, down 30.9 percent from 2016.\textsuperscript{64} In 2017, 54 cases were reported in Oklahoma, down 30.8 percent from 2016. Oklahoma ties two other states for the 14\textsuperscript{th} lower rate in the nation.\textsuperscript{64}

**Prevention and Early Identification.**

**Suicide Prevention.** According to the Centers for Disease Control and Prevention (CDC) in 2017 (the most recent year for which full data are available), 47,173 suicides were reported, making suicide the 10\textsuperscript{th} leading cause of death for Americans.\textsuperscript{65} More years of life are lost to suicide than to any other single cause except heart disease and cancer.\textsuperscript{66}

- Of persons who complete suicide, 40 percent had made a previous attempt.\textsuperscript{67} 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.\textsuperscript{68}
- Those with substance use disorders are six times more likely to complete suicide than those without.\textsuperscript{69} 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 2017 suicide rate in Oklahoma was 19.1/100,000 compared to the U.S. rate of 14/100,000. Oklahoma tied with Kansas for the 13\textsuperscript{th} worse suicide rate in the nation.\textsuperscript{70}
- Oklahoma’s suicide rate increased by 37.6 percent from 1999 to 2016.\textsuperscript{71}

- In 2016, there were 812 suicides by Oklahoma residents, 647 males and 165 females.\textsuperscript{72}

- Suicides comprised 68% of all violent deaths.

  - Suicide is the most common type of violent death in Oklahoma, with an average of 742 deaths per years.\textsuperscript{73}

  - 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 a 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 Pan 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 2008-2017, Oklahoma’s rate of motor vehicle crash fatalities involving a driver with a blood alcohol concentration of ≥0.01 was 4.9/100,000 compared to the national rate of 3.9/100,000.\(^{80}\)
- The percentage of high school students who used alcohol in the past 30 days was 31.6% compare to 29.8% in the nation for 2017.\(^{81}\)
- The prevalence of past year alcohol use disorder for individuals aged 12 and older for 2016-2017 was 5.9% compared to the US rate of 5.5%.\(^{82}\)

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.** Oklahoma has strategically designed its funding model to maximize the number of Oklahomans exposed to primary prevention strategies.

The prevention portion of the SABG funds a Regional Prevention Coordinator (RPC) system. Each RPC covers one of seventeen regions in Oklahoma. Each region comprises one to seven counties (with region size based on a combination of population and geographic area). RPCs serve as primary prevention strategists, coordinators, and service providers in their respective regions. Their primary mission is to make all individuals and systems within every domain in their region “prevention-capable”; meaning that those citizens living within those regions are knowledgeable, ready, and equipped to reduce risk and increase protection for substance use disorders as they carry out their daily lives and job duties. Due to the complexity of this task, each RPC is required to provide a set of “core regional prevention services” throughout their entire region so that all Oklahoma citizens within that region receive basic primary prevention
services. In addition, RPCs are required to prioritize communities of high need (based on data) within their region to implement primary prevention services with the goal of increasing that community’s prevention capacity in a sustainable manner.

Furthermore, Oklahoma braids its prevention set-aside with its SPF-PFS, SPF Rx, STR, SOR and other discretionary funds to maximize resources and expenditures for communities. In addition, Oklahoma maximizes its resources through strong tribal partnerships (joint training, evaluation, planning) toward primary prevention strategies.

**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. Overdose deaths involving prescription opioids were five times higher in 2016 than in 1999.

- Of all of the unintentional poisoning deaths involving prescription drugs, illicit drugs, or alcohol in Oklahoma in 2017, 46 percent were due to a prescription, 37.3 percent were due to opioid prescription, 12.8 percent were due to anti-anxiety, 16 percent were due to alcohol, 41.3 percent were due to methamphetamine, and 9.3 percent were due to illicit opiates.

- According to data from the 2016-17 NSDUH, Oklahoma was higher than the national average for the nonmedical use of pain killers in the past year for all age categories. Oklahoma has been above the national average for the percentage of residents reporting nonmedical use of pain relievers since 2004.

**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.

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.
- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.
- Increase their confidence in and likelihood to help an individual in distress.
- Show increased mental wellness themselves.
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. 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 FY2019 there were 283 newly certified PRSSs bringing the total of active statewide PRSS workforce to 705. Below are the specialized PRSS supplemental training and the number trained in each category.

- PRSS Supervisors - 51
- PRSS Veterans - 35
- PRSS Youth - 81
- PRSS Older Adult - 7
- PRSS Gambling - 25

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. (Carrie sent me the updated list of members).

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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
1. United States Census Bureau, State and County Quick Facts. Retrieved from https://www.google.com/search?q=quick+facts+ok&rlz=1C1CHZL_enUS765US765&oq=quick&aqs=chrome.2.69i57j0j69i59j0l2j69i60.3174j0j8&sourceid=chrome&ie=UTF-8.


75. Mental Health First Aid, USA. Retrieved from https://www.mentalhealthfirstaid.org/.
76. Mental Health First Aid, Research and Evidence Base. Retrieved from https://www.mentalhealthfirstaid.org/about/research/.
92. The Bruns Institute for Justice Fairness and Equity, Unbalanced Youth Justice, Oklahoma. Retrieved from: http://data.burnsinstitute.org/decision-
Planning Steps

Quality and Data Collection Readiness

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

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

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

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

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

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

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners. SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

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

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

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

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

Footnotes:
PLANNING STEPS

Quality and Data Collection Readiness

In 2010, the ODMHSAS and the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, merged the two agencies’ management information systems into a consolidated claims system, establishing standardized processes, including eligibility determination, authorizations, claims filing and outcome reporting for all publically funded behavioral health care. At the same time, the combined payer system was designed to maximize federal Medicaid matching funds by ensuring that services for consumers eligible for Medicaid payments are paid from this funding source rather than State or block grant funds. The system uses a unique identifier that allows consumers to be linked across providers and over time. Because it is a relational database, pharmacy claims and encounter data, including inpatient and outpatient claims, can be linked back to the individual. Demographics, diagnosis, assessment scores and outcome data are also linked. The ODMHSAS was the first state to submit both the admission and the discharge set to the Treatment Episode Data Set (TEDS) program. Each facility, facility location and clinician has a unique identifier and can be linked back to the service and consumer. There are over 100 service codes and modifier combinations which provide detailed information about the types and duration of services each consumer is receiving. Rates are attached to all of the services, which allow cost reports to be calculated.

The ODMHSAS designed and manages the prior authorization system which interacts with the Medicaid Management Information System (MMIS). The prior authorization system, the Person-Centered Integrated Client Information System (PICIS) not only authorizes services and payment amounts but also collects data for outcome measures. These data include information about demographic characteristics, living arrangements, employment, income, legal and marital status, language proficiency, education, disabilities, diagnoses, level of functioning, drugs of choice (including tobacco), frequency of use, and client assessment results. Consumer information is collected and reported at admission, six-month update, and discharge. Comparisons can be made from admission to updates on items such employment status, housing status, frequency of alcohol/drug use, and level of functioning. PICIS data on age, race, ethnicity, gender, marital status, language, physical disabilities, drugs of choice, level of functioning scores, and other elements can be cross-tabulated with services, retention, and outcome information to determine where behavioral health disparities are occurring. This information is linked to claims and encounter data giving the ODMHSAS the ability to report data at the client, program, provider and state level.

The Medicaid Management Information System (MMIS), where all claims are submitted, collects data on behavioral health, physical health (including outpatient and inpatient), pharmacy, and dental care paid for by Medicaid and the ODMHSAS. The PICIS system is an integrated prior authorization and outcomes database that is specific to mental health and substance abuse treatment funded by Medicaid and the ODMHSAS. The systems are linked through unique identifiers.
The ODMHSAS has been reporting data at the client level since the late 1980s to the TEDS and reported client level data through the SAMHSA Client Level Data (CLD) reporting process for the 2011-13 block grant periods. In 2014 the client level data was submitted through the MH-TEDS process.

The ODMHSAS collects primary prevention data, including NOMs, through numerous methods. Oklahoma uses several state and national data sets to assess substance abuse consumption and consequences. National data sets include NSDUH, BRFSS, YRBS, PRAMS, TEDS, FARS, the Uniform Crime Report, and the National Vital Statics System. State data sources include statistics from OBNDD, the Oklahoma PMP, state hospital data associated with opiate use, recovery support program data, and the Oklahoma Prevention Needs Assessment Survey (OPNA). The OPNA is a statewide survey administered by ODMHSAS to students in grades 6, 8, 10, and 12 during even-numbered spring semesters to avoid conflicting with the YRBS, which is administered in odd-numbered years. The ODMHSAS has also developed an online database which is intended to complement the written state epidemiology profile report and allow substance abuse prevention professionals to access and download SEOW data at the community level for further analysis as needed. The website also allows users to generate customizable queries of indicators by county for several years of data and examine trends within certain demographic variables—such as gender, grade, and age—when these data are available.

