Oklahoma

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/31/2023 8.55.52 AM)

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

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	X5K6JYC467J7

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

Agency Name	Oklahoma Department of Mental Health and Substance Abuse Services
Organizational Unit	Treatment and Recovery Services
Mailing Address	2000 N. Classen Blvd. Suite 600
City	Oklahoma City
Zip Code	73106

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Carrie
Last Name	Slatton-Hodges
Agency Name	Oklahoma Department of Mental Health and Substance Abuse Services
Mailing Address	2000 N. Classen Blvd. Suite 600
City	Oklahoma City
Zip Code	73106
Telephone	405-248-9201
Fax	
Email Address	CHodges@odmhsas.org

State CMHS Unique Entity Identification

Unique Entity ID	X5K6JYC467J7

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

Agency Name	Oklahoma Department of Mental Health and Substance Abuse Services
Organizational Unit	Treatment and Recovery Services
Mailing Address	2000 N. Classen Blvd. Suite 600
City	Oklahoma City
Zip Code	73106

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Carrie
Last Name	Slatton-Hodges
Agency Name	Oklahoma Department of Mental Health and Substance Abuse Services
Mailing Address	2000 N. Classen Blvd.
City	Oklahoma City

Zip Code	73106
Telephone	4053088088
Fax	
Email Address	sgay@odmhsas.org

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	8/30/2023 7:32:23 PM
Revision Date	8/30/2023 7:32:58 PM

VI. Contact Person Responsible for Application Submission

First Name	Stephanie
Last Name	Gay
Telephone	405-308-8088
Fax	
Email Address	sgay@odmhsas.org

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

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

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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Carrie Slatton-Hodges

Signature of CEO or Designee[1]: _____

Title: Commissioner

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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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 [sam.gov]
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

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

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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Oklahoma

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

Signature of CEO or Designee[1]:

Title: Commissioner

Date Signed: 7/27/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

J. Kevin Stitt
Office of the Governor
State of Oklahoma

July 12th, 2019

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

RE: Delegation of Authority

Dear Commissioner:

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

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

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

Sincerely,

J. Kevin Stitt
Governor

STATE CAPITOL BUILDING • 2300 N. LINCOLN BOULEVARD, SUITE 100 • OKLAHOMA CITY, OKLAHOMA 73105 • (405) 521-2342 • (405) 521-3353

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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.
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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
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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;
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   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;
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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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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.
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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: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [sam.gov]
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

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

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

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

Signature of CEO or Designee[1]: CSH

Title: Commissioner

Date Signed: 7/27/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

J. Kevin Stitt
Office of the Governor
State of Oklahoma

July 12th, 2019

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

RE: Delegation of Authority

Dear Commissioner:

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

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

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

Sincerely,

J. Kevin Stitt
Governor

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BSCA Funding Plan 2024

***Introduction*.** The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) will utilize the Bipartisan Safer Communities funds to enhance and expand A SAFE PLACE TO BE by expanding Child and Adolescent Urgent Recovery Centers (URC). The ODMHSAS will utilize the funds to staff the expansion of the URCs.

Background. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) collaborates with behavioral health providers, child-serving agencies, and family organization partners across the state in providing services to children, youth, and young adults experiencing serious emotional disturbance. ODMHSAS supports, maintains, and grows Oklahoma Systems of Care (OKSOC) by providing leadership, vision, infrastructure, resources, accountability, workforce development, and technical assistance. All state behavioral health services for children, youth, and young adults are under the Oklahoma Systems of Care umbrella. ODMHSAS and its partners have expanded OKSOC services across the state through:Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding, Medicaid, and ODMHSAS funding to offer comprehensive services and supports to Oklahoma'schildren and families. Oklahoma has been working toward one of the most dramatic and positive transformations in state history with the culmination of recent Medicaid expansion, the largest ever legislative investment in the crisis system infrastructure, federal block grant investments, and the recent launch of 988 as the national behavioral health crisis helpline. All of which have all supported the implementation of the Oklahoma Comprehensive Crisis Continuum (OCCC).

The Oklahoma Comprehensive Crisis Continuum (OCCC) is a behavioral health crisis continuum of care, serving individuals in the least restrictive means possible: prioritizing community-based diversion approaches to prevent the need for higher levels of care and to avoidunnecessary law enforcement and criminal justice involvement. The OCCC is comprised of threeprimary pillars and supporting services that work together to address the individual needs of Oklahomans: a 988 Call Center, Youth Mobile Response and Stabilization, and Urgent Recoveryand Crisis Centers.

To support all levels of integrated community-based care, Oklahoma has expanded Certified Community Behavioral Health Clinics (CCBHCs) statewide. Oklahoma was an original CCBHC demonstration site and has continued to garner national attention for proven success in the model with reductions in emergency room visits, diversion from higher levels of care, and increased rates of integrated care.

These CCBHCs operate as the state's safety net of behavioral health care, serving thousands of Oklahomans in crisis, outpatient, inpatient, and residential settings.

ODMHSAS has long been a leader in the development and sustainment of evidence-based interventions along the continuum of care. For example, Oklahoma has successfully sustained a statewide telehealth network that uses tablets to connect individuals in crisis with law enforcement and/or directly to a behavioral health professional. The state's first Urgent Recovery Center (URC), the Oklahoma County Crisis Intervention Center, developed a proven community-based crisis diversion model which has now become one of the three primary pillars in the crisis response system and is being expanded statewide. This includes Child and Adolescent Urgent

Recovery Centers (URC). Oklahoma currently has four Child and Adolescent URCs with four more expected to be added by March 2024. Among those four will be a URC and Crisis Stabilization Unit (CSU) specifically designed to meet the needs of children and youth with intellectual disabilities, autism and other developmental disabilities.

Description. ODMHSAS will support the workforce to expand Child and Adolescent Urgent Recovery Centers across Oklahoma so that we are able to serve children and youth across our state in order to prevent families from traveling long distances when their child is experiencing a mental health crisis. Oklahoma is using a family model to support children, youth and their caregivers in the Child and Adolescent Urgent Recovery Center.

Project Plan. ODMHSAS proposes funding to support staffing to be able to implement and expand Child and Adolescent Urgent Recovery Centers (URC) across the state.

Justification. Oklahoma is developing Child and Adolescent Urgent Recovery Centers across the state to provide assessment and rapid crisis stabilization so that children and youth can access crisis care in their own community. ODMHSAS will support the development of the URCs across the state to help caregivers access crisis care in their community rather than travel across the state to access this care. Oklahoma is using a family program model to support children, youth and their families in the child and adolescent Urgent Recovery Centers (URC). This model includes caregivers staying with their child during the assessment and crisis stabilization period. Staffing patterns also need to support 24 hour follow up appointments to ensure connection to ongoing appropriate care in their community. The URCs will also utilize the Family Peer Support role to engage families who may have difficulties following up with their outpatient care.

Staffing for new Urgent Recovery Centers will be on boarded by July, 2025.

Budget.

Staff Role	**Number of staff**	**Cost**	**Cost**
Mental Health Technician	10	$29,234.00	$293,234.00
Family Support Provider	1	$30,000.00	$30,000.00
Lead Case Manager	1	$51,000.00	$51,000.00
Lead Clinician	1	$74,000.00	$74,000.00
Benefits	13	$10,769.23	$140,000.00
eSMI Setaside	1	$69,204.00	$69,204.00
Crisis Setaside	1	$34,602.00	$34,602.00
		Total	**$692,040**

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Carrie Slatton-Hodges

Title

Commissioner

Organization

Oklahoma Department of Mental Health and Substance Abuse Services

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Not Applicable.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

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Footnotes:

PLANNING STEPS

<u>Step One:</u> 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 Certified Community Behavioral Health Centers (CCBHCs), 53 substance use disorder treatment providers, 41 county courts for the administration of treatment court, 43 prevention providers, and 53 specialty providers, including housing, advocacy, and consumer and family-operated programs. Oklahoma has completed a transition from Community Mental Health Centers (CMHCs) to statewide coverage of the Certified Community Behavioral Health Clinic model. All of the former Oklahoma CMHCs have made the transition to CCBHCs and are either operating under the state plan or federal demonstration programs. These CCBHCs are required to provide care coordination and care management to ensure integrated behavioral health and health care. In addition, there are 2 RA1SE NAVIGATE programs to assist individuals who are experiencing a First Episode of Psychosis (FEP), along with 1 FEP Crisis Care program, and statewide early Serious Mental Illness (eSMI) Outreach Programs provided through 14 CCBHC 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.

System Structure

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

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

Licensure (certification) of most treatment and support service organizations is statutorily required and administered through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Provider Certification Division. The ODMHSAS also supervises mandated

direct care certifications for Behavioral Health Case Managers and Peer Recovery Support Specialists, and the Alcohol and Drug Substance Abuse Course process (organizations, individual assessors, and course facilitators, related to driver's licenses administrative law reinstatement).

On a daily basis, approximately 1,925 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 CCBHCs. However, other providers are represented in this workforce including Peer Recovery Support Specialists, Family Support Providers, and residential support staff.

Certified Community Behavioral Health Centers (CCBHC). In December 2016, Oklahoma was awarded the Medicaid Demonstration project for Certified Community Behavioral Health Centers. This demonstration has increased the capacity to serve individuals that qualify for Medicaid and allows 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. Oklahoma has expanded the CCBHC model statewide through a State Plan Amendment (SPA). All 13 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 it is highly suggested to do Level II. The additional 5 services 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.

For those CCBHCs operating under federal demonstration programs, the payment structure is a per member per month rate. The demo sites' Special Populations were changed to match the SPA sites' Special Populations. There are 2 Special Populations. Special Population 1 is adults and Special Population 2 is children- both focusing on Oklahoma's "Most in Need". The special populations will be identified through a 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.

Oklahoma was the first CCBHC state with an approved State Plan Amendment for CCBHC services. Oklahoma will be able to continue to provide CCBHC services with no interruption with the State Plan Amendment. Currently, there are 10 CCBHC sites approved and providing services under the SPA. Each agency had to pass a rigorous new certification specifically designed for this comprehensive fully integrated service model.

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 a 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 the standard population and receive the standard per member per month rate.

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

Partnerships. Collaborations with community-based organizations and other state agencies are discussed throughout this application. These partnerships have resulted in more services and improved access for Oklahomans in need of mental health and substance use disorder treatment.

Training/Technical Assistance. The ODMHSAS provides ongoing training, technical assistance, and performance improvement opportunities to all providers throughout the system, including employees of the ODMHSAS and staff from partnering organizations. Introductory and advanced trainings are offered, in a variety of EBPs (Evidence-Based Practices) at no or minimal cost, so that providers across the state may have access to opportunities and resources for professional development, to support the implementation of evidence-based practices and emerging models in our ongoing efforts to enhance our systems to leverage technology, research, and education to support children, youth, and families. The ODMHSAS also hosts up to three major conferences each year, including the Children's Behavioral Health Conference, Zero Suicide Summit, and the Momentum Conference (which covers Prevention, Justice, and Recovery topics.) The ODMHSAS Human Resources Development training programs recorded combined audiences of over 52,090 participants from all areas of Oklahoma in the state fiscal year 2023. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce.

The Children's Behavioral Health Conference was held earlier this year and was attended by 720 participants. The theme "Illuminating the Path" was chosen as it reflects clarified transparency throughout the process, supported by highlighting ongoing partnerships and collaborations with other agencies. Families are unintentionally in the dark due to a lack of awareness of existing resources. In addition, families whose children are involved with child welfare, the juvenile justice system, or who may have co-occurring disorders are not always aware of the available resources and supports. The conference aimed to create a transparent process and empower youth, families, children, and advocates by increasing awareness of these services, resources, and tools. This year's conference provided three days of live sessions from April 11th through April 13th. Additionally, access to more than fifty hours of recorded sessions was provided after the Conference from April 24th until May 5th. Sessions that were held belonged to four different tracks: Substance Use Disorders, Special Populations (IDD/Co-occurring), Partnerships and Collaborations, and Children's Crisis Continuum Response/988 to Date. Ethics was also provided. Sessions were from 9 am to 5 pm and included topics such as Multi-Tiered System of Supports in Schools, Trauma-Informed Crisis Care, The Current State of Oklahoma Adolescent Substance Use, Treating the Whole Traumatized Family, Working Through Challenging Infant Mental Health Cases, and Youth Substance Use Disorders and Co-occurring Depression.

Person-Centered Services. Person-centered and strengths-based service planning is required in all state funded and certified programs. 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 ongoing 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). The format of this training is web-based which ensures that it can be taken at any time, by clinicians anywhere. Because of this, newly hired clinicians do not need to wait on a live training in order to take this and begin utilizing the person-centered approach with their consumers. This training is available state-wide to all clinicians and the agencies are encouraged to use it as orientation as well as a refresher, as needed. Training opportunities with regard to strengths-based case management also help with continued development in this area. The increased presence of Peer Recovery Support Specialists within ODMHSAS funded organizations also assists with promoting and supporting shared decision-making.

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.

Service Monitoring and Technical Assistance. ODMHSAS monitors CCBHC and contracted 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.

Recovery Support Services

The ODMHSAS promotes a recovery-focused service system with a focus on improving access to quality health and behavioral health treatment; incorporating peer, family, and other community supports; emphasis on person-centered care that includes shared decision-making; and continued efforts to try to improve access to housing, employment, education, and related supports. CCBHCs require and promote peer recovery support in its model which has increased the hiring and integration of Certified Peer Recovery Support Specialists (PRSSs). PRSSs are also heavily utilized by our substance use disorder treatment providers. 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. Additionally, the ODMHSAS' Enhanced Tier Payment System (ETPS) provides additional funding to providers who increase recovery support services to consumers. This system encourages providers to hire recovery support staff and to deliver recovery support services.

ODMHSAS currently trains and certifies Oklahoma's Peer Recovery Support Specialist workforce. To ensure a well-equipped and quality workforce, ODMHSAS provides specialty tracts that enhance knowledge, skills, and competency in a variety of areas and populations served. Currently specialty tracts are provided for transitional age youth, older adults, veterans, methamphetamine use, criminal justice, domestic violence, gambling, group facilitation skills, crisis care, African American Culture, and Latinx. ODMHSAS also provides e-learnings on self-care to help ensure the well-being of the peer workforce and provide skills they can teach and role model to their clients. Oklahoma provides and supports training for the professional workforce on recovery principles and recovery-oriented practices and systems, including the role of peer providers in the continuum of services. ODMHSAS' annual Momentum Conference and Children's Behavioral Health Conference provide a forum for presentations on recovery principles and practices and the role of peer providers. Staff in recovery and national leaders in recovery support services have presented at these annual conferences.

Peer Recovery Support Services is also offered for adolescents age 16 and up and is, as with adults, a Medicaid compensable service. 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 into the curriculum for PRSS Certification.

The Peer Recovery Support System extends from support rendered in the treatment area to education/employment and housing. This will be discussed more in-depth in those sections.

Prevention Services

The primary function of Prevention Services is to plan, direct, manage, evaluate, and guide strategies to prevent substance use and mental health problems in the state of Oklahoma. Prevention is viewed as a proactive process by which conditions that promote well-being are created and risk factors are reduced. Prevention activities empower individuals, organizations, and communities to meet the challenges of life events and transitions by creating conditions and reinforcing individual and collective behaviors that lead to healthy communities and lifestyles. The Oklahoma Plan: Preventing Mental, Emotional and Behavioral Disorders is available for download on the Department's website: https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/prevention/ODMHSAS-Prevention-Plan-2021.pdf. The mission of Prevention Services Division is to: (1) Implement effective prevention strategies that are evidence-based and accountable; (2) Leverage the power of community leadership; and (3) Enhance the capacity of communities, schools, healthcare providers, workplaces, and families to forever practice prevention.

Communities are an effective organizing force for bringing evidence-based policies and programs to scale. With the understanding that local issues need local solutions and local leadership, the ODMHSAS will support community and neighborhood-level prevention coalitions across the state to provide community-based prevention services. Coalitions are comprised of residents, governmental and nongovernmental organizational leaders, schools, young people, faith partners,

and many more to systematically:

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

Community level prevention work is based on the Strategic Prevention Framework and aligns with state prevention priorities. Services focus on achieving sustainable, population level outcomes. The ODMHSAS also coordinates federal and state prevention funds to integrate evidence-informed prevention services into other key sectors of everyday living in Oklahoma – business employers, faith-based families, healthcare practices, and schools. Included in this strategic prevention approach are *primary* prevention services such as the ODMHSAS administers Responsible Beverage Service and Sales Training (RBSS) as an overarching moniker of Oklahoma's underage drinking prevention initiative. The Oklahoma Alcoholic Beverage Laws Enforcement (ABLE) Commission requires every employee/retailer to complete an approved RBSS training. Synar inspections are conducted in partnership with the Oklahoma Alcoholic Beverage Laws Enforcement (ABLE) Commission to reduce and maintain Oklahoma's number of illegal tobacco purchases by individuals under the age of 21. SUPTRS Block Grant funds are not used for enforcement, only for training and technical assistance, and support services to communities and law enforcement agencies.

Other programs administered through the ODMHSAS prevention initiatives include the following: The Family Field Guide campaign, Faith Partners equips people of faith to serve with an informed, compassionate response to the risk and prevalence of addiction and related mental health issues. Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for adolescents in primary care offices and other community-based settings funded by the SAMHSA Center for Substance Abuse Treatment, state and foundation sources; the Office of Suicide Prevention funded by the SAMHSA Center for Mental Health Services (CMHS) and state appropriated funds; Mental Health First Aid training program funded by state appropriated resources; the Strategic Prevention Framework (SFP) Partnerships For Success and SPF Rx programs, the State Opioid and Stimulant Response Grant, Prescription Drug Overdose project, First Responders CARA project funded by SAMHSA Center for Substance Abuse Prevention and state appropriated funds and Oklahoma's Ok I'm Ready communications campaign initiative supported by state appropriated funds. Additional emerging prevention services include partnerships with the Oklahoma State Department of Education (OSDE) and Local Education Agencies (LEAs) to provide leadership in planning and implementing best practice prevention services in schools. State-level support is provided by the ODMHSAS to help school sectors adopt Multi-Tiered System of Supports (MTSS), a prevention-based framework to serve the needs of all students, and implement student prevention programs such as the PAX Good Behavior Game (PAX GBG), Botvin LifeSkills Training (LST) and 3rd Millennium Classrooms. The ODMHSAS funds an array of prevention and promotion services in Oklahoma addressing overdose, suicide, and youth/adult mental health outcomes as well as data collection, prevention training, and prevention workforce development and consultation services.

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 CCBHC 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. Oklahoma was recently awarded the Clinical High Risk for Psychosis (CHR-P) grant which will be used to serve students at two universities who, upon being referred to a CCBHC, are identified (assessed) as being at clinical high risk for psychosis. They will receive a stepped model of care including assessment, psychoeducation, cognitive behavioral therapy (CBT), supported education and employment, substance use treatment, pharmacotherapy, recovery support services, and also a seamless transfer to specialty care, if they develop an emergent disorder of psychosis. Oklahoma's CHR-P grant will improve symptomatic and behavioral functioning; enable students to resume age-appropriate social, academic, and vocational activities; delay or prevent the onset of psychosis; and minimize the duration of untreated psychosis for those who develop psychotic symptoms.

Treatment

Mental Health Services

The ODMHSAS provides a mental health services continuum of care that provides outreach, community-based crisis stabilization, facility-based crisis stabilization, inpatient services, and transitional services and supports. The 13 CCBHCs referenced earlier serve the state with programs established in approximately 69 cities and towns. Department employees operate four CCBHCs with administrative offices in Lawton, McAlester, Norman, and Woodward. The other 9 CCBHCs are private, nonprofit organizations under contract with the Department. All CCBHCs are also Medicaid providers and access funding from a variety of other sources. The ODMHSAS funds thirteen adult Community Based Structured Crisis Centers (CBSCCs) across the state of Oklahoma and four other adult crisis centers are in the process of opening. 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 twenty adult urgent care centers across the state of Oklahoma. The Urgent Care Centers provide outpatient services including medication management for persons needing immediate care to prevent a psychiatric emergency. The Centers also provide 23-hour 59-minute respite and observation to divert persons as indicated from inpatient or CBSCC placement. Additionally, ODMHSAS passed new CCBHC state rules which required the establishment of

24/7 outpatient or urgent recovery centers in all counties with a catchment area of 20,000, and each adjacent county for every county under the 20,000 population threshold, within three years or initial CCBHC certification of by July 1, 2024, whichever is later. The ODMHSAS has created a statewide, 24/7 crisis response network that includes 988 call centers and community-integrated adult and child mobile crisis teams.

Currently, 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. Three more will open in January 2024, with one in Muskogee and two in Sapulpa. One of those in Sapulpa will specialize in serving children and youth with special needs such as IDD/DD or autism. Each of these crisis centers is legislatively required to provide detoxification for children and adolescents if needed. These detox services are in addition to the 12 specific contracts for adolescent substance use. There are 4 Child and Adolescent Recovery Centers (URCs) that are open in Tulsa, Elk City, Norman, and McAlester. These URCs use a family model of care so the caregiver stays with the child during the crisis stabilization process. All families will receive a 24-hour follow-up appointment after leaving the URC. Oklahoma will have 5 more URCs open by January 2024 in Lawton, Muskogee, Edmond, and two in Sapulpa with one serving children and youth with special needs such as IDD/DD or autism. All URCs will have access to an infant and early childhood specialist for consultation. All URCs will be equipped with a sensory kit purchased through the Autism Foundation of Oklahoma to help support those with sensory needs because of trauma or autism. All staff will have access to free training on the use of those kits from the Autism Foundation of Oklahoma. For the two URCs that were opened during FY23, there was 518 youth served and 649 caregivers served.

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

A suicide prevention protocol is in place for all ODMHSAS contracted mental health treatment facilities. At admission and 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, the client participates in the Collaborative Assessment and Management of Suicidality (CAMS) therapeutic framework.

Substance Use Disorder Services

The substance use disorder (SUD) treatment and recovery services funded through the ODMHSAS service system are provided at 53 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. CCBHCs are also able to render substance use disorder treatment services. Also, the ODMHSAS directly operates one SUD residential facility that is staffed with state employees. 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 SUPTRS Block Grant funds and state appropriations. These agencies include SUD treatment facilities, CCBHCs, 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 for screening, assessment, and treatment planning for children with Fetal Alcohol Spectrum Disorder. An essential component of the recovery system is the state's network of Oklahoma Alliance for Recovery Residences (OKARR). OKARR launched in January 2020 as a private, not-for-profit agency to promote access to recovery supportive living environments and provide certification as a state affiliate of the National Alliance for Recovery Residences (NARR). Forty-six recovery residences with over 850 beds have been certified in Oklahoma and are following best practices within the social model of recovery.

Currently, there are 137 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 residents who utilize MAT (Medication Assisted Treatment), 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.

MAT is provided through the CCBHCs, CCARCs, and OTPs (Opioid Treatment Programs). The number of CCBHCs and CCARCs has already been addressed in previous sections. There are 20 Opioid Treatment Programs, serving 14 counties. The OTPs are mandated to be certified by the ODMHSAS, in addition to having certification/approval by SAMHSA, DEA, CARF, and OBNDD (Oklahoma Bureau of Narcotics and Dangerous Drugs) and they are private, for-profit organizations. Currently, the ODMHSAS contracts for MAT services, at the CCBHCs, CCARCs, and one OTP through the SOR grant. ODMHSAS also implemented a program to get MAT into county jails. Currently, MAT is being provided in 33 of Oklahoma's county jails through ODMHSAS.

The ODMHSAS currently has 12 specific outpatient contracts for adolescent substance use. ODMHSAS operates one residential facility and also contracts with one male residential facility. More information on adolescent treatment for substance use disorder is in the Comprehensive Substance Use Disorder Services section of this application. 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 CCBHC or a substance use disorder treatment agency can provide integrated co-occurring services for children and adolescents.

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

In addition to training CCBHCs contracted to provide adolescent and young adult substance use services, the ODMHSAS has also trained several other substance use treatment providers and CCBHCs in the following EBP's: Motivational Interviewing, GAIN SS, Community Reinforcement Approach and Adolescent Community Reinforcement Approach. to help improve the services they provide to adolescents and young adults.

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

OJA assessments report that 64% of youth have a moderate to high risk for substance use and 79% report mental health and behavioral issues. Research shows early intervention and appropriate referrals and supports in place for these youth show decreased recidivism. By continuing collaborations and partnerships with other youth serving agencies, we will bring supports to identify youth who are considered to be at risk within these systems for mental health, co-occurring, or substance use disorders and link to appropriate supports and services.

Problem Gambling Treatment Services

The Oklahoma Gaming industry is represented by over 120 casinos, four horse tracks/racinos, and the Oklahoma Lottery. A prevalence study in the State of Oklahoma was conducted in 2022 on those individuals who might have a problem with gambling. The statewide prevalence has almost doubled from the first prevalence study, in 2015, from 3.2% to 6.3% in the 2022 prevalence study. The size of the at-risk population is 23.5%. Altogether, nearly a third of Oklahomans (29.8% or 1 million people) are experiencing harm related to gambling. Many subgroups of the population have problem gambling prevalence above the adult average, African-Americans, Asians, men, individuals aged 25-44, those who did not graduate from college, and the military. 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 FY14, legislation was approved directing the Oklahoma Lottery to increase funding for problem gambling services by $250,000.

Effective July 1, 2014, ODMHSAS certification rules were revised for CMHCs (now CCBHCs), 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

Oklahoma Systems of Care (SOC). Systems of Care are the preferred approach to coordinate services for children and their families. The Oklahoma Systems of Care Initiative (OKSOC) is strategically designed to have local Systems of Care available to children, youth, and their families in all 77 counties. Currently, Oklahoma has 80 local Systems of Care sites that cover 77 counties. Funding from SAMHSA and the Oklahoma Legislature has been leveraged to facilitate the development of the OKSOC. CCBHCs 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, which includes the Community Based Structured Crisis Centers and Urgent Recovery Centers for children that were addressed previously. 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.

OKSOC Teams work to build and enhance the capacity of Oklahoma Systems of Care providers to support families, children, youth, and young adults with high quality services and supports. The OKSOC Team also works to ensure meaningful and intentional youth and family involvement from the individual youth and family level, as well as at the community, state, tribe, and national levels. OKSOC also ensures that the OKSOC Core Values of family-driven treatment are guided, and implemented at all levels.

OKSOC provides high quality, relevant, and useful training, technical assistance, and professional development to individual family members to build their capacity to advocate for themselves and assume ever-growing leadership around children’s behavioral health issues.

OKSOC currently contracts with state level family and youth advocacy organizations as a priority and this is sustained through state funding. The OK Family Network (OFN), the National Alliance

on Mental Illness (NAMI OK), and the Evolution Foundation (EF – a non-profit that focuses on community development for OKSOC and is run by family members) contribute daily to policy development and work tirelessly to help meet the needs of individual children, youth, and families while creating the opportunity for youth and family members to grow into leaders at all levels.

Families and youth participate as full partners at the individual treatment level, in local systems of care, and in state level policy groups. The Children's Behavioral Health Network (CBHN) is a partnership between NAMI OK, OFN, and Parents Helping Parents (PHP), a non-profit family-run organization for parents of children with substance use disorders. The CBHN is designed for developing an effective statewide behavioral health peer and family support network and is looking to extend to include The Mental Health Alliance and Peaceful Family Oklahoma.

Mobile Response. Oklahoma has developed the Oklahoma Mobile Response and Stabilization Services (MRSS) which provides statewide rapid, community-based mobile response and stabilization services for children, youth, and young adults up to the age of 25 who are experiencing behavioral health or psychiatric crises. MRSS is an integral component of Oklahoma Systems of Care (OKSOC) and is founded on the OKSOC values and principles, which provide the driving force for the provision of behavioral health services to Oklahoma's children, youth, young adults, and families. In FY23, there were a total of 5,326 children served through MRSS. There was a higher level of care diversion rate of 81.62% and a return to class rate of 89.1%.

Early Childhood Systems of Care. 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 increase collaboration and enhance coordination of services with 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: Circle of Security, Facilitating Attuned Interactions (FAN), Attachment Biobehavioral Catch-up, the Growing Brain, and Child Parent Psychotherapy. To support continued efforts to best meet the needs of children 0-5 and their families, ODMHSAS provides technical assistance opportunities on an "as requested" basis. A foundational training series has also been developed that educates clinicians serving the 0-5 population on appropriate assessment (utilizing relational assessment procedures including the Working Model of the Child Interview & the Crowell) and diagnostic procedures (DC:0-5) to serve as an entry point for those working with the 0-5 population.

School Based Services. School-based services are working to establish new Behavioral Intervention Services and Support in Schools (BISSS) provider networks throughout the state of Oklahoma. Currently, there are 10 BISSS providers in Oklahoma working in 157 schools. Continuum of Supports: BISSS utilizes a school-wide structural framework with a 3-tiered intervention for identifying and addressing academic and behavioral issues for students. The goal of a tiered approach is to create a school culture and behavioral supports that encourage and improve academic, behavioral, and social outcomes for all students. This allows for a continuum of supports to be provided based on the identified risk, character, and severity of students' issues and needs.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) is a manually-guided and empirically-supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma

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

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 63 licensed behavioral health disaster volunteers.

Per FEMA, Oklahoma has the 3rd highest disaster rate in the Nation. During the past several years Oklahoma has experienced multiple natural disasters and because of this, intense focus has been on continued community collaboration, volunteer infrastructure, and training. Clinicians are trained in Psychological First Aid (PFA), through the National Child Traumatic Stress Network, 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 2020, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 332,791 comprising 9.5 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 areas: training, data provision, data collection, and meetings of collaboration and consultation. The tribal liaison attends Southern Plains Tribal Health Board Quarterly Meetings and the SAMHSA Tribal Consultation and coordinates with the Oklahoma Health Care Authority, the Oklahoma Department of Human Services, and the Oklahoma Health Department.

Activities for the last year include formal consultations, collaborations, and partnerships with the tribes located in the state of Oklahoma. The tribal liaison for the department attended community meetings, tribal grant advisory councils, tribal consortiums, and tribal state workgroups, Topics

addressed during these activities included prevention, substance abuse treatment, drug court, the opioid crisis, reentry programs, and cultural competence. The tribal liaison is involved in every aspect of the ODMHSAS internal teams, including Systems of Care, Transitional Age Youth, Housing, Homeless, Employment, Re-Entry, Specialty Courts, State Opioid Response, Communications, Legal, Marketing, and Prevention. The tribal liaison implemented a monthly Tribal Behavioral Health Meeting and the 988 Tribal Collaboration that meets monthly. One of the workgroups is working to develop a cultural competency training over Oklahoma Tribal Nations that will be housed on the ODMHSAS Training Institute and available for any contracted provider to use at any time.

The CCBHCs 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 SUPTRS 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. An overview of CCBHC development was presented to the Veterans Alliance. A meeting was held between CCBHC staff and Major General Deering, the 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, dishonorably 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 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 CCBHCs, and representatives from the National Alliance on Mental Illness (NAMI). The training prepares officers to safely de-escalate a crisis, determine the need for emergency treatment, and get the individual to professional treatment as quickly as possible. In the last ten years, ODMHSAS and all supporting CIT partners, have trained around 1,663 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 crises and diverting individuals to crisis centers. CIT programs have been modified for detention officers and other law enforcement populations.

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

- Law enforcement iPads – Through legislative appropriations, the ODMHSAS made available iPads to all law enforcement officers in the state of Oklahoma to serve as a telehealth connection to the network of local CCBHCs. This connection provides an opportunity to provide consultation and evaluations remotely to support the diversion into behavioral health services from the criminal justice response.

- *Pretrial Support* is offered to pretrial service agencies, courts, and jails 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.

- *Offender Screening,* as authorized by 43A O.S. 3-704, is conducted by ODMHSAS certified treatment providers to determine felony offenders' risk to re-offend 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 a person spends awaiting sentencing by 57 days, resulting in an estimated savings of over $200 million in jail costs since the program's inception. 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. As of March 2023, over 66,510 screens have been completed and nearly 60,246 final dispositions recorded. Approximately, 82% of those individuals screened have received a case disposition other than prison. Recently, eligibility for these screenings has been expanded to individuals facing misdemeanor charges.

- *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 a 94.5 percent drop in unemployment, a 176.1 percent jump in monthly income, a 78 percent increase in participants with private health insurance and better than 95% percent of graduates can again live with their children. A tracking study of over 4,000 graduates monitored for five years 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). Currently, the drug courts, in Oklahoma, serve 67 counties.

- *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 37 percent drop in unemployment, a 90 percent decrease in arrests, and a 72 percent decrease in the number of days spent in jail. There are currently mental health courts in 35 Oklahoma counties, with an additional mental health court being added soon.

- *Misdemeanor/Early Diversion Programs* partner criminal justice accountability with evidence-based substance use and mental health treatment services to decrease future involvement with the criminal justice system. Misdemeanor/Early Diversion generally operates within two models (1) Misdemeanor/Early Diversion programs which focus on individualized case management and wrap-around services. The focus of these programs is to connect and engage participants with certified treatment agencies and other community-based services to address basic life needs or (2) Deferred Adjudication Treatment programs that 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 35 counties operating misdemeanor/early diversion programs. Over the last two years, the early diversion census has risen from 614 participants to over 1700 participants.

- *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 amended their policies and operations to more quickly identify justice-involved veterans in the criminal justice system. Several programs across the state have received Zone4Vets honors and are providing exceptional care to veterans in their communities. In addition, the ODMHSAS has partnered with the Center for Justice Innovation to develop a five-year strategic plan to increase and enhance services to veterans in the criminal justice system.