The ODMHSAS implemented a new prevention contractor reporting data system, OKPROS (Oklahoma Prevention Reporting Outcomes System), in the fall of 2011. OKPROS can be used for planning, resource allocation, and evaluation of prevention strategies, and collects and reports all SAMHSA required NOMs data for the block grant application. Each contractor of primary prevention services through the SABG are assigned a unique identifier and report prevention services by evidence-based strategy, sub strategy, IOM classification, CSAP prevention strategies, population served, date of transaction, time dedicated, and supporting documentation.

The ODMHSAS disseminates evidence based practices (EBPs) and promising practices strategically and systematically. It starts with analyzing need, readiness, and sustainability prior to model selection. Once a model is selected, a budget is developed for contracting with purveyors for training. Models which provide a train the trainer model are preferred, and at times the ODMHSAS has been successful negotiating with purveyors who have not previously offered that option. Also, training is not put into place without follow up consultation and/or coaching. The agency enjoys a successful track record of statewide dissemination. It typically utilizes grants to contract with purveyors and offer training and consultation free of charge. When possible through grant funding, agencies are reimbursed for lost billing time in order to bring effective practices to scale with fidelity. EBPs that are practical and affordable for statewide implementation within a public behavioral health system are chosen, with preference to those tested on a wide group of persons. EBP models that are determined will not
eventually result in state capacity to sustain without ongoing high payments to the purveyor are rejected.

The following models have been chosen for statewide dissemination and the state planning process has reinforced this direction and fit all the criteria explained above. In addition, they are effective for prevalent MH and SUD issues and conditions in our state. Oklahomans experience a high degree of trauma from a variety of sources which predisposes them to negative MH, overall health, and SUD outcomes. We are consistently ranked near the top nationally in percentage of adults with serious mental illness and unhealthiest citizens. For all the reasons given in the previous two paragraphs, the following models have been chosen:

1) **Cognitive Behavior Therapy (CBT)** is one of the few forms of psychotherapy that has been scientifically tested and found to be effective in hundreds of clinical trials for many different disorders. In contrast to other forms of psychotherapy, CBT is more focused on the present, is more time-limited, and is more problem-solving oriented (Beck Institute, n.d.). The ODMHSAS has provided CBT training to CMHCs through the Beck Institute. All CMHCs employ clinical staff trained in CBT. This will be a requirement for CCBHCs ongoing. Also, a review of literature of EBPs reveals quickly that CBT is the most common element between EBPs.

2) **Collaborative Assessment and Management of Suicidality (CAMS)** is being implemented at the state level as the required clinical training for the treatment of clients presenting with risk of suicide. CAMS is an evidence based approach to the care of clients at risk of suicide. It can be used by a clinician regardless of his or her preferred form of therapy. CAMS has been proven to reduce suicidal thoughts of patients in six published, peer reviewed trials and one randomized clinical trial (Jobes, 2012). A number of trials have shown success in working with veterans, an identified at-risk population in OK. The ODMHSAS chose this framework based on its adaptability across a variety of therapeutic disciplines and efficacy in reducing symptoms. CAMS is the chosen model for the OK Zero Suicide Initiative. The ODMHSAS provided training and consultation to clinical staff in all CMHCs, and will continue to do so. This will be a requirement for CCBHCs ongoing.

3) **Trauma-focused Cognitive Behavioral Therapy (TF-CBT)** has consistently demonstrated it is useful in reducing symptoms of PTSD and depression, and behavioral difficulties in children who have experienced sexual abuse and other traumas (Cohen and Mannarino, 1996; Deblinger, et al., 1996; Stauffer and Deblinger, 1999; Cohen and Mannarino, 1997; Deblinger, et al., 1999; King et al., 2000; Deblinger et al., 2001; and Cohen et al., 2004). Furthermore, TF-CBT has been identified as a model program by SAMHSA (SAMHSA, 2005). TF-CBT is effective for children in foster care who have experienced any trauma, including multiple traumas. It has been
demonstrated to be effective with children from diverse backgrounds and works in as few as 12 treatment sessions. It has also been used in home-based and residential treatment facilities. The model works even if there is no parent or caregiver to participate in treatment. To provide a culturally competent approach TF-CBT has been used effectively in a variety of languages and countries. OK has been involved with training the workforce in the TF-CBT model. TF-CBT training is required for all CMHCs, along with the screening tool and protocol selected through the BeMe initiative, and will be required ongoing for all CCBHCs.

4) *Wraparound*: Wraparound is under review for inclusion in the National Registry of Evidence-based Programs and Practices (NREPP) as an EBP. It is a promising practice that is gaining in research evidence (Suter and Bruns, 2009). In 2005, Bob Friedman and David Drews stated in *Evidence-Based Practices, Systems of Care, and Individualized Care*, “It should be noted at the outset that the Wraparound process may be considered to be an evidence-based process by itself.” The ODMHSAS has enjoyed great success in disseminating the Wraparound process and outcomes, as analyzed and reported by external evaluators, the OU E-TEAM, and results continue to prove strong each year. Wraparound is the process model that OK has chosen for children up to age 21 who experience SED, including those with a co-occurring substance use disorder. It is also listed as an EBP by the California Evidence-Based Clearinghouse for Child Welfare, the State of Oregon Inventory of EBPs, and the Washington Institute for Public Policy.

5) *Motivational Interviewing (MI)* is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI has been applied to a wide range of problem behaviors related to SUD, as well as health promotion, medical treatment adherence, and MH issues. As of 2013, MI has been implemented at more than 30,000 sites in all 50 states and around the world, with an estimated 3 million clients (SAMHSA, 2005). This is one of the foundational models to ensure successful outcomes and will be an ongoing requirement for all clinicians in CCBHCs.

6) *Chronic Care Model* is well established within primary care as best practice for managing chronic illnesses. However, this model has not been fully established in specialty care settings, such as MH (Woltmann, et al., 2012). Chronic diseases are the leading cause of disability and death in the United States (CDC, n.d.). People with mental illness are especially vulnerable: 68% of people with a mental illness also have a physical health condition such as cardiovascular disease, diabetes, and hypertension. These high-need individuals often receive uncoordinated, inefficient care, resulting in higher costs and poorer health outcomes (SAMHSA, 2012). This model has
been adopted for BHHs in OK and will be required for the CCBHCs. Training in integrated care is provided and required.

In addition to the required EBPs for CCBHCs, the ODMHSAS is disseminating the following EBPs to address service gaps already known and/or identified in the needs assessment process:

**Adolescent Community Reinforcement Approach:** Selection of A-CRA was based on the strength of evidence as an effective treatment model and the documented skill of the purveyor to efficiently disseminate the practice through training and consultation. In addition, it is a cost effective approach which must be a priority for a publicly-funded behavioral health system. The effectiveness of A-CRA is supported by several randomized clinical trials (Godley et al. 2001). This will assist in addressing the following statistics listed by SAMHSA: “An estimated 1.3 million U.S. adolescents 12 to 17 had an SUD in 2014 which is 5% of all adolescents and youth transitioning into adulthood have some of the highest rates of SUD.

**Seeking Safety** is a very cost effective evidence based model for helping individuals with SUD or co-occurring disorders. There is currently a pilot project that has trained Peer Recovery Supports in this model to provide the service, which will assist in addressing the workforce shortage issues. This EBP addresses the youth and up cultural needs around trauma. All three CCBHCs have been trained and are actively utilizing the model. The blended Wraparound/TIP model will also be used to serve the young adults with SED or severe SUD issues. (Clark, 2009; Suter and Bruns, 2009). The Wraparound/TIP model is an adaptation to meet the growing need for youth and young adults who are transitioning through life, potentially without familial support.

**Child Parent Psychotherapy** is a treatment for trauma-exposed children ages birth to five (0-5). This will be offered within the demonstration period to enhance the services for the birth to five population who are in need of early infant MH services. **Circle of Security® (COS)** protocol is an early intervention program designed to prevent insecure attachment and child mental disorders. It includes a user-friendly, visually based approach utilizing extensive graphics and video clips to help parents better understand the needs of their children. It is based upon attachment theory and current affective neuroscience. COS is considered a promising practice based on research to date.

All providers have been trained in **Strengthening and Celebrating Families Programs** (SAMHSA, n.d.) to meet the cultural needs of the whole family whether they have SUD, MH, or familial issues. RR will be trained in the **RA1SE NAVIGATE Early Treatment Program** (ETP) model and provide this program within the year to serve youth and young adults in transition with a first episode of psychosis (NIMH.nih.gov, n.d.).
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs (illicit or misuse of prescription). SBIRT can be used to effectively encourage individuals to reduce or eliminate problematic drug or alcohol use. There are three components of SBIRT.

- **Screening** quickly assesses the severity of substance use and identifies the appropriate level of response.
- **Brief intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to treatment** provides those identified as needing more extensive treatment with access to specialty care.