- *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 to reduce the recidivism of municipal offenders by offering individualized behavioral health treatment instead of traditional case processing.

- *Reentry Teams, Discharge Managers, and Co-Occurring Treatment Specialist*. The state funds four Reentry Intensive Care Coordination Teams (RICCTs). These contracts with community-based teams include a specifically trained Intensive Case Manager and a Peer Recovery Support Specialist to provide success oriented and strengths-based reentry support following incarceration. The ODMHSAS provides seven Discharge Managers to work in targeted correctional facilities. Discharge Managers work alongside prison treatment staff to identify and assist persons preparing for reentry who are expected to have ongoing mental health and substance abuse treatment needs. All RICCT teams operated under the CCBHC model where clients receive an array of wraparound services to include medication assisted treatment.

  The Discharge Managers 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

- *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.

Mental Health Block Grant Criterion

Children with Serious Emotional Disturbances (SED) and Their Families

As referenced above, the CCBHC 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 FY23, a total of 88,650 children under age 18 were served in the ODMHSAS system by both mental health and substance use disorder providers; 30,630 children with SED. Additional information is provided below to address specific MHSBG requirements.

- *Mental Health and Rehabilitation Services for Children with SED.* CCBHCs 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
    - Supported employment and education
    - Peer family support
    - Family self-sufficiency (housing supports)
    - 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. CCBHCs and SOC sites are developing collaborations with Federally Qualified Health Centers (FQHCs), tribal health services, clinics, homeless clinics, and county health departments. CCBHCs, for children with SED, integrate behavioral health care and primary care services by 1) directly providing primary care in-house performed by a qualified employee, or purchasing through a contract, or 2) establishing written agreements with external primary care providers and ensuring the coordination of care and treatment for identified physical care issues.

- *Employment and Vocational Services.* Employment services are addressed further in the application, in the "Adults with Serious Mental Illnesses (SMI)" section.

- *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 expanded upon, in detail, in the following section "Adults with Serious Mental Illnesses (SMI)".

- *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 CCBHC 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 a 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, CCBHCs and local SOCs provide specific substance use disorder treatment and support services across the lifespan. All treatment providers are to meet minimum requirements to be co-occurring capable service treatment sites. This is covered more in-depth in the Comprehensive Substance Use Disorder Services section.

- *Other Activities Leading to Reduction of Hospitalization.* CCBHCs 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 the 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. CCBHCs are now responsible to ensure a smooth transition of care between

any and all higher levels of care and CCBHC 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 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. In FY23, the total number of children served through Mobile Response and Stabilization Services was 5,326. There was an 81.62% higher level of care diversion rate and an 89.1% return to class rate. Crisis Centers and URCs, for children/youth and adults, were previously addressed.

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

- *Transition Services.* ODMHSAS was awarded the Oklahoma Healthy Transitions Initiative-2 (OHTI-2) that began on October 1st, 2021. ODMHSAS is currently involved with 2 initiatives that support agencies and community partners in providing culturally relevant services and supports to underserved communities in overcoming generational and historical trauma and in providing treatment, crisis, and support services to TAY's (Transitional Aged Youth). We have begun to expand comprehensive treatment, and recovery support services for youth and young adults (ages 16-25) with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD), and their families. Movement has been made towards operationalizing a recovery-oriented system, building out infrastructure that supports capacity, implementation, and sustainability, developing our workforce, taking tactical action to streamline processes and remove barriers to treatment, and putting in place a mechanism and protocol by which to connect African American youth, young adults, and their families to recovery-oriented continuum of care services and supports. OHTI has currently been conducting significant work partnerships with local colleges and universities, where we have collaborated with student led mental health groups to create impactful projects for the college student body. Additionally, our contracted agencies and providers have established streamlined referral processes and services for colleges in their counties, while our embedded coordinator offers direct support to college students on campus, promoting accessibility to services and fostering a culture of care.

- *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 the 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.

- *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 720 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 the emergency room, health personnel, law enforcement staff, and school districts.

Adults with Serious Mental Illnesses (SMI)

Oklahoma is statewide with Certified Community Behavioral Health Clinics (CCBHC), as of July 1, 2022. All 13 CMHCs have transitioned to the CCBHC model of care. The statewide network of CCBHCs 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 Mental Health Courts serving 35 Oklahoma counties with an additional mental health court being added soon, drug courts serving 67 counties, jail-based screenings in all 77 counties, 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 FY23, a total of 111,405 adults over age 18 were served in the ODMHSAS system by both mental health and substance use disorder providers; 65,959 adults with SMI.

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

    - Crisis Services
    - Psychiatric Rehabilitation
    - Care Coordination
    - Housing & Employment Services
    - Targeted Case Management
    - Veterans Services
    - Outreach & Engagement
    - Integrated Care & Health Promotion

- Screening, Assessment, and Diagnosis
- Outpatient Mental Health & Substance Use Services
- Primary Care Screening & Monitoring
- Comprehensive Integrated Care Planning
- Peer Support & Family Support Services

Additional information is provided below to address specific MHBG (Mental Health Block Grant) requirements regarding service to adults.

- *Employment Services*. 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 practice models followed by the ODMHSAS and affiliated providers and has allowed for better service provision for Oklahoma's most vulnerable. IPS has expanded to fifteen teams serving 40 counties across the state of Oklahoma funded through various grants, including the Mental Health Block Grant; and the State Opioid Response grant. On July 1, 2018, the ODMHSAS activated IPS specific billing codes, and the IPS credential process for IPS employment specialists and supervisors. This allows providers to submit payment claims for the delivery of IPS services to ODMHSAS. We have also added benefits counseling by Certified Work Incentives Counseling to our IPS teams. Their main role is to provide intensive counseling about benefits and the effect of work on those benefits.

  At the end of 2022, IPS participants were earning an average hourly wage of $10.50. The competitive integrated employment rate is 30.4% which is impressive due to the pandemic.

  NextGen project is a research project with the Weststat and Mathematic groups and Social Security Administration. It hopes to determine if those exiting jails and offered IPS services will have a better recidivism rate than those that are not offered IPS services. Originally, Oklahoma was selected for two of the five sites. Rogers County Detention Center/GLMHC and Cleveland County Detention Center/ODMHSAS embedded at COCMCH will serve over 400 individuals exiting incarceration. In 2023, Oklahoma County Detention Center/Hope Community Services joined the project.

- *Education Services for Adults with SMI.* Adult basic education, like GED classes, is offered onsite at two clubhouse programs, and at some CCBHCs. CCBHCs 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, supported education services are offered to help individuals improve their educational status from obtaining their GED and technical skills acquisition to obtaining their college degree.

- *Housing Services.* Connecting individuals and families to safe, appropriate, and affordable housing is a high priority for ODMHSAS and our contracted providers. In addition to accessing an array of supportive and subsidized housing options, providers can utilize the ODMHSAS flexible funds to address immediate and short-term needs to stabilize family housing situations. ODMHSAS funds, both directly and through collaborative grant efforts, a variety of housing services and supports targeted at assisting those at risk of being homeless and those experiencing homelessness. All CCBHCs are required to have a housing team to focus on this effort and have specialized training in housing first, eviction prevention, working with housing authorities, fair housing, and HUD's continuum of care with coordinated entry.

- *Homeless Services.* Services supporting those experiencing homelessness assist them to achieve positive change in their lives and reduce the use of homeless services, emergency rooms, and other welfare services. ODMHSAS believes that everyone has a different path out of homelessness, and we are mindful of their personal journey. We and our community providers work collaboratively with HUD's continuum of care to coordinate housing, scattered site, and services for those that are chronically homeless. This is addressed more in-depth in the "*Targeted Services for Homeless Section*". We also lead the nation in access to disability income through SSI/SSDI Outreach, Access, Recovery (SOAR). We also work closely with the two largest homeless day shelters, Tulsa Day Center and the Homeless Alliance, to ensure that homeless individuals have access to the needed mental health treatment and supports. Additional housing programs and supports are offered to homeless individuals through three housing programs through our partner, Mental Health Association Oklahoma (MHAO). One program, ION (Intensive Outreach and Navigation), is for those discharging from ODMHSAS crisis centers and inpatient facilities; scattered site apartments offer support services and Safe Haven provides housing with access to support services with transition to permanent housing. In Tulsa and OKC, MHAO owns scattered site apartments with connections to support services following the housing first model.

  ODMHSAS partners with four community providers to offer supervised transitional living, supported transitional living, and permanent supported housing for individuals with mental illness who need additional supports temporarily or longer as they acquire the skills to transition into a more independent living situation. There are 163 beds of these housing options available.

Our runaway and homeless youth (RHY) services include support for and collaborations with street outreach and an array of targeted services and supports to serve and protect young persons aged 17-24. Three housing program options are available—supervised transitional living, supported transitional living, and host homes. We also partner with Pivot and Sisu to provide emergency shelter for young adults who are experiencing challenges with mental health and substance use.

Recovery housing promotes recovery founded on the social model recovery principles which leads to long-term sobriety, improved health and wellness, and community involvement. ODMHSAS has partnered with Oxford House since 2006 to bring democratically, peer-run sober living homes to Oklahoma. Currently, there are 137 Oxford Houses. A state affiliate, Oklahoma Alliance for Recovery Residences (OKARR), of the National Alliance for Recovery Residences (NARR) launched in 2020 with ODMHSAS support. OKARR certifies recovery houses to meet national best practice standards. There are 105 certified Level 2 and Level 3 houses.

Residential Care Facilities is our highest level of community-based housing providing 24-hour supportive assistance to include physical exercise, daily living skills, and social activities with the hope to be a stepping stone to independent living in the future. ODMHSAS contracts with 15 RCFs across the state. Housing assistance and resources are also available through ODMHSAS. Discharge planning subsidies are funds to assist very low-income individuals with rent and utilities who are discharging from inpatient, incarceration, or foster care. Recovery housing scholarships are funds to assist individuals with opioid or stimulant use history with recovery housing. Housing assistance for specialized populations with a history of substance abuse to have immediate access to OKARR Level 3 housing is available through recovery housing vouchers. RISE Above Program (RAP)offers rental and utility funds to assist individuals who are survivors of human trafficking (sex and/or labor) and ensures connections to victim services. There are dedicated funds for transition age youth to assist with very low-income Transitional Aged Youth (TAY) with rent and utilities. Housing is Recovery is not only our motto but also a special fund to provide immediate access to housing assistance funds to prevent and end homelessness.

Additional housing related services and supports embedded in the system for adults with SMI include flexible funds available to each CCBHC that can be used to augment a variety of housing supports, including rental and utility deposits.

- *Substance Use Disorder Services Within CCBHCs including Services for Persons with Co-Occurring Disorders.* CCBHCs are able to render substance use disorder treatment services 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 CCBHCs for mental health assessment and other CCBHC services as needed. Individualized, gender, and culturally specific substance use disorder treatment is required of all providers.

- *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 1,182 individuals certified as Case Managers in 2022. 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 online 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.

- *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 to focus on the primary health needs of adults with SMI. Memorandums of Understanding (MOUs), Care Coordination Agreements, and Collaborations continue with Federally Qualified Health Centers (FQHCs), tribal health and Indian Health services, homeless clinics, county health departments, and pro bono health care providers. Dental services are also provided in local communities through free dental clinics and pro bono providers. Oklahoma is statewide with the CCBHC model of integrated care. CCBHCs continue to provide and/or coordinate both physical and behavioral healthcare. CCBHCs integrate behavioral health care and primary care services by 1) directly providing primary care in-house performed by a qualified employee, or purchasing through a contract, or 2) establishing written agreements with external primary care providers and ensuring the coordination of care and treatment for identified physical care issues. The CCBHCs are required to directly provide, at a minimum, primary care screening and monitoring, care coordination, and health promotion.

  Oklahoma also has a SAMHSA grant, Promoting Integration of Primary and Behavioral Health Care (PIPBHC). PIPBHC is a 5 year grant that supports the promotion of integrating and collaboration between primary care and behavioral health care services and promoting the availability of integrated care services related to screening, prevention, diagnosis, and treatment of mental illnesses, substance use disorder, and co-occurring physical health

conditions and chronic diseases. The goal of the grant is to serve a total of 2,000 people by the end of year five. Four CCBHCs have partnered with FQHC to provide services, CREOKS partnered with Arkansas Verigris and Northeastern Oklahoma Community Health (NeoHeath), Family and Children's partnered with Morton (FQHC), Green Country partnered with NeoHealth (FQHC), and Northcare partnered with Variety Care (FQHC). These partnerships will ensure that primary care, including prevention, wellness activities, tobacco cessation, screening assessment, and needed services, are an integral part of the behavioral health system, and are accessible to all who access our system regardless of pay source. This grant will end on September 30th, 2023. Integrated care efforts continue through the CCBHC model.

- *Support Services and Psychiatric Rehabilitation.* All ODMHSAS certified CCBHCs 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). CCBHCs typically elect to provide either a general psychiatric rehabilitation program or individual and group rehabilitation services, which are reviewed under their state CCBHC certification (licensure). In addition, two clubhouses certified by Clubhouse International currently operate independently of CCBHCs -- Crossroads Clubhouse (Tulsa) and Thunderbird Clubhouse (Norman).

- *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 interests, 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. CCBHCs 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 and URCs are previously addressed in this application. 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 2016, Oklahoma state law implemented Assisted Outpatient Treatment (AOT) under Oklahoma Title 43A to ensure that adults with serious mental illness (SMI) can receive services through the civil commitment process. The civil commitment process is unique because it does not have any association with criminal charges. The AOT order helps to ensure a mechanism for treatment and unifies community partners in the approach to the client's care. The community partners that commonly work together include Mental Health and Substance Use Disorder Service Providers, Law Enforcement, Court Staff, and

essential Community Partners. AOT referrals can be sent by Community Partners, family, and friends of the individual. Once a referral is received the local staff will access it to determine if criteria are met for an AOT order. The AOT order lasts for one year with Judges requesting updates throughout the order. The AOT Mental Health and Substance Use Disorder Providers provide consumers with a strength-based, non-threatening process for ensuring that adults with serious mental illness (SMI), who do not recognize the need for treatment have access to participate in treatment. Treatment also includes targeted case management, Peer Recovery Support Specialist, therapy, doctors, rehabilitation options, and medication management. AOT can be viewed as a preventative measure to prevent future law enforcement interactions, jail stays, inpatient hospitalizations, and emergency room visits.

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

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.

- *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 to 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 the 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 at individuals who are homeless are described below.

- The ODMHSAS implemented a state level Care Coordination Team beginning in May 2022. This Care Coordination Team, (CCT) consists of 4 Care Coordinators and an Access Specialist. The Care Coordinators focus their efforts on high need individuals, Care Coordination activities include an elevated level of care alerts to providers, facilitating case staffings with multiple providers and serving agencies as applicable, and assistance with accessing resources including housing when needed.

- *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.

- *Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH).* The PATH allocation for Oklahoma for grant year 09/01/2022 – 08/31/2023 is $464,982. 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 CCBHCs, 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 CCBHCs 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 the state FY24 and FY25. Safe Haven services assist homeless persons in building relationships with mental health service providers, accessing community programs, and facilitating 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 CCBHCs 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 80 Oklahoma counties that are serviced by SOC, 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 CCBHCs 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. CCBHCs 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 Oklahomans in need. ODMHSAS Telehealth Service provides access in most substance use disorder treatment facilities.

- *Technology Supports in Rural Areas.* ODMHSAS maintains a statewide telemedicine network. Units are placed in treatment facilities 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 addition to its traditional telemedicine network, thousands of iPads have been distributed to state-operated or contracted CCBHCs, law enforcement for assistance during mental health-related calls, and more than 80 city/county health departments to help rural residents immediately access behavioral healthcare. In calendar year 2022, an average of 73,072 services were provided to 30,007 unique service recipients per month.

- For Statewide Prevention Services, the ODMHSAS sector-based prevention system aims to integrate prevention services within the domains of Oklahomans' everyday living and experiences. This approach recognizes that Oklahoma cultural norms, influences, and experiences are shaped by several key sectors of living: the family, the educational system, workplaces, neighborhoods, communities at large, the healthcare delivery system, faith communities, and media. Each of these sectors presents opportunities for the delivery of direct prevention services and programs; Communication and reinforcement of healthy behaviors and resources; Sector leader influence and modeling of healthy behaviors; and Policies and practices that shape norms – expectations, attitudes, and behaviors. These prevention services cover all 77 counties within the state. All contracted prevention service providers within this system are required to provide a basic level of core prevention services throughout their service areas, as well as identify areas of high need based on data.

Services for Older Adults

In preparation for the profound demographic shift in which older adults will soon outnumber children and youth, ODMHSAS continues to build its capacity to facilitate age-informed behavioral health care. The Department recognizes older adults have unique strengths, lived experiences, and needs. Therefore, after several years of surveying the landscape to determine the need and feasibility of elevating behavioral health as a foundation for older adult health and well-being, ODMHSAS initiated a Division of Aging Services in the fall of 2022.

Before this, the Department collaboratively engaged in several age-focused initiatives, from 2015 forward. Four examples include:

- Sponsor of the Collaborative Positive Aging Institute, which has convened three transdisciplinary trainings since 2018; a fourth is likely in FY24. Other sponsors include the Oklahoma Healthy Aging Initiative and the Fran and Earl Ziegler College of Nursing at the University of Oklahoma with leadership provided by the Oklahoma Mental Health and Aging Coalition and the Anne and Henry Zarrow School of Social Work at the University of Oklahoma.
- Delivered its first Older Adult Specialty training for Peer Recovery Support Specialists (2018); the curriculum was designed by an expert recognized in the field of aging at both the state and national levels.
- Provided its first trainings on Mental Health First Aid for Older Adults (2018).

ODMHSAS is generating awareness of the need, and meeting the demand, for age-informed care. During FY22, ODMHSAS offered 2 age-informed courses resulting in 110 course completions. During FY 2023, there were 8 age-informed courses resulting in 395 course completions; both courses and completions are projected to increase during FY24. Concurrent with this growth, ODMHSAS fulfilled a primary role in Oklahoma convening an Older Adult Behavioral Health Policy Academy, which was led by the Oklahoma Mental Health and Aging Coalition and Rush University's E4 Center of Excellence for Behavioral Health Disparities in Aging. Additionally, ODMHSAS is laying the foundation to collaboratively develop a comprehensive system of care that promotes age-informed health, behavioral health, and social services through its newly developing Behavioral Health Forum on Aging.

ODMHSAS is involved in several age-forward arenas, including the State Council on Aging, Mental Health and Aging Coalition, and Oklahoma's Multi-Sector Plan on Aging. The Department also promotes age-informed care by being involved in sectors that may not target older adults, but do indeed interface with older adults either directly or indirectly (i.e. housing, prevention, crisis).

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, technical assistance (discussed previously), and peer review. With the exception of monitoring and technical assistance, these functions are briefly described below to set the context within which specific SUPTRS block grant 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 the 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 SUD screening and assessment. The ODMHSAS continues to provide regular ASI and ASAM trainings, via in-person and online e-learning. The ODMHSAS has developed an instrument to determine the level of service needed based on the ASAM criteria. This online tool identifies the level of need for each of the six ASAM Dimensions and matches the need to a particular level of care.

- *Capacity Reporting.* In Oklahoma, the residential facilities enter their daily census into an online bed availability list (odmhsas.org/picis/TrainingInfo/arc_Training_Information.htm). Contracted providers utilize an online ASAM screening tool to ascertain what level of treatment is appropriate for persons seeking treatment. Training for the online ASAM screening tool is available on the ODMHSAS website and is free of charge to clinicians. If the person meets criteria for a higher level of care and would like to obtain treatment, from a higher level of care, the contracted provider will then go online to see the bed availability list and connect the person to a residential facility that is located in the area that they desire. Due to contracting for more residential treatment beds, the 1115 IMD waiver and Medicaid expansion, higher level of care treatment beds are available to all that need them, which has allowed Oklahoma to discontinue a waitlist. For those who are unsure about treatment at a higher level of care, they are offered outpatient services by the contracted provider.

- *Peer Review.* The ODMHSAS continues to request that SUPTRS 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 41% of the SUPTRS Block Grant funded treatment providers received peer reviews in FY22. In FY23, approximately 44% of the SUPTRS Block Grant funded treatment providers received peer reviews.

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 SUPTRS Block Grant requirements. Those are detailed below.

- *Persons who Inject Drugs.* Persons who inject drugs are served by all contracted ODMHSAS substance use disorder service providers, CCBHCs, and state operated facilities. As a priority status population, clients involved with IDU (Injection Drug Use) can access residential substance disorder treatment within a few days of initial contact. Interim services are required by contract for persons who inject drugs that 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 visit their local downtown and high-risk areas in which the homeless and persons who use drugs congregate. Information and education are 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.* The ODMHSAS currently has 12 specific outpatient contracts for adolescent substance use. 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. The ODMHSAS also has a contract with Street School, an alternative school, that targets at-risk youth in the Tulsa School System. ODMHSAS provides substance use education to teachers to help them respond therapeutically to those students who have SUD. This alternative school provides screening, assessment, and therapy through other financial means. CCBHCs are also able to provide co-occurring and substance use disorder treatment to adolescents.

  Adolescent treatment services include two adolescent substance use disorder and co-occurring residential programs. Tulsa Boys Home has 12 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 girl's or boy's dorm, but youth with primary addiction issues are served on one side, and kids with primary mental illness are served on the other side.

  Oklahoma offers statewide support to parents through the Parents Helping Parents program. The program provides parents with the ability to connect to resources and provide peer support to families. Oklahoma has also developed a partnership between the ODMHSAS and The Oklahoma Office of Juvenile Affairs. The partnership includes a field service coordinator position that assists in connecting youth held in custody at the Central Oklahoma Juvenile Center with housing, family engagement, mental health, and substance use services.

  Peer Recovery Support Services is a Medicaid compensable service for adolescents aged 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 into the curriculum for PRSS Certification.

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

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

- *Women who are Pregnant and have a Substance Use Disorder.* The Addiction Severity Index (ASI) and the current edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM) are utilized to assess the severity and placement needs of all clients. Pregnant women assessed as needing outpatient substance use disorder services can admit into any outpatient program of their choice in the state. Pregnant women that are located in the following counties: Creek, Cherokee, Tulsa, Okmulgee, Wagoner, Muskogee, Rogers, Washington, Kay, and Osage, can participate in the Oklahoma Families First Project. This is a three year SAMHSA funded grant that seeks to enhance outpatient services for pregnant women and their families. The grant focuses on a family treatment approach to improve services, parenting, and attachment, expanding case management and resources and providing a system change in the treatment of pregnant or postpartum women and their children. Pregnant women assessed as needing outpatient substance use disorder services can admit into any outpatient program of their choice in the state. Pregnant women assessed at a higher level and in need of a residential program can 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.

  Oklahoma's STARS Program. ODMHSAS has partnered with the University of Oklahoma Health Sciences Center at Children's Hospital as well as the A Better Chance Clinic to launch Oklahoma's Substance Use Treatment and Access to Recovery and Supports (STARS) Program. STARS is designed to increase the well-being of and improve permanency outcomes for children and families affected by or exposed to opioids or other

substance use. As a part of these efforts, the STAR Prenatal Clinic provides comprehensive specialized prenatal care for women with substance use disorders in pregnancy in a collaborative environment, with an emphasis on coordination of care with supportive psychosocial services and substance use treatment providers. This STARS program's focus is to develop training and cross-training to increase the knowledge base of the medical, therapy, and child welfare systems; enhance the well-being of children, parents, and families and improve safe and permanent caregiving relationships; improve retention in substance use treatment and successful completion of treatment for parents; facilitate the implementation, delivery, and effectiveness of prevention services and programs for at-risk families; decrease the number of out-of-home placements for children by enhancing the safety of children prior to delivery; and decrease the number of out-of-home placements for children at-risk of removal.

Through the efforts of the STARS Program, 215 individuals have given birth at the STAR Prenatal Clinic with 85% able to go home with their infants at the time of discharge as of March 2023. The STAR Clinic has also implemented further innovations such as the inclusion of prenatal consultations for all patients, the addition of Peer Recovery Support Specialists (PRSS) as a support service to all patients, a decrease in discharge follow-up from 6 weeks to 2 weeks, the addition of legal advocacy through a medical-legal partnership with Legal Aid of Oklahoma and the adoption of Family Care Plans as a mechanism to further empower and provide ownership to the mom's along their recovery journey.

ODMHSAS recently launched the Tough as a Mother campaign, which was modeled after Colorado's Tough as a Mother campaign. This campaign is targeted towards mothers who live with substance use disorders. The stigma associated with pregnant and parenting persons with a substance use disorder, along with potential legal and societal consequences, has resulted in this population being difficult to reach and oftentimes reluctant to seek treatment or engage in prenatal care. The purpose of this campaign is to reach this population, destigmatize their substance use issues, and provide a connection to treatment providers. For more information on this campaign, please click on this link: Tough As A Mother - Oklahoma Resources (okimready.org).

- *Parents with Substance Use Disorders who have Dependent Children.* Oklahoma contracts with four residential programs to provide services for women with dependent children (WWC) and two WWC halfway house treatment programs. All four residential programs participate in the Oklahoma Pregnant and Post Partum Women grant funded by SAMHSA. This is a five year grant opportunity that seeks to enhance residential women's treatment services through utilizing evident based practices that improve parenting, attachment, and a family-focused approach to treatment. One of the halfway houses for WWC also operates a residential treatment program for women only. The Oklahoma City Housing Authority collaborates with the ODMHSAS to provide women with 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, and 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. Community Reinforcement Approach (CRA), Circle of Security (COS), Strengthening Families and Celebrating Families, are some of the EBPs used provided to families with parental substance use disorders.

Family Treatment Courts. The ODMHSAS has a strong history of implementing and sustaining specialty court approaches across Oklahoma, including the Family Treatment Court (FTC) which uses a multidisciplinary, collaborative approach to serve families with substance use disorder (SUD) and/or co-occurring disorders and who are involved with the child welfare system. The FTC approach was created to address the poor outcomes of traditional reunification with caregivers who struggle with substance use issues and have had their child(ren) placed in the custody of Oklahoma's Department of Human Services (DHS). The ODMHSAS has established with FTCs located in Kay, Oklahoma, Tulsa, Okmulgee, and the combined jurisdiction of Custer/Washita County. In FY23, the ODMHSAS received legislative funds to assist in the establishment of new FTCs across the state. Newly established courts are located in Creek, Johnston, Marshall, Murray, Canadian, and Garfield, with a plan to continue expansion in FY24 to at least two more counties. The FTC approach strives to ensure the safety and well-being of children and to offer caregivers a viable option to reunify in a timely manner. Through collaboration among the ODMHSAS, county juvenile court (deprived) systems, treatment, and service providers, and DHS, FTC seeks to provide safe environments for children with intensive judicial monitoring and interventions to treat caregivers' SUD and other co-occurring risk factors. The court utilizes a multidisciplinary team made up of the Judge, District Attorney, a FTC Coordinator, Attorneys, mental health and substance use treatment providers, and child welfare to monitor and staff the case. In an FTC, SUD treatment and case management services form the core of the intervention. The FTCs 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 their time in the FTC to incentivize positive behavior and individualized therapeutic responses to negative

behaviors. The overall goals for the participant are increased family reunification and treatment completion.

The ODMHSAS has been awarded multiple implementation grants to establish FTCs as well as multiple enhancement grants aimed at enhancing treatment services within the existing FTCs. In 2018 ODMHSAS applied for and was awarded the Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) initiative in an effort to improve outcomes for substance using pregnant and postnatal women and their newborns. This initiative provided the platform for intentional strategic education and training around the importance of treating women prenatally and post-natally using plans of safe care. While this grant opportunity ended in April of 2021, it provided the foundation and opportunity to receive additional support to expand services to pregnant and parenting women with an SUD. In March 2020, the ODMHSAS and partner agencies applied for and received In Depth Technical Assistance (IDTA) from the National Center for Substance Abuse and Child Welfare (NCSACW) and the Center for Children and Family Futures (CCFF) to continue the goals and initiatives identified in the QIC-CCCT project. From this work, Safely Advocating for Families Engaged in Recovery (SAFER) was born. SAFER is a statewide effort involving multiple state and local agencies and initiatives addressing the continuum of care for women who are pregnant or parenting, or are wanting to become pregnant and have a substance use, mental health, or co-occurring disorder. SAFER aims to expand timely access and provide a holistic approach to family-centered treatment through policies, practices, and processes intended to improve parent-child interactions, child and parent well-being, and reduce potential adverse childhood experiences (ACEs) along with the likelihood of, or ongoing involvement with, child welfare and/or legal systems. SAFER helps to nurture hope while providing the tools for families to lead their recovery journey.

Additional work focused on the enhancement of the FTCs includes the project titled the Oklahoma Multi-Site Family Treatment Court Model Standards Study (OKMSS). The ODMHSAS and Dr. Margaret Lloyd-Sieger from the University of Connecticut were awarded a National Institute of Justice research grant to develop an instrument measuring FTC fidelity with the National Family Treatment Court Best Practice Standards (the Standards) and to conduct the most robust analysis of FTC outcomes to date. OKMSS is a five-year research project that involves five contracted counties, in Oklahoma, with FTC dockets: Oklahoma, Tulsa, Okmulgee, Custer-Washita, and Kay. Through the work of OKMSS, the Model Standards Implementation Scale (MSIS) was created. The OKMSS team developed the MSIS so that FTCs, program evaluators, county or state administrators, and other interested parties can assess one or more FTCs for fidelity to the Standards (Children and Family Futures and National Association of Drug Court Professionals, 2019), which includes eight standards comprised of a total of 67 provisions. The MSIS is a fidelity review tool and process that balances measurement precision and replicability with feasibility and usability.

The development of the 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).

- *Services for Persons with or At Risk of Contracting Communicable Diseases: Individuals with Tuberculosis; Persons with or At Risk for HIV/AIDS.* CCBHCs and 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 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 to provide or arrange access to education, counseling, and testing for HIV, AIDS, and STDs for consumers and their partners as requested.

  Harm Reduction. The ODMHSAS supports a state-level prevention "Ok, I'm Ready" campaign which serves as a resource for print and electronic materials (OK I'm Ready | Substance Use and Drug Addiction Resources (okimready.org). This site offers information on substance use disorder treatment, prevention, education, and support. The ODMHSAS Mail Out Program provides free Naloxone (Narcan) and Fentanyl test strips to anyone in Oklahoma through the okimready.org site. This resource is available 24/7and eliminates common barriers to access. Participants watch a brief training video and complete a demographic survey to receive a free Naloxone kit.

  This year ODMHSAS is rolling out a Naloxone/Harm Reduction Vending Machines campaign. These vending machines, placed in high need areas, allow any citizen 24/7 access to free Naloxone and Fentanyl test strips. With 8 machines ready for placement and 34 additional units on the way, Oklahoma's vending machine project will be the largest of its kind in the country.

- *SOR Grant*. ODMHSAS continues to render substance use disorder treatment and supportive services under a State Opioid Response (SOR) grant. Treatment services are rendered by CCBHCs, contracted substance use disorder treatment providers, and one OTP. This grant is for those with a history or current issue of opioid or stimulant use/misuse. Services include promotion, prevention, early intervention, treatment, and recovery supports.

  Goals set for the SOR grant are : 1) Increase community knowledge base to prevent abuse of opioids and increase access to services; 2) Increase community awareness and develop readiness for community action related to opioid prescribing practices, Opioid Use Disorder, and available prevention and treatment services; 3) Enhance the knowledge base for the workforce and better support individuals at risk or with an OUD, families and the

community in prevention, treatment, and recovery supports through trainings, consultation, as well as distribution of naloxone kits; 4) Promote social and emotional health for students of Oklahoma to decrease disruptive behavior and increase quality instruction time in the classroom; 5) Increase collaboration and sustain community referral base for individuals with OUD; 6) Increase access to an array of treatments for individuals with or at risk for OUDs, including those who are uninsured and underinsured, with an emphasis on veterans, pregnant women, tribal, those coming out of jails and prisons. 7) Enhance the existing infrastructure to deliver evidence-based treatment interventions that include medication(s) which FDA-approved specifically for the treatment of OUD and stimulant misuse and use disorders, including for cocaine, methamphetamine, and/or co-occurring disorders including but not limited to trauma and suicidal ideation in a continuum of care; 8) Ensure contracted providers utilize DATA waivered prescribers to provide MAT services; and 9) Enhance Recovery Supports for individuals with an OUD that are receiving MAT.

The SOR grant has increased and will continue to 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. In addition to opioids, stimulant misuse is also being treated under the current SOR grant. These funds will enable individuals that are uninsured or underinsured the opportunity to receive individualized treatment, supportive services such as case management, and medication assisted recovery, if appropriate. Other services include housing, and peer recovery supports designed specifically for individuals with an SUD and/or medication assisted recovery. SOR funds have also assisted individuals reentering the community from prison by connecting them with treatment services. The ODMHSAS partnered with Oklahoma State University Health Science Center to provide consultation, training, and support to prescribers. Through this grant, evidence-based trainings, such as Community Reinforcement Approach/Adolescent Community Reinforcement Approach, Contingency Management (CM), and Recovery Management Check-ups and Support (RMCS) have been provided to the providers. Seeking Safety is being trained and expanded to address the potential trauma an individual with SUD may have experienced.

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 systems, 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 behavioral health system, including for 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. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

PLANNING STEPS

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

Introduction. Step One in this section summarized services and supports currently in place for behavioral health prevention, early intervention, treatment, and support for Oklahomans. That review also identified a listing of access, disparity, capacity, and resource issues that are continually under review by the ODMHSAS. Step Two delves deeper into and clearly articulates these priorities for Oklahoma within the context of this combined SUPTRS and MHS Block Grant application for FFYs 2024-2025. 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 modeled 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 the causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state. Other primary sources have induced the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and peer-reviewed journal articles.

Overview of Oklahoma. According to the 2022 Census population estimates, Oklahoma has a population of 4,019,800 and ranks 20th in area among the 50 states, spanning nearly 70,000 square miles[1]. Oklahoma is comprised of 77 counties with a population density of 57.7 persons per square mile. There are four metropolitan statistical areas and two combined statistical areas. Youth (under 18 years of age) are 23.7% of the population in Oklahoma. Females comprise 50.1% of the population. The census estimates 73% of the population is White; 7.9 percent is Black; 9.5% is American Indian/Alaska Native; 2.6% is Asian; 0.3% percent is Native Hawaiian and Other Pacific Islander; and 6.7% are of two or more races. Oklahoma also has a Hispanic/Latino population of 12.1%. Of note, is the American Indian/Alaska Native population. Oklahoma has the second largest Native American population after California and is home to 38 federally recognized tribes. The median household income for 2015-2019 is $59,679 compared to the US median income of $69,021. The percentage of persons below the poverty level is 15.6% which is higher than the national percentage of 11.6%.

Health Status for Behavioral Health Consumers with Complex Health Needs. According to America's Health Rankings® 2022, Oklahoma ranks 45th for overall health status.[2] The state ranked 48th for non-medical drug use, 47th for avoided care due to cost, 49th for uninsured, 49th for

preventive clinical services, colorectal cancer screening, 45th for childhood immunizations, 48th for exercise, 49th for fruit and vegetable consumption, 47th for teen births, 49th for e-cigarette use, 42nd for frequent mental distress, 39th for depression, 43rd for premature deaths, 44th, and 46th for obesity.

The 2022 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance, 50th in the COVID-19 domain, 44th in the healthy lives domain, 50th in access and affordability for health insurance, and 42nd for racial and ethnic equity.[3] Many factors contribute to this ranking and a 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.

In 2023 the Oklahoma State Department of Health listed the top five health concerns for Oklahomans as:[4]

1. Behavioral Health
2. Substance Abuse
3. Obesity
4. Poor eating habits
5. Lack of exercise

Health Disparities

The U.S. government defines health disparity as "a particular type of health difference that is closely linked with social or economic disadvantage."[5] These disparities negatively impact whole groups of people that already face significantly more obstacles to maintaining good health, often because of specific social or economic factors.

While the rates of mental health disorders, conditions ranging from mild to moderate depression and anxiety to more severe and pervasive conditions such as schizophrenia, are similar across races and ethnicities, research shows white adults are nearly twice as likely to receive mental health services as Black or Hispanic adults.[6]

When they do receive care, research shows they are treated differently from their white peers. Black adults are less likely to be offered medication or behavioral therapy and are more likely to be incarcerated than any other racial or ethnic group as a result of a mental illness, according to the American Psychiatric Association. Black, Hispanic, Asian, American Indian, and Alaskan Native adults with serious mental illnesses also are more likely to be over-diagnosed with conditions such as schizophrenia and to be involuntarily hospitalized when they seek care.[6]

Disparities in treatment begin well before adulthood. Black and Hispanic teenagers and other young people of color with behavioral health issues are more prone to be involved in the juvenile justice system compared to white adolescents, who are more likely to receive treatment from a mental health professional. [6]

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; utilizing culturally and linguistically appropriate services; 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 service. Initially, three behavioral health clinics were participating in this program. Following the approval of the CMS CCBHC state plan amendment (SPA), in 2019, the model has expanded across the state. It is significant to note that all 13 CMHCs have now received CCBHC certification.

Tobacco Use

According to the Oklahoma Tobacco Settlement Endowment Trust:[7]

- The Oklahoma high school smoking rate is 9.1%, compared to the nation's percentage of 4.6%.
- 19.1% of adult Oklahomans smoke, compared to the national rate of 15.5%.
- 10.1% of male high school students use smokeless tobacco, compared to 5.8% nationally.
- 52.1% of adult Oklahomans are exposed to secondhand smoke, compared to 47.7% nationally.
- The annual healthcare costs in Oklahoma directly caused by smoking is $1.62 billion, of this $264 million is covered by the state Medicaid program.
- 7,500 adults die each year from their own smoking in Oklahoma.
- 1,300 kids under 188 in Oklahoma become new daily smokers each year.
- 88,000 Oklahoma kids under 18 will ultimately die prematurely from smoking.
- 300,000 kids suffer respiratory infections from secondhand smoke each year in Oklahoma.

The high rate of tobacco use in Oklahoma is especially troubling when working with people with mental illnesses and addictions. A larger proportion of people diagnosed with mental disorders report cigarette smoking compared with people without mental disorders.[8] Among US adults in 2019, the percentage who reported past-month cigarette smoking was 1.8 times higher for those with any past-year mental illness than those without (28.2% vs. 15.8%). Smoking rates are particularly high among people with serious mental illness (those who demonstrate greater functional impairment). While estimates vary, as many as 70-85% of people with schizophrenia and as many as 50-70% of people with bipolar disorder smoke.[8]

The ODMHSAS Wellness Division has continued to work with treatment providers on tobacco cessation methods and has 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 SFY2023, 65,959 persons with the SMI designation were served through the Oklahoma publicly funded behavioral health system. This represents 59.2% of the 111,405 adults served.[9]

- According to the NSDUH 2019-2020 Report, Oklahoma is ranked 34th for serious mental illness in the past year, with a rate of 5.6% compared to the national rate of 5.5%.[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, 25.6%, and 22.8%, respectively. Oklahoma has the 6th highest rate in the nation.[10]

- The State is ranked 11th in the nation for "major depressive episode" in the past year and has a higher rate at 9.5% vs. 8%.[10]

- An estimated 156,506 (5.2%) persons 18 years and older had serious thoughts of suicide in the past year. Another 39,127 (1.3%) of adults made any suicide plans in the past year. Of these, 20,310 (.7%) attempted suicide in the past year. [10]

The statewide network of CCBHCs is primarily responsible for comprehensive services for adults with SMI. CCBHCs, 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.

The ODMHSAS funds thirteen adult Community Based Structured Crisis Centers (CBSCCs) across the state of Oklahoma and four other adult crisis centers are in the process of opening. The ODMHSAS funds twenty adult urgent care centers across the state of Oklahoma. Additionally, ODMHSAS passed new CCBHC state rules which required the establishment of 24/7 outpatient or urgent recovery centers in all counties with a catchment area of 20,000, and each adjacent county for every county under the 20,000 population threshold, within three years or initial CCBHC certification of by July 1, 2024, whichever is later.

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.[10]

- In state FY2023, the total number of children 0-18 served was 88,650. The total number of children 0-18 years with a SED designation served was 30,630 (35).[9]

The 13 CMHC/CCBHCs are participating in the Oklahoma Systems of Care (SOC) Initiative. Currently, Oklahoma has 80 local SOC sites that cover 77 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. Three more children's crisis units will open in January 2024. There are four child and adolescent recovery centers that are open, with five more opening in January 2024.

Substance Abuse
According to the NSDUH 2021 report, Oklahoma is higher on several measures than the national rate.

- *Methamphetamine Use in the Past Year* for persons 12 years and older was 1.63%, compared to the US rate of .9%, and ranks 39th in the nation.[10]

- *Alcohol Use Disorder in the Past Year* for persons 12 years and older the State rate was10.94% compared to the national rate of 10.6.[10]

- *Substance Use Disorder in the Past Year* for persons 12 years and older the Oklahoma rate was 18.8% versus the US rate of 7.41; for persons 18 years and older the State rate was 19.67 versus the US rate of 16.5%.[10]

- *Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year* for persons 12 years and older the Oklahoma rate was 16.04% compared to the national rate of 6.88; for persons 18 years and older, the State rate is 16.37% versus the US rate of 15.6%.[10]

- *Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year* for persons 12 years and older the State rate was 10.77% compared to the US rate of 5.09; for persons 18 years and older the Oklahoma rate was 11.43% versus the national rate of 5.44.[10]

The substance use disorder (SUD) treatment and recovery services network is comprised of 53 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. CCBHCs may also render substance use disorder treatment services. 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 SUPTRS Block Grant funds and state appropriations. These contracted agencies include SUD treatment facilities, community mental health centers, community action agencies, youth and family services agencies, and schools.

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.

- Opioid addiction is the most lethal drug problem in Oklahoma, with prescription opioids being the leading cause of opioid-related deaths. According to the National Institute on Drug Abuse, in 2017, 172 of 308 opioid-related deaths in Oklahoma were caused by prescription opioids, a rate of 4.3 deaths for every 100,000 people living in Oklahoma.[11]

- Oklahoma also has one of the highest rates of opioid prescriptions per population in the nation. In 2018, Oklahoma doctors wrote 79.1 prescriptions for opioid pain relievers for every 100 residents in the state, compared to the national average of 51.4 such prescriptions for every resident. That means Oklahoma's prescribing rate is more than 1.5 times the national average. [11]

- Approximately 9.66% of Oklahomans use drugs, compared to the national average of 8.82%. Also, the rate of drug-related deaths in Oklahoma is higher than the national average, likely exacerbated by the high rate of prescription drug use in this state. More Oklahoma residents die from drug use than from motor vehicle accidents or firearms every year. [11]

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. The Department distributes naloxone kits to first responders, treatment agencies, and those in need. The ODMHSAS supports a state-level prevention "Ok, I'm Ready" campaign which serves as a resource for print and electronic materials (OK I'm Ready | Substance Use and Drug Addiction Resources (okimready.org). This site offers information on substance use disorder treatment, prevention, education, and support. The ODMHSAS Mail Out Program provides free Naloxone (Narcan) and Fentanyl test strips to anyone in Oklahoma through the okimready.org site. This resource is available 24/7and eliminates common barriers to access. Participants watch a brief training video and complete a demographic survey to receive a free Naloxone kit.

This year ODMHSAS is rolling out a Naloxone/Harm Reduction Vending Machines campaign. These vending machines, placed in high need areas, allow any citizen 24/7 access to free Naloxone and Fentanyl test strips. With 8 machines ready for placement and 34 additional units on the way, Oklahoma's vending machine project will be the largest of its kind in the country.

Persons Who Inject Drugs (PWID). Persons who inject drugs are at risk for several 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.

- According to the CDC, about 1 in 10 new HIV diagnoses in the United States are attributed to injection drug use or male-to-male sexual contact and injection drug use (men who report both risk factors).[12]

- According to the CDC, 32% of PWID share syringes.[13]

- The U.S. Department of Health & Human Services (HHS) reports acute hepatitis C infections became much more common from 2010 to 2020. This is largely due to the increased use of injection drugs such as opioids. In 2020, 66% of new hepatitis C cases reported the use of injection drugs.[14]

- Nationally, in 2017, 9.7% (3,690) of the 38,226 new HIV diagnoses were attributed to IDU. Among males, 8.6% (2,655) of new diagnoses were transmitted via IDU or male-to-male sexual contact and IDU. Among females, 14.2% (1,035) of new diagnoses were transmitted via IDU.[15]

- Of the new HIV diagnoses in 2017, 299 occurred in Oklahoma—a rate of 9.2. Among males, 18.0% of new HIV diagnoses were attributed to IDU or male-to-male sexual contact and IDU. Among females, 18.0% of new HIV diagnoses were attributed to IDU. [15]

- In 2017, 6,216 persons were living with a diagnosed HIV infection in Oklahoma—a rate of 127.3. Of those, 14.5% of male cases were attributed to IDU or male-to-male sexual contact and IDU. Among females, 20.5% were living with HIV attributed to IDU. [15]

- In 2017, 6,216 persons were living with a diagnosed HIV infection in Oklahoma—a rate of 127.3. Of those, 14.5% of male cases were attributed to IDU or male-to-male sexual contact and IDU. Among females, 20.5% were living with HIV attributed to IDU. [15]In 2017, there were an estimated 44,700 new cases of acute HCV. Among case reports that contained information about IDU, 86.6% indicated injection drug use prior to onset of acute, symptomatic HCV. [15]In 2017, 46 cases of acute HCV (a rate of 1.2) were reported in Oklahoma. [15]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.[15]

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 the homeless and persons who use drugs congregate. Information and education are 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 (TB). Although the number of people with the disease has declined, TB remains a public health concern in Oklahoma. Oklahoma currently ranks #25 in the U.S. for TB disease. There were 67 reported cases of TB in Oklahoma in 2020.[16]

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 2020, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 332,791, comprising 8.4 percent of the state's total population and ranking Oklahoma second among all states for the number of AI/AN in its population.[1]
- At least 18.7% of American Indian/Alaska Natives have experienced a mental health condition within the past year.[17]
- American Indian/Alaska Natives are 60 percent more likely to experience the feeling that everything is an effort, all or most of the time, as compared to non-Hispanic whites. [17]
- The overall death rate from suicide for American Indian/Alaska Native adults is about 20 percent higher as compared to the non-Hispanic white population. [17]
- Native Americans experience serious psychological distress 1.5 times more than the general population. [17]
- Native Americans experience PTSD more than twice as often as the general population.
- Native/Indigenous people in America report experiencing serious psychological distress 2.5 times more than the general population over a month's time. [17]

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) has allowed Oklahoma to leverage prevention resources.

The CCBHCs focuses on outreach to AI individuals and have approached tribal nations and Indian Health Service clinics about establishing processes for referrals and linkages. The children's wraparound teams work to reach out to AI families.

African American Children. While Black or African Americans comprise only 7.8 percent of the Oklahoma population, they are too often overrepresented in negative consequences.

- Black youth in the United States experience significant illness, poverty, and discrimination," according to the American Psychological Association. "These issues put them at higher risk for suicide, depression, and other mental health problems."[18]

- For example, a recent study in Pediatrics found Black youth ages 5 to 24 saw a much greater increase in suicide deaths than White youth during the first 10 months of the pandemic when looking at the expected suicide rate versus the actual rate.[19] A 2021 report from the U.S. surgeon general noted that suicide rates in Black kids under 13 have risen so much in recent years that they're now almost twice as likely to die by suicide as White kids.[20]

- A 2022 study published in the journal Current Psychiatry Reports found that rates of depression, anxiety, post-traumatic stress, substance use disorders, and suicide are rising in minority youth.[21]

- But at the same time, Black kids are less likely to receive mental health treatment for a range of reasons, from stigma to a lack of diverse providers, the American Psychological Association stated. And when they do receive treatment, it's less likely to be evidence-based, per a 2020 study in Children and Youth Services Review.[22]

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.[23]

- In state prisons, 73 percent of women and 55 percent of men have at least one mental health problem.[24]

- In federal prisons, 61 percent of women and 44 percent of men have at least one mental health problem.[24]

- In local jails, 75 percent of women and 63 percent of men have at least one mental health problem.[24]

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.

- There are 27,000 people in state prison in Oklahoma. Another 13,000 inmates reside in local county jails and 2,700 in federal prisons.[25]

In the most recent Bureau of Justice study of substance use disorders in jail inmates (2020) found:[26]

- More than two-thirds of jail inmates were found to be dependent on or to abuse alcohol or drugs. [26]

- 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. [26]

- In 2019 there were 15,365 adults arrested for drug-related crimes and 21,725 arrested for alcohol-related crimes.[26] For the same time period, there were 1,002 juvenile drug arrests and 351 juvenile alcohol arrests. These numbers do not include arrests for crimes resulting from alcohol and drug abuse, such as check forgery, burglary, disorderly conduct, and vagrancy. [26]

Oklahoma uses the Sequential Intercept Model in strategic planning and aligning 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 Drug Courts serving 67 counties, 35 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 Managers at 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 is an evidence-based offender management strategy that in short matches the appropriate amount and type of supervision and treatment to individuals to reduce their likelihood of recidivism. Also, training is provided on evidence-based pretrial programming, teaching pretrial service agencies and courts to identify appropriate bond conditions to enhance pretrial success.

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

The most publicized mental health challenges facing veteran service members are PTSD and depression.[27] Some research has suggested that approximately 14% to 16% of U.S. service members deployed to Afghanistan and Iraq have PTSD or depression.[27] Although these mental health concerns are highlighted, other issues like suicide, traumatic brain injury (TBI), substance abuse, and interpersonal violence can be equally harmful to this population. The effects of these issues can be wide-reaching and substantially impact service members and their families.

Veteran suicide rates are at the highest level in recorded history, with annual deaths by suicide at over 6,000 veterans per year. Overall suicide rates within the United States have increased by 30% between 1999 and 2016. A study involving 27 states estimated 17.8% of these recorded suicides were by veterans. The U.S. Department of Veterans Affairs (VA) published data in 2016 that

indicated veteran suicide rates were 1.5 times greater than non-veterans. Research has shown that veterans are at a significantly increased risk of suicide during their first year outside of the military.[27]

According to the Census, 312,492 Oklahomans are veterans and another 21,436 are active military duty.[1]

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. An overview of CCBHC development was presented to the Veterans Alliance. A meeting was held between CCBHC staff and Major General Deering, the Secretary of Veteran Affairs, and the Executive Director of the Oklahoma Department of Veteran Affairs, to educate them on the CCBHC and how this evolution of services could benefit veterans, dishonorably discharged veterans and inactive duty reservists.

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 the Substance Abuse and Mental Health Services Administration, lesbian, gay, bisexual, and trans adults are more than twice as likely to experience mental health conditions as their heterosexual and cisgender counterparts.[28]

- The 2017 Youth Risk Behavior study from the Centers for Disease Control and Prevention sheds some light on the situation with these sobering youth LGBTQ+ statistics:[29]
    - 33% have experienced bullying on school property
    - 27.1% have experienced cyberbullying
    - 10% reported not going to school due to concerns over safety
- Recent estimates suggest there are substantial LGBTQ+ mental health disparities. LGBTQ+ depression statistics include the fact that this group is more than twice as likely to suffer from the disorder and other mental health conditions. About 10% of these youth have a mood disorder like depression, and 25% have an anxiety disorder.[30]
- The LGBTQ+ suicide rate is exceptionally high, and the problem is growing among youth. The Trevor Project offers these insights about suicide in LGBTQ+ youth:[31]
    - They experience severe suicidal ideation at almost three times the rate of heterosexual youth.
    - They are four times more likely to have attempted suicide.

- Their suicide attempts were almost five times as likely to require medical intervention than suicide attempts by heterosexual youth.
- LGBTQ+ youth whose families reject them are more than eight times more likely to attempt suicide than LGBT youth who report little or no rejection from family.
- Every situation where an LGBTQ+ youth is harassed or abused increases the likelihood of self-harm behaviors by an average of two and a half times.
- Notably, 40% of transgender adults report having attempted suicide at least once, and 92% of those report they first attempted suicide before age 25.

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.[32]

It is estimated that 20% of people age 55 years or older experience some type of mental health concern.[33]

The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder).[33]

Mental health issues are often implicated as a factor in cases of suicide.[33]

Older men have the highest suicide rate of any age group.[33]

While illicit drug use typically declines after young adulthood, nearly 1 million adults aged 65 and older live with a substance use disorder (SUD), as reported in 2018 NSDUH data.[34]

One study of 3,000 adults aged 57-85 showed common mixing of prescription medicines, nonprescription drugs, and dietary supplements. More than 80% of participants used at least one prescription medication daily, with nearly half using more than five medications or supplements, putting at least 1 in 25 people in this age group at risk for a major drug-drug interaction.[35]

Between 4-9% of adults age 65 or older use prescription opioid medications for pain relief.[36]

One U.S. study suggests that close to a quarter of marijuana users age 65 or older report that a doctor had recommended marijuana in the past year.[37]

Alcohol is the most used drug among older adults, with about 65% of people 65 and older reporting high-risk drinking, defined as exceeding daily guidelines at least weekly in the past year.[38] Of particular concern, more than a tenth of adults age 65 and older currently binge drink.[39]

In addition, research published in 2020 shows that increases in alcohol consumption in recent years have been greater for people aged 50 and older relative to younger age-groups.[40]

To meet the treatment needs of older adults, the ODMHSAS is providing training to service providers and other stakeholders to improve their skills 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. ODMHSAS fulfilled a primary role in Oklahoma convening an Older Adult Behavioral Health Policy Academy, which was led by the Oklahoma Mental Health and Aging Coalition and Rush University's E4 Center of Excellence for Behavioral Health Disparities in Aging. Additionally, ODMHSAS is laying the foundation to collaboratively develop a comprehensive system of care that promotes age-informed health, behavioral health, and social services through its newly developing Behavioral Health Forum on Aging. ODMHSAS is involved in several age-forward arenas, including the State Council on Aging, Mental Health and Aging Coalition, and Oklahoma's Multi-Sector Plan on Aging. The Department also promotes age-informed care by being involved in sectors that may not target older adults, but do indeed interface with older adults either directly or indirectly (i.e. housing, prevention, crisis).

Pregnant Women. Research shows that the 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.[41] 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.[42] Estimates suggest that about 5 percent of pregnant women use one or more addictive substances.[43]

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 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 2021 (the most recent period available) 1,206 infants had a diagnosis due to prenatal AOD use.

Hospital Discharges with Prenatal AOD Use ICD Codes							
ICD Code	**ICD Code Description**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
P961	Neonatal withdrawal symptoms from maternal use of drugs of addiction	387	422	347	382	365	358
P962	Withdrawal symptoms from therapeutic use of drugs in newborn	31	22	47	49	46	48
P043	Newborn affected by maternal use of alcohol	40	30	32	45	19	28
P0441	Newborn affected by maternal use of cocaine	21	24	19	29	32	43
P0449	Newborn affected by maternal use of other drugs of addiction	1079	945	753	660	626	668
Q860	Fetal alcohol syndrome (dysmorphic)	30	42	34	34	29	26
Hospital Discharges with Any Prenatal AOD Use ICD Code		1481	1347	1114	1092	971	1026
Source: Oklahoma Hospital Discharge Data, 2016-2021							

Data from the Adoption and Foster Care Analysis indicate that the prevalence of parental alcohol or other drug abuse as an identified condition of removal of children and placement in out-of-home care has increased from 2000 to 2019. Data from 2000 show a prevalence rate of 18.5%. This increased to 38.9% in 2019, an increase of 20.4%.[44]

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

Women with Dependent Children. As defined by the National Alliance for Drug Endangered Children, drug-endangered children are those who are at risk for suffering physical or emotional harm as a result of their caregiver's substance use, possession, manufacturing, cultivation, or distribution.[45] Children also may be endangered when parents' substance use interferes with their ability to raise their children and provide a safe, nurturing environment. Parents' substance use may affect their ability to consistently prioritize the child's basic physical and emotional needs over their own need for substances. Cigarette smoking often accompanies substance use and can pose additional hazards to children. Furthermore, the home environment may be unsanitary or unsafe, particularly if illegal or legal drugs, chemicals, or paraphernalia are accessible or if drugs are being cultivated or manufactured in the home. Such conditions can lead to poor child health and developmental outcomes or child maltreatment and even child death.

Children exposed to a parent's substance use commonly experience educational delays and inadequate medical and dental care.[46] Almost a quarter of children of mothers with identified substance use disorders (SUDs) do not receive routine child health maintenance services in their

first 2 years of life. Children of parents with SUDs are also at greater risk of later mental health and behavioral problems, including SUDs.[47,48]

Findings from the literature suggest that children of substance-abusing parents have a high risk of developing physical, mental health, and behavioral problems. In addition, parental substance abuse has been linked to ongoing behavioral problems, such as adolescent drug use. According to NSDUH data, an annual average of 8.7 million children aged 17 or younger live in households in the United States with at least one parent who had an SUD.[49] This represents about 12.3 percent of children aged 17 or younger who resided with at least one parent with an SUD. An annual average of 1.5 million children aged 0 to 2 (12.8 percent of this age group), 1.4 million children aged 3 to 5 (12.1 percent of this age group), 2.8 million children aged 6 to 11 (11.8 percent of this age group), and 3.0 million children aged 12 to 17 (12.5 percent of this age group) lived with at least one parent who had an SUD.

Oklahoma contracts with four residential programs to provide services for women with dependent children (WWC) and two WWC halfway house treatment programs. One of the halfway houses for WWC operates a residential treatment program for women only. The Oklahoma City Housing Authority collaborates with the ODMHSAS to provide women with 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, and 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. Community Reinforcement Approach (CRA), Circle of Security (COS), Strengthening Families and Celebrating Families, are some of the EBPs used provided to families with parental substance use disorders.

As stated above, the ODMHSAS has implemented an online bed availability list with priority given to parenting women. This list is updated on a daily basis and contains information about how many beds are open and the ages of children that are accepted. This ensures that the appropriate treatment facility is located for the person.

ODMHSAS recently launched the Tough as a Mother campaign, which was modeled after Colorado's Tough as a Mother campaign. This campaign is targeted towards mothers who live with substance use disorders. The stigma associated with pregnant and parenting persons with a substance use disorder, along with potential legal and societal consequences, has resulted in this population being difficult to reach and oftentimes reluctant to seek treatment or engage in prenatal care. The purpose of this campaign is to reach this population, destigmatize their substance use issues, and provide a connection to treatment providers. For more information on this campaign, please click on this link: Tough As A Mother - Oklahoma Resources (okimready.org).

Persons Impacted by Trauma. Results from the Adverse Childhood Experiences (ACE) Study indicate 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.[50] 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.

In the HRSA National Survey of Children's Health, Adverse Childhood Experiences Data Brief, June 2020, reported Oklahoma had the highest percentage of children with two or more parent-reported ACEs at 23.1%.[51]

The 2003, 2007, 2011-2012, and 2014 National Survey of Children's Health directed by the Health Resources and Services Administration found Oklahoma has a 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 2014 survey found Oklahoma had the highest rate at 12%.[51]
- Oklahoma and Montana were tied 17 percent for children with three or more, the highest rate in the nation.[51]
- In fact, 38% of Oklahoma children in the survey had one or two ACEs and 17% had three or more Aces. [51]
- Oklahoma's most common ACEs were attributed to economic hardship (30%), divorce (30%), alcohol (17%), violence (13%), and mental illness (12%).[51]

The ODMHSAS utilizes the Seeking Safety curriculum which addresses trauma, mental illness, and substance use disorders for adults and adolescents. 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 persons less than 18 years of 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.[52]

- Psychosis often begins when a person is in their late teens to mid-twenties.[52]
- Three out of 100 people will experience psychosis at some time in their lives.[52]

The ODMHSAS continues to develop a full continuum of care for persons 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, outreach for eSMI (early Severe Mental Illness) is performed, by all CCBHCs, between the CCBHCs and emergency rooms as well as with counselors and counseling centers at universities, community colleges, and technology centers. The CCBHCs have been able to develop and maintain relationships with these facilities which has resulted in a more streamlined referral process for those people who are experiencing signs and symptoms of early Severe Mental Illness. The CCBHCs are also able to provide training and technical assistance, to these facilities, on identifying and supporting those with eSMI. Oklahoma was recently awarded the Clinical High Risk for Psychosis (CHR-P) grant which will be used to serve students at two universities who, upon being referred to a CCBHC, are identified (assessed) as being at clinical high risk for psychosis. They will receive a stepped model of care including assessment, psychoeducation, cognitive behavioral therapy (CBT), supported education and employment, substance use treatment, pharmacotherapy, recovery support services, and also a seamless transfer to specialty care, if they develop an emergent disorder of psychosis. Oklahoma's CHR-P grant will improve symptomatic and behavioral functioning; enable students to resume age-appropriate social, academic, and vocational activities; delay or prevent the onset of psychosis; and minimize the duration of untreated psychosis for those who develop psychotic symptoms. The ODMHSAS furnishes trainings in CBT to service providers across the state on a wide range of topics. Training in Recovery Oriented Cognitive Therapy, which is an extension of CBT for Psychosis, is offered annually. All CBT trainings are offered free of charge.

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 2020 was $49,787, although rural per capita income lagged at $42,046.[53] The ERS reports that the poverty rate in rural Oklahoma is 16.8%, compared with 13.1% in urban areas of the state. Of the rural population, 13.1% have not completed high school, while 10.4% of the urban population lacks a high school diploma.[53] The unemployment rate in rural Oklahoma is 3.8%, while in urban Oklahoma, it is 3.9%.[1]

Of the 117,230 persons served through the ODMHSAS treatment system in FY2023, 46% resided in a rural county.[9]

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 the 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.

Thousands of iPads were distributed to state-operated or contracted Certified Community Behavioral Health Centers (CCBHC), law enforcement for assistance during mental health-related calls, and more than 80 city/county health departments to help rural residents immediately access behavioral healthcare. The tablet program has strengthened ODMHSAS's relationships with others, as well, including firefighters, emergency departments, schools, courtrooms, and jails. By putting iPads directly into the hands of consumers with more intense needs, they have immediate access to crisis de-escalation, which greatly reduces the number of calls to both 911 and 988 and results in fewer hospitalizations.

An average of 73,311 telehealth services were provided monthly in FY2023 for a monthly average of 29,925 unique individuals.[9]

Individuals with SMI or SED in the homeless population. Over the last decade, the number of people experiencing homelessness in Oklahoma has been declining, but how the coronavirus pandemic has affected those numbers remains unclear because of an absence of up-to-date data.

The state reached a recent peak of just under 4,200 people experiencing homelessness in 2017, according to the U.S. Interagency Council on Homelessness. In early 2020, that number had dropped to about 3,900 people. But the numbers look different in the state's urban centers.

In Tulsa, homelessness has steadily increased since 2015 when under 800 people were experiencing homelessness. At the beginning of 2020, over 1,000 people were counted during the city's point-in-time count, an annual survey of those experiencing homelessness.[54]

In Oklahoma City, the number of people who were homeless was on the decline, hitting a low point of 1,183 in 2018, according to Oklahoma City's point-in-time count. By early 2020, though, that number was over 1,500 people.[55]

Many service providers did not complete full 2021 counts of homeless populations because of COVID-19 concerns. But the unstable economy, evictions, and health complications have had a negative effect on housing stability. And the yearly counts already don't include people who are couch homeless, meaning they are staying with friends or family but don't have a home of their own.[56]

According to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness.[57] The HUD estimates that in 2019, 36% percent of the chronically homeless suffered from a chronic substance use problem, a severe mental illness, or both.[58]

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 CMHCs. 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 allows 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 on 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, 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 FY2023, about two-thirds (66%) 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 persons with SMI, with only 17.5% having any employment.[9]

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 risks and outcomes. As the ODMHSAS moves forward with more integrated healthcare, it's vital that there is trained staff to coordinate services and provide necessary referrals and linkages.

Persons at Risk for Tuberculosis. Oklahoma currently ranks #25 in the US for tuberculosis. In 2020, 67 cases were reported in Oklahoma.[59]

Suicide Prevention. According to the Centers for Disease Control and Prevention (CDC) in 2019 (the most recent year for which full data are available), more than 47,500 suicides were reported, which is about one death every 11 minutes**.**[60] The number of people who think about or attempt suicide is even higher. In 2019, 12 million American adults seriously thought about suicide, 3.5 million planned a suicide attempt, and 1.4 million attempted suicide.

- The 2020 suicide rate in Oklahoma was 20/100,000 compared to the U.S. rate of 14.2/100,000.[53] Oklahoma had the 9th worse suicide rate in the nation.[61]
- On average, one Oklahoman dies by suicide every 11 hours in the State.[61]
- It is the 2nd leading cause of death for ages 10-34; the 3rd leading cause of death for ages 35-44; the 5th leading cause of death for ages 45-54; the 8th leading cause of death for ages 55-64; and the 16th leading cause of death for ages 65+.[61]
- Suicide comprised 67% of all violent death in Oklahoma.[61]
- Males had a higher suicide rate than females, regardless of age group. The suicide rate peaked for males 85 years of age and older at 69.8 per 100,000.[61]
- For females, the suicide rate peaked in the 35 to 44 age group with a rate of 12.9 per 100,000.[61]
- The suicide rate among American Indian, non-Hispanics was 1.1 times higher than White, non-Hispanics and 2.1 times higher than Black, non-Hispanics. [61]
- Forty-one percent of suicide victims had a positive blood alcohol content (BAC) at the time of death; 27% of all BACs were ≥ 0.08%.[61]
- Among males and females, firearms were the leading method of suicide; males had a higher percentage than females, 63% and 39%, respectively.[61]
- Among males and females, firearms were the leading method of suicide; males had a higher percentage than females, 63% and 39%, respectively.[61]
- Among females, the leading circumstances of suicide were mental health problems (55%) and intimate partner problems (38%).[61]
- Females more often had a history of suicide attempts than males, 30% and 14% respectively.[61]

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

A suicide prevention protocol is in place for all ODMHSAS contracted mental health treatment facilities. At admission and 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, the 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 underage and heavy drinking, work must continue to ensure these trends continue.