**Mental Health First Aid** is a public education program that introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews appropriate supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect people to the appropriate professional, peer, social and self-help care. The program also teaches common risk factors and warning signs of specific illnesses like anxiety, depression, substance use, bipolar disorder, eating disorders and schizophrenia. Mental Health First Aid is included on the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices (NREPP).

Mental Health First Aid teaches participants a five-step action plan, ALGEE, to support someone developing signs and symptoms of a mental illness or experiencing an emotional crisis: Assess risk of suicide or harm; Listen non-judgmental; Give reassurance and information; Encourage the person to get appropriate professional help; and Encourage self-help and other support strategies from peers, family members, and friends.

Like CPR, Mental Health First Aid prepares participants to interact with a person in crisis and connect the person with help. First Aiders do not diagnose or provide any counseling or therapy. Instead, the program offers concrete tools and answers key questions like, “What do I do?” and, “Where can someone find help?” Certified Mental Health First Aid instructors provide a list of community healthcare providers and national resources, support groups and online tools for mental health and addictions treatment and support. All trainees receive a program manual to complement the course material.

**Strengthening Families Program (SFP)** is a nationally recognized parenting and family strengthening program for high-risk and general population families. SFP is a 14-
session manualized evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

*Kognito At-Risk for Educators* is a suite of 50-minute, online, interactive evidence-based gatekeeper training program that teaches educators and staff how to (1) identify students exhibiting signs of psychological distress, including depression and thoughts of suicide, (2) approach students to discuss their concern, and (3) make a referral to school support personnel. During the training, learners assume the role of a teacher concerned about three students. Learners explore each student’s profile, including descriptions of social and classroom behavior. Then they engage in simulated conversations with each student. In these virtual conversations, users learn effective conversation strategies for broaching the topic of psychological distress, motivating the student to seek help, and avoiding pitfalls, such as attempting to counsel. Specific attention is paid to increasing student resiliency, discerning situations of potential bullying and/or cyber-bullying, and intervening when concerned for a student’s immediate safety.

*Kognito Resilient Together: Coping with Loss at School* is an interactive role-play simulation to prepare schools for responding to a death in the school community. Teachers and administrators learn key elements of a crisis response plan, including postvention, and best practices for communicating with students and colleagues impacted by a loss in the school.

*QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention* is a 1-2 hour educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond. Gatekeepers can include anyone who is strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers). The process follows three steps: (1) Question the individual's desire or intent regarding suicide, (2) Persuade the person to seek and accept help, and (3) Refer the person to appropriate resources. Trainees receive a QPR booklet and wallet card as a review and resource tool that includes local referral resources.

*Lifelines Postvention. Responding to Suicide and Other Traumatic Death* is a 170-page manual with accompanying electronic material that provides a template for creating a school-based response to the death of a member of the school community by suicide or other traumatic means.
Stanley-Brown Safety Plan Intervention. The purpose of this EBP is to provide people who are experiencing suicidal ideation with a specific set of concrete strategies to use in order to decrease the risk of suicidal behavior. The safety plan includes coping strategies that may be used and individuals or agencies that may be contacted during a crisis. Staff from an accredited crisis intervention center and National Suicide Prevention Lifeline Network affiliate, use this EBP as part of follow up protocol with individuals discharged from a hospital following a suicide attempt/acute suicide ideation.

Overdose Education and Naloxone Distribution: OEND services provide education on prevention and response to opioid overdose and access to naloxone nasal spray to provide immediate treatment of opioid overdose. OEND models show that access to naloxone can reduce the number of overdose deaths in a community(Walley, 2013).
# 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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<th>Footnotes:</th>
</tr>
</thead>
</table>

NOT FINAL
## 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 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

### Planning Tables

<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>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$25,720,916</td>
<td></td>
<td>$68,954,714</td>
<td>$12,539,154</td>
<td>$78,173,692</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$12,471,200</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$6,858,912</td>
<td>0</td>
<td>$10,324,380</td>
<td>$9,568,942</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$1,714,728</td>
<td>0</td>
<td>0</td>
<td>$4,865,874</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>10. Total</td>
<td>$34,294,556</td>
<td>0</td>
<td>$68,954,714</td>
<td>$22,863,534</td>
<td>$92,608,508</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention
** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
### 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 2020/2021.

**Planning Period Start Date:** 7/1/2019  
**Planning Period End Date:** 6/30/2021

<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>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**</td>
<td>$1,458,780</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$12,399,628</td>
<td>$278,901,776</td>
<td>$34,803,388</td>
<td>$574,421,604</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)***</td>
<td>$729,390</td>
<td>$0</td>
<td>$0</td>
<td>$6,104,598</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$0</td>
<td>$14,587,798</td>
<td>$278,901,776</td>
<td>$34,803,388</td>
<td>$580,526,202</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

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

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.
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>1618</td>
<td>974</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>24134</td>
<td>24134</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>134065</td>
<td>6966</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>76249</td>
<td>8555</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>5854</td>
<td>4725</td>
</tr>
</tbody>
</table>

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

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

Footnotes:
## Planning Tables

### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment*</td>
<td>$12,860,458</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$3,429,456</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV**</td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$857,364</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$17,147,278</strong></td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that 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; 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 will be 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 are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for 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 a 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 will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:
# Planning Tables

## Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019  Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FFY 2020</th>
<th>SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td></td>
<td>$188,283</td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td>$188,283</td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$171,402</td>
<td></td>
</tr>
<tr>
<td>2. Education</td>
<td>Selective</td>
<td>$6,665</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td>$178,067</td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$20,539</td>
<td></td>
</tr>
<tr>
<td>3. Alternatives</td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td>$20,539</td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$2,738</td>
<td></td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td>Indicated</td>
<td></td>
<td>$2,738</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td>$2,738</td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$1,364,899</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Selective</td>
<td>Indicated</td>
<td>Unspecified</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>5. Community-Based Process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Environmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Section 1926 Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Prevention Expenditures**

|                  | $3,430,229 |

**Total SABG Award**

|                  | $17,147,278 |

**Planned Primary Prevention Percentage**

|                  | 20.00 %     |

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019  
Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td></td>
</tr>
<tr>
<td>Universal Indirect</td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
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<tr>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$17,147,278</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>0.00 %</strong></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020  

**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 2020 and FFY 2021 SABG awards.

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Targeted Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
</tr>
<tr>
<td>Military Families</td>
</tr>
<tr>
<td>LGBTQ</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
</tr>
</tbody>
</table>
## Planning Tables

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

Planning Period Start Date: 10/1/2019     Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</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>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td>$690,000</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$690,000</strong></td>
<td><strong>$0</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.*

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020
### Table 6 Non-Direct-Services/System Development [MH]

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$100,000</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
</tr>
<tr>
<td>8. Total</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

**Footnotes:**
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. 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. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

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. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. 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.

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.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. 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. 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. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. 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. 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. 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. 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.


26 http://www.samhsa.gov/health-disparities/strategic-initiatives


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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 21 Health Homes operating statewide for persons with SMI/SED. This includes individuals with co-occurring substance use disorders. Oklahoma Health Homes coordinates care with primary care physicians utilizing MOUs to ensure all necessary services are provided. Oklahoma Health Homes is a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the Oklahoma SoonerCare Program. The ODMHSAS has partnered with the OHCA to expand upon the patient-centered medical home model and existing behavioral health case management and System of Care (SOC) infrastructure to provide coordinated primary and behavioral health integration. In accordance with the CMS, a Health Home must have the capacity to provide all of the following services, as appropriate, based on members' changing needs: comprehensive care management; care coordination; health promotion; comprehensive transitional care (including appropriate follow-up from inpatient to other settings); individual and family support; and referral to community and social support services.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, 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 and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

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

   b) and Medicaid? Yes No
4. Who is responsible for monitoring access to M/SUD services 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  
      Yes  No
   b) Health risks such as
      i) heart disease  
         Yes  No
      ii) hypertension  
         Yes  No
      iv) high cholesterol  
         Yes  No
      v) diabetes  
         Yes  No
   c) Recovery supports  
      Yes  No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  
   Yes  No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  
   Yes  No

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. During this planning year, Oklahoma is conducting a thorough Needs Assessment in partnership with three Community Mental Health Centers (CMHCs) chosen to participate in a technical assistance process to assist them in readiness for certification by July, 2016. These include Grand Lake Community Mental Health Center, Red Rock Behavioral Health Services, and North Care. The purpose of the planned Demonstration is to improve the availability of, access to, and participation in, community based mental health and substance use disorder services for individuals eligible for medical assistance under the Medicaid program. The goal is to provide the most complete scope of services possible, utilizing best practices, including evidence based treatments.

Oklahoma was 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 in April of 2017. Oklahoma’s CCBHC goals are: of (1) providing the most complete scope of services required in the CCBHC, and (2) improving the availability of, access to, and participation in Assisted Outpatient Treatment in the state.