- Binge drinking is the most common and costly pattern of **excessive alcohol use** in the United States.[62,63]
- Binge drinking is associated with serious injuries and diseases, as well as with a higher risk of alcohol use disorder.[64]
- One in six US adults binge drinks, with 25% doing so at least weekly.[65]
- Binge drinking is just one pattern of excessive drinking, but it accounts for nearly all excessive drinking. Over 90% of US adults who drink excessively report binge drinking.[66]
- People with lower incomes and lower levels of education consume more binge drinks per year.[67]

- Most people younger than 21 who drink alcohol report binge drinking, often consuming large amounts. Among high school students who binge drink, 44% consumed eight or more drinks in a row.[68]

In Oklahoma results from FY23 SBIRT screenings have shown that only 13 percent of those screened need more than a brief education on depression; only 3 percent need more than brief education on drug use; and only 18 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.

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

Communities are an effective organizing force for bringing evidence-based policies and programs to scale. With the understanding that local issues need local solutions and local leadership, the ODMHSAS will support community and neighborhood-level prevention coalitions across the state to provide community-based prevention services. Coalitions are comprised of residents, governmental and nongovernmental organizational leaders, schools, young people, and many more to systematically:

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

The ODMHSAS also coordinates federal and state prevention funds to integrate evidence-informed prevention services into other key sectors of everyday living in Oklahoma – business employers, families, healthcare practices, and schools. Included in this strategic prevention approach are *primary* prevention services such as the ODMHSAS administers Responsible Beverage Service and Sales Training (RBSS) as an overarching moniker of Oklahoma's underage drinking prevention initiative. This mandated training is an alcohol service employee training for retailers. Synar inspections are conducted in partnership with the Oklahoma Alcoholic Beverage Laws Enforcement (ABLE) Commission to reduce and maintain Oklahoma's number of illegal tobacco purchases by individuals under the age of 21. SUPTRS Block Grant funds are not used for enforcement, only for training and technical assistance, and support services to communities

and law enforcement agencies. Other programs administered through the ODMHSAS prevention initiatives include the following:

Other programs administered through the ODMHSAS prevention initiatives include the following: The Family Field Guide campaign, Faith Partners equips people of faith to serve with an informed, compassionate response to the risk and prevalence of addiction and related mental health issues. Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for adolescents in primary care offices and other community-based settings funded by the SAMHSA Center for Substance Abuse Treatment, state and foundation sources; the Office of Suicide Prevention funded by the SAMHSA Center for Mental Health Services (CMHS) and state appropriated funds; Mental Health First Aid training program funded by state appropriated resources; the Strategic Prevention Framework (SFP) Partnerships For Success and SPF Rx programs, the State Opioid and Stimulant Response Grant, Prescription Drug Overdose project, First Responders CARA project funded by SAMHSA Center for Substance Abuse Prevention and state appropriated funds and Oklahoma's Ok I'm Ready communications campaign initiative supported by state appropriated funds. Additional emerging prevention services include partnerships with the Oklahoma State Department of Education (OSDE) and Local Education Agencies (LEAs) to provide leadership in planning and implementing best practice prevention services in schools. State-level support is provided by the ODMHSAS to help school sectors adopt Multi-Tiered System of Supports (MTSS), a prevention-based framework to serve the needs of all students, and implement student prevention programs such as the PAX Good Behavior Game (PAX GBG), Botvin LifeSkills Training (LST) and 3rd Millennium Classrooms. The ODMHSAS funds an array of prevention and promotion services in Oklahoma addressing overdose, suicide, and youth/adult mental health outcomes as well as data collection, prevention training, and prevention workforce development and consultation services.

Misuse of Prescription Drugs. According to Oklahoma's Department of Health, of the more than 700 Oklahoma residents who lose their lives to drug overdoses each year, six out of ten of those overdoses involve at least one prescription drug.[69] This makes prescription drugs the leading cause of drug-related deaths in the state. No other drug lays claim to this high of a percentage of total drug deaths as prescription drugs. In fact, more deaths in Oklahoma occur from prescription drugs than all other drug-related deaths in the state combined.

- Prescription drug overdoses are the leading cause of injury death for Oklahomans ages 25-64. Most drug-related deaths involve more than one drug. Alcohol overdoses were responsible for no deaths on their own but contributed to 95 deaths involving multiple substances. [70]

- The vast majority of those who abuse prescription painkillers don't purchase them from the stereotypical dealer on street corners. Almost 9 out of every 10 Oklahomans who used prescription painkillers nonmedically got them from their doctor, a friend, or a relative. Only four percent purchased the painkillers from a dealer. [69]

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.[70]

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.[71] Both quantitative and qualitative evidence indicates 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 FY2023 there were 1,164 individuals trained as a PRSS or in a specialty. Below are the specialized PRSS supplemental training and the number trained in each category.

	Completed
PRSS Ethics	539
PRSS Older Adult	150
PRSS- Supervisor	112
PRSS- Gambling	104
PRSS-Veteran	47
PRSS-Methamphetamine	128
PRSS-Group Facilitation	84

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 the 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 two teams: the Prescription Monitoring Program (PMP) Team and the Capacity Building Team.

First Name	Last Name	Organization
Ceciley	Thomason-Murphy	CARECG
Kristi	Allen	CARECG
Jeremy	Goldbach	CARECG
Chelsey	Russell	CARECG
Brady	Garrett	Cherokee Nation
Melissa	Foreman	Cherokee Nation
Sam	Bradshaw	Cherokee Nation Behavioral Health
Coleman	Cox	Cherokee Nation Behavioral Health
Andrea	Blair	Cherokee Nation
Melissa	Foreman	Cherokee Nation
Shelli	Byrd	Muscogee (Creek) Nation
Jessica	McGuire	Oklahoma Bureau of Narcotics and Dangerous Drugs
Josh	DeBartolo	Oklahoma Department of Mental Health and Substance Abuse Services-Tribal & Multicultural Liaison
Dr. Ray	Bottger	Oklahoma Department of Mental Health and Substance Abuse Services - Decision Support Services
Dr. David	Wright	Oklahoma Department of Mental Health and Substance Abuse Services - Decision Support Services
Young	Onuorah	Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Division
Sheena	Ford	Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Services
Carrie	Daniels	Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Services
Lauren	Kidwell	Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Services
Vi	Pham	Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Services
Jeanette	Cosby	Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Services
Paul	Harris	Oklahoma Highway Safety Office
Claire	Nguyen	Oklahoma State Department of Health - Injury Prevention Service
Avy	Redus	Oklahoma State Department of Health - Injury Prevention Service
Marvin	Smith	Oklahoma State Department of Health - Injury Prevention Service

First Name	Last Name	Organization
Thad	Burk	Oklahoma State Department of Health - Maternal Child Health Assessment
Bailey	Collins	Oklahoma State Department of Health- Center for Health Statistics
Ashleigh	Chiaf	Oklahoma State University-Center for Health Sciences
Dallas	McNance	Oklahoma State University-Center for Health Sciences
Matt	Condley	Oklahoma State University-Center for Health Sciences
Deborah	Jones-Saumty	Osage Nation
Dana	Lott	Osage Nation Prevention
Amruta	Abre	Southern Plains Tribal Health Board
Moone	Akbaran	Southern Plains Tribal Health Board
Britanny	Wilson	Southern Plains Tribal Health Board
Marifrances	Montell	Southern Plains Tribal Health Board
Fransesca	Toledo-Alexander	Southern Plains Tribal Health Board
Christi	Erwin	Southern Plains Tribal Health Board
Elizabeth	Kruger	Southern Plains Tribal Health Board
Jamie	Piatt	Southern Plains Tribal Health Board
Sydney	Sevier	Southern Plains Tribal Health Board
Julie	Seward	Southern Plains Tribal Health Board
Brittany	Wilson	Southern Plains Tribal Health Board
Wesley	Wilaon	Southern Plains Tribal Health Board
Vi	Dinh	Healthy Minds Policy Institute
Leslie	Ballenger	University of Oklahoma College of Public Health
Demetrick	Jones	University of Oklahoma Southwest Prevention Center
Kathrine	McCoy	Oklahoma Health Care Authority
Ashley	Johnson	Oklahoma Health Care Authority
Vickie	Sams	Oklahoma Health Care Authority

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.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Overall Health Promotion

Priority Type: SUT, MHS

Population(s): SMI, SED, PWID, Other

Goal of the priority area:

This priority will have multiple goals supported by objectives, strategies, and indicators. This is detailed on the Plan Matrix that is attached.

Strategies to attain the goal:

There will be multiple strategies supporting the objectives and goals in this priority area. This is detailed on the Plan Matrix that is attached.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Follow-up by physician after hospitalization for Mental Illness – 7 days after discharge

Baseline Measurement: 50%

First-year target/outcome measurement: 55%

Second-year target/outcome measurement: 58%

Data Source:

ODMHSAS CCBHC Quality Measure Reports

Description of Data:

reported by CCBHCs to ODMHSAS

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Presence of a fasting lipid profile within past 12 months for patients with diabetes

Baseline Measurement: 38%

First-year target/outcome measurement: 46%

Second-year target/outcome measurement: 50%

Data Source:

Relias Reports

Description of Data:

reported by CCBHCs to ODMHSAS

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Body Mass Index assessment for children/adolescents

Baseline Measurement: 20%

First-year target/outcome measurement: 50%

Second-year target/outcome measurement: 50%

Data Source:

ODMHSAS CCBHC Quality Measure Reports

Description of Data:

reported by CCBHCs to ODMHSAS

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of persons served who inject drugs and high risk persons with substance use disorders

Baseline Measurement: 5,600

First-year target/outcome measurement: 6,000

Second-year target/outcome measurement: 6,200

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data is compiled through claims database.

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Number of credentialed wellness coaches

Baseline Measurement: 1,000

First-year target/outcome measurement: 1,000

Second-year target/outcome measurement: 2,000

Data Source:

ODMHSAS training records

Description of Data:

ODMHSAS will keep a record of those completing training.

Data issues/caveats that affect outcome measures:

None

Indicator #: 6

Indicator: Number of wellness coaches trained in Wellness Coach Youth e-learning

Baseline Measurement: 100

First-year target/outcome measurement: 122

Second-year target/outcome measurement: 140

Data Source:

ODMHSAS Human Resources Development database

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Indicator #: 7

Indicator: Number of behavioral health organizations that adopt and/or adapt Wellness Policies

Baseline Measurement: 4

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 10

Data Source:

Wellness Division Data Set

Description of Data:

Smartsheet in partnership with TSET

Data issues/caveats that affect outcome measures:

None

Indicator #: 8

Indicator: Number of online referrals submitted from behavioral health providers to the OK Tobacco Helpline

Baseline Measurement: 7,500

First-year target/outcome measurement: 7,500

Second-year target/outcome measurement: 8,000

Data Source:

OK Tobacco Helpline database

Description of Data:

The OK Tobacco Helpline keeps a database of where each online referral comes from (by agency) and provides monthly reports.

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Improved Access and Reduced Disparities

Priority Type: SUP, SUT, SUR, MHS, ESMI

Population(s): SMI, SED, ESMI, PWWDC, PP, PWID, EIS/HIV, Other

Goal of the priority area:

This priority will have multiple goals supported by objectives, strategies, and indicators. This is detailed on the Plan Matrix that is attached.

Strategies to attain the goal:

There will be multiple strategies supporting the objectives and goals in this priority area. This is detailed on the Plan Matrix that is attached.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of services provided by Wellness Coaches

Baseline Measurement: 120,000

First-year target/outcome measurement: 150,000

Second-year target/outcome measurement: 160,000

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data is compiled through claims database and matched with staff IDs who are Wellness Coaches.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of American Indian children and youth who received Systems of Care services

Baseline Measurement: 300

First-year target/outcome measurement: 1,500

Second-year target/outcome measurement: 1,550

Data Source:

Medicaid Management Information System (MMIS) & Youth Information System (YIS)

Description of Data:

Data is compiled through the claims database for outreach services and matched to the eligibility file containing race.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of American Indians who received substance use disorder services

Baseline Measurement: 4,000

First-year target/outcome measurement: 4,000

Second-year target/outcome measurement: 4,500

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database for outreach services and matched to the eligibility file containing race.

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of collaborative events conducted together between state agency, contracted agencies and tribes

Baseline Measurement: 2

First-year target/outcome measurement: 4

Second-year target/outcome measurement: 6

Data Source:

ODMHSAS staff coordinating the events

Description of Data:

The ODMHSAS staff coordinating the events will provide the number of events held during the reporting period.

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Number of veterans certified through Veteran specific PRSS training

Baseline Measurement: 12

First-year target/outcome measurement: 25

Second-year target/outcome measurement: 30

Data Source:

ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database

Description of Data:

The number of veterans who acquire their ODMHSAS certification as a PRSS will be pulled from the ODMHSAS PRSS Certification database.

Data issues/caveats that affect outcome measures:

None

Indicator #: 6

Indicator: Number of individuals currently and previously active in the military served in CCBHCs

Baseline Measurement: 2,000

First-year target/outcome measurement: 2,050

Second-year target/outcome measurement: 2,100

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database for services provided by CCBHCs, and matched to the eligibility file containing military

status information.

Data issues/caveats that affect outcome measures:

None

Indicator #: 7

Indicator: Number of children with SED and/or co-occurring substance use disorders admitted to Systems of Care programs

Baseline Measurement: 12,000

First-year target/outcome measurement: 17,000

Second-year target/outcome measurement: 18,000

Data Source:

Statewide Behavioral Health Reporting System (PICIS)

Description of Data:

Data will be compiled through the Statewide Behavioral Health Reporting System (PICIS).

Data issues/caveats that affect outcome measures:

None

Indicator #: 8

Indicator: Number of people completing age-informed trainings that are developed and/or delivered by ODMHSAS via in-person, web-based, and/or hybrid modalities

Baseline Measurement: 5

First-year target/outcome measurement: 275

Second-year target/outcome measurement: 300

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Indicator #: 9

Indicator: Number of targeted outreach engagements via events, publications, or other method

Baseline Measurement: 0

First-year target/outcome measurement: 4

Second-year target/outcome measurement: 4

Data Source:

ODMHSAS Clinical Support Manager

Description of Data:

ODMHSAS designated staff will coordinate with the Communications Team to report on targeted outreach engagements.

Data issues/caveats that affect outcome measures:

None

Indicator #: 10

Indicator: Number of older adults engaging within the CCBHC system compared to previous year

Baseline Measurement: 21,874

First-year target/outcome measurement: Increase of 100 over the previous year

Second-year target/outcome measurement: Increase of 100 over the previous year

Data Source:

ODMHSAS Clinical Support Manager and ODMHSAS Division of Support Services (DSS) database

Description of Data:

The ODMHSAS designated staff will coordinate with DSS to compare the number of older adults served at any point within the CCBHC system to determine if an increase has occurred over the previous year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 11

Indicator: Number of persons who become certified PRSS for older persons

Baseline Measurement: 25

First-year target/outcome measurement: 25

Second-year target/outcome measurement: 30

Data Source:

ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database

Description of Data:

The number of persons who acquire their ODMHSAS certification as a PRSS for older persons will be pulled from the ODMHSAS PRSS Certification database.

Data issues/caveats that affect outcome measures:

None

Indicator #: 12

Indicator: Number of participants in Strengthening Families and Celebrating Families programs

Baseline Measurement: 700

First-year target/outcome measurement: 1,300

Second-year target/outcome measurement: 1,400

Data Source:

Provider reports

Description of Data:

Field Services Coordinator for Strengthening and Celebrating Families! Programming will poll providers, and maintain responses.

Data issues/caveats that affect outcome measures:

None

Indicator #: 13

Indicator: Number of EBP trainings provided for residential SUD treatment providers for pregnant women, and women with children

Baseline Measurement: 3

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 6

Data Source:

ODMHSAS staff coordinating the trainings

Description of Data:

The ODMHSAS staff coordinating the trainings will provide the number of EBP trainings held during the reporting period.

Data issues/caveats that affect outcome measures:

None

Indicator #: 14

Indicator: Number of individuals receiving opioid treatment and support services, including MAT services

Baseline Measurement: 4,000

First-year target/outcome measurement: 5,500

Second-year target/outcome measurement: 5,500

Data Source:

Agency surveys and billing

Description of Data:

Providers are required to report monthly on individuals receiving FDA approved MAT medications. ODMHSAS creates a quarterly report.

Data issues/caveats that affect outcome measures:

Only if providers are not accurately documenting or submitting required information.

Indicator #: 15

Indicator: Number of jail sites offering MAT

Baseline Measurement: 23

First-year target/outcome measurement: 26

Second-year target/outcome measurement: 33

Data Source:

Medication provider database

Description of Data:

ODMHSAS will receive regular reports from medication provider contractor.

Data issues/caveats that affect outcome measures:

None

Indicator #: 16

Indicator: Number of specialized SUD services to the LGBT population

Baseline Measurement: 40

First-year target/outcome measurement: 75

Second-year target/outcome measurement: 100

Data Source:

Provider reporting to ODMHSAS staff

Description of Data:

Provider of specialized LGBT SUD treatment services submits regular reporting that include the number of individuals receiving these services.

Data issues/caveats that affect outcome measures:

None

Indicator #: 17

Indicator: Number of partnerships developed in targeted communities

Baseline Measurement: 1

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 6

Data Source:

OU Evaluation Team (E-Team)

Description of Data:

Provider reports

Data issues/caveats that affect outcome measures:

None

Indicator #: 18

Indicator: Number of African Americans served in targeted communities

Baseline Measurement: 1,000

First-year target/outcome measurement: 2,000

Second-year target/outcome measurement: 2,500

Data Source:

OU Evaluation Team (E-Team)

Description of Data:

Provider report

Data issues/caveats that affect outcome measures:

None

Indicator #: 19

Indicator: Number of persons who become certified PRSS for Latinx persons

Baseline Measurement: 5

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 25

Data Source:

ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database

Description of Data:

The number of persons who acquire their ODMHSAS certification as a PRSS for Latinx persons will be pulled from the ODMHSAS PRSS Certification database.

Data issues/caveats that affect outcome measures:

None

Indicator #: 20

Indicator: Number of attendees for IMH specific training annually

Baseline Measurement: 50

First-year target/outcome measurement: 100

Second-year target/outcome measurement: 150

Data Source:

ODMHSAS Human Resources Development (HRD) database

Description of Data:

ODMHSAS HRD maintains a database of individuals who complete training.

Data issues/caveats that affect outcome measures:

None

Indicator #: 21

Indicator: Number of people completing CBT trainings that focus on early interventions to address eSMI, such as CBT, CT-R and CBT-p

Baseline Measurement: 175

First-year target/outcome measurement: 230

Second-year target/outcome measurement: 250

Data Source:

Attendance logs for trainings stored in ODMHSAS database

Description of Data:

Completed attendance of trainings

Data issues/caveats that affect outcome measures:

None

Indicator #: 22

Indicator: Number of youth and young adults with early Serious Mental Illness who are identified through eSMI Outreach and are connected with behavioral health EBP treatment services,

such as CBT (including CT-R), RA1SE NAVIGATE, SOC, or IPS

Baseline Measurement: 20

First-year target/outcome measurement: 40

Second-year target/outcome measurement: 50

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data is compiled through the claims database.

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Enhance Service Quality and Accountability

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PWID, EIS/HIV, Other

Goal of the priority area:

This priority will have multiple goals supported by objectives, strategies, and indicators. This is detailed on the Plan Matrix that is attached.

Strategies to attain the goal:

There will be multiple strategies supporting the objectives and goals in this priority area. This is detailed on the Plan Matrix that is attached.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of PRSSs certified

Baseline Measurement: 200

First-year target/outcome measurement: 275

Second-year target/outcome measurement: 300

Data Source:

PRSS Certification Database

Description of Data:

ODMHSAS maintains a database of all certified PRSSs.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of services provided by PRSSs

Baseline Measurement: 170,000

First-year target/outcome measurement: 210,000

Second-year target/outcome measurement: 210,000

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through claims database and matched with staff IDs who are PRSSs.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of persons who complete the PRSS Supervisory training

Baseline Measurement: 25

First-year target/outcome measurement: 100

Second-year target/outcome measurement: 125

Data Source:

PRSS database

Description of Data:

Number of persons completing this training will be pulled from the PRSS database.

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of Certified PRSS trained in Crisis Specific PRSS Trainings

Baseline Measurement: 10

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 25

Data Source:

ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database

Description of Data:

The number of persons who complete the PRSS Crisis Training will be pulled from the ODMHSAS PRSS Certification database.

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Number of Case Managers Certified and renewing certification

Baseline Measurement: 500

First-year target/outcome measurement: 1,000

Second-year target/outcome measurement: 1,200

Data Source:

Case Management (CM) Database

Description of Data:

Data is collected using the application process and also using the CM system in ODMHSAS Access Control.

Data issues/caveats that affect outcome measures:

None

Indicator #: 6

Indicator: Number of youth receiving children and adolescent trauma screening, for example CATS screening

Baseline Measurement: 10,000

First-year target/outcome measurement: 13,000

Second-year target/outcome measurement: 14,000

Data Source:

ODMHSAS evaluation database

Description of Data:

The ODMHSAS conducts evaluation of the above practices. The outcome and utilization data will be used to report on this measure.

Data issues/caveats that affect outcome measures:

None

Indicator #: 7

Indicator: Number of Peer-run drop-in services provided

Baseline Measurement: 20,000

First-year target/outcome measurement: 25,000

Second-year target/outcome measurement: 25,000

Data Source:

Contractor invoices

Description of Data:

Contractors submit monthly invoices with the number of individuals served that month.

Data issues/caveats that affect outcome measures:

None

Indicator #: 8

Indicator: Number of persons who have completed the web based Person-centered Planning training

Baseline Measurement: 100

First-year target/outcome measurement: 150

Second-year target/outcome measurement: 170

Data Source:

ODMHSAS Human Resources Development (HRD) database

Description of Data:

ODMHSAS HRD maintains a database of individuals who complete training.

Data issues/caveats that affect outcome measures:

None

Indicator #: 9

Indicator: Number of services provided through telehealth for persons with SMI, SED or SUD living in rural areas

Baseline Measurement: 30,000

First-year target/outcome measurement: 100,000

Second-year target/outcome measurement: 110,000

Data Source:

Medicaid Management Information System (MMIS)

Description of Data:

Data are compiled through the claims database. Telehealth services are identified in the claims system with a unique code modifier.

Data issues/caveats that affect outcome measures:

None

Indicator #: 10

Indicator: Percent of time agencies meet the benchmark for the incentive payment

Baseline Measurement: 89%

First-year target/outcome measurement: 90%

Second-year target/outcome measurement: 90%

Data Source:

Medicaid Management Information System (MMIS) and other administrative databases

Description of Data:

Data are compiled through the MMIS database, ODMHSAS PICIS database and telephone calls.

Data issues/caveats that affect outcome measures:

None

Indicator #: 11

Indicator: Number of individuals trained in IPS 101

Baseline Measurement: 30

First-year target/outcome measurement: 80

Second-year target/outcome measurement: 90

Data Source:

The ODMHSAS Human Resources Development (HRD) databases

Description of Data:

The ODMHSAS HRD maintains a database of individuals who complete training.

Data issues/caveats that affect outcome measures:

None

Indicator #: 12

Indicator: Reduce unemployment to all those in care

Baseline Measurement: 0%

First-year target/outcome measurement: 30%

Second-year target/outcome measurement: 30%

Data Source:

ODMHSAS database

Description of Data:

Number of people who are becoming employed

Data issues/caveats that affect outcome measures:

None

Indicator #: 13

Indicator: Percentage of individuals with SMI and SUD who are competitively employed through IPS

Baseline Measurement: 40%

First-year target/outcome measurement: 49%

Second-year target/outcome measurement: 49%

Data Source:

Provider report to ODMHSAS IPS staff

Description of Data:

IPS launched teams submit a quarterly data report that includes the number of individuals served through IPS and the percentage of those individuals that competitively employed.

Data issues/caveats that affect outcome measures:

None

Indicator #: 14

Indicator: Expand use of master lease agreements within CCBHCs in Oklahoma and Tulsa Counties to support housing for most in need clients

Baseline Measurement: 0

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 4

Data Source:

ODMHSAS database

Description of Data:

Number of master lease agreements

Data issues/caveats that affect outcome measures:

None

Indicator #: 15

Indicator: Expand Recovery Housing (Oxford House and other OKARR certified housing)

Baseline Measurement: 17

First-year target/outcome measurement: Increase from 17 counties to 23 counties

Second-year target/outcome measurement: Increase from 17 counties to 23 counties

Data Source:

OKARR certification and Oxford House reports

Description of Data:

The ODMHSAS will review the OKARR certification list and Oxford House reports.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Reduced Criminal Justice Involvement

Priority Type: SUT, MHS, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWID, Other

Goal of the priority area:

This priority will have multiple goals supported by objectives, strategies, and indicators. This is detailed on the Plan Matrix that is attached.

Strategies to attain the goal:

There will be multiple strategies supporting the objectives and goals in this priority area. This is detailed on the Plan Matrix that is attached.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of police officers trained in CIT

Baseline Measurement: 400

First-year target/outcome measurement: 750

Second-year target/outcome measurement: 750

Data Source:

Data maintained by ODMHSAS CIT trainer

Description of Data:

ODMHSAS staff maintain a roster of all individuals who complete the CIT course.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Percentage of number of services through law enforcement officers' iPads

Baseline Measurement: 0%

First-year target/outcome measurement: 10%

Second-year target/outcome measurement: 15%

Data Source:

ODMHSAS database

Description of Data:

ODMHSAS maintains databased in partnership with iPad vendor.

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Prevention of Mental Illness and Substance Use Disorders

Priority Type: SUP, SUT, MHS, BHCS

Population(s): SMI, SED, BHCS, PWWDC, PP, PWID, EIS/HIV, Other

Goal of the priority area:

This priority will have multiple goals supported by objectives, strategies, and indicators. This is detailed on the Plan Matrix that is attached.

Strategies to attain the goal:

There will be multiple strategies supporting the objectives and goals in this priority area. This is detailed on the Plan Matrix that is attached.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Collect data on number of text messages received and who is utilizing the services and why

Baseline Measurement: 0

First-year target/outcome measurement: Launch local texting features and track metrics, receive 12,000 text messages

Second-year target/outcome measurement: Reach younger groups and advertise texting services and receive at least 13,000 text messages

Data Source:

ODMHSAS contract

Description of Data:

ODMHSAS contract

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Place information on their website, social media or co-host events

Baseline Measurement: 0

First-year target/outcome measurement: Place content in OPERS newsletter by end of FY24

Second-year target/outcome measurement: Place 988 information on OSDH or OHCA websites by end of FY25

Data Source:

Information available on site

Description of Data:

Information available on site

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of people trained in suicide prevention

Baseline Measurement: 7,000

First-year target/outcome measurement: 13,000

Second-year target/outcome measurement: 13,000

Data Source:

DMH Training Logs, Kognito online system data

Description of Data:

Count of people who have completed training

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of people trained in Mental Health First Aid

Baseline Measurement: 1,700

First-year target/outcome measurement: 3,000

Second-year target/outcome measurement: 3,000

Data Source:

Prevention division database

Description of Data:

Prevention division staff maintain a database of all who have received the training.

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Number of Business Sectors who have developed policies and practices regarding training in MHFA

Baseline Measurement: 0

First-year target/outcome measurement: Increase by 4

Second-year target/outcome measurement: Increase by 4

Data Source:

ODMHSAS Database

Description of Data:

ODMHSAS Database

Data issues/caveats that affect outcome measures:

None

Indicator #: 6

Indicator: Increase number of medical practice sites that are using SBIRT

Baseline Measurement: 20

First-year target/outcome measurement: 40 additional medical practice sites

Second-year target/outcome measurement: 40 additional medical practice sites

Data Source:

ODMHSAS Access Control

Description of Data:

The screening tool/assessment is housed in Access Control. DSS collects and summarizes the data.

Data issues/caveats that affect outcome measures:

None

Indicator #: 7

Indicator: Number of faith-based partnerships

Baseline Measurement: 1

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 5

Data Source:

ODMHSAS database

Description of Data:

ODMHSAS database

Data issues/caveats that affect outcome measures:

None

Indicator #: 8

Indicator: Number of substance abuse prevention practices implemented through contracted community/campus coalitions

Baseline Measurement: 25

First-year target/outcome measurement: additional 50% with a goal of 2,952

Second-year target/outcome measurement: additional 50% with a goal of 2,952

Data Source:

Oklahoma Prevention Reporting System (PRS)

Description of Data:

EBPs used in delivering community level/campus strategies are reported by subrecipients in the PRS and compiled by project evaluators.

Data issues/caveats that affect outcome measures:

None

Indicator #: 9

Indicator: Number of districts utilizing MTSS approach

Baseline Measurement: 28

First-year target/outcome measurement: Additional 4 school districts

Second-year target/outcome measurement: Additional 4 school districts

Data Source:

ODMHSAS database

Description of Data:

ODMHSAS database

Data issues/caveats that affect outcome measures:

None

Indicator #: 10

Indicator: Number of school sites utilizing Botvin LifeSkills Training, 3rd Millennium Classrooms, PAX Good Behavior Game, ASPIRE

Baseline Measurement: 130

First-year target/outcome measurement: additional 25% school sites

Second-year target/outcome measurement: additional 25% school sites

Data Source:

ODMHSAS database

Description of Data:

ODMHSAS database

Data issues/caveats that affect outcome measures:

None

Indicator #: 11

Indicator: Number trained in Responsible Beverage Sales and Service training

Baseline Measurement: 1,500

First-year target/outcome measurement: 2,000

Second-year target/outcome measurement: 2,000

Data Source:

Prevention division database

Description of Data:

Prevention division staff maintain a database of all who have received the training.

Data issues/caveats that affect outcome measures:

None

Indicator #: 12

Indicator: Number of medical professionals who receive the practices

Baseline Measurement: 40

First-year target/outcome measurement: 500

Second-year target/outcome measurement: 500

Data Source:

Prevention division database

Description of Data:

Prevention division staff track and maintain this information.

Data issues/caveats that affect outcome measures:

None

Indicator #: 13

Indicator: Number of law enforcement agencies who have MOU's (new or renewed) to administer overdose reversal medication

Baseline Measurement: 60

First-year target/outcome measurement: 60

Second-year target/outcome measurement: 60

Data Source:

ODMHSAS logs

Description of Data:

Count of MOU's

Data issues/caveats that affect outcome measures:

None

Indicator #: 14

Indicator: Number of harm reduction vending machines

Baseline Measurement: 1

First-year target/outcome measurement: 40

Second-year target/outcome measurement: 40

Data Source:

Placement records

Description of Data:

Records of placements of vending machines

Data issues/caveats that affect outcome measures:

None

Indicator #: 15

Indicator: Number of overdose reversal medications distributed

Baseline Measurement: 22,000

First-year target/outcome measurement: 40,000

Second-year target/outcome measurement: 40,000

Data Source:

Prevention division database

Description of Data:

Prevention division staff track and maintain this information.

Data issues/caveats that affect outcome measures:

Relies on submission of report back forms from law enforcement or members of the public getting refills

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Indicator #: 16

Indicator: Number of Fentanyl test strips distributed

Baseline Measurement: 35,000

First-year target/outcome measurement: 100,000

Second-year target/outcome measurement: 100,000

Data Source:

Prevention division database

Description of Data:

Prevention division staff track and maintain this information.

Data issues/caveats that affect outcome measures:

Relies on submission of report back forms from law enforcement or members of the public getting refills

---

Indicator #: 17

Indicator: Number of medication lockboxes distributed

Baseline Measurement: 618

First-year target/outcome measurement: 2,000

Second-year target/outcome measurement: 2,000

Data Source:

Oklahoma Prevention Reporting System (OPERS)

Description of Data:

Lockboxes used in delivering community level/campus strategies are reported by subrecipients in the PRS and compiled by project evaluators.

Data issues/caveats that affect outcome measures:

None

Indicator #: 18

Indicator: Number of medication disposal bags distributed

Baseline Measurement: 900

First-year target/outcome measurement: 6,000

Second-year target/outcome measurement: 6,000

Data Source:

Oklahoma Prevention Reporting System (OPERS)

Description of Data:

Medication disposal bags used in delivering community level/campus strategies are reported by subrecipients in the PRS and compiled by project evaluators.

Data issues/caveats that affect outcome measures:

None

Priority #: 6

Priority Area: Public Awareness

Priority Type: SUP, SUT, MHS, BHCS

Population(s): SMI, SED, BHCS, PWWDC, PWID, EIS/HIV, Other

Goal of the priority area:

This priority will have multiple goals supported by objectives, strategies, and indicators. This is detailed on the Plan Matrix that is attached.

Strategies to attain the goal:

There will be multiple strategies supporting the objectives and goals in this priority area. This is detailed on the Plan Matrix that is attached.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Oklahomans reached with the Harm Reduction Campaign

Baseline Measurement: 0

First-year target/outcome measurement: 5,500,000 impressions through all media channels

Second-year target/outcome measurement: 5,500,000 impressions through all media channels

Data Source:

ODMHSAS Prevention and Communications division

Description of Data:

Counters are used to record the number of hits.

Data issues/caveats that affect outcome measures:

User preference and available social media platforms are difficult to predict.

Indicator #: 2

Indicator: Percentage of Oklahomans reached with 988 and call data into the center

Baseline Measurement: 0

First-year target/outcome measurement: Maintain awareness campaigns and garner 4,500,000 impressions by reaching new groups across Oklahoma including: faith-based and minority

Second-year target/outcome measurement: Maintain awareness campaigns and garner 4,500,000 impressions by reaching new groups across Oklahoma including: faith-based and minority

Data Source:

ODMHSAS contract

Description of Data:

ODMHSAS contract

Data issues/caveats that affect outcome measures:

None

Footnotes:

Plan Matrix is attached.