• Increase the number of services to adults age 16—25 years of age - ensure age-appropriate services are being provided and address gaps identified through the needs assessments.

• Increase the number of SUD services provided.

• Increase the number of mobile crisis services - targeted towards the span of services that the needs assessment identified as lacking in the treatment system.

• Increase the number of MOUs or other formal agreements with consulting physicians - ensure coordination with and inclusion of primary care in the CCBHCs.

• Increase the number of clients served - demonstrate the improved availability to persons who may not have been able to access services in the past.

• Increase the number of clients receiving PRSS services - PRSSs foster hope and promote a belief in the possibility of recovery (SAMHSA, 2015). Measure promotes PRSS use.

• Increase the number of clients engaging in treatment as defined by a 3rd and 4th service within 30 days of the 2nd service - ensure improved participation in services.

• Increase the number of veterans and military personnel served.

• Increase the number of Hispanics served.

• Increase the number of LGBT community served - address underserved populations identified through the needs assessments.

Goal 3: OK’s third goal is improving the availability of, access to, and participation in assisted outpatient mental health treatment.

• Increase in treatment adherence for persons served through the AOT program.

• Reduction in inpatient hospitalizations for persons served through the AOT program.

• Reduction in homelessness for persons served through the AOT program.

• Reduction in arrests/incarceration for persons served through the AOT program - address treatment adherence and the desired outcomes of the AOT programs.

The State will capitalize on the high standards required for CCBHCs to build on the foundation laid the past several years with pay
for performance, zero suicide and Health Home initiatives to ensure: 1) better access to and availability of service; 2) integration of mental health, substance abuse and primary care to individualize holistic care for all individuals; 3) high quality of service through disseminating evidence based practices with an Oklahoma-proven method to ensure fidelity; 4) innovative financial solutions to ensure service regardless of ability to pay; 5) formal relationships with emergency departments and other crisis services; 6) ability to assist with transportation and/or deliver service through telemedicine; and 7) meaningful consumer involvement and voice at every level of the system.

Please indicate areas of technical assistance needed related to this section

No technical assistance needed.
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf), [Healthy People, 2020](http://www.healthypeople.gov/2020/default.aspx), [National Stakeholder Strategy for Achieving Health Equity](http://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf), 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)](http://www.ThinkCulturalHealth.hhs.gov).

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.”

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. 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. 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.

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44 [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)
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

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?

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

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?

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

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

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. 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.

   Please indicate areas of technical assistance needed related to this section

   No technical assistance 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:

\[
\text{Health Care Value} = \frac{\text{Quality}}{\text{Cost}}, \quad (V = \frac{Q}{C})
\]

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, The New Freedom Commission on Mental Health, the IOM, NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). 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.”

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) 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) 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.

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 focus on consumer outcomes rather than care processes.
   - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, 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.

   No technical assistance needed.

OJB No. 0910-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:


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 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf
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
   - No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes
   - 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 become 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.
   • 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.

RAISE 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)

8. Individual Placement Services (IPS)

Please describe the planned activities for FFY 2020 and FFY 2021 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.

No Technical Assistance is needed at this time.

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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.

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.

   Please indicate areas of technical assistance needed related to this section.
   - No technical assistance is needed.

Footnotes:
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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
   - No technical assistance is needed.

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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. In order to address this in a more collaborative manner, 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.
Please indicate areas of technical assistance needed related to this section.

No technical assistance needed.

Footnotes:
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)
   - Yes □ No □
   a) [ ] Data on consequences of substance-using behaviors
   b) [ ] Substance-using behaviors
   c) [ ] Intervening variables (including risk and protective factors)
   d) [ ] 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)
   - Yes □ No □
   - 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)
5. Does your state use needs assessment data to make decisions about the allocation of 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 SEOW 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 SEOW 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 in 17 prevention service regions of Oklahoma serving all 77 counties. Oklahoma uses a funding that allocated a baseline amount to each of the 17 regions, with additional funding based on population and geographic size. Prevention sub-recipients are required to 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;
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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 CAPT 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 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?

   Yes □  No □

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

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):  
   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, adaptations, 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.
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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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)

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 resource center which serves as a clearinghouse for print and electronic materials. Making extensive use of private and public resources, the Oklahoma Prevention Resource Center provides materials to all 17 RPCs, 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 fulfills requests for information via an online library and order fulfillment system, which was recognized through a Governor’s Commendation in 2008 for saving staff time and other resources. 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.

   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 Specialist Training, community and law enforcement youth access to alcohol training, youth leadership development, and numerous trainings on evidence-based prevention practices. At the local level, the RPCs conduct skill based community and coalition training 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
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;
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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):
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>
</tr>
<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>
<tr>
<td></td>
<td>Current, 30-day drinking and driving among adults age 18 and older</td>
</tr>
<tr>
<td>Nonmedical Use of Prescription Drugs</td>
<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>
</tr>
<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

### RBSS Pre-Post Results by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>N</th>
<th>Pre</th>
<th>Post</th>
<th>Abs. Diff</th>
<th>Std. Dev</th>
<th>t-test</th>
<th>p value</th>
<th>Effect Size</th>
<th>E.S. Rank</th>
</tr>
</thead>
</table>

### Alcohol Compliance Checks

<table>
<thead>
<tr>
<th>Region</th>
<th>Sale</th>
<th>No Sale</th>
<th>Total</th>
<th>Percent of State Checks</th>
<th>Sale %</th>
<th>No Sale Rank</th>
</tr>
</thead>
</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 17 Regional Prevention Coordinators (RPCs) in order to plan and implement alcohol and other drug prevention services. Each RPC contractor is required to develop an approved evaluation plan which includes the following components as they relate to their region and/or high need communities:

- National Outcome Measures (NOMs)
- Participation in any other ODMHSAS or SAMHSA required evaluations
- Consequence Data

#### Sample Measures

<table>
<thead>
<tr>
<th>Construct</th>
<th>Indicator/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underage Drinking</strong></td>
<td>Alcohol-Related Car Crashes</td>
</tr>
<tr>
<td></td>
<td>Alcohol-Related Mortality</td>
</tr>
<tr>
<td></td>
<td>Alcohol Poisoning Deaths</td>
</tr>
<tr>
<td><strong>Adult Binge Drinking</strong></td>
<td>Alcohol-Related Car Crashes</td>
</tr>
<tr>
<td></td>
<td>Alcohol-Related Mortality</td>
</tr>
<tr>
<td></td>
<td>Alcohol Poisoning Deaths</td>
</tr>
<tr>
<td><strong>Non-Medical Use of Prescription Drugs</strong></td>
<td>Opioid Overdose Deaths</td>
</tr>
</tbody>
</table>

- Consumption Data

#### Sample Measures

<table>
<thead>
<tr>
<th>Construct</th>
<th>Indicator/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underage Drinking</strong></td>
<td>Current, 30-day alcohol use among youth under</td>
</tr>
<tr>
<td>Indicator/Measure</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Retail Access</td>
<td></td>
</tr>
<tr>
<td>Social Access</td>
<td></td>
</tr>
<tr>
<td>Visible and Consistent Enforcement of Laws</td>
<td></td>
</tr>
<tr>
<td>Perception of Risk</td>
<td></td>
</tr>
<tr>
<td>Perception of Harm</td>
<td></td>
</tr>
<tr>
<td>Community Norms favorable to use</td>
<td></td>
</tr>
<tr>
<td>Promotion</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator/Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Law Enforcement Trainings</td>
<td></td>
</tr>
<tr>
<td># Policies Passed / Reach</td>
<td></td>
</tr>
<tr>
<td># Practices Changed / Reach</td>
<td></td>
</tr>
<tr>
<td># of Media Outputs/Media Reach</td>
<td></td>
</tr>
<tr>
<td># of Trainings</td>
<td></td>
</tr>
<tr>
<td># of Risk Assessments</td>
<td></td>
</tr>
</tbody>
</table>
- 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>47,813</td>
<td>48,501</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>57,753</td>
<td>14,993</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.

1. Adults with SMI – prevalence – 47,813
2. Adults with SMI – incidence – 48,501
3. Children with SED – prevalence – 57,753
4. Children with SED – Incidence – 14,993

2. Oklahoma Department of Mental Health and Substance Abuse Services, Data query accessed 08/15/2019.
4. Oklahoma Department of Mental Health and Substance Abuse Services, Data query accessed 08/15/2019.
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?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Social Services</td>
</tr>
<tr>
<td>b)</td>
<td>Educational services, including services provided under IDE</td>
</tr>
<tr>
<td>c)</td>
<td>Juvenile justice services</td>
</tr>
<tr>
<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
</tr>
<tr>
<td>e)</td>
<td>Health and mental health services</td>
</tr>
<tr>
<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
</tr>
</tbody>
</table>

- [ ] Yes  - [ ] No
Narrative Question

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. 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 to psychiatric, therapy, and administrative meetings. The ODMHSAS is utilizing the latest in software based access (Cisco Jabber) 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.
b. 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.

b. 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.

b. 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 plans 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.

b. 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.

b. 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.

b. 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.

b. HUD Continuum of Care (CoC) Projects. These sites are operated by two CMHCs, Central Oklahoma Community Mental Health Center (Clay 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.

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**

**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
      ★ Yes □ No

      ii) Education
      ★ Yes □ No

      iii) Brief Intervention
      ★ Yes □ No

      iv) Assessment
      ★ Yes □ No

      v) Detox (inpatient/social)
      ★ Yes □ No

      vi) Outpatient
      ★ Yes □ No

      vii) Intensive Outpatient
      ★ Yes □ No

      viii) Inpatient/Residential
      ★ Yes □ No

      ix) Aftercare; Recovery support
      ★ Yes □ No

   b) Services for special populations:

      Targeted services for veterans?
      ★ Yes □ No

      Adolescents?
      ★ Yes □ No

      Other Adults?
      ★ Yes □ No

      Medication-Assisted Treatment (MAT)?
      ★ Yes □ No
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.

At the beginning of the fiscal year, providers are requested to provide a form to document staff hire dates, position, credentials, and dates of required trainings. At this time, providers also specify any specialty staff contractually required. Providers provide documents to verify information recorded on the form. Reviewer checks documents for compliance with both licensing/certification requirements as well as required training for the position held. In the event any information documented suggests non-compliance, the reviewer discusses the matter with the provider regarding non-compliance. A written report is submitted to the provider and a plan of correction is requested. A date is established for a second review to confirm compliance. At any time during this process, the reviewer may assist the provider with appropriate technical assistance to resolve the issue. Providers are expected to update the assigned reviewer of any staff changes affecting the services to consumers throughout the fiscal year. During the fiscal year, the reviewer has the capacity to check billing information and assure all staff providing services have been reported to the ODMHSAS reviewer. If a reviewer finds a person billing for contracted services provided and the assigned ODMHSAS reviewer has not received required information concerning the eligibility of that person to provide services, the provider is notified and recoupment of those funds are possible.

At the time of the clinical review, the ODMHSAS reviewer notifies the provider via letter, (email) of the specific information via the contract to be reviewed for compliance. The notification also cites the specific location in the contract with ODMHSAS to provide services for the provider’s review. Providers are supplied with a list of ten (10) randomly chosen records of consumers with instructions to submit these records for review.

The ODMHSAS reviewer considers all information supplied from the record concerning the consumer to confirm presented needs were addressed per the contract. After all records are reviewed, the ODMHSAS reviewer discusses all findings. The reviewer will discuss areas of non-compliance as well as offer technical assistance when it appears the Department can specifically help to improve services in any given area. The reviewer also commends the provider regarding positive practices observed in the records as well as recommendations based on items needing improvement.

For providers with non-compliance issues, a written report is delivered and the provider must submit a plan of correction for those items. A second review is conducted to confirm the provider has made adequate improvements to meet compliance. The provider receives a second document to confirm compliance at the follow up review.

ODMHSAS reviewers have access to the Departments database to follow a provider’s utilization and services provided.
**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

**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
   - 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.

   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.

   At the beginning of the fiscal year, providers are requested to provide a form to document staff hire dates, position, credentials, and dates of required trainings. At this time, providers also specify any specialty staff contractually required. Providers provide documents to verify information recorded on the form. Reviewer checks documents for compliance for both licensing/certification requirements as well as required training for the position held. In the event any information documented suggests non-compliance, the reviewer discusses the matter with the provider regarding non-compliance. A written report is submitted to the provider and a plan of correction is requested. A date is established for a second review to confirm compliance. At any time during this process, the reviewer may assist the provider with appropriate technical assistance to resolve the issue. Providers are expected to update the assigned reviewer of any staff changes affecting the services to consumers throughout the fiscal year. During the fiscal year, the reviewer has the capacity to check billing information and assure all staff providing services have been reported to the ODMHSAS reviewer. If a reviewer finds a person billing for contracted services provided and the assigned ODMHSAS reviewer has not received required information concerning the eligibility of that person to provide services, the provider is notified and recoupment of those funds are possible.

   At the time of the clinical review, the ODMHSAS reviewer notifies the provider via letter, (email) of the specific information via the contract to be reviewed for compliance. The notification also cites the specific location in the contract with ODMHSAS to provide services for the provider’s review. Providers are supplied with a list of ten (10) randomly chosen records of consumers with instructions to submit these records for review.

   The ODMHSAS reviewer considers all information supplied from the record concerning the consumer to confirm presented needs were addressed per the contract. After all records are reviewed, the ODMHSAS reviewer discusses all findings. The reviewer will discuss areas of non-compliance as well as offer technical assistance when it appears the Department can specifically help to improve services in any given area. The reviewer also commends the provider regarding positive practices observed in the records as well as recommendations based on items needing improvement.

   For providers with non-compliance issues, a written report is delivered and the provider must submit a plan of correction for those items. A second review is conducted to confirm the provider has made adequate improvements to meet compliance. The provider receives a second document to confirm compliance at the follow up review.

   ODMHSAS reviewers have access to the Departments database to follow a provider’s utilization and services provided.

**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  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  

c) Established co-located SUD professionals within FQHCs  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  

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.

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.

At the beginning of the fiscal year, providers are requested to provide a form to document staff hire dates, position, credentials, and dates of required trainings. At this time, providers also specify any specialty staff contractually required. Providers provide documents to verify information recorded on the form. Reviewer checks documents for compliance for both licensing/certification requirements as well as required training for the position held. In the event any information documented suggests non-compliance, the reviewer discusses the matter with the provider regarding non-compliance. A written report is submitted to the provider and a plan of correction is requested. A date is established for a second review to confirm compliance. At any time during this process, the reviewer may assist the provider with appropriate technical assistance to resolve the issue. Providers are expected to update the assigned reviewer of any staff changes affecting the services to consumers throughout the fiscal year. During the fiscal year, the reviewer has the capacity to check billing information and assure all staff providing services have been reported to the ODMHSAS reviewer. If a reviewer finds a person billing for contracted services provided and the assigned ODMHSAS reviewer has not received required information concerning the eligibility of that person to provide services, the provider is notified and recoupment of those funds are possible.

At the time of the clinical review, the ODMHSAS reviewer notifies the provider via letter, (email) of the specific information via the contract to be reviewed for compliance. The notification also cites the specific location in the contract with ODMHSAS to provide services for the provider’s review. Providers are supplied with a list of ten (10) randomly chosen records of consumers with instructions to submit these records for review.

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ODMHSAS reviewers have access to the Departments database to follow a provider’s utilization and services provided.

**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?  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  

2. Has your state identified a need for any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  
   b) Establishment or expansion of tele-health and social media support services  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  
   ![Choice](Yes/No)  
   ![Choice](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.A§ 300x-31(a)(1))?  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
   ![Choice](Yes/No)  
   ![Choice](Yes/No)  

If yes, please provide a brief description of the elements and the arrangement.
**Criterion 8, 9 & 10**

**Service System Needs**

1. Has your state identified a need for any of the following:
   - Workforce development efforts to expand service access
   - Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   - Establish a peer recovery support network to assist in filling the gaps
   - Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   - 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
   - Explore expansion of services for:
     - MAT
     - Tele-Health
     - Social Media Outreach

2. Does your state have an agreement to ensure the protection of client records?

**Service Coordination**

1. Has your state identified a need for any of the following:
   - Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   - Establish a program to provide trauma-informed care
   - 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

**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)?

2. Does your state provide any of the following:
   - Notice to Program Beneficiaries
   - An organized referral system to identify alternative providers?
   - A system to maintain a list of referrals made by religious organizations?

**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?

2. Has your state identified a need for any of the following:
   - Review and update of screening and assessment instruments
   - Review of current levels of care to determine changes or additions
   - Identify workforce needs to expand service capabilities
   - 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?