Plan Matrix

Priority 1 Measures

Priority Type is SUT, MHS

Populations: SMI, SED, PWID, Other

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
1. Overall Health Promotion	Continue to integrate primary health care with behavioral health care	Improve health outcomes within CCBHCs	For adults with SMI and children with SED	Follow-up by physician after hospitalization for Mental Illness – 7 days after discharge	**Year 1:** Baseline: 50% Target- 55% **Year 2:** Target- 58% **Data Source:** ODMHSAS CCBHC Quality Measure Reports **Description of Data:** reported by CCBHCs to ODMHSAS **Data issues/caveats that affect outcome measures:** None
				Presence of a fasting lipid profile within past 12 months for patients with diabetes	**Year 1:** Baseline: 38% Target- 46% **Year 2:** Target- 50% **Data Source:** Relias Reports **Description of Data:** reported by CCBHCs to ODMHSAS **Data issues/caveats that affect outcome measures:** None

Priority 1 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
1. Overall Health Promotion **(cont.)**	Continue to integrate primary health care with behavioral health care **(cont.)**	Increase targeted interventions to those with high BMIs and their families	Establish a BMI data collection tool	Body Mass Index assessment for children/adolescents	**Year 1:** Baseline: 20% Target- 50% **Year 2:** Target- 50% **Data Source:** ODMHSAS CCBHC Quality Measure Reports **Description of Data:** reported by CCBHCs to ODMHSAS **Data issues/caveats that affect outcome measures:** None
	Improve the health status of behavioral health consumers with complex health needs	Increase the number served of persons who inject drugs and high risk persons with substance use disorders	Outreach and engagement for persons who inject drugs	Number of persons served who inject drugs and high risk persons with substance use disorders	**Year 1:** Baseline: 5,600 Target- 6,000 **Year 2:** Target- 6,200 **Data Source:** Medicaid Management Information System (MMIS) **Description of Data:** Data is compiled through claims database. **Data issues/caveats that affect outcome measures:** None

Priority 1 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Target
1. Overall Health Promotion **(cont.)**	Increase a culture of wellness in behavioral health organizations	Increase the number of credentialed Wellness Coaches	Provide wellness coach training	Number of credentialed wellness coaches	**Year 1:** Baseline: 1,000 Target- 1,000 **Year 2:** Target- 1,200 **Data Source:** ODMHSAS training records **Description of Data:** ODMHSAS will keep a record of those completing training. **Data issues/caveats that affect outcome measures:** None
		Increase the number of credentialed Wellness Coaches trained in Youth Focused competencies	Train Wellness Coaches in Youth Focused competencies in behavioral health settings	Number of wellness coaches trained in Wellness Coach Youth e-learning	**Year 1:** Baseline: 100 Target- 122 **Year 2:** Target- 140 **Data Source:** ODMHSAS Human Resources Development database **Description of Data:** The ODMHSAS designated staff will report on training development and the ODMHSAS HRD maintains a database of individuals who complete training. **Data issues/caveats that affect outcome measures:** None

Priority 1 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Target
1. Overall Health Promotion **(cont.)**	Increase a culture of wellness in behavioral health organizations **(cont.)**	Increase the number of behavioral health serving organizations to adopt worksite wellness polices addressing nutrition and physical activity for employees and consumers.	Provide Technical Assistance, Wellness Policy Templates, and Outreach to organizations.	Number of behavioral health organizations that adopt and/or adapt Wellness Policies	**Year 1:** Baseline: 4 Target-5 **Year 2:** Target-10 **Data Source:** Wellness Division Data Set **Description of Data:** Smartsheet in partnership with TSET **Data issues/caveats that affect outcome measures:** None
	Reduce the use of tobacco	Increase the number of online referrals made from behavioral health providers to the OK Tobacco Helpline	Promotion of OK Tobacco Helpline	Number of online referrals submitted from behavioral health providers to the OK Tobacco Helpline	**Year 1:** Baseline: 7,500 Target- 7,500 **Year 2:** Target- 8,000 **Data Source:** OK Tobacco Helpline database **Description of Data:** The OK Tobacco Helpline keeps a database of where each online referral comes from (by agency) and provides monthly reports. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Type: SUP, SUT, SUR, MHS, ESMI; Population: SMI, SED, ESMI, PWWDC, PP, PWID, EIS/HIV, Other

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities	Expand the integration of physical health interventions	Increase the number of services provided by Wellness Coaches	Expand use of the Wellness Coaches in substance use disorder and behavioral health settings	Number of services provided by Wellness Coaches	**Year 1:** Baseline: 120,000 Target- 150,000 **Year 2:** Target- 160,000 **Data Source:** Medicaid Management Information System (MMIS) **Description of Data:** Data is compiled through claims database and matched with staff IDs who are Wellness Coaches. **Data Issues/caveats that affect outcome measures:** None
	Expand services for American Indians (AIs)	Increase access to Systems of Care services for AI children and youth	Promotion of Systems of Care services for AI children and youth	Number of AI children and youth who received Systems of Care services	**Year 1:** Baseline: 300 Target- 1,500 **Year 2:** Target- 1,550 **Data Source:** Medicaid Management Information System (MMIS) & Youth Information System (YIS) **Description of Data:** Data is compiled through the claims database for outreach services and matched to the eligibility file containing race. **Data issues/caveats that affect outcome measures**: None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Expand services for American Indians (AIs) **(cont.)**	Continued access to substance use disorder treatment for AI	Outreach activities done through contracted providers	Number of AI who received substance use disorder services	**Year 1:** Baseline: 4,000 Target- 4,000 **Year 2:** Target- 4,500 **Data Source:** Medicaid Management Information System (MMIS) **Description of Data**: Data are compiled through the claims database for outreach services and matched to the eligibility file containing race. **Data issues/caveats that affect outcome measures**: None
	Increase collaborative efforts with Tribes on mental health and substance use issues	Increase collaborative efforts between state agency, contracted agencies and tribes.	Conduct events together to educate the community or cross systems about mental health or substance use issues.	Number of collaborative events conducted together between state agency, contracted agencies and tribes	**Year 1:** Baseline: 2 Target- 4 **Year 2:** Target- 6 **Data Source**: ODMHSAS staff coordinating the events **Description of Data:** The ODMHSAS staff coordinating the events will provide the number of events held during the reporting period. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improve access for military personnel and their families	Increase the number of veteran Peer Recovery Support Specialists (PRSS) certified through a Veteran specific PRSS training	Promotion of veteran specific PRSS training	Number of veterans certified through Veteran specific PRSS training	**Year 1:** Baseline: 12 Target- 25 **Year 2:** Target- 30 **Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database **Description of Data:** The number of veterans who acquire their ODMHSAS certification as a PRSS will be pulled from the ODMHSAS PRSS Certification database. **Data issues/caveats that affect outcome measures:** None
	Expand services for individuals currently and previously active in the military	Increase the number of individuals currently and previously active in the military served in CCBHCs	Promotion of CCBHCs to meet the service needs of individuals currently and previously active in the military	Number of individuals currently and previously active in the military served in CCBHCs	**Year 1:** Baseline: 2,000 Target- 2,050 **Year 2:** Target- 2,100 **Data Source:** Medicaid Management Information System (MMIS) **Description of Data:** Data are compiled through the claims database for services provided by CCBHCs, and matched to the eligibility file containing military status information. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Expand services for children with SED	Maintain the number of children with SED and/or co-occurring substance use disorders admitted to Systems of Care programs	Local systems of care and Wraparound sites	Number of children with SED and/or co-occurring substance use disorders admitted to Systems of Care programs	**Year 1:** Baseline: 12,000 Target- 17,000 **Year 2:** Target- 18,000 **Data Source:** Statewide Behavioral Health Reporting System (PICIS) **Description of Data:** Data will be compiled through the Statewide Behavioral Health Reporting System (PICIS). **Data issues/caveats that affect outcome measures:** None
	Improved services for older adults	Increase number of people completing ODMHSAS age-informed trainings each year	Develop and/or deliver age-informed trainings	Number of people completing age-informed trainings that are developed and/or delivered by ODMHSAS via in-person, web-based, and/or hybrid modalities	**Year 1:** Baseline: 5 Target- 275 **Year 2:** Target- 300 **Data Source:** The ODMHSAS Clinical Support Manager and the ODMHSAS Human Resources Development (HRD) database **Description of Data:** The ODMHSAS designated staff will report on training development and the ODMHSAS HRD maintains a database of individuals who complete training. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improved services for older adults **(cont.)**	Increase awareness among older adults about the 988 Crisis Care Continuum	Targeted 988 awareness outreach with older adult providers and/or audiences	Number of targeted outreach engagements via events, publications, or other method	**Year 1:** Baseline: 0 Target- 4 **Year 2:** Target- 4 **Data Source:** ODMHSAS Clinical Support Manager **Description of Data:** ODMHSAS designated staff will coordinate with the Communications Team to report on targeted outreach engagements. **Data issues/caveats that affect outcome measures:** None
		Increase number of older adults who receive behavioral health care through Comprehensive Community Behavioral Health Centers (CCBHCs)	Work with CCBHCs to strengthen age-inclusive and age-informed outreach and engagements	Number of older adults engaging within the CCBHC system compared to previous year	**Year 1:** Baseline: 21,874 Target- Increase of 100 over the previous year **Year 2:** Target- Increase of 100 over the previous year **Data Source:** ODMHSAS Clinical Support Manager and ODMHSAS Division of Support Services (DSS) database **Description of Data:** The ODMHSAS designated staff will coordinate with DSS to compare the number of older adults served at any point within the CCBHC system to determine if an increase has occurred over the previous year. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improved services for older adults **(cont.)**	Implement Peer Recovery Support Specialist (PRSS) training specific to older persons	Promotion of older person's peer specific trainings	Number of persons who become certified PRSS for older persons	**Year 1:** Baseline: 25 Target- 25 **Year 2:** Target- 30 **Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database **Description of Data:** The number of persons who acquire their ODMHSAS certification as a PRSS for older persons will be pulled from the ODMHSAS PRSS Certification database. **Data issues/caveats that affect outcome measures**: None
	Improve access to treatment for parents in substance use disorder treatment programs and their families	Increase the number of participants in Strengthening Families and Celebrating Families programs	Strengthening Families and Celebrating Families – EBP family group counseling – for parents (and their children) in substance use disorder treatment programs and faith based organizations	Number of participants in Strengthening Families and Celebrating Families programs	**Year 1:** Baseline: 700 Target- 1,300 **Year 2:** Target- 1,400 **Data Source:** Provider reports **Description of Data:** Field Services Coordinator for Strengthening and Celebrating Families! Programming will poll providers, and maintain responses. **Data issues/caveats that affect outcome measures**: None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improve access to EBPs within residential substance use disorder (SUD) treatment for pregnant women, women and children	Provide and maintain EBPs within residential SUD treatment for pregnant women, women and children	Train residential SUD treatment providers for pregnant women, women and children in EBPs including Celebrating Families, Community Reinforcement Approach, Seeking Safety, and ABC infant model	Number of EBP trainings provided for residential SUD treatment providers for pregnant women, and women with children	**Year 1:** Baseline: 3 Target- 5 **Year 2:** Target- 6 **Data Source:** ODMHSAS staff coordinating the trainings **Description of Data:** The ODMHSAS staff coordinating the trainings will provide the number of EBP trainings held during the reporting period. **Data issues/caveats that affect outcome measures:** None
	Increase access to an array of treatments for individuals with or at risk for OUDs, including those who are uninsured and underinsured, with emphasis on veterans, pregnant women, tribal, those coming out of jail and prisons.	Increase the number of individuals receiving opioid treatment and support services, including MAT.	Expand access to opioid treatment and support services	Number of individuals receiving opioid treatment and support services, including MAT services	**Year 1:** Baseline: 4,000 Target- 5,500 **Year 2:** Target- 5,500 **Data Source:** Agency surveys and billing **Description of Data:** Providers are required to report monthly on individuals receiving FDA approved MAT medications. ODMHSAS creates a quarterly report. **Data issues/caveats that affect outcome measures:** Only if providers are not accurately documenting or submitting required information.

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Increase access to an array of treatments for individuals with or at risk for OUDs, including those who are uninsured and underinsured, with emphasis on veterans, pregnant women, tribal, those coming out of jail and prisons. **(cont.)**	Increase access to MAT for individuals in county jails	Expand access to MAT in county jails in collaboration with jail medical providers and partner pharmacy	Number of jail sites offering MAT	**Year 1:** Baseline: 23 Target- 26 **Year 2:** Target- 33 **Data Source:** Medication provider database **Description of Data:** ODMHSAS will receive regular reports from medication provider contractor. **Data issues/caveats that affect outcome measures:** None
	Improve access to treatment for the LGBT population	Increase the number of substance use disorder (SUD) services to LGBT population	Provide specialized LGBT substance use disorder treatment and support services	Number of specialized SUD services to the LGBT population	**Year 1:** Baseline: 40 Target- 75 **Year 2:** Target- 100 **Data Source:** Provider reporting to ODMHSAS staff **Description of Data:** Provider of specialized LGBT SUD treatment services submits regular reporting that include the number of individuals receiving these services. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improve access to treatment for the African American population	Increase the number of African Americans served in urban communities with a high percentage of African American population	Development and implementation of community/school partnership model for outreach, treatment and support	Number of partnerships developed in targeted communities	**Year 1:** Baseline: 1 Target- 2 **Year 2:** Target- 6 **Data Source:** OU Evaluation Team (E-Team) **Description of Data:** Provider reports **Data issues/caveats that affect outcome measures:** None
				Number of African Americans served in targeted communities	**Year 1:** Baseline: 1,000 Target- 2,000 **Year 2:** Target- 2,500 **Data Source:** OU Evaluation Team (E-Team) **Description of Data:** Provider report **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improve access to treatment for the Latinx population.	Implement Peer Recovery Support Specialist (PRSS) training specific Latinx persons	Promotion of Latinx persons peer specific trainings	Number of persons who become certified PRSS for Latinx persons	**Year 1:** Baseline: 5 Target- 20 **Year 2:** Target- 25 **Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database **Description of Data:** The number of persons who acquire their ODMHSAS certification as a PRSS for Latinx persons will be pulled from the ODMHSAS PRSS Certification database. **Data issues/caveats that affect outcome measures**: None
	Expand access to specialized treatment services for children 0-5 and their families across Oklahoma, especially in rural and frontier counties.	Increase number of clinicians trained in EBP's appropriate for treatment of children 0-5, especially in rural and frontier counties.	Continue to offer training in assessment, diagnosis, and treatment of children 0-5 to include EBP's such as COS, CPP, and ABC.	Number of attendees for IMH specific training annually	**Year 1:** Baseline: 50 Target - 100 **Year 2:** Target- 150 **Data source:** ODMHSAS Human Resources Development (HRD) database **Description of Data:** ODMHSAS HRD maintains a database of individuals who complete training. **Data issues/caveats that affect outcome measures:** None

Priority 2 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
2. Improved Access and Reduced Disparities **(cont.)**	Improve access to evidenced based practices for early interventions to address Early Serious Mental Illness (SMI)	Increase the number of people completing trainings in Evidence-Based Practices to address early intervention for Serious Mental Illness	Implement the Evidence-Based Practice of Cognitive Behavioral Therapy (CBT), Recovery Oriented Cognitive Therapy (CT-R) and Cognitive Behavioral Therapy for Psychosis (CBT-p) to treat youth and young adults with Serious Mental Illness	Number of people completing CBT trainings that focus on early interventions to address eSMI, such as CBT, CT-R and CBT-p	**Year 1:** Baseline: 175 Target- 230 **Year 2:** Target- 250 **Data Source:** Attendance logs for trainings stored in ODMHSAS database **Description of Data:** Completed attendance of trainings **Data issues/caveats that affect outcome measures:** None
		Implement process for early identification and engagement of youth and young adults experiencing early SMI	Implement statewide eSMI Outreach to build collaborative relationships with local Higher Education and hospital to assist with early identification, engagement and intervention for youth and young adults experiencing early SMI	Number of youth and young adults with early Serious Mental Illness who are identified through eSMI Outreach and are connected with behavioral health EBP treatment services, such as CBT (including CT-R), RA1SE NAVIGATE, SOC, or IPS	**Year 1:** Baseline: 20 Target- 40 **Year 2:** Target- 50 **Data Source**: Medicaid Management Information System (MMIS) **Description of Data:** Data is compiled through the claims database. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Type: SUT, SUR, MHS, ESMI, BHCS; Population: SMI, SED, ESMI, BHCS, PWWDC, PWID, EIS/HIV, Other

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability	Expand use of recovery support services	Increase the number of PRSSs certified	Certification program for Peer Recovery Support Specialists (PRSS)	Number of PRSSs certified	**Year 1:** Baseline: 200 Target- 275 **Year 2:** Target- 300 **Data Source:** PRSS Certification Database **Description of Data:** ODMHSAS maintains a database of all certified PRSSs. **Data issues/caveats that affect outcome measures**: None
		Increase the number of services provided by PRSSs	Expand use of PRSSs in substance abuse and mental health settings	Number of services provided by PRSSs	**Year 1:** Baseline: 170,000 Target- 210,000 **Year 2:** Target- 210,000 **Data Source:** Medicaid Management Information System (MMIS) **Description of Data:** Data are compiled through claims database and matched with staff IDs who are PRSSs. **Data issues/caveats that affect outcome measures:** None
		Increase the number of PRSS Supervisors	Promote PRSS Supervisory training	Number of persons who complete the PRSS Supervisory training	**Year 1:** Baseline: 25 Target- 100 **Year 2:** Target- 125 **Data Source:** PRSS database **Description of Data:** Number of persons completing this training will be pulled from the PRSS database. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability **(cont.)**	Improve Crisis Education and Skills of PRSS Workforce	Implement Crisis Specific PRSS Trainings	Promote Crisis Specific PRSS Trainings	Number of Certified PRSS trained in Crisis Specific PRSS Trainings	**Year 1:** Baseline: 10 Target- 20 **Year 2:** Target- 25 **Data Source:** ODMHSAS Peer Recovery Support Specialist (PRSS) Certification database **Description of Data:** The number of persons who complete the PRSS Crisis Training will be pulled from the ODMHSAS PRSS Certification database. **Data issues/caveats that affect outcome measures:** None
	Expand use of behavioral health case management services	Increase the number of case managers who are certified and renewing certification	Certification for Behavioral Health Case Managers	Number of Case Managers Certified and renewing certification	**Year 1:** Baseline: 500 Target- 1,000 **Year 2:** Target- 1,200 **Data Source:** Case Management (CM) Database **Data Base Description of Data:** Data is collected using the application process and also using the CM system in ODMHSAS Access Control. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability **(cont.)**	Utilize evidence based practices for individuals impacted by trauma	Maintain the number of youth receiving trauma screening, for example, Children and Adolescent Trauma Screening (CATS)	Require use of trauma screening for youth, for example CATS screening	Number of youth receiving children and adolescent trauma screening, for example CATS screening	**Year 1:** Baseline: 10,000 Target- 13,000 **Year 2:** Target- 14,000 **Data Source:** ODMHSAS evaluation database **Description of Data:** The ODMHSAS conducts evaluation of the above practices. The outcome and utilization data will be used to report on this measure. **Data issues/caveats that affect outcome measures:** None
	Increase options for self-directed care	Increase the number of individuals receiving drop-in center services	Peer-run, drop-in centers as option for services and supports	Number of Peer-run drop-in services provided	**Year 1:** Baseline: 20,000 Target- 25,000 **Year 2:** Target- 25,000 **Data Source:** Contractor invoices **Description of Data:** Contractors submit monthly invoices with the number of individuals served that month. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability **(cont.)**	Increase access to training on Person-centered Planning	Increase the number of behavioral health providers trained on Person-centered Planning	Web-based training on Person centered Planning	Number of persons who have completed the web based Person-centered Planning training	**Year 1:** Baseline: 100 Target- 150 **Year 2:** Target- 170 **Data Source:** ODMHSAS Human Resources Development (HRD) database **Description of Data:** ODMHSAS HRD maintains a database of individuals who complete training. **Data issues/caveats that affect outcome measures:** None
	Leverage technology to improve access and quality of care for persons with SMI, SED or SUD living in rural areas	Increase the number of services provided through telehealth	Telehealth services for both substance use disorder (SUD) treatment and mental health services	Number of services provided through telehealth for persons with SMI, SED or SUD living in rural areas	**Year 1:** Baseline: 30,000 Target- 100,000 **Year 2:** Target- 110,000 **Data Source:** Medicaid Management Information System (MMIS) **Description of Data:** Data are compiled through the claims database. Telehealth services are identified in the claims system with a unique code modifier. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability **(cont.)**	Incentivize for more efficient use of resources and improved service outcomes	Maintain the percentage of time agencies meet the benchmark for the incentive payment as a result of indicators of improved care	Use of the Enhanced Tiered Payment System (ETPS)	Percent of time agencies meet the benchmark for the incentive payment	**Year 1:** Baseline: 89% Target- 90% **Year 2:** Target- 90% **Data Source:** Medicaid Management Information System (MMIS) and other administrative databases **Description of Data:** Data are compiled through the MMIS database, ODMHSAS PICIS database and telephone calls. **Data issues/caveats that affect outcome measures:** None
	Improve access to supported employment and education for individuals with SMI and SUD	Increase the number of individuals trained in the EBP-Individual Placement and Supports (IPS)	Provide IPS training for providers and community stakeholders	Number of individuals trained in IPS 101	**Year 1**: Baseline: 30 Target- 80 **Year 2:** Target- 90 **Data Source:** The ODMHSAS Human Resources Development (HRD) databases **Description of Data:** The ODMHSAS HRD maintains a database of individuals who complete training. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability **(cont.)**	Improve access to supported employment and education for individuals with SMI and SUD **(cont.)**	Reduce unemployment to all those that are being treated within the ODMHSAs system	Treatment providers within the ODMHSAS system will work with consumers on assisting with employment needs	Reduce unemployment to all those in care	**Year 1:** Baseline: 0% Target- 30% **Year 2:** Target- 30% **Data Source:** ODMHSAS database **Description of Data:** Number of people who are becoming employed **Data issues/caveats that affect outcome measures:** None
		Increase the number of individuals with SMI and SUD that are competitively employed	Provide technical assistance to providers regarding successful implementation of the EBP Individual Placement and Supports (IPS)	Percentage of individuals with SMI and SUD who are competitively employed through IPS	**Year 1:** Baseline: 40% Target- 49% **Year 2:** Target- 49% **Data Source:** Provider report to ODMHSAS IPS staff **Description of Data:** IPS launched teams submit a quarterly data report that includes the number of individuals served through IPS and the percentage of those individuals that competitively employed. **Data issues/caveats that affect outcome measures:** None

Priority 3 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
3. Enhance Service Quality and Accountability **(cont.)**	Increase evidence based housing programming availability	Increase access to housing	Increase access to housing by expanding use of master lease agreements	Expand use of master lease agreements within CCBHCs in Oklahoma and Tulsa Counties to support housing for most in need clients	**Year 1:** Baseline: 0 Target- 2 **Year 2:** Target- 4 **Data Source:** ODMHSAS database **Description of Data:** Number of master lease agreements **Data issues/caveats that affect outcome measures:** None
		Increase the number of evidence based and certified recovery residences	Provide financial support for housing to become certified through the Oklahoma Association of Recovery Residences (OKARR) and for more Oxford Houses to be opened across the state	Expand Recovery Housing (Oxford House and other OKARR certified housing)	**Year 1:** Baseline: 17 Target: Increase from 17 counties to 23 counties **Year 2:** Target: Increase from 17 counties to 23 counties **Data Source:** OKARR certification and Oxford House reports **Description of Data:** The ODMHSAS will review the OKARR certification list and Oxford House reports. **Data issues/caveats that affect outcome measures:** None

Priority 4 Measures

Priority Type: SUT, MHS, BHCS

Population: SMI, SED, ESMI, BHCS, PWID, Other

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
4. Reduced Criminal Justice Involvement	Improve workforce capacity and skills in response to individuals with criminal justice/public safety involvement	Increase the number of police officers trained in CIT	Law enforcement training – Memphis Model Crisis Intervention Training (CIT)	Number of police officers trained in CIT	**Year 1:** Baseline: 400 Target- 750 **Year 2**: Target- 750 **Data Source:** Data maintained by ODMHSAS CIT trainer **Description of Data:** ODMHSAS staff maintain a roster of all individuals who complete the CIT course. **Data issues/caveats that affect outcome measures:** None
		Increase law enforcement access to mental health experts	Increase number of services through law enforcement officers' iPads	Percentage of number of services through law enforcement officers' iPads	**Year 1:** Baseline: 0% Target- 10% **Year 2:** Target- 15% **Data Source:** ODMHSAS database **Description of Data:** ODMHSAS maintains databased in partnership with iPad vendor. **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Type: SUP, SUT, MHS, BHCS; Population: SMI, SED, BHCS, PWWDC, PP, PWID, EIS/HIV, Other

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders	Reduce rates of suicide	Further develop 988 Call Center functionality and service	Further develop 988 Call Center capacity. Implement local texting features while also advertising to those who need help with substance use and addiction.	Collect data on number of text messages received and who is utilizing the services and why	**Year 1:** Baseline: 0 Target- Launch local texting features and track metrics, receive 12,000 text messages **Year 2:** Target- Reach younger groups and advertise texting services and receive at least 13,000 text messages **Data Source:** ODMHSAS contract **Description of Data:** ODMHSAS contract **Data issues/caveats that affect outcome measures:** None
		Continue to increase suicide prevention among Oklahoma adults by collaborating with other state agencies for focused populations	Work with OPERS and OSDH and/or OHCA on 988 resources for their consumers, increasing visibility for Medicare and older adult populations Outreach/education to those receiving services from the Employment Security Commission and those reaching SMVF (service members, vets and families) populations, and employers.	Place information on their website, social media or co-host events	**Year 1:** Baseline: 0 Target- Place content in OPERS newsletter by end of FY24 **Year 2:** Target- Place 988 information on OSDH or OHCA websites by end of FY25 **Data Source:** Information available on site **Description of Data:** Information available on site **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce rates of suicide **(cont.)**	Increase number of people trained in suicide prevention (ex. QPR, CAMS, school staff, physicians, etc.)	Train people in suicide prevention training (ex. QPR, CAMS, school staff, physicians, etc.)	Number of people trained in suicide prevention	**Year 1:** Baseline: 7,000 Target- 13,000 **Year 2:** Target- 13,000 **Data Source:** DMH Training Logs, Kognito online system data **Description of Data:** Count of people who have completed training **Data issues/caveats that affect outcome measures:** None
	Early identification and intervention of substance use problems	Increase Mental Health First Aid (MHFA) training to an increased number of people on how to identify, understand and respond to signs and symptoms of mental health and substance use challenges	Increase the number of people completing MHFA Trainings	Number of people trained in Mental Health First Aid	**Year 1:** Baseline: 1,700 Target: 3,000 **Year 2:** Target: 3,000 **Data Source:** Prevention division database **Description of Data:** Prevention division staff maintain a database of all who have received the training. **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Early identification and intervention of substance use problems **(cont.)**	Increase the number of Business Sectors developing policies and practices to train managers/supervisors in MHFA so they can assist employees experiencing a mental health or substance use crisis in the workplace	Increase the number of Business Sectors developing policies and practices regarding training in MHFA	Number of Business Sectors who have developed policies and practices regarding training in MHFA	**Year 1:** Baseline: 0 Target: Increase by 4 **Year 2:** Target: Increase by 4 **Data Source:** ODMHSAS Database **Description of Data:** ODMHSAS Database **Data issues/caveats that affect outcome measures:** None
		Increase use of Screening, Brief Intervention and Referral to Treatment (SBIRT) in healthcare settings	Medical practice sites for screening, brief intervention and referral to treatment (SBIRT)	Increase number of medical practice sites that are using SBIRT	**Year 1:** Baseline: 20 Target- 40 additional medical practice sites **Year 2:** Target- 40 additional medical practice sites **Data Source:** ODMHSAS Access Control **Description of Data:** The screening tool/assessment is housed in Access Control. DSS collects and summarizes the data. **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce substance use	Increase faith-based partnerships to participate in prevention outreach efforts with Faith-based Prevention Services by increasing faith-based partnerships	Increase faith-based partnerships	Number of faith-based partnerships	**Year 1:** Baseline: 1 Target- 5 **Year 2:** Target- 5 **Data Source:** ODMHSAS database **Description of Data:** ODMHSAS database **Data issues/caveats that affect outcome measures:** **None**
		Increase the number of prevention practices implemented through contracted community/campus coalitions	Community level/campus strategies for substance abuse prevention	Number of substance abuse prevention practices implemented through contracted community/campus coalitions	**Year 1:** Baseline: 25 Target: additional 50% with a goal of 2,952 **Year 2:** Target- additional 50% with a goal of 2,952 **Data Source:** Oklahoma Prevention Reporting System (PRS) **Description of Data:** EBPs used in delivering community level/campus strategies are reported by subrecipients in the PRS and compiled by project evaluators. **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce substance use **(cont.)**	Increase number of school districts utilizing the Multi-Tiered Systems of Supports approach to preventing/ treating mental, emotional, and behavioral (MEB) problems among youth	School level strategies for prevention of MEB (mental, emotional and behavioral) problems.	Number of districts utilizing MTSS approach	**Year 1:** Baseline 28 Target- additional 4 school districts **Year 2:** Target: additional 4 school districts **Data Source:** ODMHSAS database **Description of Data:** ODMHSAS database **Data issues/caveats that affect outcome measures:** None
		Increase school-based primary and secondary substance use prevention services (Botvin LifeSkills Training, 3rd Millennium Classrooms, PAX Good Behavior Game, ASPIRE)	Botvin LifeSkills Training, AlcoholEdu, 3rd Millennium Classrooms , ASPIRE, PAX Good Behavior Games	Number of school sites utilizing Botvin LifeSkills Training, 3rd Millennium Classrooms, PAX Good Behavior Game, ASPIRE	**Year 1:** Baseline: 130 Target: additional 25% school sites **Year 2:** Target: additional 25% school sites **Data Source:** ODMHSAS database **Description of Data:** ODMHSAS database **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce underage drinking	Increase the number of Retailers and Servers accessing ODMHSAS Responsible Beverage Sales & Service (RBSS) on-demand educational training	Consistent and highly visible enforcement of state and local laws related to underage and high risk drinking	Number trained in Responsible Beverage Sales and Service training	**Year 1:** Baseline: 1,500 Target- 2,000 **Year 2:** Target- 2,000 **Data Source:** Prevention division database **Description of Data:** Prevention division staff maintain a database of all who have received the training. **Data issues/caveats that affect outcome measures:** None
	Reduce misuse of prescription drugs	Statewide education and dissemination of Do No Harm (DNH) Pain Management and Safe Opioid Prescribing Practices to medical professionals	Increase safe opioid prescribing and pain management practices	Number of medical professionals who receive the practices	**Year 1:** Baseline: 40 Target- 500 **Year 2:** Target- 500 **Data Source:** Prevention division database **Description of Data:** Prevention division staff track and maintain this information. **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce misuse of prescription drugs **(cont.)**	Establish/renew MOUs with law enforcement agencies to administer overdose reversal medication	Increase opioid overdose prevention training and access to Naloxone	Number of law enforcement agencies who have MOU's (new or renewed) to administer overdose reversal medication	**Year 1:** Baseline: 60 Target- 60 **Year 2:** Target- 60 **Data Source:** ODMHSAS logs **Description of Data:** Count of MOU's **Data issues/caveats that affect outcome measures**: None
		Establish harm reduction vending machines operating in high risk regions of the state		Number of harm reduction vending machines	**Year 1**: Baseline: 1 Target- 40 **Year 2**: Target- 40 **Data Source:** Placement records **Description of Data:** Records of placements of vending machines **Data issues/caveats that affect outcome measures:** None

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce misuse of prescription drugs **(cont.)**	Distribute overdose reversal medications, prioritizing locations by using Google search data	Increase opioid overdose prevention training and access to Naloxone (cont.)	Number of overdose reversal medications distributed	**Year 1:** Baseline: 22,000 Target- 40,000 **Year 2:** Target- 40,000 **Data Source:** Prevention division database **Description of Data:** Prevention division staff track and maintain this information. **Data issues/caveats that affect outcome measures**: Relies on submission of report back forms from law enforcement or members of the public getting refills
		Distribute 100,000 fentanyl test strips, prioritizing locations by using Google search data	Harm reduction strategy	Number of Fentanyl test strips distributed	**Year 1:** Baseline: 35,000 Target- 100,000 **Year 2:** Target- 100,000 **Data Source:** Prevention division database **Description of Data:** Prevention division staff track and maintain this information. **Data issues/caveats that affect outcome measures**: Relies on submission of report back forms from law enforcement or members of the public getting refills

Priority 5 Measures

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
5. Prevention of Mental Illness and Substance Use Disorders **(cont.)**	Reduce misuse of prescription drugs **(cont.)**	Decrease overdose deaths by distributing medication lockboxes	Harm reduction strategy **(cont.)**	Number of medication lockboxes distributed	**Year 1:** Baseline: 618 Target: 2,000 **Year 2:** Target- 2,000 **Data Source:** Oklahoma Prevention Reporting System (OPERS) **Description of Data:** Lockboxes used in delivering community level/campus strategies are reported by subrecipients in the PRS and compiled by project evaluators. **Data issues/caveats that affect outcome measures**: None
		Decrease overdose deaths by distributing medication disposal bags		Number of medication disposal bags distributed	**Year 1**: Baseline: 900 Target- 6,000 **Year 2**: Target- 6,000 **Data Source:** Oklahoma Prevention Reporting System (OPERS) **Description of Data:** Medication disposal bags used in delivering community level/campus strategies are reported by subrecipients in the PRS and compiled by project evaluators. **Data issues/caveats that affect outcome measures:** None

Priority 6 Measures

Priority Type: SUP, SUT, MHS, BHCS; Population: SMI, SED, BHCS, PWWDC, PWID, PP, EIS/HIV, Other

Priority Area	Goals	Objectives	Strategies	Performance Indicators	Targets
6. Public Awareness	Utilize social media to provide awareness around behavioral health issues such as stigma and access to care	Increase public reach of treatment and prevention information	Optimize OK I'm Ready substance use service offerings by creating an interactive map of treatment and pull analytics related to site traffic	Percentage of Oklahomans reached with the Harm Reduction Campaign	**Year 1:** Baseline: 0 Target- 5,500,000 impressions through all media channels **Year 2:** Target- 5,500,000 impressions though all media channels **Data Source:** ODMHSAS Prevention and Communications division **Description of Data:** Counters are used to record the number of hits. **Data issues/caveats that affect outcome measures:** User preference and available social media platforms are difficult to predict.
			Increase traffic to 988 so that all Oklahomans realize it's power to connect people to care	Percentage of Oklahomans reached with 988 and call data into the center	**Year 1:** Baseline: 0 Target- Maintain awareness campaigns and garner 4,500,000 impressions by reaching new groups across Oklahoma including: faith-based and minority groups **Year 2:** Target- Maintain awareness campaigns and garner 4,500,000 impressions by reaching new groups across Oklahoma including: faith-based and minority groups **Data Source:** ODMHSAS contract **Description of Data:** ODMHSAS contract **Data issues/caveats that affect outcome measures:** None

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$14,350,351.00		$18,261,054.00	$19,990,186.00	$65,328,913.00	$0.00	$0.00		$0.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$1,579,136.00			$226,108.00	$115,262.00					
b. Recovery Support Services	$410,600.00									
c. All Other	$12,360,615.00		$18,261,054.00	$19,764,078.00	$65,213,651.00					
2. Primary Prevention[d]	$3,826,760.00		$0.00	$8,217,223.00	$4,373,169.00	$0.00	$0.00		$0.00	$0.00
a. Substance Use Primary Prevention	$3,826,760.00			$8,217,223.00	$4,373,169.00					
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$956,690.00				$2,008,596.00					
12. Total	**$19,133,801.00**	**$0.00**	**$18,261,054.00**	**$28,207,409.00**	**$71,710,678.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$5,394,843.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$1,085,193.00								$1,227,933.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$8,681,547.00	$125,215,543.00	$21,128,703.00	$304,331,968.00					$9,823,466.00	
10. Crisis Services (5 percent set-aside)[f]		$542,597.00								$613,967.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$542,597.00								$613,967.00	
12. Total	**$0.00**	**$10,851,934.00**	**$125,215,543.00**	**$21,128,703.00**	**$304,331,968.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$12,279,333.00**	**$692,040.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

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

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2,421	234
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	106,773	18,815
4. Persons who inject drugs	44,219	6,956
5. Persons experiencing homelessness	3,754	4,929

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

We are unable to gather data on the aggregate number estimated in need and aggregate number in treatment for women with dependent children. This would be an area in which we would like technical assistance.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$13,939,751.00		$4,046,132.00
2 . Substance Use Primary Prevention	$3,826,760.00		$1,078,969.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$410,600.00		
6 . Administration (SSA Level Only)	$956,690.00		$269,742.00
7. Total	**$19,133,801.00**	**$0.00**	**$5,394,843.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	**IOM Target**	**FFY 2024**		
		SUPTRS BG Award	**COVID-19 Award[1]**	**ARP Award[2]**
1. Information Dissemination	Universal	$890,206		$165,475
	Selected			
	Indicated			
	Unspecified			
	Total	**$890,206**	**$0**	**$165,475**
2. Education	Universal	$323,713		$380,804
	Selected			
	Indicated			
	Unspecified			
	Total	**$323,713**	**$0**	**$380,804**
3. Alternatives	Universal	$19,423		$5,508
	Selected			
	Indicated			
	Unspecified			
	Total	**$19,423**	**$0**	**$5,508**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal	$890,259		$165,475

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$890,259**	**$0**	**$165,475**
6. Environmental	Universal	$1,356,460		$361,707
	Selected			
	Indicated			
	Unspecified			
	Total	**$1,356,460**	**$0**	**$361,707**
7. Section 1926 (Synar)-Tobacco	Universal	$130,000		$0
	Selected			
	Indicated			
	Unspecified			
	Total	**$130,000**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$3,610,061**	**$0**	**$1,078,969**
Total SUPTRS BG Award[3]		**$19,133,801**	**$0**	**$5,394,843**
Planned Primary Prevention Percentage		**18.87 %**		**20.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Prevention total is $3,826,760.00. However, after subtracting the $216,699.00 allocated on Table 6 for Prevention, the total is now $3,610,061.00

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct			
Universal Indirect			
Selected			
Indicated			
Column Total	**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]	**$19,133,801**	**$0**	**$5,394,843**
Planned Primary Prevention Percentage	**0.00 %**		**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Not applicable. Completed in Table 5a.

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☐	☐
Tobacco	☑	☐	☐
Marijuana	☑	☐	☐
Prescription Drugs	☑	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☑	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☑	☐	☐
Military Families	☑	☐	☐
LGBTQI+	☑	☐	☐
American Indians/Alaska Natives	☑	☐	☐
African American	☑	☐	☐
Hispanic	☑	☐	☐
Persons Experiencing Homelessness	☑	☐	☐
Native Hawaiian/Other Pacific Islanders	☑	☐	☐
Asian	☑	☐	☐
Rural	☑	☐	☐

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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Footnotes:

Fentanyl is being addressed through Oklahoma's SOR grant.

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation					
7. Training and Education			$416,600.00		$25,000.00
8. Total	**$0.00**	**$0.00**	**$416,600.00**	**$0.00**	**$25,000.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

A, J: The ODMHSAS is now a statewide CCBHC state. Oklahoma has 3 Demonstration CCBHCs, with the remaining 10 CCBHCs operating under a CMS approved State Plan Amendment. Per established SAMHSA criteria, CCBHCs must complete a needs assessment at implementation and every 3 years after. The needs assessment helps to identify barriers such as transportation, income and hours of operation. A needs assessment also provides information on linguistic needs, resources, staffing needs, etc. CCBHCs are required to provide accessible and available resources including the following; service times and settings that are convenient to the community, services where the recipient lives, prompt intake and engagement of services, access to adequate crisis services and services available in the community and via telehealth where applicable.

B) In 2018 ODMHSAS applied for and was awarded the Quality Improvement Center for Collaborative Community Court Teams (QIC -CCCT) initiative in an effort to improve outcomes for substance using pregnant and postnatal women and their newborns. This initiative provided the platform for intentional strategic education and training around the importance of treating women prenatally and post-natally using plans of safe care. While this grant opportunity ended in April of 2021, it provided the foundation and opportunity to receive additional support to expand services to pregnant and parenting women with a SUD. In March of 2020, the ODMHSAS and partner agencies applied for and received In Depth Technical Assistance (IDTA) from the National Center for Substance Abuse and Child Welfare (NCSACW) and the Center for Children and Family Futures (CCFF) to continue the goals and initiatives identified in the QIC-CCCT project. From this work, Safely Advocating for Families Engaged in Recovery (SAFER) was born. SAFER is a statewide effort involving multiple state and local agencies and initiatives addressing the continuum of care for women who are pregnant or parenting, or are wanting to become pregnant and have a substance use, mental health, or co-occurring disorder. SAFER aims to expand timely access and provide a holistic approach to family centered treatment through policies, practices, and processes intended to improve parent-child interactions, child and parent well-being, and reduce potential adverse childhood experiences (ACEs) along with the likelihood of, or ongoing involvement with, child welfare and/or legal systems.
ODMHSAS recently launched the Tough as a Mother campaign, which was modeled after Colorado's Tough as a Mother campaign. This campaign is targeted towards mothers who live with substance use disorders. The stigma associated with pregnant and parenting persons with a substance use disorder, along with potential legal and societal consequences, has resulted in this population being difficult to reach and oftentimes reluctant to seek treatment or engage in prenatal care. The purpose of this campaign is to reach this population, destigmatize their substance use issues, and provide a connection to treatment providers. For more information on this campaign, please click on this link: Tough As A Mother - Oklahoma Resources (okimready.org)

C) Oklahoma contracts with four residential programs to provide services for women with dependent children (WWC) and two WWC halfway house treatment programs. All four residential programs participate in the Oklahoma Pregnant and Post Partum Women grant funded by SAMHSA. This is a five year grant opportunity that seeks to enhance residential women's treatment services through utilizing evident based practices that improve parenting, attachment, and a family focused approach to treatment. One of the halfway houses 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.
Additionally, pregnant women that are located in the following counties: Creek, Cherokee, Tulsa, Okmulgee, Wagoner, Muskogee, Rogers, Washington, Kay and Osage, are able to participate in the Oklahoma Families First Project. This is a three year SAMHSA funded grant that seeks to enhance outpatient services for pregnant women and their families. The grant focuses on a family treatment approach to improve services, parenting, and attachment, expanding case management and resources and providing a system change in the treatment of pregnant or postpartum women and their children.
All 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.

D) Persons who inject drugs are served by all contracted ODMHSAS substance use disorder service providers, CCBHCs and state operated facilities. As a priority status population, clients involved with IDU (Injection Drug Use) 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. Outreach staff visit 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.

E) CCBHCs and 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.

F) The ODMHSAS provides programs and services that address diversion at each step of the Sequential Intercept Model. Crisis Intervention Training (CIT) is provided to CLEET-commissioned law enforcement officers throughout the state through partnership with multiple law enforcement agencies. Through legislative appropriations, the ODMHSAS made iPads available to all law enforcement officers in the state. These iPads serve as telehealth connections to the network of local CCBHCs. These connections provide remote consultations and evaluations to support diversion from the criminal justice response into behavioral health services. Additionally, the ODMHSAS has implemented a pre-sentence criminogenic risk and needs assessment program to provide courts, prosecutors, and defense counsel with information about evidence-based diversion sentencing recommendations that best meet the defendants' individualized needs and are most likely to lead to decreased recidivism and improved quality of life. With over 66,510 felony defendants screened to date, this program has resulted in fewer jail days between arrest and case disposition. Recently, eligibility for these screenings has been expanded to individuals facing misdemeanor charges. Oklahoma continues to have strong drug, DUI, mental health, and Veterans treatment courts that follow the latest best practice standards published by All Rise (formerly the National Drug Court Institute). All Oklahoma treatment courts demonstrate tremendous success through outcomes such as a reduction in recidivism, an increase in employment and education, a decrease in arrests and jail days, and an increase in child custody. The success of these programs has led to the development of additional court-based diversion opportunities including early/ misdemeanor diversion and pretrial services. Lastly, through collaboration with the Department of Corrections, the ODMHSAS has prison-embedded reentry staff (discharge managers) supporting the treatment reentry needs of individuals being discharged from prison who have behavioral health treatment needs.

G) The ODMHSAS supports a state-level prevention “Ok, I’m Ready” campaign which serves as a resource for print and electronic materials (OK I'm Ready | Substance Use and Drug Addiction Resources (okimready.org). This site offers information on substance use disorder treatment, prevention, education and support and people can also order packages containing Narcan and/or Fentanyl test strips. In July, ODMHSAS partnered with the Tulsa Day Center to place a harm reduction vending machine at the Tulsa Day Center. This machine dispenses Naloxone and Fentanyl test strips for free. These vending machines, placed in high need areas, allow any citizen 24/7 access to free Narcan and Fentanyl test strips. With 8 machines ready for placement and 34 additional units on the way, Oklahoma’s vending machine project will be the largest of its kind in the country.
With regards to suicide, the ODMHSAS has created a statewide, 24/7 crisis response network that includes 988 call centers and community-integrated adult and child mobile crisis teams. The ODMHSAS funds thirteen adult Community Based Structured Crisis Centers (CBSCCs) across the state of Oklahoma and four other adult crisis centers are in the process of opening. The ODMHSAS funds twenty adult urgent care centers across Oklahoma. Additionally, ODMHSAS passed new CCBHC state rules which required the establishment of 24/7 outpatient or urgent recovery center in all counties within a catchment area with a population of 20,000, and each adjacent county for every county under the 20,000 population threshold, within three years or initial CCBHC certification of by July 1, 2024 whichever is later. Additionally, the ODMHSAS has worked to expand access to telehealth services in the crisis continuum with a special emphasis on providing telehealth devices to all law enforcement officers which have a direct connection with local community based providers. These law enforcement devices provided real time, telehealth service connections to provide mental health consultations, assessments, and debriefing opportunities for officers themselves and the citizens with which they interact. Lastly, through legislation passed during the previous state legislative sessions, the ODMHSAS established a network of transportation vendors throughout the state to provide mental health transports, in lieu of law enforcement, for some individuals in need of higher levels of care. There are three children's crisis centers, with three more opening in January 2024. There are four child and adolescent recovery centers that are open, with five more opening in January 2024.
A suicide prevention protocol is in 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. Collaborative Assessment and Management of Suicidality (CAMS) is performed in all 77 counties, ensuring that consumers receive appropriate treatment and decreasing suicidality. At this present time, we have trained 2102 clinicians in CAMS. ODMHSAS has also increased training for Colleges and Universities and consultations to provide treatment for their more specific demographic groups of student population in their college counseling programs for treatment of suicidal and substance abuse issues.

H) The substance use disorder (SUD) treatment and recovery services funded through the ODMHSAS service system are provided at 53 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. CCBHCs are also able to render substance use disorder treatment services. 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.

I) The CCBHC network and the coordinated OKSOC (Oklahoma Systems of Care) 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. CCBHCs 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. Currently, there are 80 Systems of Care communities covering 74 counties. Other communities are in the formative stages of Systems of Care development.
With regards to SUD, 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. Oklahoma offers support statewide to parents through the Parents Helping Parents program. The program provides parents with the ability to connect to resources and provide peer support to families. Oklahoma has also developed a partnership between the ODMHSAS and The Oklahoma Office of Juvenile Affairs. The partnership includes a field service coordinator position that assists in connecting youth held in custody at the Central Oklahoma Juvenile Center with housing, family engagement, mental health, and substance use services.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

ODMHSAS works closely with OHCA on behavioral health Medicaid policy, including policies for managed care implementation anticipated in April 2024. ODMHSAS has and will continue to work with OHCA to ensure managed care entities will implement their Medicaid plans in accordance with mental health parity laws, as well as state-specific requirements for managed care entities that ensure timely and appropriate access to behavioral health benefits in the Medicaid program.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

A-C: CCBHCs are required to offer a full array of services to treat and support the population served. Oklahoma CCHBCs have built upon the foundation of Health Homes to promote enhanced integration and coordination of behavioral health, primary care, acute care, and long-term services and supports for individuals across the lifespan with chronic illness. Care is delivered using an integrated interdisciplinary team that addresses mental health needs, substance use disorder treatment and physical health needs. It is the CCBHCs responsibility, as the primary provider of care to ensure all needs of the consumer are being addressed in a coordinated fashion. Examples of care coordination activities that relate to primary care include; ensuring every enrollee is aligned with a PCP through which care is coordinated, partnerships or formal agreements with treating providers, ongoing communication and collaboration with treating PCPs, reviewing HIE and population health management platforms, monitoring physical healthcare follow-up activities, development of clinical care pathways for common medical conditions and participating in transitional care. CCBHCs are required to maintain formal relationships with the following Primary Care related care settings; Federally Qualified Health Centers (FQHCS), inpatient psychiatric facilities, Veteran's Affairs, inpatient acute care hospitals, hospital outpatient clinics, Health Management Programs (HMP) and Health Access Networks (HAN).

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

A-C:

Care Coordination activities are the foundation of the CCBHC model. CCBHC care coordination facilitates transitions in and out of CCBHC care and facilitates integrated care by intentionally organizing client care needs and services across all appropriate care settings. Care coordination is a required component of the CCBHC model and is funding through the Prospective Payment System (PPS) of CCBHC.

Oklahoma CCBHC have enhanced care coordination for the Most In Need (MIN) population, which includes individuals with high number of elevated level of care episodes. A state level Care Coordination Team (CCT) has been implemented to add another layer of coordination of care. The CCT receives daily data alerts when MIN individuals receive an elevated level of care. CCT then informs both elevated level of care provider and outpatient CCBHC, coordinates warm handoff, facilitates staffing if needed, monitors discharge and monitors outpatient services after discharge.

CCBHCs are required to maintain formal relationships with the following care settings for care coordination purposes: • Federally Qualified Health Centers and/or Rural Health Clinics; • Inpatient psychiatric facilities, substance use outpatient and residential programs; • Other community supports such as: • Schools, child welfare, • Juvenile and criminal justice systems and facilities, • Indian Health Services, • Child placing agencies/therapeutic foster care services, and • Other social and human services; • Veteran's Affairs • Inpatient acute care hospitals and hospital outpatient clinics; • Health Management Programs (HMP) and Health Access Networks (HAN).

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Required primary care screening and monitoring of key health indications and health risks are as follows; adult body mass index screening and follow up, weight assessment for children and adolescents, weight assessment and nutrition and physical activity for children and adolescents, blood pressure, tobacco use/screening and cessation intervention, screening for clinical depression and follow up plan, unhealthy alcohol use, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, diabetes care for people with serious mental illness, metabolic monitoring for children and adolescents on antipsychotics, cardiovascular health screening for people with diabetes, adherence to mood stabilizers for individuals with bipolar disorder, adherence to antipsychotic medications for individuals with schizophrenia and antidepressant medication management. The CCBHC will ensure children receive age-appropriate screening and preventative interventions .

The CCBHC directly provides person-centered and family driven care planning. The individualized care plan must integrate behavioral health, medical and prevention needs.

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

None needed.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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[5]. 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[6]. 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, LGBTQI+ 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.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 — Yes / No

b) Ethnicity — Yes / No

c) Gender — Yes / No

d) Sexual orientation — Yes / No

e) Gender identity — Yes / No

f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes / No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? — Yes / No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? — Yes / No

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

The ODMHSAS was one of the original eight states participating in the SAMHSA Certified Community Behavioral Health Center Demonstration Project (CCBHC) with three facilities receiving certification as CCBHCs. In 2019, Oklahoma received a State Plan Amendment allowing it to additional facilities. As of July1, 2022, all 13 CMHCs have been certified as CCBHCs. Part of the certification process requires each CCBHC to conduct an extensive needs assessment to determine gaps in services, underserved populations, and other disparities occurring in the service delivery system. Surveys are conducted with persons with lived experience, family members, community partners, and facility staff to determine underserved population and gaps in services. County-level census data was heavily employed to compare the general population's demographics to persons currently served and also to the staff. Examples of demographic and cultural variables include race, ethnicity, language, disability, and military status. Multiple tables were produced to display data by agency locations so weaknesses at the site or agency level could be addressed. In addition, a staff survey was administered by the ODMHSAS to determine distribution of sexual orientation, disability, lived experience/family member, race, age, gender, languages spoken, length in the MH system and at agency, license/certificate/credential held, EBPs trained in, and primary age group of clients seen. Agencies also conducted "walk-throughs" to access handicap accessibility, and culturally inclusive signage, paperwork, and artwork. These needs assessments are completed every three years by each CCBHC. In addition, all of the CCBHCs have received CCBHC expansion grants requiring them to conduct health disparity statements.

Please indicate areas of technical assistance needed related to this section

None needed.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ÷ Cost, (**V = 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. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] 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)**[8] 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. Each 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, 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 Certified Community Behavioral Health Center (CCBHC) 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 CCBHCs based on the data outcomes of these twelve measures. The outcomes are based on how close to the benchmarks each CCBHC comes for each of the 12 measures, with the goal to improve consumer outcomes.

In addition, ODMHSAS initiated a value-based payment for Residential SUD providers and SUD Outpatient providers. Together, ODMHSAS and the providers determined the measures. Additional payments are made to the SUD providers on the data outcomes of the measures, with the goal to improve consumer outcomes throughout the service provider network.

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

None needed.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Raise Navigate	2
eSMI Outreach	14

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
1085193	1085193

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Ra1se Navigate is billed cost reimbursement - based on a budget. eSMI is billed both Fee For Service (OCCIC) and fixed 1/12 monthly amount (CCBHCs). Related to Medicaid, on the Fee For Service contracts, if the client has Medicaid then Medicaid pays. If the client does not have Medicaid or the service is not covered by Medicaid and it's a service we have approval for, then DMH pays.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

RA1SE NAVIGATE is a Coordinated Specialty Care model that is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family, as active participants. This comprehensive early treatment model is focused on helping young people aged 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, Individual Placement and Support staff (who assist with employment/education and housing), and a Psychiatrist. A Case Manager and Peer Recovery Support Specialist are recommended but not required by the model. However, because the Raise Navigate teams are located at Certified Community Behavioral Health Clinics (CCBHCs), Raise Navigate have access to PRSSs, case managers and all of the other services that the CCBHC has to offer.

EBP: RA1SE NAVIGATE
• Family and Children's Services is a Certified Community Behavioral Health Clinic (CCBHC) 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 RA1SE NAVIGATE Early Treatment Program.

• Red Rock Behavioral Health is also a CCBHC with a full array of services available. Red Rock is one of three CCBHCs in Oklahoma County. This agency services the entire county and has the resources to provide and support this EBP.

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

EBP: Cognitive Behavioral Therapy (CBT) and Recovery Oriented Cognitive Therapy (CT-R)- currently in the process of implementation at all 13 CCBHC's.

Statewide, eSMI outreach programs are provided through 14 CCBHC service areas to develop and maintain collaborative relationships with local higher education institutions and local hospitals to connect with the age range that is most at risk for eSMI. This outreach allows for intervention at the earliest juncture (prior to significant consequences such as homelessness, multiple hospitalizations, etc.) The outreach staff develop relationships with personnel located at these facilities and these maintained connections result in rapid referrals as well as the outreach staff being available for any trainings or technical assistance, associated with eSMI, that the facilities may need.

5. Does the state monitor fidelity of the chosen EBP(s)?
(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?
(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Each Navigate program has Individual Placement and Support which assists with education/employment and housing. Every Navigate client has access to the state wide Youth Subsidy housing program that provides rental assistance and utility assistance for up to 12 months. In addition to the Navigate program itself, because the program is located within a CCBHC, the individual has access to all of the other services that the CCBHC offers, including PRSSs, CMs, crisis services, wellness services, medication clinic services. CCBHC's also are responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Required primary care screening and monitoring of key health indications and health risks, for this population, include: adult body mass index screening and follow up, blood pressure, tobacco use/screening and cessation intervention, screening for clinical depression and follow up plan, unhealthy alcohol use, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, diabetes care for people with serious mental illness, metabolic monitoring adolescents on antipsychotics, cardiovascular health screening for people with diabetes, adherence to mood stabilizers for individuals with bipolar disorder, adherence to antipsychotic medications for individuals with schizophrenia and antidepressant medication management.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

ODMHSAS recently received the CHRP grant which will allow work to be done at two colleges, OU in Cleveland County and Carl Albert

State College in LeFlore County. Staff personnel will be trained on how to identify the risks of early psychosis, including the presence of hallucinations, delusions, disorganized speech/behavior and on how to refer these students for screening. Students will then be offered services and supports appropriate to their screening results. Those students with positive screenings will be referred for further assessment of psychosis risk and again offered services and supports appropriate to their assessment results. Those students assessed as at risk of psychosis will be offered Raise Navigate services and CBTp (Cognitive Behavioral Therapy for Psychosis).

Continued work will be done at the current Raise Navigate sites. Continued work will also be done with those sites conducting eSMI outreach. A focus will be on developing relationships with colleges and vo-techs, as there are already relationships with many hospitals. A recorded webinar on Psychosis 101 is in the planning stages. Once the webinar is developed, this will educate any clinicians in the state, working with individuals experiencing eSMI or FEP. Because it will be recorded, it will be able to be viewed at any time.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Our two NAVIGATE programs are serving those aged 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 aged 16-30 who are newly diagnosed with a mental illness and meet criteria for Serious Mental Illness.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

1,990

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Continued outreach will be done with colleges, vo-techs and hospitals. In addition to this, ODMHSAS also has a Healthy Transitions Grant and, through this, has established a streamlined referral process and services for colleges in their counties that this grant is serviced through. CCBHC's perform outreach with the homeless population, going into homeless shelters and drop-in centers, to assist with services and referrals to treatment.

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

None needed.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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

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

N/A.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The state has policy in place that requires service providers to actively engage consumers, and their caregivers when applicable, in the development and update of their plan of service. The ODMHSAS offers training to assist service providers with successful engagement and communication.

4. Describe the person-centered planning process in your state.

Person centered and strengths based service planning are required in all state funded and certified programs. 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). The format of this training is web-based which ensures that it can be taken at any time, by clinicians anywhere. Because of this, newly hired clinicians do not need to wait on a live training in order to take this and begin utilizing the person centered approach with their consumers. This training is available state-wide to all clinicians and the agencies are encouraged to use it as orientation as well as a refresher, as needed. 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.

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. 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.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

CCBHC's are required to develop a crisis plan with each consumer, such as a Psychiatric Advanced Directive or a Wellness Recovery Action Plan. This requirement is also a requirement for certification for operation as a CCBHC. Training has been done with treatment providers to furnish them information so that they can implement this process.

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

None needed.

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6. Program Integrity - Required

Narrative Question

SAMHSA has 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:

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 Senior Director of Behavioral Health Policy and Planning. This function monitors contract compliance and performance for provisions related to SABG and MHBG funded treatment services.

Please indicate areas of technical assistance needed related to this section

None needed.

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] 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.

[56] **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 Services has a bi-annual Tribal Consultation. Throughout this process, ODMHSAS will send out official letters to all the Federally Recognized Tribal Nations in Oklahoma, email those invitations, and call to follow-up with delivery and attendance. The Tribal Consultation is our bi-yearly annual meeting between ODMHSAS Commissioner and Leadership meeting with Oklahoma Tribal Nation Elected Officials and appointed designees. The ODMHSAS Tribal & Multicultural Liaison noticed that a bi-yearly meeting was not going to meet the need of collaborating effectively with Oklahoma Tribal Nations and Tribal Behavioral Health staff. ODMHSAS Tribal & Multicultural Liaison initiated a monthly ODMHSAS Tribal Behavioral Health meeting that has ODMHSAS Contracted Providers, Oklahoma Tribal Nations Behavioral Health staff and community partners attend. At the monthly ODMHSAS Tribal Behavioral Health meeting there is a ODMHSAS presentation from a division or team and a Tribal Behavioral Health presentation. From this meeting there has been many relationships formed and it has promoted synergy of the different systems.

2. What specific concerns were raised during the consultation session(s) noted above?

- Information about 988 Oklahoma and how it impacts Tribal Nation and Tribal Citizens/ Members
- Oklahoma Health Information Exchange
- Crisis Intervention Team Training- Caddo County
- Mental Health Awareness of Tribal Communities
- Explore ways that the state and tribal nations can partner.

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

ODMHSAS Tribal & Multicultural Liaison has visited the majority of Oklahoma Tribal Nations in their community to learn about their behavioral health programs. This includes Tribal Opioid Response, Tribal 988 Collaborative, Circles of Care and has explored ways to support and collaborate with each other. Through this process there has been gains made to help understand the gaps

that may exist from one system to another and making sure we are creating warm handoffs.

ODMHSAS and 988 Call Center Vender (Solari) have worked with Oklahoma Tribal Nations to establish a referral process from call-center to Tribal Behavioral Health Services through referral process. There was a 988 Questionnaire that was developed by ODMHSAS and Solari to help understand the referral process for Tribal Nations.

The Oklahoma Department of Mental Health and Substance Abuse Services implemented a monthly ODMHSAS Tribal Behavioral Health Meeting. Through this meeting there is an ability to meet and have a constant exchange of information. There is always a feature of ODMHSAS Team presentation and a Tribal Nation presentation. Through the meeting we have created and tailored messaging for 988 Tribal Collaboration. We also helped to provide data and letters of commitment for the Oklahoma Tribal Entities in Oklahoma.

There has been a monthly call established between Oklahoma Tribal 988 Grantees and ODMHSAS. Even Tribal Nations that did not apply for the grant have been welcomed to join. The Tribal Nations are leading this group and have developed a workgroup that is focused on cultural competency training and featuring the uniqueness' of the Oklahoma Tribal Nations.

This past year there has been targeted 988 messaging for Tribal Communities that include billboards, posters, cards, and 988 materials. All that material was shared with Tribal Nations for events and their communities. There have been 9 more messages developed with Oklahoma Tribal Nations to target their communities and we are incorporating Tribal Language as well.

ODMHSAS has helped to get Tribal Behavioral Programs connected to local media to promote and feature their upcoming events. Also included having open editorials for newspapers to help raise awareness of 988 in their local communities.

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

None needed.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

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)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [x] Other (please list)

Capacity Assessment, Community Readiness Survey, Coalition Readiness Assessment, Organizational Capacity Assessment.

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [x] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [x] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) ☑ Archival indicators (Please list)

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

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

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

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

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

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

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

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

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☑ Communities that Care

g) ☑ State - developed survey instrument

h) ☑ Others (please list)

Prescription Drug Monitoring Program data

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

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

The Oklahoma Evidence Based Practices Workgroup was established in 2011 and actively supports subrecipients' implementation of the SPF for the SUPTRS BG priorities. The Workgroup includes academic researchers, prevention professionals, tribal government representatives, prevention evaluators, and key state agency representatives. The EBP Workgroup conducts reviews of subrecipient workplans, develops evidence-based intervention matrices and guidance documents, and advises subrecipients in selection, adaptions, and fidelity issues. Plans to sustain the EBP Workgroup include a review of existing evidence-based matrices on prescription drug abuse prevention interventions, intervention cost/benefit evaluation, expanded application to other prevention fields, and ongoing membership evaluation and recruitment.
*Please find attached the EB Criteria Scoring Tool

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Demographic data will be collected on a regular basis to monitor the impact of the strategies on sub-populations. Ongoing, periodic assessments of the grant state staff and sub-recipients' activities will be conducted to ensure CLAS-related activities are being conducted appropriately. The results of ongoing assessment and monitoring processes will be communicated in regular intervals to grant staff, sub-recipients, and partners.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Oklahoma integrates sustainability into the needs assessment step by sharing data and making recommendations

through the State/Tribal Epidemiological Outcomes Workgroup; creating tools for subrecipients to track and monitor data; and working to establish systems for updating and disseminating data on a regular basis.

b) If no, please explain in the box below.

Narratve Question

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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.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) 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 SUPTRS BG 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 primary prevention workforce? (●) Yes ( ) No

a) 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 which can be found here (https://odmhsas.docebosaas.com/learn/signin); 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 SUPTRS BG is intentionally aligned with the SPF and shares an infrastructure with Oklahoma's SPF PFS initiative. Oklahoma will continue to work collaboratively with the PTTC system on additional training needs through regular capacity planning. Capacity planning and TTA development is conducted in partnership with the Cherokee Nation and Southern Plains Tribal Health Board (SPTHB) and made available to the full prevention workforce, including Drug Free Communities grantees.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) 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.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The ODMHSAS project staff will advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocating resources and ensure sub-recipients receive guidance and training on CLAS implementation strategies. The ODMHSAS will conduct ongoing assessments of the organizations' CLAS-related activities and integrate CLAS-related criteria into measurement and continuous quality improvement activities. Work plans and progress will be reviewed during contract monitoring, project meetings and site visits, providing an opportunity to discuss health equity success/challenges and linguistically appropriate services. The percentage of culturally sensitive protocols implemented, and the percentage of staff trained in these protocols, of all protocols implemented and staff trained will be monitored to measure the impact of this enhanced CLAS standard. Sub-populations experiencing behavioral health disparities are encouraged and will be encouraged to participate on community coalitions.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Yes, the ODMHSAS focuses on sub-recipients developing their own community level sustainability plans. The ODMHSAS does provide sustainability and capacity building training to prevention service providers that addresses ways of increasing coalition and community member knowledge and skill sets through them utilizing community presentations and trainings and tracking them. The ODMHSAS utilizes and encourages communities to utilize an organizational readiness tool consistently to understand workforce needs and deliver trainings as needed to the workforce i.e., coalitions and community members as needed to expand the prevention efforts and programs.

b) If no, please explain in the box below.

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary 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.

The ODMHSAS Prevention Strategic Plan was developed in 2021. It is attached.

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

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [ ] Timelines
- **c)** [ ] Roles and responsibilities
- **d)** [ ] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [x] Sustainability component
- **h)** [x] Other (please list):

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

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG 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 SUPTRS BG primary prevention funds? (●) Yes ( ) No

- **a)** 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 SUPTRS BG priorities. The Workgroup includes academic researchers, prevention professionals, tribal

government representatives, prevention evaluators, and key state agency representatives. The EBP Workgroup conducts reviews of subrecipient workplans, develops evidence-based intervention matrices and guidance documents, and advises subrecipients in selection, adaptions, and fidelity issues. Plans to sustain the EBP Workgroup include a review of existing evidence-based matrices on prescription drug abuse prevention interventions, intervention cost/benefit evaluation, expanded application to other prevention fields, and ongoing membership evaluation and recruitment.
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8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The low population density, high poverty rates, and multi-linguistic characteristic of Oklahoma reflect geographical and cultural barriers that can affect the implementation of services. Project materials, products, and strategies, including evidence-based practices, will be produced, and reviewed with the culture, languages, health literacy, and values of the focus populations in mind. Oklahoma's prevention and treatment systems actively attempt to serve all populations equitably and in culturally relevant and responsive ways. Oklahoma plans to implement culturally appropriate policies, media campaigns, and practices through partnerships between agencies and local community members. The percentage of translated materials and available interpreters of all materials utilized and created will be monitored to measure impact of this enhanced CLAS standard. This will occur in the Planning Phase.

b) If no, please explain in the box below.