2. Has your state identified a need for any of the following:
   - Training staff and community partners on confidentiality requirements
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 include 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 FFY2020/2021;
   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.
3.2.1 Waivers

**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) Preformance-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 [Yes] [No]

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.ok.gov/odmhsas/Additional_Information/Provider_Certification/ODMHSAS_Administrative_Rules/Administrative_Rules_That_Are_Currently_In_Effect.html
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 2018-FFY 2019?  Yes  No

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

Health information technology has also been used to develop performance measurement infrastructure and guide CQI processes. Through a HRSA-SAMHSA-funded Behavioral Health and Physical Health Care Data Exchange grant, safety net providers were able to secure health information exchange (HIE) connectivity and secure direct messaging at no initial cost to the agencies. All 14 CMHCs have contracts with an HIE. The ODMHSAS has procured a Behavioral Health Home Information Management System, referred to as the “registry” through Relias. The registry provides abstraction, aggregation, analysis and interpretation of data, both prospectively and retrospectively, to aid clinical risk analysis and management of a population. The registry integrates large volumes of disparate data (including claims data, medical services and pharmacy data) and analyzes this convergence of information for the eligible population in respect to proportional risk, including adherence markers, gaps in care, substandard or inappropriate care, co-morbid physical and MH conditions that are associated with elevated cost burden, and chemical dependency or underlying addictions that may be undermining overall health care and increasing costs. The registry provides secure, 24/7 access to patient health care analytics by providing data on best practice for psychopharmacologic application relative to psychotropic and pain medicines and disease management flags relative to gaps in care for chronic disease states most frequently associated with those suffering from mental illness. All data and data analytics are displayed for each patient in an Integrated Health Profile (IHP) for holistic health management. These data are used by care coordinators, quality improvement staff and clinical and financial administrators to understand the patient/population needs and to direct intervention. Each CMHC has been trained individually, using its own respective data, to demonstrate actionable insights in population management, compliance measurement and complex case management.

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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.

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.

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
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.

No technical assistance needed.

Footnotes:
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.

The ODMHSAS has also supported CIT programs to help reduce recidivism. Oklahoma has a state CIT program, which has assisted in the dissemination of the training to rural and frontier areas. The ODMHSAS also supports CIT training programs through a partnership with the Oklahoma City Police Department. The ODMHSAS has secured competitive federal grant funds through the Bureau of Justice Assistance to reimburse certain law enforcement agencies for officers’ time during the 40 hour CIT training program, which has assisted in the continued dissemination of the training to rural and frontier areas. Through a combination of state appropriated and Bureau of Justice Assistance funds, the ODMHSAS has implemented a pre-sentence criminogenic risk and needs screening program to provide courts with information about evidence based diversion sentencing recommendations which best meet defendants’ individualized needs. With over 20,000 felony defendants screened to date, this program has resulted in fewer jail days between arrest and case disposition. Oklahoma also continues to have a strong drug and mental health court system, serving around 4,500 participants on any given day. These treatment court programs 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 increased in child custody. Additionally, through collaboration with the Department of Corrections, the ODMHSAS

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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?
   - Yes
   - No

The ODMHSAS provides programs and services that addresses diversion at each step of the Sequential Intercept Model. Crisis Intervention Training (CIT) is provided to law enforcement officers within sheriffs’ departments and city police throughout the state through a partnership with the Oklahoma City Police Department. The ODMHSAS has secured competitive federal grant funds through the Bureau of Justice Assistance to reimburse certain law enforcement agencies for officers’ time during the 40 hour CIT training program, which has assisted in the continued dissemination of the training to rural and frontier areas. Through a combination of state appropriated and Bureau of Justice Assistance funds, the ODMHSAS has implemented a pre-sentence criminogenic risk and needs screening program to provide courts with information about evidence based diversion sentencing recommendations which best meet defendants’ individualized needs. With over 20,000 felony defendants screened to date, this program has resulted in fewer jail days between arrest and case disposition. Oklahoma also continues to have a strong drug and mental health court system, serving around 4,500 participants on any given day. These treatment court programs 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 increased in child custody. Additionally, through collaboration with the Department of Corrections, the ODMHSAS
employs prison-based discharge managers to assist with identification of discharging inmates to specialized re-entry teams which
significantly reduce recidivism for individuals with serious mental illness. Most recently the ODMHSAS has partnered with the
courts, district attorneys, defense attorneys, and community providers to begin misdemeanor diversion pilot programs which have
served over 800 individuals charged with misdemeanors in state courts who have behavioral health treatment needs. Additionally,
the ODMHSAS has begun providing training and technical assistance support to pretrial service entities in pilot sites to train on
the use of validated pretrial risk and needs assessments, education on essential elements of pretrial practices, and expedite bond
decisions to reduce the number of pretrial jail days and increase collaboration with community based treatment providers.

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

No technical assistance needed.
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

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.

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Environmental Factors and Plan

15. Crisis Services - Requested

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.\(^{61}\) 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\(^{62}\),

"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 funds four urgent care centers: 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.

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

No technical assistance 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.

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:
4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

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:

a) Recovery is self-directed, personal and individualized;
b) Recovery is holistic;
c) Recovery moves beyond symptom reduction and relief;
d) Recovery is a process of healing and discovery;
e) Recovery encompasses the possibility of individuals to test, make mistakes and try again; and
f) 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 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. The annual Recovery and Prevention conference provides 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.

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. Expansion of the peer support services to better reach and engage special populations exists. Currently, there are tracts for Peers to specialize in youth and young adults, veterans, forensic/criminal justice, medication assisted recovery, older adults, gambling and peer administration/leadership/supervision. Expansion of the peer’s role and the workforce will continue on this next fiscal year as we develop tracts for populations with experience in child welfare, older adults and the LGBTQ 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. Currently, the number of Peer Recovery Support Specialists (PRSS) working in state operated, contracted and certified providers. There are currently 600 705 actively working PRSS across programs and providers.

• 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). 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.
“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:

a) Recovery is self-directed, personal and individualized;
b) Recovery is holistic;
c) Recovery moves beyond symptom reduction and relief;
d) Recovery is a process of healing and discovery;
e) Recovery encompasses the possibility of individuals to test, make mistakes and try again; and
f) 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. The annual Recovery and Prevention conference provides 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.

Following are examples of exemplary activities related to recovery support services.

• Initiating Recovery Oriented Systems of Care (ROSC) trainings and extensive Oxford House availability incorporate important aspects of peer guided and provided recovery services.

• Expansion of the peer support services to better reach and engage special populations exists. Currently, there are tracts for Peers to specialize in youth and young adults, veterans, forensic/criminal justice, medication assisted recovery and peer administration/leadership/supervision. Expansion of the peer’s role and the workforce will continue on this next fiscal year as we develop tracts for populations with experience in child welfare, older adults and the LGBTQ 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 will expand in the upcoming fiscal year has expanded to include crisis centers as well as additional RTPs.

• 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. Currently, the number of Peer Recovery Support Specialists (PRSS) working in state operated, contracted and certified providers. There are currently 600 705 actively working PRSS across programs and providers.

• 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). 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 funds a variety of transitional and permanent supported housing options, along with housing subsidy assistance. One of the housing subsidy programs is specific to those individuals who are discharging from psychiatric inpatient, corrections, or aging out of foster care. The ODMHSAS maintains focus on expanding community based housing options for persons served, and participates in a variety of community collaborative efforts to address housing needs. Behavioral health case management services are offered at all the CMHCs and at many other provider agencies, and these services are used to assist persons served with accessing other housing assistance like Section 8, and to access housing through working with local landlords in the community.

For persons with substance abuse issues ODMHSAS funds Oxford House housing options as well as transitional and supportive
housing and permanent housing. This year, the ODMHSAS partnered with the National Association of Recovery Residences (NARR) in order to officially establish standards for recovery housing across the state. An initial gathering for interested partners and a steering committee has formed. The ODMHSAS aims to have a NARR Oklahoma affiliate within the next year.

Although there is still some congregate housing, the ODMHSAS maintains primary focus on the promotion of housing opportunities that are truly integrated into the community. The ODMHSAS funds scattered site permanent housing opportunities, where individuals are assisted with finding apartments or houses in the community of their choice (usually owned by private landlords), and then receive on-going supports to help with long-term housing success. The supports include assisting the person served with developing and maintaining natural supports within their immediate community (ex: neighbors, landlords, etc.). The ODMHSAS launched a new transitional to permanent housing pilot project this year through a partnership with the Mental Health Association of Oklahoma. This project, named Intensive Outreach and Navigation (ION) program, is specific to individuals discharging from crisis and inpatient levels of care to homelessness in the Oklahoma County area. The aim is to imbed an ION team member into the discharge planning processes at these locations in order to directly place homeless individuals into temporary housing at discharge. Individuals then receive intensive services from the ION team member to include employment support and connection to outpatient treatment services while working to get into more permanent housing. The ODMHSAS will continue to utilize the block grant to fund, in part, supportive housing initiatives.

Though behavioral health case management, both youth (ages 14 and older) and adults can receive employment assistance with job search, and job placement and retention skills. Additionally, they can receive assistance with furthering their education through referrals to GED classes, vocational-technical schools, colleges and universities.

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

No technical assistance needed.

Footnotes:
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? [Yes] [No]

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   The ODMHSAS continues to help facilitate the Community Integration Committee (CIC), which is a breakout committee of the Oklahoma Behavioral Health Planning and Advisory Council. The CIC is developing a system description of the programs, services and supports that are currently in place to help promote successful community integration. Once that is completed, an analysis of needs will be done, and an updated community integration plan will be formulated.