N/A.

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Yes, the ODMHSAS focuses on sub-recipients developing their own community level sustainability plans. The ODMHSAS does provide sustainability and planning training to prevention service providers that addresses ways they can capture findings from their community-based work. Reviewing the program and what was successful what was challenging. Considering what programmatic adaptations are necessary moving forward to successfully implement the program.

b) If no, please explain in the box below.

N/A.

Narratve Question

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Implementation

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

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

  Funded Oklahoma Faith Network

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

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

b) Education:

The ODMHSAS and its prevention contractors are the single largest deliverer of substance abuse prevention education in the State. At the state level, the ODMHSAS offers training in public health competencies (SPF), prevention ethics,

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

c) Alternatives:

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

d) Problem Identification and Referral:

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

e) Community-Based Processes:

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

f) Environmental:

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

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

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

The ODMHSAS carefully plans and coordinates allocation of resources from the SUPTRS BG, 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 SUPTRS BG primary prevention funds.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Community coalitions work to ensure that the disparate population are represented on coalitions and are key partners in implementing interventions. They also work to ensure environmental interventions and materials are culturally and

linguistically appropriate for their disparate populations. Available data related to the number of their disparate population reached by specific interventions are reported monthly in a prevention reporting system. The reporting system also collects information on considerations or actions taken to ensure cultural competency when implementing strategies and challenges/barriers to implementing these interventions and how to overcome them. Work plans and progress are reviewed during contract monitoring and TA calls, providing an opportunity to discuss health equity success/challenges and linguistically appropriate services.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Yes, the ODMHSAS focuses on sub-recipients developing their own community level sustainability plans. The ODMHSAS does provide sustainability and implementation training to prevention service providers that addresses ways to review fidelity for each strategy implemented and document any adaptions.

b) If no, please explain in the box below

Narratve Question

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The SUPTRS BG 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 Processes*** 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 primary 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.

The updated Oklahoma Prevention Evaluation Plan is attached.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use

c) ☑ Binge use

d) ☑ Perception of harm

e) ☑ Disapproval of use

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

g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The primary way CLAS standards are integrated into our evaluation is by collecting demographic data through subrecipients monthly. This allows us to identify trends across demographics, which in turn allows ODMHSAS and subrecipients to identify needs and target resources to ensure we are targeting prevention efforts to those who are at highest risk. Additionally, we plan to administer the next round of the Oklahoma Prevention Needs Assessment (OPNA) in both English and Spanish in order to better meet the language needs of our population.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Sustainability is an important part of everything we do at the ODMHSAS. We will sustain efforts by investing in our prevention network by building ownership and identifying program Champions we do this through training and technical assistance we provide to subrecipients. This allows them to continue evaluating their efforts and using their evaluation to make decisions about programs and interventions. The ODMHSAS will continue to share data and findings to secure more funding for prevention initiatives. The ODMHSAS is developing evaluation guides for commonly used interventions so the subrecipients have resources to work from with or without our support.

b) If no, please explain in the box below.

Footnotes:

Three attachments are uploaded: (1) Oklahoma EB (Evidence Based) Criteria Scoring Tool (for question 5a), ODMHSAS Prevention Strategic Plan and Oklahoma Prevention Evaluation Plan.

Oklahoma Evidence-Based Practices Workgroup

Criteria for Rating Level of Evidence

Intervention based upon a theory of change that is documented in a clear logic model or conceptual model:

Contents:

1. Process of implementation
2. State short and long term outcomes
3. Who is responsible for measuring the objectives / completing program components.
4. Identification of the specific behavior targeted
5. Identification of specific populations (separate model for each)
6. Identification of intervening variables
7. Identification of the type of strategy
8. Inclusion of timeline of project activity

Quality of contents:

1. Use of SMART format
2. Best fit of strategies identified with goals / objectives / population, etc. Will the proposed program yield the listed short and long term outcomes? Are the proposed activities an appropriate match with the population served?
3. Feasibility of proposed project components (staffing, timeline, resources – from grantee or in-kind or match)
4. Linkage of proposed plan with needs assessment data – rationale of the strategies selected. Do these strategies link with the population / priorities selected?

Strategies are similar in content and structure: (program fidelity component of our program review)

1. Need to use consistent language throughout our guidance.
2. List separately the similarities and differences between proposed programs and programs on registries / journals. (implementation checklist)
3. Provide justification for any differences between registry / literature and program proposal.
4. To what extent will these differences impact the proposed outcomes? (see 6 and 7)
5. Ensure acceptable deviation in program design or delivery
6. **We need to identify various dimensions** of program differences in terms of their level of impact (intricate workings of a program vs. generalizability to populations and settings).
7. Is there documentation in the literature of similar program adjustment?

Strategy is supported by documentation of credible results from past use.

1. Results from the applicant in its own use of the proposed strategy
2. Results from an outside organization in its use of the proposed strategy
3. These results were obtained by a third party evaluator
4. These results were obtained by internal evaluators
5. Submission of evaluation tools and protocols from these evaluations
6. Submission of evaluation results
7. Look at Service to Science tools
8. Proprietary evaluation materials?

Strategy is reviewed and deemed appropriate by the EBP workgroup: **This is our decision point.**

1. Baseline data and follow-up (post intervention data) submitted
    a. The data is representative of who was intended to receive the intervention
    b. Data collection and methodologies
    c. CSAP Service to Science Tools
2. Was the selected intervention the best fit?
3. Is there a written justification as to why the selected strategy will produce the intended results?

Scoring Tool / Document 70 Points Required for Criteria to be Met

Criteria 1 – Proposed strategy appears on a national registry of evidence based practices:

1.1 – Strategy appears on a registry? If no, proceed to criteria #2 ***(Yes / No)***

1.2 – Are there additional studies cited in support of this intervention approach? If no, proceed to criteria #2 ***(Yes / No) or 25 Points***

1.3 – Do these citations include a synopsis that justifies the use of this strategy? If no, proceed to criteria #2 ***(Yes / No) or 25 Points***

1.4 – Proposed implementation falls within acceptable deviation from original implementation design (provider supplies a justification for all strategy deviations)? If no, proceed to criteria #2 ***(Yes / No) or 25 Points***

1.5 – Proposed strategy meets the "best fit" criteria? ***100 or 25 Points***

Criteria 2 – Proposed strategy appears in a peer-reviewed publication with positive effects.

2.1 – Strategy appears in peer-reviewed publications? If no, proceed to criteria #3

- Applicant has submitted a summary / justification of the publications selected ***10 Points***
- Applicant has included a copy of all publications cited. ***10 Points***
- Applicant has included an implementation description ***10 Points***

2.2 – Proposed implementation falls within acceptable deviation from original implementation design (provider supplies a justification for all strategy deviations)? If no, proceed to criteria #3 ***40 Points***

2.3 – Proposed strategy meets the "good fit" criteria? ***30 Points***

Criteria 3 – Documented effectiveness supported by other sources of information and the consensus judgment of informed experts. (must supply guideline #1 and at minimum and one of the following: Guidelines 2, 3)

3.1 - Intervention is based upon a theory of change that is documented in a clear logic model or conceptual model:

3.1.1 – Identification of a specific theory ***(Yes / No)***

3.1.2 – Inclusion of a Logic / Conceptual Model ***(Yes/No)***

3.2 - Strategies are similar in content and structure to interventions that appear in registries and / or the peer reviewed literature. ***100 Points***

3.3 – The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

3.3.1 – Dates of implementation, location and setting of implementation and number of participants involved in strategy implementation must be included for each strategy. ***50 Points***

3.3.2 – Outcome data must be included and document measurable change must be included for each strategy. ***50 Points***

3.4 – The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: (complete guideline 4 here……)

3.4.1 – Group composition (size of group and types of members) **25 Points**

3.4.2 – Criteria for determining appropriateness to population dynamics **25 Points**

3.4.3 – Criteria for determining effectiveness **25 Points**

3.4.4 – Criteria for determining fidelity (if a replicated strategy) **25 Points**

3.5 – Proposed strategy meets the "good fit" criteria? **30 points**

Exhibit titled Strategic Plan

PREVENTING
Mental, Emotional & Behavioral Disorders

OKLAHOMA STRATEGIC PLAN

OKLAHOMA
Mental Health &
Substance Abuse

PREVENTING
Mental, Emotional & Behavioral Disorders

OKLAHOMA STRATEGIC PLAN

Our Vision

The Strategic Plan provides a vision for Oklahoma in which everyone is provided the opportunity to achieve a state of health and well-being free from problems related to mental, emotional, and behavioral disorders.

Our Mission

The mission of this Strategic Plan is to:

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

Overview of Prevention & Promotion

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

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

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Prevention Service Standards

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

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

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

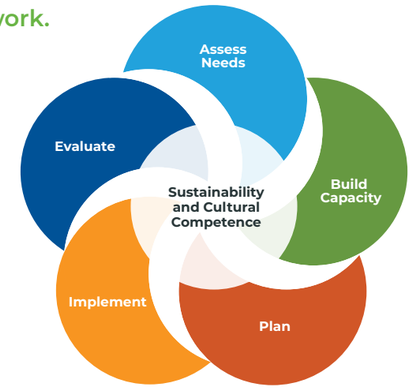
2. Mental, emotional, and behavioral problems are developmental, and opportunities for preventive intervention exist beginning at pre-conception and throughout the lifespan, with a particular focus on children, youth, and young adults.

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

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

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

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



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

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

The SPF includes these five sequential steps:

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

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

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

OKLAHOMA Mental Health & Substance Abuse

Guiding Principle #3: We utilize evidence-informed interventions.

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

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

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

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

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

Guiding Principle #4 *continued*

CLAS Standard: Governance, Leadership and Workforce
The ODMHSAS prevention staff advances and sustains organizational governance and leadership that promotes health equity through policy, practices and allocating resources to populations experiencing behavioral health disparities.

CLAS Standard: Communication and Language Assistance
The low population density, high poverty rates, and multi-linguistic characteristic of Oklahoma reflect geographical and cultural barriers that can affect the implementation of services. Project materials, products, and strategies, including evidence-based practices, are produced and reviewed with the culture, languages, health literacy, and values of the focus populations in mind.

CLAS Standard: Engagement, Continuous Improvement, and Accountability.
Demographic data is collected on a regular basis to monitor the impact of the strategies on sub-populations. The prevention system works with diverse populations to help ensure activities conducted by the state prevention system are culturally appropriate.

Guiding Principle #5: **We are a hopeful, capable, and accountable prevention workforce.**

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

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

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

Strategic Priorities

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

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

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

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

Consequence

These negative Outcomes...

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

Problem Areas

Result from these types of problem areas...

- Youth alcohol, marijuana, prescription opioid, and tobacco use
- Youth depression and psychological distress
- Adult problem alcohol, marijuana, opioid, stimulant, and tobacco use
- Adult depression

Intervening Variables

Driven by these common factors...

- Access to substances
- Favorable attitudes to substance use
- Peer norms and low perception of disapproval
- Early initiation of use; intention to use
- Favorable parental attitudes to substance use
- Family conflict
- Poor **parent communication**
- Low **commitment to school**
- Low **perception of risk**
- Low **neighborhood attachment**
- **Rebelliousness**
- **Depressive symptoms**
- **Adverse childhood experiences**
- **Unemployment**
- **Depression, anxiety**
- **Mental health/substance use disorders**
- **Loneliness, social support**
- **Access to lethal means**
- **Socio-economic status**
- **Incarceration**

Strategies

...Can be addressed by installing these prevention services within and between sectors.

Schools
- MTSS, Multi-Tiered Systems of Support Development
- School-Based Primary & Secondary Prevention Programs
- Nurturing Practices

Communities
- Community Coalition Organizing, Problem Solving & Community Design
- Outreach & Education Services
- Safety Planning
- Action-Oriented Prevention Communication Campaigns

Healthcare
- Screening and Brief Intervention
- Care Management and Referral
- Safety Planning
- Prescribing Guidelines
- Prevention Education

Employers
- Mental Health Literacy
- Workplace Suicide Prevention and Mental Health Promotion
- Responsible Alcohol & Tobacco Sales, Training & Enforcement

Families
- Parent Supports
- Family-Based Prevention Programs
- Home Safety

PREVENTING
Mental, Emotional & Behavioral Disorders

Oklahoma's outcome-driven logic model visually depicts the prevention system change process. Priorities are elevated at the state-level to identify key areas for improvement. The model presents a roadmap of cause-effect relationships and preventive actions to be taken.

Prevention System Infrastructure

An effective state prevention system requires a strong infrastructure that supports high-quality service delivery. The ODMHSAS Prevention Services will strive to advance the following infrastructure priorities:

Partnerships

- Build upon the success and aid in the future development of existing state-level prevention organizing bodies through continued ODMHSAS leadership or support such as the Oklahoma Rx Workgroup, Oklahoma Suicide Prevention Council, and the SBIRT-OK Collaborative.
- Support the State Epidemiological Outcomes Workgroup and Evidence-Based Practices Workgroup to provide the ODMHSAS prevention system with critical, guiding expert consultation for data and best practice implementation.
- Maximize interagency state partnerships, including focused prevention endeavors with the Oklahoma State Department of Education, Oklahoma Department of Veterans Affairs, Oklahoma Regents for Higher Education, Oklahoma State Department of Health, Oklahoma Juvenile Affairs, and Oklahoma Department of Human Services.
- Develop an ODMHSAS prevention 'Collaboratory' comprised of contracted service providers, consumer groups, and other key prevention stakeholders to regularly convene for cross-sector learning, peer sharing, and state system planning.
- Understand and help elevate policy or other systemic solutions that can improve prevention outcomes in the state; maintain connection to prevention-related policy committees.

Workforce

- Continue to support the development of certified prevention specialists while cultivating a diverse workforce of laypersons and professionals in other fields who can serve as preventionists.
- Provide high-quality prevention training opportunities, including a regular Prevention Academy and Prevention Grand Rounds.
- Provide high-quality consultation and technical assistance to the prevention workforce through capable, customer-service oriented staff who serve assigned providers, constituents, and communities.
- Utilize practice dissemination models – structured processes of teaching and installing research-based practices - to widely disseminate and sustain evidence-based prevention.

Data

- Develop the ODMHSAS capacity to support prevention data collection, analysis, and utilization under the leadership of dedicated epidemiologists and data specialists..
- Provide high utility data products to the Oklahoma prevention system, including web-based dashboards and query systems as well as custom products for communities, population groups, and issue-based reports.
- Develop a centralized, uniform reporting system for improved ODMHSAS prevention performance monitoring.
- Actively seek solutions to address identified data gaps that create barriers to understanding and measuring prevention needs.

Resources

- Allocate resources to the sectors best positioned to influence and install prevention; diversify prevention funding allocations to include schools, communities, faith, families, healthcare, and business/workplaces.
- Actively seek funding for Oklahoma to support the advancement of this plan's strategic priorities.
- Actively support local and state-level organizations in successfully applying for available prevention funds.
- Maintain Oklahoma's role in the national and regional prevention agenda through active roles with the PTTC, National Prevention Network, SAMHSA, and other key organizations.

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Sector Based Prevention System

A sector-based prevention system aims to integrate prevention services within the domains of Oklahomans' everyday living and experiences. This approach recognizes that Oklahoma cultural norms, influences, and experiences are shaped by several key sectors of living: the family, the educational system, workplaces, neighborhoods and communities at large, the healthcare delivery system, faith communities, and media. Each of these sectors presents opportunities for:

- **The delivery of direct prevention services and programs;**
- **Communication and reinforcement of healthy behaviors and resources;**
- **Sector leader influence and modeling of healthy behaviors; and**
- **Policies and practices that shape norms – expectations, attitudes, behaviors.**

Investments in a prevention system with specific aims in each of these sectors of everyday living will improve Oklahoman's wellbeing, reduce risk, and shape new norms related to positive mental, emotional, and behavioral health. This approach relies on a prevention workforce made up of: (1) certified prevention professionals, (2) sector leaders such as physicians, school principals, or business owners who take on prevention responsibilities, and (3) laypersons who adopt, reinforce, and lead prevention-oriented beliefs and practices.

Prevention science helps organize factors that predict (or protect from) the development of mental, emotional, and behavioral problems. These factors, known as risk and protective factors (or intervening variables) can be more easily understood when grouped into domains - typically individual, peer, school, family, and community. The ODMHSAS will organize the state's prevention service delivery system in the following Oklahoma sectors:

Education

Common and higher education settings are powerfully formative and important venues for the delivery of direct and indirect prevention services to young people. As employers, education systems also impact the lives and wellbeing of Oklahoma adults. The ODMHSAS will continue to provide leadership in planning and implementing best practice prevention services in schools and college campuses. State-level tools to help education adopt MTSS frameworks will be provided, and prevention programs such as the Pax Good Behavior Game and Botvin LifeSkills will be disseminated.

Families

Family experiences, circumstances, and relationships are powerful. Family-based risk factors are highly predictive of future mental, emotional, and behavioral problems; in turn, families can offer high levels of protection from problems. The ODMHSAS will offer effective family sector prevention services such as Strengthening Families Program, parent education, and support.

Communities

Communities are an effective organizing force for bringing evidence-based policies and programs to scale. With the understanding that local issues need local solutions and local leadership, the ODMHSAS will support community and neighborhood-level prevention coalitions across the state to provide community-based prevention services with local partners such as county/municipal governments, school districts, faith communities, and businesses.

Healthcare

The encounters between healthcare providers and patients are critically important in shaping health behaviors. Screening, education, and planning between healthcare staff and their patients can effectively prevent mental health and substance use problems. The ODMHSAS will support statewide efforts to disseminate best practices in primary care, specialty care, and emergency department settings. Key partnerships with providers, practices, associations/boards, and payors will help embed these approaches in Oklahoman's routine experience at their doctors' offices.

Sector Based Prevention System *continued*

Business/Employer

Oklahoma businesses have the high potential to boost employee wellness to protect from the harms of substance use or mental health problems. As gatekeepers in the community, certain Oklahoma businesses such as alcohol retailers, can help guard against harmful consequences by practicing prevention while at work. The ODMHSAS will build upon its prevention investment in the business/employer sector with increased efforts to educate employees, connect them to needed services, and adopt preventive business practices.

Faith:

The ODMHSAS will support faith-based communities across the state to provide prevention services to their congregations and communities. Faith-based sector providers will deliver direct prevention services, link faith-based organizations with community resources, and build relationships between groups at risk in the community.

These sectors will work with the ODMHSAS to uptake prevention within their spheres of influence. The ODMHSAS will seek ways to stimulant collaboration across the sectors in direct and indirect ways. Certain sectors will work directly together to deliver prevention services, other sectors will focus within their own community or organization. Underlying the sector-based prevention work will be a communications plan to broadcast prevention education messages and resources to Oklahomans.

PREVENTING
Mental, Emotional & Behavioral Disorders

OKLAHOMA STRATEGIC PLAN

OKLAHOMA
Mental Health &
Substance Abuse

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

Construct	Indicator/Measure
Underage Drinking	**Current, 30-day alcohol use among youth under age 21**
	Current, 30-day binge drinking among youth under age 21
	Current, 30-day drinking and driving among youth under age 21
Adult Binge Drinking	**Current, 30-day binge drinking among adults age 18 and older**
	Current, 30-day drinking and driving among adults age 18 and older
Nonmedical Use of Prescription Drugs	**Adults ≥ 18 years old use of prescription drugs without a prescription in their lifetime**
	Adults ≥ 18 years old non-medical use of prescription drugs in the past 30 days
	Current, 30-day use of prescription drugs among 6, 8, 10, and 12 graders
Methamphetamine Use	**Current, 30-day methamphetamine use among 6, 8, 10 and 12 graders**
Marijuana Use	**Current 30-day marijuana use among 6, 8, 10 and 12 graders**
	Current, 30-day marijuana use among adults age 18-25 and > 26 years old
Alcohol Use During Pregnancy	**Any alcoholic drinks during last 3 months of pregnancy, Pregnancy**
	Alcohol use during pregnancy

- 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								
Region	N	Pre	Post	Abs. Diff	Std. Dev.	two-tailed paired t-test p value	Effect Size	E.S. Rank

Alcohol Compliance Checks						
Region	Sale	No Sale	Total	Percent of State Checks	Sale %	No Sale Rank

Local-Level Evaluation

The ODMHSAS utilizes a public health approach termed hereafter as the Strategic Prevention Framework (SPF).The SPF is a community-based approach to prevention and a series of implementation principles intended to produce population-level outcomes. The state invests in Community Based Prevention Services (CBPS) in order to plan and implement alcohol and other drug prevention services. Each CBPS provider is required to develop an approved evaluation plan which includes the following components as they relate to their high need communities:

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

Sample Measures

Construct	Indicator/Measure
Underage Drinking	**Alcohol-Related Car Crashes**
	Alcohol-Related Mortality
	Alcohol Poisoning Deaths

Adult Binge Drinking	**Alcohol-Related Car Crashes**
	Alcohol-Related Mortality
	Alcohol Poisoning Deaths
Non-Medical Use of Prescription Drugs	**Opioid Overdose Deaths**

Marijuana	**Cannabis-Related Inpatient Hospitalizations**
	Cannabis-Related Calls to Poison Control

- Consumption Data

Sample Measures

Construct	Indicator/Measure
Underage Drinking	**Current, 30-day alcohol use among youth under age 21**
	Current, 30-day binge drinking among youth under age 21
	Current, 30-day drinking and driving among youth under age 21
Adult Binge Drinking	**Current, 30-day binge drinking among adults age 18 and older**
	Current, 30-day drinking and driving among adults age 18 and older
Nonmedical Use of Prescription Drugs	**Adults ≥ 18 years old use of prescription drugs without a prescription in their lifetime**
	Adults ≥ 18 years old non-medical use of prescription drugs in the past 30 days
	Current, 30-day use of prescription drugs among 6, 8, 10, and 12 graders
Methamphetamine Use	**Current, 30-day methamphetamine use among 6, 8, 10 and 12 graders**
Marijuana Use	**Current 30-day marijuana use among 6, 8, 10 and 12 graders**
	Current, 30-day marijuana use among adults age 18-25 and > 26 years old
Alcohol Use During Pregnancy	**Any alcoholic drinks during last 3 months of pregnancy, Pregnancy**
	Alcohol use during pregnancy

- Intervening Variable Data

  Sample Measures

Indicator/Measure
Retail Access
Social Access
Visible and Consistent Enforcement of Laws
Perception of Risk
Perception of Harm
Community Norms favorable to use
Promotion

- Process and Outcome Data

  Sample Measures

# of Law Enforcement Trainings
 # Policies Adopted
 # Practices Implemented
# of Media Outputs/Media Reach
# of Trainings
# of Risk Assessments
# of students receiving primary substance use

prevention programs
 # trained in delivering primary youth substance use prevention programs

- 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-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The statewide network of CCBHC 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 35 mental health courts, a day reporting center in Oklahoma City, jail-based screenings in all 77 counties, 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 managers, and community-based re-entry intensive care coordination teams. Oklahoma sunsetted the Health Home initiative, however care coordination and integrated care remain integral components to our CCBHC model.

CCBHCs, by regulation, must provide the following basic services: Crisis Services, Screening, Assessment and Diagnosis, Primary Care Screening and Monitoring, Comprehensive Integrated Care Planning, Outpatient Mental Health & Substance Use Services, Targeted Case Management, Psychiatric Rehabilitation, Peer Support & Family Support Services, Veterans Services, Care Coordination, Outreach & Engagement, Housing & Employment Services, Integrated Care & Health Promotion. In addition, the following services are also made available: Employment services; Housing services; Educational services; Substance Use Disorder services within CCBHCs 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-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Please see the answer to Question 1 above.

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. CCBHCs 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. There are seventeen Urgent Care Centers which 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 implemented a state level Care Coordination Team (CCT). This CCT is comprised of 1 Access Specialist, 4 Behavioral Health Care Coordinators and is led by the Senior Director of Adult Outpatient Services. The CCT focuses on coordination of care of high need individuals. The CCT primarily focuses on Most In Need (MIN) population. The MIN population consists of individuals with high utilization of elevated levels of care. The CCT receives daily reports of MIN individuals who have entered a higher level of care. The CCT then coordinates with the higher level of care and the outpatient provider to insure a warm handoff and smooth discharge. Staffings are frequently held prior to discharge to review needs and barriers of the individual. The CCT works closely with our safety net outpatient providers, CCBHCs, crisis centers and inpatient hospitals.

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.

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

None needed.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

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.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	162,342	1,065
2.Children with SED	54,945	1,000

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.

Prevalence was obtained through the National Survey on Drug Use and Health for various years. Incident was derived from the difference between current year and prior year. For children with SED, the 2020 SED number was subtracted from the 2021 SED number since the rate stayed the same (0.11). For adults with SMI, the population of adults 18+ year went down and so did the number of adults with SMI, yet the prevalence rate remained the same (0.054). Therefore, the 2020 rate was compared to the 2018 rate (2019 rate could not be located) and the difference was divided by two to determine the annual incidence.

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

The ODMHSAS does not feel it has the sources of information to accurately calculate the incidence rate; and, therefore, it is not used. We would like TA on calculating the incidence rate.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDEA	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes ( ) No

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

a. Medication Assisted Treatment guidance and education for adolescences.
b. Substance Use education and treatment for neurodivergent adolescences.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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. **See SAMHSA's Rural Behavioral Health page for program resources**

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 CCBHCs 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 CCBHCs 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. CCBHCs 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 Oklahomans in need. Beginning in SFY 2011, Oklahoma's telehealth initiative expanded to target specific rural based substance use disorder treatment facilities by adding units in seven facilities. Today ODMHSAS Telehealth Service provides access in most substance use disorder treatment facilities.

• Technology Supports in Rural Areas. The ODMHSAS maintains a statewide telemedicine network. This network increases access to services and information including medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. The ODMHSAS has partnered with a software vendor, MyCare, to provide simple, cost effective, telehealth connectively to the "most remote" areas of Oklahoma.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH)-The PATH allocation for Oklahoma for grant year 09/01/2022 – 08/31/2023 is $464,982.00. 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 CCBHCs, 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 CCCBHCs also participate in local Continuums of Care.

Discharge Planning Bridge Subsidy Program-The ODMHSAS provides targeted funds to assist very low-income individuals (aged 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. **See SAMHSA's Resources for Older Adults webpage for resources.**

In preparation for the profound demographic shift in which older adults will soon outnumber children and youth, ODMHSAS continues to build its capacity to facilitate age-informed behavioral health care. The Department recognizes older adults have unique strengths, lived experiences, and needs. Therefore, after several years of surveying the landscape to determine need and feasibility of elevating behavioral health as a foundation to older adult health and well-being, ODMHSAS initiated a Division of Aging Services in the fall of 2022.

Prior to this, the Department collaboratively engaged in several age focused initiatives, from 2015 forward. Four examples:
• Sponsor of the Collaborative Positive Aging Institute, which has convened three transdisciplinary trainings since 2018; a fourth is likely in SFY 2024. Other sponsors include the Oklahoma Healthy Aging Initiative and the Fran and Earl Ziegler College of Nursing at the University of Oklahoma with leadership provided by the Oklahoma Mental Health and Aging Coalition and the Anne and Henry Zarrow School of Social Work at the University of Oklahoma.
• Delivered its first Older Adult Specialty training for Peer Recovery Support Specialists (2018); the curriculum was designed by an expert recognized in the field of aging at both the state and national level.
• Provided its first trainings on Mental Health First Aid for Older Adults (2018).

ODMHSAS provides reoccurring trainings in Cognitive Behavioral Therapy (CBT), both a foundational training as well as specialty trainings to address a multitude of areas in which older adults may be experiencing issues. These trainings are offered to clinicians throughout the state of Oklahoma, allowing this modality to be used with consumers ranging in age from children to older adults.

ODMHSAS is generating awareness of the need, and meeting the demand, for age-informed care. During SFY 2022, ODMHSAS offered 2 age-informed courses resulting in 110 course completions. During SFY 2023, there were 8 age-informed courses resulting in 398 course completions; both courses and completions are projected to increase during SFY 2024. Concurrent to this growth, ODMHSAS fulfilled a primary role in Oklahoma convening an Older Adult Behavioral Health Policy Academy, which was led by the Oklahoma Mental Health and Aging Coalition and Rush University's E4 Center of Excellence for Behavioral Health Disparities in Aging. Additionally, ODMHSAS is laying the foundation to collaboratively develop a comprehensive system-of-care that promotes age-informed health, behavioral health, and social services through its newly developing Behavioral Health Forum on Aging.

ODMHSAS is involved in several age-forward arenas, including the State Council on Aging, Mental Health and Aging Coalition, and Oklahoma's Multi-Sector Plan on Aging. The Department also promotes age-informed care by being involved in sectors that may not target older adults, but do indeed interface with older adults either directly or indirectly (i.e. housing, prevention, crisis).

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

None needed.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. 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.

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

Licensure (certification) of most treatment and support service organizations is statutorily required and administered through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Provider Certification Division. The ODMHSAS also supervises mandated direct care certifications for Behavioral Health Case Managers 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 1,925 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 52,090 participants from all areas of Oklahoma in state fiscal year 2023. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

ODMHSAS maintains a statewide telemedicine network. Units are placed in treatment facilities 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 addition to its traditional telemedicine network, thousands of iPads have been distributed to state-operated or contracted Certified Community Behavioral Health Centers (CCBHC), law enforcement for assistance during mental health-related calls, and more than 80 city/county health departments to help rural residents immediately access behavioral healthcare. In CY2022, an average of 73,072 services were provided to 30,007 unique service recipients per month.

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

None Needed.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/residential)	(•) 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:

i)	Prioritized services for veterans?	(•) Yes ( ) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

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. Following a contract monitoring review, if a plan of correction is warranted, the Contractor must submit a written plan of correction, addressing the steps that will be taken to correct the issue. The reviewer will then verify that correction action has been enacted according to the plan of correction. If the findings are not resolved according to ODMHSAS contract requirements, the Contractor may be subject to disciplinary action or termination.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(●) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(●) Yes ( ) No
c)	Outreach activities	(●) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (●) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(●) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (●) No
c)	Use of peer recovery supports to maintain contact and support	(●) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	( ) Yes (●) No

3. States are required to monitor program compliance related to activites 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. Following a contract monitoring review, if a plan of correction is warranted, the Contractor must submit a written plan of correction, addressing the steps that will be taken to correct the issue. The reviewer will then verify that correction action has been enacted according to the plan of correction. If the findings are not resolved according to ODMHSAS contract requirements, the Contractor may be subject to disciplinary action or termination.

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? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (●) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (●) No
c)	Established co-located SUD professionals within FQHCs	( ) 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. Following a contract monitoring review, if a plan of correction is warranted, the Contractor must submit a written plan of correction, addressing the steps that will be taken to correct the issue. The reviewer will then verify that correction action has been enacted according to the plan of correction. If the findings are not resolved according to ODMHSAS contract requirements, the Contractor may be subject to disciplinary action or termination.

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 ( ) Yes ( ) No

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 such service delivery?

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ○ Yes ◉ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ○ Yes ◉ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ○ Yes ◉ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ○ Yes ◉ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ○ Yes ◉ No
- **f)** Explore expansion of services for:
  - **i)** MOUD — ○ Yes ◉ No
  - **ii)** Tele-Health — ○ Yes ◉ No
  - **iii)** Social Media Outreach — ◉ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ○ Yes ◉ No
- **b)** Establish a program to provide trauma-informed care — ◉ Yes ○ No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ◉ Yes ○ No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ◉ Yes ○ No
- **b)** An organized referral system to identify alternative providers? — ○ Yes ◉ No
- **c)** A system to maintain a list of referrals made by religious organizations? — ◉ Yes ○ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) 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 fourteen (14) providers will participate in the Independent Peer Review process during FFY2024/2025; approximately seven (7) providers each year. This exceeds the percentage that is statutorily mandated.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☑ Other (please specify)

The ODMHSAS certifies sub-recipients based on the Administrative Rules/Standards relative to the services they are providing. The ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children, Inc. (COA), or the American Osteopathic Association (AOA) as compliance with certain specific ODMHSAS standards.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Performance-based accountability: (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

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

https://oklahoma.gov/odmhsas/policy/administrative-rules.html

If the answer is No to any of the above, please explain the reason.

Footnotes:

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 2022-FFY 2023? ○ Yes ◉ No

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

None needed.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *Ibid*

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

1.	Does the state have a plan or policy for M/SUD providers that guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	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
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No

7. 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 by 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 CCBHCs are currently transitioning to the updated CATS 2.0. Biannual calls are held with each agency to review CATS data and trauma

treatment measures. Oklahoma has a statewide TFCBT program for our CCBHCs and it is in contract how each agency must have staff trained to provide this service. Oklahoma has launched a pilot project for FY24 to expand TFCBT trainings to additional providers across the state and has also supported the development and implementation of a group TFCBT model.

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 its easier. Effective FY24 Peers are also eligible to receive training in administering the CATS with families.

Oklahoma has supported the use of the Seeking Safety model throughout the state for several years now and is continuing to grow and expand access to these trainings to any level of provider. Several hundred providers are trained in Seeking Safety annually. Additionally, Oklahoma hosted the very first training of the newly published Seeking Safety Adolescent Toolkit in the past year. Oklahoma has a 3 hour trauma-informed 101 eLearning and a 1hour self-care eLearning so that all levels of staff can be trained on site. Oklahoma is currently taking steps to expand training offerings related to trauma and secondary traumatic stress.

Oklahoma has continued to grow and strengthen our Domestic Violence Liaison program which requires contracted agencies to identify at least one individual per agency to serve in this role. This program is helping to support the needs of survivors in accessing mental health and substance use treatment resources. A training series is now offered for behavioral health providers on domestic violence to promote trauma informed care and treatment for survivors.

Finally, the ODMHSAS has recently sent three staff members to begin the process of becoming NEAR Science (neurobiology, epigenetics, adverse childhood experiences, and resilience) Mentor Trainers. This will allow us to support work already happening in the state to educate a wide array of audiences on these trauma-related topics.

The ODMHSAS is currently a member of the National Child Traumatic Stress Network as a Category III site. This is part of a 5 year grant to provide high quality, culturally responsive, trauma-focused treatment to children and their families living within 10 identified zip codes in East Oklahoma City. Individuals living in these zip codes collectively have higher rates of trauma exposure (including environmental adversities such as poverty and food deserts, as well as historical and racial trauma), lower quality of life outcomes, and increased barriers to services when compared to Oklahoma City metro as a whole.

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

None needed.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. 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

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

The ODMHSAS provides programs and services that address diversion at each step of the Sequential Intercept Model. Crisis Intervention Training (CIT) is provided to CLEET-commissioned law enforcement officers throughout the state through partnership with multiple law enforcement agencies. Through legislative appropriations, the ODMHSAS made iPads available to all law enforcement officers in the state. These iPads serve as telehealth connections to the network of local CCBHCs. These connections provide remote consultations and evaluations to support diversion from the criminal justice response into behavioral health services. Additionally, the ODMHSAS has implemented a pre-sentence criminogenic risk and needs assessment program to provide courts, prosecutors, and defense counsel with information about evidence-based diversion sentencing recommendations that best meet the defendants' individualized needs and are most likely to lead to decreased recidivism and improved quality of life. With over 66,510 felony defendants screened to date, this program has resulted in fewer jail days between arrest and case disposition. Recently, eligibility for these screenings has been expanded to individuals facing misdemeanor charges.

Oklahoma continues to have strong drug, DUI, mental health, and Veterans treatment courts that follow the latest best practice standards published by All Rise (formerly the National Drug Court Institute). All Oklahoma treatment courts demonstrate tremendous success through outcomes such as a reduction in recidivism, an increase in employment and education, a decrease in arrests and jail days, and an increase in child custody. Drug courts serve 67 counties and there are 35 mental health courts. The success of these programs has led to the development of additional court-based diversion opportunities including early/ misdemeanor diversion and pretrial services. Lastly, through collaboration with the Department of Corrections, the ODMHSAS has prison-embedded reentry staff supporting the treatment reentry needs of individuals being discharged from prison who have behavioral health treatment needs.

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

None needed.

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☑ Buprenophine, 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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

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

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 copays 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.

Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

The ODMHSAS is leading the state's efforts to develop a comprehensive behavioral health crisis response system. The state's Comprehensive Crisis Response plan describes the system of responses which ODMHSAS has rolled out over several years and continues to expand. After an extensive planning process - which included collaboration from SAMHSA, Vibrant, 911 PSAPs, tribes, behavioral health contractors, and others - the ODMHSAS selected Solari Crisis and Human Services as the single statewide 988 call center vendor. Solari began operation in Oklahoma on July 5, 2022 and is serving as the primary answer center through the NSPL. The ODMHSAS has additionally contracted with two in-state NSPL centers to provide back up coverage to ensure that, once fully

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☐	☐	☑	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to- The ODMHSAS has begun operation of a single statewide 988 call center and two back up centers to answer all incoming 988 calls instate.

Someone to respond – The ODMHSAS has developed a dedicated network of 988 dispatching mobile crisis teams in addition to statewide CCBHC coverage which provides for additional mobile crisis coverage. ODMHSAS is continually reviewing data to determine additional mobile crisis coverage needs.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The ODMHSAS has implemented and continues to expand the entire crisis continuum model as described by the SAMHSA National Guidelines. While portions of the continuum existed previously, a priority for the state during the past year was preparing for the launch of 988 with the establishment of a 988 call center with all of the air traffic control type functions described by SAMHSA, creation of dedicated 988 mobile crisis teams, and the expansion of community-based crisis services such as urgent recovery and crisis centers. Additionally, the ODMHSAS has worked to expand access to telehealth services in the crisis continuum with a special emphasis on providing telehealth devices to all law enforcement officers which have a direct connection with local community-based

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The ODMHSAS anticipates utilizing the 5% crisis set aside to support the expansion of community-based crisis centers and urgent recovery centers. These services provide the "somewhere to go" component of the crisis continuum offering respite and an array of crisis de-escalation when mobile crisis teams aren't able to resolve the situation.

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

None needed.

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

None needed.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining 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- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. 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:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The ODMHSAS promotes a recovery-focused service system with focus on improving access to quality health and behavioral health treatment; incorporating peer, family, and other community supports; emphasis on person-centered care that includes shared decision-making and continued efforts to try to improve access to housing, employment, education, and related supports.

The ODMHSAS defines recovery in the Oklahoma Administrative Code (OAC) 450:53.
"Recovery is a '…journey of healing and transformation enabling a person with a mental health or substance abuse diagnosis to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential. The process of recovery leads individuals to the highest level of autonomy of which they are capable.

Key characteristics of recovery include:
• Recovery is self-directed, personal and individualized;
• Recovery is holistic;
• Recovery moves beyond symptom reduction and relief;
• Recovery is a process of healing and discovery;
• Recovery encompasses the possibility of individuals to test, make mistakes and try again; and
• Recovery can occur within or outside the context of professionally directed treatment."

Consumer and family education is offered throughout the state on an ongoing basis by multiple advocacy organizations including some that have more experience working specifically with individuals with SMI or SED, such as the National Alliance on Mental Illness, the Mental Health Association of Oklahoma, the Oklahoma Federation of Families (OFF) and the Evolution Foundation.

Oklahoma provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services. ODMHSAS' annual Recovery and Prevention Conference, Justice and Recovery Conference, and Children's Behavioral Health Conference provide a forum for presentations on recovery principles and practices and the role of peer providers. Staff in recovery and national leaders in recovery support services have presented at these annual conferences.

The following are examples of exemplary activities related to recovery support services:
• The ODMHSAS' Enhanced Tier Payment System (ETPS) provides additional funding to providers who increase recovery support services to consumers. This system encourages providers to hire recovery support staff and to deliver recovery support services.

• ODMHSAS' Behavioral Health System has evolved its Community Mental Health Centers into Certified Community Behavioral Health Centers (CCBHCs). CCBHCs require and promote peer recovery support in its model which has increased the hiring and integration of Certified Peer Recovery Support Specialists. Currently there are over 1600actively certified Peer Recovery Support Specialists working across programs and providers.

• Expansion of the peer support services has helped increase engagement of special populations. Currently, there are tracts for Peers to specialize in youth and young adults, veterans, /criminal justice, Domestic Violence, Crisis care, , Older Adults, gambling, Latinx, African American Culture, and Peer Supervision. Expansion of the peer's role and the workforce will continue this next fiscal year as we develop a mentoring program to support the navigation of workplace norms by Peer Recovery Support Specialists.

• The ODMHSAS hires people in recovery in leadership roles and throughout the system. The ODMHSAS Supporting Treatment and Recovery Services (STARS) Division has staff that are self-identified consumers working in the division. The ODMHSAS Peer Division Trainers of the Peer Certification self-identify as peers in recovery and are certified as Peer Recovery Support Specialists. ODMHSAS' Chief Communications Officer, Director of Recovery Supports, Senior Program Manager of Recovery Supports and Program Manager of the state's Employee Assistance Program identify as individuals in recovery and are certified as Peer Recovery Support Specialists. The current CEO of one of the largest providers in Oklahoma identifies as an individual in recovery and is currently certified as a Peer Recovery Support Specialist in Oklahoma. This is also the case for much of the organization's leadership team.

• The ODMHSAS encourages providers to use person-centered planning. The ODMHSAS offers a comprehensive training that assists service providers with understanding how to implement person-centered planning in all aspects of the service process (from assessment, to plan development, to the provision of services, to on-going evaluation of progress). The training also addresses how this process translates to clinical documentation (in a way that is collaborative with the person served and conducive to self-direction). To further reinforce this process, the ODMHSAS and OHCA requirements for clinical progress notes allow for time spent by the service provider and the consumer completing a treatment progress note together to be compensable. Time spent by the service provider completing the progress note without the consumer is not compensable.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

The ODMHSAS promotes a recovery-focused service system focusing on improving access to quality health and behavioral health treatment; incorporating peer, family and other community supports, emphasis on person-centered care that includes shared decision-making, and continued efforts to try to improve access to housing, employment, education, and related supports.

The ODMHSAS defines recovery in the Oklahoma Administrative Code (OAC) 450:53.
"Recovery is a "…journey of healing and transformation enabling a person with a mental health or substance abuse diagnosis to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential. The process of recovery leads individuals to the highest level of autonomy of which they are capable. Key characteristics of recovery include:
• Recovery is self-directed, personal and individualized;
• Recovery is holistic;
• Recovery moves beyond symptom reduction and relief;
• Recovery is a process of healing and discovery;
• Recovery encompasses the possibility of individuals to test, make mistakes and try again; and
• Recovery can occur within or outside the context of professionally directed treatment."

Consumer and family education is offered throughout the state on an ongoing basis by multiple advocacy organizations including some that have more experience working specifically with individuals with substance use disorders, which include the National Association of Black Veterans (NABVETS), the Oklahoma Citizen Advocates for Alcohol Recovery and Transformation Association (OCARTA), and Parent's Helping Parents (PHP).

Oklahoma provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services. ODMHSAS' annual Recovery and Prevention Conference, Justice and Recovery Conference, and Children's Behavioral Health Conference provide a forum for presentations on recovery principles and practices and the role of peer providers. Staff in recovery and national leaders in recovery support services have presented at these annual conferences.

The following are examples of exemplary activities related to recovery support services:
• The Oklahoma Association for Recovery Residences (OKARR) is the Oklahoma state affiliate of the National Alliance for Recovery Residences (NARR). OKARR: links individuals seeking and sustaining recovery from substance use issues with quality recovery housing, promotes the quality of recovery housing by offering training and resources to recovery housing providers and workforce, and certifies recovery housing that meets national best practice. ODMHSAS provides Peer Recovery Support Specialist certification training to all appropriate and qualified staff of the OKARR certified Recovery Residence to promote and provide recovery support to their residents.

• The expansion of peer support services has helped increase engagement of special populations. Currently, there are tracts for Peers to specialize in youth and young adults, veterans, criminal justice, Crisis Care, Domestic Violence, , methamphetamine use, older adults, gambling, Latinx, African American Culture, and Peer administration/leadership/supervision. a mentoring program to support the navigation of workplace norms by Peer Recovery Support Specialists. Particular focus, as it relates to tobacco cessation within the system has been a primary recovery support for both the SMI and SUD populations. However, particular to the SUD population has been a focus to better incorporate recovery support services as a whole health initiative. Specifically, the ODMHSAS has partnered with Residential Treatment Providers (RTP) to integrate peer staff in roles to facilitate cessation support groups and establish coordinated referrals to community resources such as the Oklahoma Tobacco Helpline. This project was piloted with three RTPs and proved to be successful. That is, a total of 390 residents at RTPs were connected to the Oklahoma Tobacco Helpline and 30% of these individuals have stayed quit at 7-month follow up. This project has since expanded and now includes 10 crisis units, 10 RTPs, 8 outpatient providers, and 4 inpatient providers.

• The ODMHSAS hires people in recovery in leadership roles and throughout the system. The ODMHSAS Supporting Treatment and Recovery Services (STARS) Division has staff that are self-identified consumers working in the division. The ODMHSAS Peer Division Trainers of the Peer Certification self-identify as peers in recovery and are certified as Peer Recovery Support Specialists. ODMHSAS' Chief Communications Officer, Director of Recovery Supports, and Program Manager of the state's Employee Assistance Program identify as individuals in recovery and are certified as Peer Recovery Support Specialists. The current CEO of one of the largest providers in Oklahoma identifies as an individual in recovery and is currently certified as a Peer Recovery Support Specialist in Oklahoma. This is also the case for much of the organization's leadership team.

• The ODMHSAS encourages providers to use person-centered planning. The ODMHSAS offers a comprehensive training that assists service providers with understanding how to implement person-centered planning in all aspects of the service process (from assessment, to plan development, to the provision of services, to on-going evaluation of progress). The training also addresses how this process translates to clinical documentation (in a way that is collaborative with the person served and conducive to self-direction). To further reinforce this process, the ODMHSAS and OHCA requirements for clinical progress notes allow for time spent by the service provider and the consumer completing a treatment progress note together to be compensable. Time spent by the service provider completing the progress note without the consumer is not compensable.

5. Does the state have any activities that it would like to highlight?

ODMHSAS currently trains and certifies Oklahoma's Peer Recovery Support Specialist work force. In order to ensure a well-equipped and quality workforce, ODMHSAS provides specialty tracts that enhance knowledge, skills, and competency in a variety of areas and populations served. Currently specialty tracts are provided for transitional age youth, older adults, veterans, methamphetamine use, criminal justice, Domestic Violence, gambling, group facilitation skills, Crisis Care, African American Culture, and Latinx. ODMHSAS provides e-learnings on self-care to help ensure the wellbeing of the peer workforce and provide skills they can teach and role model to their clients. With the role out of 988 and the expansion of crisis services in the state, we felt a crisis tract was a necessity. ODMHSAS believes that Peer Recovery Support Staff also need support and provides virtual bi-monthly support meetings for the peer workforce and a special support call for peers that work in crisis services. ODMHSAS believes that ensuring quality peer support requires quality supervision. ODMHSAS provides a Peer Recovery Support Supervisory Training for all those that supervise Peer Recovery Support Specialists. It is a contractual requirement for providers to ensure those supervising peer support staff receive the supervisory training.

• In order to ensure quality and accountability, the ODMHSAS' Peer Division has established a Peer Advisory Council consisting of a variety of individuals in recovery working in a variety of organizations. The Peer Advisory Council has established bylaws as well as voted in a Chair and Vice-Chair with technical assistance from the ODMHSAS Peer Division.

• The Oklahoma Recovery Alliance, which consists of many community partners that are Recovery Community and Advocacy Organizations have recently adopted by-laws and voted on a Chair, Vice Chair, and Treasurer with the technical assistance of the ODMHSAS Peer Division. The by-laws will provide needed structure for the alliance. The Oklahoma Recovery Alliance provides a monthly arena for the members to exchange ideas, information, and joint efforts to promote recovery for Oklahomans.

• ODMHSAS understands that tobacco cessation efforts are vital to the quality of life and longevity of life for those seeking services in behavioral health. Peer Recovery Support Specialists are leading the way in these efforts. ODMHSAS has included within provider contracts the use of Peer Support as an intervention for Tobacco Cessation. Trainings to help staff provide these interventions is provided through ODMHSAS. Peers lead our tobacco cessation intervention efforts and have helped decrease tobacco prevalence rates from 74% to 47% on average. ODMHSAS providers made over 10,0000 referrals to the Oklahoma Tobacco Helpline in FY23, accounting for over 50%of all referrals statewide; it's estimated that the program has averted 29 deaths and saved nearly $3 million in medical costs.

• ODMHSAS believes in preventing gaps in treatment and between levels of care. The integration of Peer Support is a vital part of closing those gaps and providing "warm hand offs" between levels of care. Within ODMHSAS' behavioral health system, in fiscal year 2020, those discharging from inpatient or crisis services: 83% had follow up within 7 days, 78% did not re-admit to inpatient/crisis within 6 months and 81% were engaged in treatment within 45 days.

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

Technical assistance needs include assistance with developing a Peer Mentor program based on an existing evidenced based program.

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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:

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?

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

None needed.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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).

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

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

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

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

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	(•) Yes	( ) No
b) The resilience of children and youth with SED?	(•) Yes	( ) No
c) The recovery of children and youth with SUD?	(•) Yes	( ) No
d) The 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) Health care?	(•) Yes	( ) No
c) Juvenile justice?	(•) Yes	( ) No
d) 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
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	(•) Yes	( ) No
d) Does the state have an established FEP program?	(•) Yes	( ) No
Does the state have an established CHRP program?	( ) Yes	(•) No
e) Is the state providing trauma informed care?	(•) Yes	( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Currently Oklahoma treatment providers within systems of care provide integrated services in the following ways:
A. OKSOC uses a Wraparound model that is able to serve anyone 0 up to 25 with mental health or substance use disorder regardless of system involvement. This model is primary for youth who are identified as SED who may or may not have a

cooccurring disorder.

B. ODMHSAS currently has several partnerships involving OSDE to include the BISS model and quarterly Leadership meetings to identify partnership opportunities for school systems in Oklahoma. School-based services is looking to establish new BISS provider networks throughout the remaining 200+ school district in Oklahoma.

C. ODMHSAS and OKDHS has several partnerships around access to treatment for youth in the child welfare system. One partnership that is currently being implemented is the Enhanced Foster Care program. ODMHSAS facilitate consultation calls with DHS staff and mental health service providers to establish and monitor mental health services.

D. The local SOC community partnership around creating community connections for youth and families and family support options connecting families to the Children's Behavioral Health Network.

E. ODMHSAS and OJA are continuing to partner around juvenile reentry. The identification of juveniles who are discharge at an OJA institution for the purpose of coordinating the behavioral health treatment for those identifies with and MH or SU disorder.

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

Currently in Oklahoma there are a total of 4 Child and Adolescent Recovery Centers (URC) open in Tulsa, Elk City, Norman and McAlester. These URC's use a family model of care so the caregiver stays with the child during the crisis stabilization process. All families will receive a 24 hour follow up appointment after leaving the URC. Oklahoma will have 5 more URC's open by January 2024 with one serving children and youth with special needs such as IDD/DD or autism. All URCs will have access to an infant and early childhood specialist for consultation. All URCs will be equipped with a sensory kit purchased through the Autism Foundation of Oklahoma to help support those with sensory needs because of trauma or autism.

Oklahoma will have three crisis stabilization units open by January 2024. One of those will specialize serving children and youth with special needs such as IDD/DD or autism.

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

a. Medication Assisted Treatment guidance and education for adolescences.
b. Substance Use education and treatment for neurodivergent adolescences.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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:

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 are 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 is provided to CCBHC's, 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

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

ODMHSAS has targeted all private and nonprofit as well as all State Operated and State Contracted Mental Health agencies that provide mental health services to individuals who may be suicidal or has tried to die by suicide in their communities. There has been increased training for Colleges and Universities and consultations to provide treatment for their more specific demographic groups of student population in their college counseling programs for treatment of suicidal and substance abuse issues.

Oklahoma continues to lead the Nation in instituting this life-saving evidenced based technique of Collaborative Assessment and Management of Suicidality (CAMS) in all 77 counties, providing better understanding and decrease suicidality. At this present time, we have trained 2102 clinicians in CAMS. ODMHSAS plans to continue to offering CAMS training during the next Block Grant period.

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

None needed.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (●) No

If yes, with whom?

N/A.

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 has ongoing partnerships with multiple state and local entities to coordinate care and regularly review collaborative strategies to care including, but not limited to criminal justice, education, health, and juvenile justice. Additionally, ODMHSAS utilizes a robust data collection and evaluation process to continuously enhance coordination of care opportunities including the recent development of a centralized care coordination team to support successful transitions to the community for individuals receiving services in higher levels of care who need additional support through those transitions.

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

None needed.

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder 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 SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

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.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Council reviews and gives feedback on the block grant's performance indicators during meetings. These performance indicators are also sent to them, prior to the meeting, so that they are have time to review, think about and formulate any questions, prior to the meeting as well. This feedback guides the modification of current indicators and development of new ones. The Council is also sent the application materials and reports prior to the meetings and, during the meetings, they give feedback on those items.

In addition to the above, the Council is able to access the application materials on the ODMHSAS website, at any time, and give any feedback that they would like. All feedback is taken into consideration with application development.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support 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 abuse 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.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. 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

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council consists of 34 members. The Council is made up of residents of Oklahoma and includes 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; and 5) the families of children with serious emotional disturbances and/or addictions.

Council membership includes several members who either coordinate or serve on local and statewide advocacy Councils and committees. They keep the PAC informed and engaged regarding state and local advocacy issues and initiatives.

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

None needed.

Footnotes:

Evolution Foundation
1620 Ridgecrest Road
Edmond, Oklahoma 73013
(405) 203-7898
jefftallentz@aol.com
August 17, 2023

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

To Whom It May Concern,

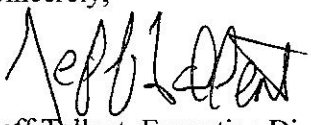
As Chair of the Planning and Advisory Council of the Oklahoma Department of Mental Health & Substance Abuse Services, I have the privilege of submitting this letter of support for the Oklahoma FY 2024-2025 Block Grant Application which was reviewed and approved by the PAC at the August 17th, 2023 meeting.

As the effects of COVID further subside, Oklahoma and the PAC group is rebounding. The size of the PAC group has grown from 22 members in January 2022 to 34 members. There has also been an increase in rural representation, as well as veteran, LGBTQI+ and Native American representation.

Our Block Grant Plan continues to focus on expanding treatment and ensuring those services are accessible to all Oklahomans. All of the community mental health centers in Oklahoma have now transitioned to Certified Community Behavioral Health Clinics (CCBHC), ensuring that integrated care is available. ODMHSAS continues their expansive work being done with Peer Recovery Support Services (PRSS), by offering a multitude of trainings in a variety of subjects to enhance their skills. PRSS's are being greatly utilized in all treatment settings in Oklahoma. There has also been an increased focus on offering trainings, services and supports specifically for the older adult population. A great deal of work has been done with pregnant/post-partum women and their families with agencies incorporating Family Care Plans and with ODMHSAS instituting their Tough as a Mother Campaign. The Prevention Department has employed a Naloxone saturation media campaign with print and media adds. They are also opening up vending machines dispensing Naloxone and Fentanyl test strips. Work with disseminating prevention information, working with schools and community coalitions and working to decrease the prevalence of underage drinking continues to be done. 988 was launched in July 2022. The 30-day crisis call volume is 4,008, with a 98.6 answer rate, and 10 seconds being the average speed of answer. The stabilization rate is 90%. Twelve additional urgency recovery centers and two additional crisis units were opened in the last fiscal year with additional crisis facilities planned for this year. Telehealth continues to be utilized well.

As the state of Oklahoma continues to rebound from COVID, ODMHSAS will continue to work to ensure that Oklahomans are able to access needed services and supports.

Sincerely,



Jeff Tallent, Executive Director

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.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Janelle Bretten	State Employees	Oklahoma Office of Juvenile Affairs	3812 N. 36th Street Oklahoma City OK, 73118	Janelle.Bretten@oja.ok.gov
Melinda Bunch	State Employees	Oklahoma Department of Rehabilitation Services	300 NE 18th St. Oklahoma City OK, 73105 PH: 405-521-3877	
Josh Cantwell	Providers	Grand Mental Health	114 W. Delaware Nowata OK, 74048 PH: 918-533-6891	jcantwell@GrandMH.com
Mary Ann Dimery	State Employees	Oklahoma Health Care Authority	4345 N. Lincoln Blvd. Oklahoma City OK, 73105 PH: 405-522-7543	Mary.dimery@okhca.org
Jeff Dismukes	Others (Advocates who are not State employees or providers)	Depression and Bipolar Support Alliance of OK	3000 United Founders Bldg, Suite 104 Oklahoma City OK, 73112 PH: 405-590-2932	jeff@dbsaok.org
Jeni Dolan	Youth/adolescent representative (or member from an organization serving young people)	Operation Aware	8990-B S. Sheridan Rd. Tulsa OK, 74133 PH: 918-606-3064	jdolan@operationaware.org
Janys Esparza	Providers		420 SW 10th St. Oklahoma City OK, 73109 PH: 405-236-0701	dirtx@latinoagencyokc.org
Karen Hall	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 180 Savanna OK, 74565 PH: 917-605-7315	karenjrod1415@gmail.com
Nola Harrison	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1000 N. Lee Oklahoma City OK, 73102 PH: 405-650-4615	mailto:Nola.Harrison@ssmhealth.com
Meadow Hazelhoff	Providers		6501 Broadway Extension 200 Oklahoma City OK, 73116	meadow.hazelhoff@gmail.com

			PH: 405-219-2271	
Cindy Hickl	Providers	OU Impact	4444 E. 41st Ste. 2900 Tulsa OK, 74135 PH: 918-660-3150	Cynthia-Hickl@ouhsc.edu
Edwina Horsechief	Persons in recovery from or providing treatment for or advocating for SUD services		301 W. Broadway Anadarko OK, 73005 PH: 405-247-2425	edwina.horsechief@wichitatribe.com
Dustin Huckabe	Persons in recovery from or providing treatment for or advocating for SUD services		212 Pecan Valley Norman OK, 73069 PH: 210-464-3267	dustin.huckabe@gmail.com
Staci Kirby	Persons in recovery from or providing treatment for or advocating for SUD services		2401 Cherokee Strip Altus OK, 73521 PH: 580-481-4184	staci.amethyst@gmail.com
Raymond LeMay	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1309 NE 22nd St. Moore OK, 73160 PH: 918-408-0965	raymond.a.lemay@gmail.com
Alesha Lily	State Employees	OK State Department of Health	1000 NE 10th St. Oklahoma City OK, 73117 PH: 405-271-4477	alesham@health.ok.gov
Kelli Litsch	State Employees	Oklahoma Department of Human Services	2400 N. Lincoln Blvd. Oklahoma City OH, 73105 PH: 405-203-8287	Kelli.Litsch@okdhs.org
Andrea Michaels	Others (Advocates who are not State employees or providers)	NAMI of Oklahoma	PO Box 1306 El Reno OK, 73036 PH: 405-456-0312	andrea@namioklahoma.org
Stephanie Morcom	Persons in recovery from or providing treatment for or advocating for SUD services		4475 W. Beech Duncan OK, 73533 PH: 940-597-0955	smorcom@ambrosiatc.com
Janna Morgan	State Employees	Oklahoma Department of Corrections	2901 N. Classen Ste. 200 Oklahoma City OK, 73106 PH: 405-761-3028	janna.morgan@doc.state.ok.us
Edie Nayfa	Persons in recovery from or providing treatment for or advocating for SUD services		3033 N. Walnut Ave. Oklahoma City OK, 73015 PH: 405-826-0105	enayfa@catalystok.org
Young Onuorah	State Employees	OK Dept. of Mental Health & Substance Abuse Srvcs	2000 N. Classen Blvd., Suite 600 Oklahoma City OK, 73106 PH: 405-626-0411	YOnuorah@odmhsas.org
Cheryl Polk	Family Members of Individuals in Recovery (to include family members of adults with SMI)		910 West Oak Duncan OK, 73533 PH: 940-839-6902	leann.polk1110112@gmail.com
Kelli Reid	State Employees	OK Dept. of Mental Health & Substance Abuse Srvcs	2000 N. Classen Blvd., Suite 600 Oklahoma City OK, 73106 PH: 405-248-9241	kreid@odmhsas.org

Lindsey Roberts	Youth/adolescent representative (or member from an organization serving young people)	Neighbors Building Neighborhoods	207 N. 2nd St. Muskogee OK, 74401 PH: 918-683-4600	lroberts@nbn-nrc.org
Tyler Ross	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3171 N. Portland Ave., Apt. 104 Oklahoma City OK, 73112 PH: 405-436-7366	tyler@ocarta.org
Lyndi Seabolt	Persons in recovery from or providing treatment for or advocating for SUD services		9705 Broadway Extension Suite 200 OK, 73114 PH: 405-620-0500	LSeabolt@spthb.org
Sarah Rachel Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5845 NW 72nd Place Warr Acres OK, 73132 PH: 405-642-8270	savingcourtney14@gmail.com
Darlene Steeves	State Employees	Oklahoma Housing Finance Agency	100 NW 63rd St. Oklahoma City OK, 73116 PH: 405-419-8211	darlene.steeves@ohfa.org
Jeff Tallent	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1620 Ridgecrest Edmond OK, 73013 PH: 405-203-7898	jefftallentz@aol.com
Lisa Webb	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1728 CR 1260 Tuttle OK, 73089 PH: 405-417-0581	llwebb@hopecsi.org
Sheamekah Williams	State Employees	OK Dept. of Mental Health & Substance Abuse Srvcs	2000 N. Classen Blvd., Suite 600 Oklahoma City OK, 73106 PH: 405-248-9393	sxwilliams@odmhsas.org
Kelly Willingham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4000 N Lincoln Blvd. OKC OK, 73105 PH: 405-249-7828	kelly.willingham@gmail.com
Louann Wiseman	Persons in recovery from or providing treatment for or advocating for SUD services		1111 West Spruce Duncan OK, 73533 PH: 580-606-2419	llwiseman@yahoo.com

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

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	6	
Parents of children with SED	0	
Vacancies (individual & family members)	5	
Others (Advocates who are not State employees or providers)	2	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**16**	**48.48%**
State Employees	10	
Providers	4	
Vacancies	1	
Total State Employees & Providers	**15**	**45.45%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	2	
Individuals/Family Members from LGBTQI+ Populations	3	
Persons in recovery from or providing treatment for or advocating for SUD services	7	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	2	
Total Membership (Should count all members of the council)	**33**	

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Footnotes:

With the above table, vacancies are added into the actual numbers of PAC members. Additionally, people in recovery from SUD, family members of people who have SUD issues, SUD treatment providers, and members from organizations that serve young people are NOT added into the top two sections of the grid, since they are not statutorily mandated. Here are the approximate numbers: There is a total of 34 PAC members. 10 of those members are state agencies, 3 are individuals in recovery from SMI, 6 are family members of people with SMI, 2 are advocates who are not state agencies or providers, 4 are MH providers, 1 is an SUD provider, 5 are individuals in recovery from SUD, 1 is a family member of a person with SUD and 2 are agencies serving youth.

Prior to January of 2022, ODMHSAS PAC had several vacancies (18) on the PAC. In 2019, many Council members termed out and COVID made recruiting new members difficult. Additional PAC members termed out in 2022. Since January of 2022, there have been twenty-two PAC

members added. ODMHSAS PAC has been and will continue to actively pursue potential members to fill spots. The ODMHSAS PAC does not currently have a representative from the Oklahoma State Department of Education (OSDE) due to recent turnover. Attempts have been made to get this vacancy filled and the attempts will continue until it is filled. The ODMHSA PAC also does not have any members of parents of minor children with SUD or parents of children with SED. (Four of our family members are parents of adult children whose mental health and substance use issues began when they were minors.) In order to fill this slot-of family members with minors having SED or SUD- we have engaged with parent advocacy agencies, such as Parents Helping Parents, which is an organization that helps advocate for and support parents whose children struggle with substance use disorder. We have also engaged with the Systems of Care programs, at treatment agencies, that work with families, children, youth and young adults in an attempt to garner referrals. These referrals have produced parents with adult children with SMI/SUD whose issues began when they were minors but we have not yet acquired a referral of a parent with a child with SED/SUD. We will continue to pursue acquiring referrals through these avenues as well as others like these.

Because there was a significant amount of PAC members that were from the urban areas and their closely surrounding communities, it has been a focus to gather PAC members from rural and more rural type settings, so as to ensure input was obtained from these areas of Oklahoma, as some of the difficulties that they encounter (i.e. no public transportation) are different from those in urban areas. This area is not asked for in the grid above. However, there is representation from rural area. Work has been done in the area of recruiting younger adults (18-25) as well as those from diverse racial, ethnic and LGBTQ populations. Work will continue to be done to recruit in these areas.

It is unfortunate that PAC member councils can only have one designation on the PAC council. We have individuals in recovery and family members, providers and state agency PAC members who are representatives of diverse racial/ethnic and LGBTQ+ groups (8) as well as those belonging to Federally Recognized Tribes (3). We have (2) veterans and also representation from rural areas. To suggest that the feedback that they share at the PAC meetings is based only on their singular designation is factually inaccurate and honestly, a disservice to them. I continue to hope that the federal government will someday allow states to spotlight the wealth of experience that is on PAC member councils.

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://oklahoma.gov/odmhsas/about/public-information/grant-and-solicitations.html

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://oklahoma.gov/odmhsas/about/public-information/grant-and-solicitations.html

c) Other (e.g. public service announcements, print media) ( ) Yes ( ) No

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

None needed.

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Footnotes:

This application and preceding years application materials have been placed on the ODMHSAS website for public comment prior to grant submission and they remain on the website to allow for public comment. Comments are recorded via web link response. There have not been any comments made on the application. In addition to posting on the ODMHSAS website, the block grant coordinator has a statement on her signature line, in her work email, directing people to the ODMHSAS website and inviting a review and feedback to the materials posted there. As she corresponds with a wide range of people throughout Oklahoma, this may be seen by a large number of people.

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

ODMHSAS is not pursuing this, at this time.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

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