   The ODMHSAS has continued to focus on growing peer support services, and increases the number of Certified Peer Recovery Support Specialists (PRSS) and the number of PRSS services provided every year. This, in addition to a strong focus on home and community based services, serve as foundational elements of Oklahoma’s community integration efforts. Housing and employment efforts are also key, and are described below.

   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. Housing services for families with children are provided in the same manner by which they are provided to adults.

Additional housing related service and supports embedded in the system for adults with SMI and children with SED 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 Transition Services to assist people with mental illness or co-occurring disorders who request assistance with
transition from a residential care home into community based permanent housing.

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.
Case managers assist children ages 14 and older with job search and job placement skills, social and interpersonal skills needed
for job retention, and specific referrals to vocational-technical schools.

Individual Placement and Support (IPS) is the supported employment and education evidenced-based model that has been
selected by the ODMHSAS to be used for both youth and adults; and is being implemented statewide.

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

No technical assistance needed.

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. 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. 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.

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. 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.

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).


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:
1. OKSOC uses a Wraparound model that is able to serve any one 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.
2. ODMHSAS currently has several partnership involving OSDE to include the BISS model and quarterly Leadership meetings to identify partnership opportunities for school systems in Oklahoma.
3. ODMHSAS and OKDHS has several partnerships around access to treatment for youth in the child welfare system, 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.
4. ODMHSAS and OJA are currently partnering around juvenile reentry. The identification of juveniles who are discharge 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?

All mental health and substance use providers have been offered training for Motivational Interviewing (MI), Seeking Safety, Adolescent Community Reinforcement Approach (ACRA), and Community Reinforcement Approach (CRA) Train the Trainer.

Please indicate areas of technical assistance needed related to this section.
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 2018-FFY 2019 plan was submitted?  
   - Yes  
   - No

If so, please describe the population targeted.

Oklahoma continues to be the only state in the Nation that instituted the 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 1031 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.

No technical assistance needed.

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

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?
   -Oklahoma City Family Justice Center to assist victims of crimes who have behavioral health issues
   -Statewide Higher Education: Universities, Community Colleges, and Technology Schools to assist with early identification and intervention for Serious Mental Illness

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

   The ODMHSAS continues to enjoy a rich experience with a variety of state and community partners. Copies of actual agreements or letters of support will not be attached to this application. Rather, the ODMHSAS will utilize this section of the plan to describe some examples of collaborations and partnerships – both formal and informal – that are essential to implementing the priorities identified in the planning process, and in overall delivery behavioral health and support services throughout Oklahoma.

   One example is the 8 positions on the current Planning and Advisory Council for the ODMHSAS represent key state agencies and are directly appointed to the PAC by each state agency director. That in itself is an indication of support and continued commitment to the work funded by the block grant programs and other initiatives managed by the ODMHSAS. Four additional members are appointed by state level advocacy organizations to membership on the Council.

   Memoranda of Understandings. Specifically articulated partnerships and support provided to ODMHSAS from other agencies are formalized through a variety of memorandum of understandings or inter-agency agreements. Present agreements for partnerships with the ODMHSAS include but are not limited the following:
• Partnership for Children’s Behavioral Health:
  Oklahoma Department of Human Services
  Office of Juvenile Affairs
  Oklahoma Federation of Families
  Department of Rehabilitation Services
  Family members
  Oklahoma State Department of Education
  Oklahoma State Department of Health
  Youth members
  Oklahoma Health Care Authority
  Oklahoma Commission on Children and Youth

• State of Oklahoma Multi-Agency Data Sharing Agreement:
  Oklahoma State Department of Health
  Oklahoma Department of Human Services
  Oklahoma Department of Mental Health and Substance Abuse Services
  Oklahoma Department of Corrections
  Office of Juvenile Affairs
  Oklahoma Health Care Authority
  Oklahoma Commission on Children and Youth
  Oklahoma Department of Rehabilitation Services
  Oklahoma Department of Education

• Governor’s Interagency Council on Homelessness:
  Faith-Based Community
  Statewide/Local Continuum of Care
  CareerTech
  Legal Aid of Oklahoma
  Disability Determination Division of the Department of Rehabilitation Services
  Current of former homeless person
  Oklahoma Legislature Member
  Office of Juvenile Affairs
  Veterans Administration
  Oklahoma Employment Security Commission
  State Department of Education
  Governor’s Office
  Persons with experience or knowledge of the subject of homelessness
  Head Start / Community Action Agencies
  Department of Corrections
  Oklahoma Health Care Authority (Medicaid)
  Oklahoma Department of Human Services
  Homeless service provider
  Oklahoma Department of Commerce
  State Department of Health
  Local Continuum of Care Representative
  State Continuum of Care Representative

• Department of Rehabilitation Services (DRS) – Coordination of Employment Services

• OKDHS Agreement for the ODMHSAS to provide assessment and treatment services for TANF & Child Welfare populations

• The Oklahoma Health Care Authority Interagency Agreement

• DOC Interagency Agreement to provide substance abuse assessment and treatment services to inmate population

• Oklahoma Tobacco Settlement Endowment Trust cooperative agreement with the ODMHSAS for the statewide Cessation Systems Initiative and the Public Health Academy of Oklahoma

• The Oklahoma State Department of Health Tobacco Use Prevention Service for contract monitoring related to statewide Cessation Systems Initiatives

• The Oklahoma State Department of Health Turning Point and Center for the Advancement of Wellness for the Public Health Academy of Oklahoma
• The Oklahoma Department of Veterans Affairs and the Oklahoma Department of Education for shared prevention staff

• The Oklahoma Leadership Academy for Wellness and Smoking Cessation Summit in collaboration with The University of California at San Francisco Smoking Cessation Leadership Center for Tobacco Dependence Treatment for People with Behavioral Health Disorders

Chesapeake Energy Corporation
BlueCross and Blue Shield of Oklahoma
The Osage Nation, Oklahoma Tobacco Research Center
Red Rock Area Resource Prevention Center
The National Alliance on Mental Illness (NAMI-OK)
Central Oklahoma Integrated Network Systems
Oklahoma Veteran’s Administration Medical Center
Oklahoma Insurance Department
Oklahoma Primary Care Association
Oklahoma State University Center for Health Sciences
NorthCare Center
Crossings Community Church
Latino Community Development Agency
The Mental Health Association of Oklahoma
Comprehensive Community Rehabilitation Services

Other Collaborations. Beyond the formal agreements listed above, ODMHSAS staff at various levels represents the ODMHSAS within many interagency initiatives. Examples of those are listed below.

• State Epidemiological Outcomes Workgroup
OU School of Social Work
Cherokee Nation Behavioral Health Services
OU Health Sciences Center
Oklahoma State Department of Health
Oklahoma Association of Chiefs of Police
Office of Juvenile Affairs
Oklahoma Bureau of Narcotics and Dangerous Drugs
Oklahoma City Area Inter-Tribal Health Board
Oklahoma Highway Patrol
Department of Corrections
Veterans Administration Hospital
Department of Human Services
Oklahoma ABLE Commission
Oklahoma Commission on Children and Youth
Oklahoma Health Care Authority
Oklahoma Department of Education

• Policy Summit Delegation – Reducing Disparities Within Healthcare Reform
Indian Health Services
The Chickasaw Nation
Oklahoma City Indian Clinic
Oklahoma State Department of Health
The Oklahoma Federation of Families
The Oklahoma Health Care Authority (Medicaid)

• Veterans Policy Academy Partners

• Oklahoma Overdose Prevention Committee

• Oklahoma Health Improvement Plan Team

• Oklahoma Health Innovation Model Team

• Consolidated Claims Process (CCP) – Shared service eligibility and claims services (Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma Health Care Authority)

• Develop Interoperable Solution Components Using Shared Services (DISCUSS)
Oklahoma State Department of Health
Oklahoma Health Care Authority
Oklahoma Department of Human Services
• DISCUSS Data Subcommittee
Oklahoma State Department of Health
Oklahoma Health Care Authority
Oklahoma Department of Human Services
Oklahoma Department of Rehabilitation Services

• Health Information Security and Privacy Council (HISPC)
University of Oklahoma Health Sciences Center
Oklahoma Health Care Authority [Medicaid]
Oklahoma State Department of Health [Public Health]
Oklahoma Foundation for Medical Quality
Oklahoma Department of Insurance
Oklahoma Primary Care Association
Oklahoma Department of Human Services
Oklahoma Osteopathic Association
Oklahoma State Medical Association
Oklahoma Hospital Association
Oklahoma State University Office of Rural Health
SMRTNet Health Information Organization

• District Attorneys Council

• Oklahoma Suicide Prevention Council

• Oklahoma Prevention Leadership Collaborative

• Oklahoma Prescription Drug and Overdose Prevention Planning Workgroup

• Oklahoma Evidence-Based Practices Workgroup

• State Underage Drinking Prevention Committee

• Oklahoma Public Health Collaborative

• Rural Law Enforcement Meth Initiative

• OSOH to provide tuberculosis data for SAPT Block Grant reporting

• OSDH for HIV rapid testing kits for the outreach program

• Oklahoma Violent Death Reporting System Advisory Committee

• Oklahoma Rehabilitation Council

Please indicate areas of technical assistance needed related to this section.
No technical assistance needed.

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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 that ensures 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?

      The State Planning and Advisory Council (PAC) to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) fully functions as an integrated body that fulfills the Council’s purposes across a broad spectrum of mental health, substance use, and prevention activities in the state. Staffs who support the Council likewise reflect representation from mental health, substance use disorder treatment, and prevention. The same mechanisms that have been utilized to plan and monitor mental health services are also used by the Council to provide guidance, support, and advocacy related to prevention and substance use disorder treatment. Because the Council is integrated, there is no separate SMHA advisory body.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

      Yes ☐
      No ☐

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

      Yes ☐
      No ☐

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.

   [External Link]

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.

No technical assistance needed.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health 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.
August 19, 2019

Ms. Odessa F. Crocker, Chief
Formula Grants Branch
Division of Grant Management, OFR, SAMHSA
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Crocker,

As Chair of the Planning and Advisory Council to the Oklahoma Department of Mental Health and Substance Abuse Services, it is my privilege to submit this letter of support for Oklahoma’s Block Grant Application for FFY2020-2021.

The Planning and Advisory Council reviewed and approved the Block Grant Application at our August 15th meeting.

Oklahoma is navigating a shifting climate that includes changes in liquor sales, the passage of medical marijuana laws, criminal justice reform and the new Governor’s appointments of State Agency Heads, and the dismantling of current Boards and creation of new Agency Boards and membership. The continued leadership of Oklahoma’s long serving and highly effective Commissioner of Mental Health and Substance Abuse Services has yet to be determined.

While outcomes are positive for treatment courts, jail diversion, increased targeting of special populations such as transitional youth and older adults, a decreased rate of suicide, Peer Support and Peer Support Specialties, Health Homes, Systems of Care, Mental Health First Aid, Naloxone distribution, and 3 CCBHCs, our status as one of the unhealthiest States has not changed.

A more stable revenue situation has allowed a respite from the continuous budget cuts of previous years, however funding remains inadequate. Rates of the uninsured are high and Medicaid expansion was rejected. High rates of incarceration coincide with high rates of grandparents raising grandchildren. Our State has been the focus of National attention due to our successful Opioid lawsuit and high rates of addiction.

We are encouraged by an increasingly strong and loud community voice that is demanding legislative action for jail diversion and criminal justice reform, increased mental health and substance use services and the protection of uninsured Oklahomans through an expansion of Medicaid,

Sincerely,

Karen Orsi, Chair
Planning and Advisory Council to the
Oklahoma Department of Mental Health
And Substance Abuse Services

Mission: To Promote Healthy Communities and Provide the Highest Quality Care to Enhance the Well-Being of all Oklahomans
August 19, 2019

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Sincerely,

Karen Orsi, 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.

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<thead>
<tr>
<th>Start Year: 2020</th>
<th>End Year: 2021</th>
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<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>Catherine Barnhill</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>Sara Berry</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>7249 Skylark Ct, Oklahoma City OK, 73162 PH: 405-250-3804</td>
<td><a href="mailto:Sara.barry@integrisok.com">Sara.barry@integrisok.com</a></td>
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<tr>
<td>Janelle Bretten</td>
<td>State Employees</td>
<td>Oklahoma Office of Juvenile Affairs</td>
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<tr>
<td>Brandy Brown-Loboto</td>
<td>Providers</td>
<td>222 E. Sheridan Suite 2 OKC OK, 73104 PH: 405-443-9991</td>
<td><a href="mailto:brandy.lobato@ycoemail.com">brandy.lobato@ycoemail.com</a></td>
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<tr>
<td>Melinda Bunch</td>
<td>State Employees</td>
<td>Oklahoma Department of Rehabilitation</td>
<td></td>
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</tr>
<tr>
<td>Christian Chavez</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>1916 Plymouth Lane OKC OK, 73120</td>
<td><a href="mailto:Christian@hopeisalive.net">Christian@hopeisalive.net</a></td>
<td></td>
</tr>
<tr>
<td>Janet Cizek</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>4845 S. Sheridan Road, Suite 510 TUlsa OK, 74145 PH: 918-810-4074</td>
<td><a href="mailto:Jcizek@ctiOklahoma.org">Jcizek@ctiOklahoma.org</a></td>
<td></td>
</tr>
<tr>
<td>Cathy Costello</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>5901 N. Santa Fe Edmond OK, 73003</td>
<td><a href="mailto:Momcostello@yahoo.com">Momcostello@yahoo.com</a></td>
<td></td>
</tr>
<tr>
<td>Todd Crawford</td>
<td>Representatives from Federally Recognized Tribes</td>
<td>124 E. Main Suite 2 Ada OK, 74820 PH: 580-310-7993</td>
<td><a href="mailto:Todd.crawford@chickasaw.net">Todd.crawford@chickasaw.net</a></td>
<td></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 OK, 73112 PH: 405-413-7778</td>
<td><a href="mailto:geoman47@hotmail.com">geoman47@hotmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Shelly Douglas</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>2600 Watermark Blvd. no. 303 OKC OK, 73134</td>
<td><a href="mailto:sdoouglas@healthcharities.org">sdoouglas@healthcharities.org</a></td>
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<tr>
<td>Name</td>
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<tr>
<td>Darlene Drew</td>
<td>State Employees</td>
<td>Oklahoma Housing Finance Agency</td>
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<tr>
<td>Nola Harrison</td>
<td>Providers</td>
<td>1000 N Lee OKC OK, 73102 PH: 405-231-8758</td>
<td><a href="mailto:Nola.harrison@ssmhealth.com">Nola.harrison@ssmhealth.com</a></td>
<td></td>
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<tr>
<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 PH: 405-471-2499</td>
<td><a href="mailto:julia@okbha.org">julia@okbha.org</a></td>
<td></td>
</tr>
<tr>
<td>Lynn Kimble</td>
<td>Parents of children with SED/SUD</td>
<td>1625 Boomer Trail Edmond OK, 73034 PH: 405-474-5251</td>
<td>Lynnkimble2@<a href="mailto:kimble2@gmail.com">kimble2@gmail.com</a></td>
<td></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 PH: 405-408-8742</td>
<td><a href="mailto:onlyamberm@gmail.com">onlyamberm@gmail.com</a></td>
<td></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:matttherm@red-rock.com">matttherm@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>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>Alec Peterson</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>4221 NW 59th OKC OK, 73112 PH: 918-991-5231</td>
<td><a href="mailto:Apeterson3325@yahoo.com">Apeterson3325@yahoo.com</a></td>
<td></td>
</tr>
<tr>
<td>Stacy Potter</td>
<td>Providers</td>
<td>PO Box 912 Vinita OK, 74301 PH: 918-256-7518</td>
<td><a href="mailto:Stacypotter442@gmail.com">Stacypotter442@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Kelli Reid</td>
<td>State Employees</td>
<td>ODMHSAS - Substance Use Representative</td>
<td></td>
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<tr>
<td>Michelle Sutherlin</td>
<td>State Employees</td>
<td>Oklahoma State Department of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jeff Tallent</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>1620 Ridgecrest Road No 8 Edmond OK, 73103 PH: 405-203-7898</td>
<td><a href="mailto:jefftallentz@aol.com">jefftallentz@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Mary Trevino</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>624 N 18th Street Clinton OK, 73601 PH: 580-275-9886</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lisa Webb</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>6100 S Walker OKC OK, 73139 PH: 405-510-3725</td>
<td><a href="mailto:llwebb@hopecsi.org">llwebb@hopecsi.org</a></td>
<td></td>
</tr>
<tr>
<td>Amanda White</td>
<td>Parents of children with SED/SUD</td>
<td>11512 Country Drive OKC OK, 73170 PH: 405-510-3725</td>
<td><a href="mailto:Amanda.White106@att.net">Amanda.White106@att.net</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Agency/organization</td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sheamekah</td>
<td>State Employees</td>
<td>ODMHSAS Mental Health Representative</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Footnotes:**
## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2020  End Year: 2021

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td>40</td>
<td></td>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
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<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>6</td>
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<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 services</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>24</td>
<td>60.00%</td>
</tr>
<tr>
<td>State Employees</td>
<td>11</td>
<td></td>
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<tr>
<td>Providers</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>2</td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>16</td>
<td>40.00%</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>5</td>
<td></td>
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<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>10</td>
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<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>0</td>
<td></td>
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</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

**Footnotes:**
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? Yes No
      If yes, provide URL:
      https://ok.gov/odmhsas/
   
   c) Other (e.g. public service announcements, print media) Yes No

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Footnotes: