Oklahoma

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 05/27/2026 11.13.25 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	X5K6JYC467J7

I. State Agency to be the SUPTRS BG 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 SUPTRS BG Grantee of the Block Grant

First Name	Gregory
Last Name	Slavonic
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	GrantNotifications@odmhsas.ok.gov

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	Gregory
Last Name	Slavonic
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	GrantNotifications@odmhsas.ok.gov

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	8/29/2025 3:40:21 PM
Revision Date	4/9/2026 12:33:15 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: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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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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: Gregory Slavonic, Rear Admiral, USN (Ret.)

Signature of CEO or Designee[1]: _____

Title: Interim 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: 05/28/2025 Expires: 01/31/2028

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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.

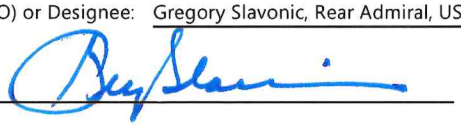
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Gregory Slavonic, Rear Admiral, USN (Ret.)

Signature of CEO or Designee[1]: 

Title: Interim Commissioner

Date Signed: 8/12/2025

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: 05/28/2025 Expires: 01/31/2028

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 2026

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 II of the Public Health Service Act		
Section	**Title**	**Chapter**
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.
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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;
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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;
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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.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: Gregory Slavonic, Rear Admiral, USN (Ret.)

Signature of CEO or Designee[1]: _____

Title: Interim 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: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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 II of the Public Health Service Act		
Section	**Title**	**Chapter**
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.
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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:

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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.

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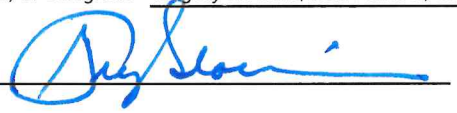
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by 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: Gregory Slavonic, Rear Admiral, USN (Ret.)

Signature of CEO or Designee[1]: 

Title: Interim Commissioner

Date Signed: 8/12/2025

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: 05/28/2025 Expires: 01/31/2028

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

Oklahoma Department of Mental Health and Substance Abuse Services

BSCA Funding Plan 2026

***Introduction*.** The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) will utilize the Bipartisan Safer Communities funds to enhance and expand crisis intervention services through support for schools developing crisis protocols, training and technical assistance for staff working in crisis services and implementing a youth council for feedback on crisis services and policies.

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's children 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 youth crisis system infrastructure, federal block grant investments, and the recent launch of 988 as the national behavioral health crisis helpline. All of which have 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 avoid unnecessary law enforcement and criminal justice involvement. The OCCC is comprised of three primary 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 Recovery and Crisis Centers.

To support all levels of integrated community-based care, Oklahoma now has Certified Community Behavioral Health Clinics (CCBHCs) in every county in the state. 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.

Among the current Community Mental Health Centers (CMHCs) that have transitioned to CCBHCs are all four of the state-operated centers. These CCBHCs operate as the state's safety net of behavioral health care across 32 of the state's 77 counties, serving thousands of Oklahomans in crisis, outpatient, inpatient, and residential settings. The transformation of all 77 counties transitioning to CCBHCs has been a heavy lift to employ many more behavioral health staff,

change the way of business – including shifts to team-based care, and changing the culture of services to widen the access for all individuals in a community.

ODMHSAS has long been a leader in prioritizing youth mental health by developing a comprehensive crisis continuum that incorporates evidence-based models of treatment. The state recognizes the critical need for early intervention and effective care to address mental health challenges among its youth population, particularly those experiencing crises. To this end, Oklahoma has implemented a multi-tiered approach that emphasizes immediate crisis intervention and ongoing support, ensuring that young people receive timely and appropriate care.

Description. ODMHSAS will enhance and expand crisis intervention services through support for schools developing crisis protocols, training and technical assistance for staff working in crisis services and implementing a youth council for feedback on crisis services and policies from those who are receiving the services.

Project Plan. Oklahoma can significantly enhance its youth crisis continuum by strategically investing in workforce training, technical assistance, and the inclusion of youth voices in the development and implementation of crisis protocols. By focusing on these areas, the state can create a more responsive, effective, and youth-centered mental health system.

1. **Technical Assistance for School Districts under HB 4106:** This is a continuation from the 3rd installment. Oklahoma has over 200 school districts and this would allow this work to continue as those schools develop their crisis protocols. House Bill 4106 mandates the development of crisis protocols with their local CCBHC and other mental health partners in school districts across Oklahoma. The state can enhance its crisis continuum by ensuring that school districts receive targeted technical assistance, as they develop and implement these protocols. This will be done by the state providing funding to the Oklahoma State Department of Education so that they can subcontract with a nonprofit entity who will then render technical assistance to them. This technical assistance could include offering workshops, resources, and expert consultation to help districts and CCBHCs create comprehensive crisis plans that align with state guidelines and best practices. By ensuring that every school has a robust crisis response plan that includes working with the current crisis continuum services our state has implemented (988, mobile response and stabilization, family model URC's and crisis units), Oklahoma can better prepare educators and staff to identify, intervene, and support students in crisis, ultimately creating safer and more supportive school environments.
2. **Crisis Assessment Tool Train the Trainer** - The CAT, originally known as the Childhood Severity of Psychiatric Illness (CSPI), is a decision support and communication tool to allow for the rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community. It is intended to be completed by individuals who are directly involved with the youth. The form serves as both a decision support tool and as documentation of the identified needs of the child served along with the decisions made with regard to treatment and placement at the time of the crisis. There are five key characteristics of the CAT that should be considered when completing the ratings.

3. **Mobile Response and Stabilization Services -** Any time a child is removed from their home, it is automatically a crisis trauma. We propose a pilot project in OK and Tulsa County to support expanded access to serve all children entering out-of-home placement for the first time due to abuse or neglect or subsequent placement disruptions with the goal of supporting the transition and preventing crisis that might cause placement disruption.

   When a child is removed from his or her home, an MRSS worker automatically is assigned and dispatched to meet with the child at the relative or foster placement within the first 72 hours. During this initial meeting, the MRSS worker meets individually with the child to acknowledge the trauma the child is experiencing and discuss how they can work together to address any worries or challenges the child might have with sleeping, eating, schoolwork, etc., as a result of this trauma. The MRSS worker also meets with the caregiver and discusses similar issues and strategies so the caregivers can feel more equipped to respond to any potentially challenging behaviors at the outset. This initial visit also establishes a relationship between the caregiver and MRSS, so that the caregiver is more likely to ask for help before there is a crisis.

   By focusing on these areas, Oklahoma can build a more robust, youth-centered crisis continuum that effectively addresses the mental health needs of its young population, ultimately leading to better outcomes and a healthier future for its youth.

   Justification. Oklahoma's Youth Mental Health Crisis Continuum lies in the urgent and growing need to address the mental health challenges faced by the state's youth population. Mental health crises among young people have become increasingly prevalent, with rising rates of depression, anxiety, self-harm, and suicide. The continuum, designed to provide a seamless and coordinated response to these crises, is essential in ensuring that youth receive timely, effective, and evidence-based care that can prevent escalation and promote long-term recovery.

Project	**Cost**	**Cost**
Crisis Technical Assistance Team for school districts	$100,000	$100,000
Crisis Assessment Tool (CAT) Train the Trainer	$50,00	$50,000
Mobile Response and Stabilization Service Expansion Pilot	$444,193.35	$444,193.35
eSMI (10%)		$69,905.10
Crisis (5%)		$34,952.55
	Total	$699,051.00

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

Gregory Slavonic, Rear Admiral, USN (Ret.)

Title

Interim Commissioner

Organization

Oklahoma Department of Mental Health and Substance Abuse Services

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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 prevention system (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 behavioral health 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 mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. 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."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

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, 35 mental health courts, drug courts serving 67 counties, 24 prevention providers, and 62 specialty providers, including housing, advocacy, and consumer and family-operated programs.

Beginning October 1, 2025, all 13 Oklahoma CCBHCs will operate under a Centers for Medicare and Medicaid Services (CMS)-approved State Plan Amendment, previously Oklahoma operated under the SAMHSA CCBHC Demonstration. This transition represents a significant advancement in the sustainability and delivery of comprehensive, community-based mental health and substance use services. CCBHCs are required to provide care coordination and care management to ensure integrated behavioral health and health care. They are also required to provide treatment for mental health disorders as well as substance use disorder and co-occurring issues.

There is 1 RA1SE NAVIGATE program, a coordinated specialty care program, to assist individuals who are experiencing a First Episode of Psychosis (FEP), and statewide early Serious Mental Illness (ESMI) Outreach Programs provided through 13 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 has 6 Children and Youth Crisis Stabilization Units (CSUs). These units provide crisis stabilization services usually lasting 3-7 days. Currently in Oklahoma there are a total of 8 Child and Adolescent Urgent Recovery Centers (URCs) open across Oklahoma. Oklahoma has 13 Adult CSUs. These units provide crisis stabilization services usually lasting 3-7 days. Consumers are referred for outpatient services upon discharge. There are currently 20 URCs open across Oklahoma.

Prevention Services

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 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 reinfrcement 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.

Early Identification for Severe Mental Illness (ESMI)

RA1SE NAVIGATE is a Coordinated Specialty Care model that is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family, as active participants. This comprehensive early treatment model is focused on helping young people 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. Oklahoma has one RA1SE Navigate program and it is located in an urban area. Family and Children's Services of Oklahoma serves consumers in Tulsa County. In addition, Oklahoma has statewide early Serious Mental Illness (ESMI) Outreach Programs provided through 13 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. More information on the RA1SE Navigate program can be found in Section 2 of the Environmental Factors and Plan section of this application.

ODMHSAS has received the Chronic High Risk for Psychosis (CHR-P) grant and has partnered with the University of Oklahoma, in Cleveland County, as well as the CCBHC in that county, Central Oklahoma Community Mental Health Center (COCMHC). College staff personnel are 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. COCMHC staff have been trained on these concepts as well as on how to administer the screening and assessment. Individuals who are screened and are not in need of CHR -P services are offered whatever services might be most needed. Individuals who screen and assess as in need of CHR-P services, are offered a scaled up, more wraparound type of treatment services. Individuals who screen and assess as needing a higher level of services, are referred to the RA1SE Navigate program.

Treatment
Mental Health Services

Overview. The ODMHSAS provides a mental health services continuum of care that provides outreach, outpatient services, 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.

For children and their families, Systems of Care is the preferred approach to coordinate services. 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 crisis stabilization and residential services for children up to the age of 18 with mental health, substance use, or co-occurring disorders.

Transition Youth. Oklahoma transition aged youth (13-25) can thrive when they have access to programs, services, and supports that foster physical, mental, emotional health and wellbeing. ODMHSAS partners with treatment service providers who provide treatment and support for emotional, mental, and behavioral health illnesses, imbalances, and disorders, as well as help for substance use and co-occurring disorders. In addition, we provide access to services and supports for homelessness, juvenile justice, drug court or child welfare issues, long term and out-patient behavioral health services, and first episode psychosis treatment.

Wraparound/TIP. Wraparound/TIP (Transition to Independence Process) is a youth driven version of traditional wraparound provided at various SOC sites. The goal is to support youth in identifying natural and formal supports to help meet their needs, attain mental and physical wellness, and achieve personal goals through a structures process adhering to the principles of Wraparound and the TIP model.

Early Childhood Systems of Care. The ODMHSAS continues to build 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.

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) delivers Infant and Early Childhood Mental Health (IECMH) services through an integrated System of Care that brings together multiple sectors to support the mental health and developmental needs of young children and their families. By partnering with social services, early childhood education programs, child welfare, juvenile justice, law enforcement, and substance use treatment providers, ODMHSAS ensures a comprehensive, family-centered approach to early intervention and prevention. Through initiatives such as IECMH consultation in childcare settings, home visiting collaboration, and cross-training with child welfare and early education professionals, services are coordinated to address trauma, attachment disruptions, developmental concerns, and caregiver mental health. Integrated care teams use a wraparound model to develop individualized service plans that involve families as active partners, reduce system fragmentation, and promote emotional well-being. ODMHSAS also supports early screening, developmental assessments, and access to evidence-based treatment for both children and caregivers. Another key component of this work includes the Safe Babies Program, which supports infants and toddlers involved in or at risk of child welfare involvement by coordinating care to promote early intervention, family reunification, and healthy development. By aligning efforts across systems, IECMH services in Oklahoma aim to strengthen family stability, reduce the long-term impact of adverse childhood experiences, and build a resilient foundation for lifelong mental health. 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.

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. Beginning Oct. 1, 2025, MRSS will be transitioned into 988 so that any family needing mobile response can receive the same response using national best practice guidelines for children and youth mobile response.

Adult Urgent Recovery Center (URCs) and Crisis Stabilization Units (CSUs). Oklahoma has 13 adult CSUs. These units provide crisis stabilization services usually lasting 3-7 days. Consumers are referred for outpatient services upon discharge. There are currently 20 adult URCs open across Oklahoma.

Children and Families Urgent Recovery Centers (URCs) and Crisis Stabilization Units (CSUs). Currently, Oklahoma has six children's CSUs in the following cities: Red Rock in Oklahoma City, The Calm Center in Tulsa, and Children's Recovery Center in Norman, Grand Mental Health in Claremore, Green Country Behavioral Health in Muskogee, Spring Creek Kids in Sapulpa. One in Sapulpa specializes in serving children and youth with special needs such as IDD (Intellectual and Developmental Disabilities)/DD (Developmental Disabilities) 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 11 specific contracts for adolescent substance use. There are 8 child and adolescent URCs that are open in Tulsa, Norman, Claremore, Muskogee, McAlester, Durant and two in Sapulpa. These URCs use a family model of care, so the caregiver stays with the child during the crisis stabilization process. In FY25, 1,514 children and youth and 1,744 caregivers received crisis services in the URCs. All families receive a 24-hour follow-up appointment after leaving the URC. All URCs must 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 can have access to free training on the use of those kits from the Autism Foundation of Oklahoma.

Adult Inpatient. 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 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. More information on adult and children's mental health services can be found in Question 3 of Planning Step 1 as well as in the following sections found in the Environmental Factors and Plan section of this application: Section 1 (Access to Care), Section 6 (Statutory Criterion for MHBG) and Section 9 (Crisis Services).

Suicide Prevention. 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. More information can be found on suicide prevention in the Section 12 of the Environmental Factors and Plan section of this application.

More information on mental health treatment as it relates to priority populations not already addressed here can be found in Question 3 of Planning Step one.

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 as well as co-occurring 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.

Specific information regarding priority populations receiving substance use disorder treatment can be found in Question 3 of

Planning Step 1.

Medication for Substance Use Disorder. Medication for Substance Use Disorder (including Alcohol Use Disorder) and Medication for Opioid Use Disorder (MOUD), both formerly falling under Medication Assisted Treatment (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 currently 16 Opioid Treatment Programs. The OTPs are mandated to be certified by the ODMHSAS, in addition to having certification/approval by SAMHSA, Drug Enforcement Administration (DEA), the Commission on Accreditation of Rehabilitation Facilities (CARF), and OBNDD (Oklahoma Bureau of Narcotics and Dangerous Drugs) and they are private, for-profit organizations. Currently, the ODMHSAS contracts for MOUD services, at the CCBHCs, CCARCs, and one OTP through the SOR grant. ODMHSAS also implemented a program to get MOUD into county jails and MOUD is now being provided in 39 of Oklahoma's county jails. Work is also being done to ensure MOUD is available to those incarcerated in prison. In partnership with the Oklahoma Department of Corrections, ODMHSAS is conducting a pilot on MOUD, partnering with Maric Health (OTP) to provide methadone dosing and maintenance with cohorts at Mabel Basset and Lexington facilities. In June, there were 43 participants across both facilities.

Substance Use Treatment for Adolescents. The ODMHSAS currently has 11 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.

Recovery Support Services

Overview. 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), the Evolution Foundation, and the Depression and Bipolar Support Alliance of Oklahoma (DBSAOK). DBSAOK provides services to bridge gaps in the treatment system and aids the SMI population in navigating services. DBSAOK serves 5,000 Oklahomans annually and partners with providers statewide to advocate for better treatment services for SMI. 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.

Peer Recovery Support Services for Adolescents. Peer Recovery Support Services is also offered for adolescents aged 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 addressed more in-depth in Planning Step 1, Question 3.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

System Structure. As the Single State Agency for Substance Abuse and the State Mental Health Authority, the ODMHSAS fulfills many state level responsibilities as a purchaser and regulator 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 Behavioral Health Policy and Provider Regulation, Certification Training, Prevention, Housing & IPS, Clinical Programs, MAT, OPTs, Opiate & Women's Treatment Services, Family/Youth and Civil Diversion Programs, Crisis Services, Children's Outpatient and School Based Programs, Treatment and Recovery Services, Decision Support Services, Grant Oversight, and Justice Services. All leadership and management structures are organized under the ODMHSAS Interim Commissioner and his executive staff including the Deputy Commissioner of Hospitals, Chief of Policy and Provider Regulation, Chief of Compliance and Accountability, Chief of Clinical Programs, Chief of Programs and Education, Chief Technology Officer, Chief Management Officer, Chief of Operations, Chief of Justice Services, and General

Counsel.

Provider. Daily, approximately 1,748 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. State operated entities consist of urgent care units and crisis stabilization facilities, CCBHC's, and inpatient mental health hospitals.

Regulator. 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).

Independent Peer Review. The ODMHSAS continues to request that Block Grant funded providers coordinate independent 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. The peer reviews review the quality and appropriateness of treatment services. Each year, the ODMHSAS exceeds the 5% minimum requirement set forth in regulations.

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 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.

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 two major conferences each year, the Children's Behavioral Health Conference, and the Momentum Conference (which covers Prevention, Justice, and Recovery topics.) The ODMHSAS Human Resources Development training programs recorded combined audiences of over 51,553 participants from all areas of Oklahoma in the state fiscal year 2025. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce.

Person-Centered Services Training. 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 implement person-centered planning more fully 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 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 regarding 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.

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: Cognitive Behavioral Therapy, CBT for Psychosis, Motivational Interviewing, GAIN SS, Community Reinforcement Approach and Adolescent Community Reinforcement Approach, Contingency Management, and Recovery Management Check-ups and Support (RMCS) to help improve the services they provide to adolescents and young adults.

PRSS Training. In addition to certifying 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 there are specialty tracts for Peers to specialize in youth and young adults, veterans, criminal justice, Domestic Violence, Crisis care, Older Adults, gambling, and Peer Supervision. 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.

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. The Annual Children's Behavioral Health Conference brings together many individuals, many who 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 provides training in various suicide intervention and crisis techniques, such as Mental Health First Aid and Overdose Education and Naloxone Distribution training to the emergency room, health personnel, and law enforcement staff.

The ODMHSAS hosts Crisis Intervention Training (CIT) trainings for law enforcement. The 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 over 2,000 law enforcement officers throughout the state. CIT programs have been modified for detention officers and other law enforcement populations. ODMH's CIT program is also actively working to develop regional training hubs to support CIT training needs. There are currently 3 training hubs serving the northern and central areas of the state.

Additionally, 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. ODMHSAS continues to work with CLEET to ensure the availability of behavioral health training is up to date and relevant to officer's needs.

Suicide Prevention Treatment, Training and Activities. 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 over 4,000 clinicians in CAMS.

ODMHSAS has also increased training for Colleges and Universities and consultations to provide treatment for their student population in their college counseling programs for treatment of suicidal and substance abuse issues.

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.

Problem Gambling Treatment Services. The Oklahoma Gaming industry is represented by over 120 casinos, four horse tracks/racinos, and the Oklahoma Lottery. Oklahoma has the second most casinos in the nation after Nevada. 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 almost doubled from the first prevalence study, in 2015, from 3.2% to 6.3% in the 2022 prevalence study. There has not been a prevalence study since 2022. The size of the at-risk population is 23.5%. Altogether, nearly a third of Oklahomans (29.8% or 1 million people) are experiencing injury related to gambling. Many subgroups of the population have problem gambling prevalence above the adult average, including African Americans, Asians, men, individuals aged 25-44, those who did not graduate from college, and the military. Stigma continues to pose a difficulty 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 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 programs mentioned above 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 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 certifying for and rendering 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.

Targeted Supports and 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.

Pretrial Support. 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.

Jail Screening. Jail 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 jail and prison-alternative sentences that best meet the offender's needs and increase the likelihood of successful diversion. By serving as central screening hubs, county jail-based screenings save diversion program resources and avoid duplicative assessment processes. Jail 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 jail screening experienced an increase in the percentage of non-violent prison receptions that was approximately twice that of counties with jail screening. ODMHSAS has made Jail 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. 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 97.1 percent drop in unemployment, a 33.1 percent jump in monthly income, a 94.5 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. 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 48.6 percent drop in unemployment, a 96 percent decrease in arrests, and a 97.9 percent decrease in the number of days spent in jail. There are currently mental health courts in 35 Oklahoma counties.

Family Treatment Courts. Family Treatment Courts (FTCs) are a vital component of Oklahoma's strategy to improve access and outcomes for families impacted by substance use and child welfare involvement. 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. FTCs use a collaborative, multidisciplinary approach to provide timely access to family-centered, trauma-informed treatment, parenting services, and wraparound supports—while maintaining judicial oversight to promote accountability and reunification. FTCs directly support Oklahoma's goals to reduce foster care entries and improve child and parent well-being and align with the HOPE Initiative and statewide family-centered practices.

Misdemeanor/Early Diversion Programs. These 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 41 counties operating

misdemeanor/early diversion programs. Over the last two years, the early diversion census has risen from 614 participants to over 2790 participants.

Veteran Support. This 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 identify justice-involved veterans more quickly 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.

Reentry Teams and Discharge Managers. The state funds three 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 prisons. 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

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. There are currently over 3,000 iPads in the field supporting law enforcement efforts.

Life Saving Overdose Prevention and Response and Other Supplies and Services. The ODMHSAS supports a state-level prevention “Ok, I’m Ready” campaign which serves as a resource for print and electronic materials (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. To empower local communities, the ODMHSAS is making vending machines that can disburse Narcan and Fentanyl test strips available to community partners at no cost. The community partners will be responsible for identifying and maintaining the location including a power source, supplying the machine software, and stocking the vending machine. After one year, the vending machines will be donated to the community partner for ongoing use.

Marketing Campaign. The ODMHSAS also engages in marketing campaigns to increase knowledge of services and decrease stigma. ODMHSAS continues to support the Tough as a Mother campaign, modeled after Colorado’s initiative of the same name. This public awareness campaign targets pregnant and parenting individuals with SUDs and aims to reduce stigma, increase public understanding, and connect women to services. Recognizing that stigma and fear of legal consequences can prevent individuals from seeking help, the campaign uses trauma-informed messaging and real-life stories to create a sense of safety and hope. The campaign is promoted through digital media, community partnerships, and provider outreach.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Mental Health Block Grant
(MHBG)

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
(Priority Populations: Adults with SMI, Individuals Who Have an ESMI, and Adults in Need of Crisis Services)

In December 2016, Oklahoma was awarded the Medicaid Demonstration project for Certified Community Behavioral Health Centers. This demonstration increased the capacity to serve individuals that qualified for Medicaid and allowed state dollars to more effectively serve individuals that were uninsured or underinsured. This Demonstration required promotion and increased services for individuals with a primary or secondary substance use disorder as well as co-occurring and mental health disorders. Oklahoma then expanded the CCBHC model statewide through a State Plan Amendment (SPA). Oklahoma was the first CCBHC state with an approved State Plan Amendment for CCBHC services.

Beginning October 1, 2025, all 13 Oklahoma CCBHCs will operate under a Centers for Medicare and Medicaid Services (CMS)-approved State Plan Amendment, previously Oklahoma operated under the SAMHSA CCBHC Demonstration. This transition represents a significant advancement in the sustainability and delivery of comprehensive, community-based mental health and substance use services. 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 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.

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 (1) crisis services, (2) screening, assessment, diagnosis and risk assessment, (3) treatment planning and (4) 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 Designated Collaborating organization (DCO) or provided by the CCBHC include (1) outpatient primary care screening and monitoring, (2) community mental health care for Veterans, (3) targeted case management, (4) peer, family support & counselor services, and (5) psychiatric and rehab services.

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

o Crisis Services
o Psychiatric Rehabilitation
o Care Coordination
o Housing & Employment Services
o Screening, Assessment, and Diagnosis
o Outpatient Mental Health & Substance Use Services o Targeted Case Management
o Veterans Services
o Outreach & Engagement
o Integrated Care & Health Promotion
o Primary Care Screening & Monitoring
o Comprehensive Integrated Care Planning
o Peer Support & Family Support Services

Many of the above topics are addressed elsewhere in this application. Crisis Services, Housing, and Veterans Services are addressed further on in Question 3. Access to care, including care coordination and primary care screening and monitoring, are addressed in Section 1 of the Environmental Factors and Plan section. Screening, Assessment and Diagnosis, and Integrated Care and Health Promotion and Planning and Case Management are also addressed in Section 6, Criterion 1 of the Statutory Criterion for MHBG, in the Environmental Factors and Plan section. Below is information on some of the items in the list above as well as other services or supports that are available to adults with SMI.

Integration of Treatment. CCBHCs are required to offer a full array of services to treat and support the population served. Screening and assessment are performed to determine the presence of mental health, co-occurring or substance use disorders. Care is delivered using an integrated interdisciplinary team that addresses physical health needs, as well as mental health needs, or substance use or co-occurring needs, appropriate treatment. 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.

Integration of Primary Care. Since the inception of the CCBHC, the ODMHSAS and providers have continued to focus on the primary health needs of adults with SMI. 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. 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).

The ODMHSAS also has a SAMHSA grant, Collaborative Care Model Project/PIPBHC (Promoting Integration of Primary and Behavioral Health Care). The program will increase access to behavioral health services through implementation of the Collaborative Care Model (CoCM) in at least 9 primary care sites. The CoCM is an evidence-based, integrated care approach that addresses mental and substance use conditions in primary care settings. Care is provided by a primary care team and includes a case manager, consulting psychiatrist, and other mental health professionals. Through training, technical assistance and staff support, the ODMHSAS collaborates with primary care offices to establish sustainable integrated behavioral health and substance use disorder treatment. The ODMHSAS has partnered with 2 primary care sites in Tulsa and 1 in Broken Arrow to reach populations in year 1 and expand services in years 2-4 to reach Oklahoma City and rural primary care practices. This grant will end on September 29th, 2029.

Peer Recovery Support. 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. 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. CCBHCs require and promote peer recovery support in its model which has increased the hiring and integration of Certified Peer Recovery Support Specialists.

Additionally, the ODMHSAS has incorporated the Family Support Provider role within the Peer Recovery Support Specialist certification. Family Support Providers are now named "Family Peer Recovery Support Specialists" (F-PRSS). An F-PRSS is an individual who has lived experience as a caregiver of a child, youth or young adult who has mental health or behavioral health challenges and is certified by ODMHSAS to offer family peer support services. Family Peers use their lived experience to ensure engagement and active participation of the family throughout the treatment process and assist family members in developing knowledge and skills to promote their family member's recovery. Currently there are over 2,212 actively certified Peer Recovery Support Specialists working across programs and providers.

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 2024, those discharging from inpatient or crisis services: 85% had follow up within 7 days, 91% did not re-admit to inpatient/crisis within 6 months and 80% were engaged in treatment within 45 days. More information on PRSS activities can be found in Section 10 (Recovery) in the Environmental Factors and Plan section.

Employment Services. Transitional employment programs are provided by Thunderbird Clubhouse, Oasis Clubhouse, and Crossroads Clubhouse. All three clubhouses are accredited by Clubhouse International (formerly the International Center for Clubhouse Development). The ODMHSAS and the Oklahoma Department of Rehabilitation Services (DRS) 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 states they are ready. This focus on the participant's choice and strengths aligns closely with other evidence-based practice models followed by 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. By the end of 2024, IPS programs had a cumulative employment rate of 43% competitively employed with participants earning an average hourly wage of $12.33.

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/Grand Lake Mental Health Center and Cleveland County Detention Center/ODMHSAS embedded at Central Oklahoma Community Mental Health Center serving over 400 individuals exiting incarceration. In 2023, Oklahoma County Detention Center/Hope Community Services joined the project.

Education Services. Adult basic education, like GED (General Educational Development) 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. IPS providers are expected to collaborate with their local Oklahoma Department of Rehabilitation Services (DRS) vocational rehabilitation counselors to further assist IPS participants reached their career and education goals.

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, three clubhouses certified by Clubhouse International currently operate independently of CCBHCs -- Crossroads Clubhouse (Tulsa), Oasis Clubhouse (Oklahoma City) and Thunderbird Clubhouse (Norman).

ESMI. RA1SE NAVIGATE is a Coordinated Specialty Care model that is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family, as active participants. This comprehensive early treatment model is focused on helping young people 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. Previously, Oklahoma had two RA1SE Navigate programs. At the end of September, one of the Navigate teams ended their contract. The remaining Navigate team at Family & Children's Services, is located in Tulsa County, which is an urban area. In addition, Oklahoma has statewide early Serious Mental Illness (ESMI) Outreach Programs provided through 13 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. More information on the RA1SE Navigate program can be found in Section 2 of the Environmental Factors and Plan section of this application. Data collection is performed both internally by the Navigate team as well as externally through a contract with the University of Oklahoma's e-TEAM. On-going program evaluation is accomplished by Individual Resiliency Training fidelity reviews that are provided by our Navigate consultants.

Other Activities Leading to a Decrease in Hospitalization. Oklahoma's service culture embraces a strengths-based and person-centered approach which begins with a thorough assessment of consumer interest, strengths and needs, and the formation of a plan to assist the consumer with successfully achieving their identified goals. The resources and supports necessary for community success are identified and facilitated through collaborative efforts among the consumer, their support systems, and the service provider. This level of focus helps to reduce the use of hospital or other institutional based resources.

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. For adults with Serious Mental Illness (SMI), care coordination focuses on ensuring seamless transitions across levels of care, managing co-occurring physical health needs, connecting individuals to housing, employment, and social services, and supporting community tenure. Intensive care coordination is available for high-risk individuals, including those in the "Most In Need" (MIN) population—defined by frequent use of crisis or inpatient services. A dedicated state-level Care Coordination Team (CCT) supports this work by monitoring real-time data alerts when MIN individuals access elevated levels of care. The CCT collaborates with inpatient providers and outpatient CCBHCs to coordinate warm handoffs, conduct joint staffing meetings when needed, monitor discharge planning, and track outpatient follow-up to ensure continuity of care. Further, the Enhanced Tier Payment System (ETPS), that ODMHSAS utilizes, provides an enhanced payment based, in part, on meeting lower inpatient utilization targets.

Crisis. CCBHCs are monitored to assure that services include cooperative discharge planning with inpatient programs and crisis stabilization 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. Oklahoma has 13 adult Crisis Stabilization Units (CSUs). These units provide crisis stabilization services usually lasting 3-7 days. Consumers are referred for outpatient services upon discharge. Urgent Care Centers (URCs) offer 23 hour 29 minute stabilization services. There are currently 20 adult URCs open across Oklahoma. Consumers are referred for outpatient services following discharge from the URCs as well. More information on CSUs and URC's can be found in Section 9 (Crisis) of the Environmental Factors and Plan Section.

Criterion 2: Mental Health System Data Epidemiology:
This information is contained in Section 6 Criterion 2 of the Statutory Criterion for MHBG, in the Environmental Factors and Plan section. The quantitative targets are contained in the Plan Table 1: Priority Area and Annual Indicators.

Criterion 3: Children's Services
(Priority Populations: Children with SED and their Families, Children/Adolescents in Need of Crisis Services)
Oklahoma Systems of Care (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.

The CCBHC network and the coordinated OKSOC sites provide statewide coverage for the comprehensive services available for children with SED and their families. Currently, Oklahoma has 80 local Systems of Care sites that cover 77 counties. All sites must be capable of screening and treating or referring children and youth with separate mental health 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.

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.

o Home-based services
o Family therapy
o Diagnosis-related education
o Client advocacy
o Outreach
o Supported employment and education o Peer family support
o Family self-sufficiency (housing supports)
o Socialization
o School-based services
o Wraparound/flexible funds
o Care Coordination

Health/Medical, Vision, and Dental Services. 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 above in the Criteria 1, Employment Services 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 below section for Criterion 4, Housing Services.

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. Additionally, all CCBHCs are required to have an MOU, Care Coordination Agreement or Protocols with all Disability Resource Services in their catchment areas, this includes with the Oklahoma Department of Rehabilitation Services.

School Based Services. School-based services are working to provide technical assistance and support for schools throughout the state of Oklahoma. Currently, we provide specific support to behavioral health providers serving 254 schools to improve behavioral health outcomes for students. Behavioral Intervention Services and Support in Schools (BISSS) provider networks throughout the state of Oklahoma utilize 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. In FY25, 6,540 students received services through this approach.

The youth and young adult team are currently partnering with BISSS providers to increase awareness in public schools regarding transition aged services and supports. This includes coordinating trainings for school staff on mental health and youth transition services and establishing a streamlined referral process for youth in need of services. In addition, ODMHSAS is currently working with contracted providers on engaging and connecting with universities in their communities and partnering with colleges and universities in bringing awareness around mental health and substance use in higher education. Specifically, ODMHSAS is focusing on areas around anxiety and depression, injury to self, and suicidal ideation, alcohol, and substance abuse.

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.

Transition Services. Oklahoma transition aged youth (13-25) can thrive when they have access to programs, services, and supports that foster physical, mental, emotional health and wellbeing. ODMHSAS partners with treatment service providers who provide treatment and support for emotional, mental, and behavioral health illnesses, imbalances, and disorders, as well as help for substance use and co-occurring disorders. In addition, we provide access to services and supports for homelessness, juvenile justice, drug court or child welfare issues, long term and out-patient behavioral health services, and first episode psychosis treatment.

Wraparound/TIP. Wraparound/TIP (Transition to Independence Process) is a youth driven version of traditional wraparound provided at various SOC sites. The goal is to support youth in identifying natural and formal supports to help meet their needs, attain mental and physical wellness, and achieve personal goals through a structures process adhering to the principles of Wraparound and the TIP model.

Special Projects/Initiatives: OHTI-2 is a program that provides services and supports for youth and young adults 16-25 with serious mental health conditions. This program creates developmentally appropriate and effective youth-guided local systems of care to improve outcomes in areas such as education, employment, housing, mental health and co-occurring services and to decrease contact with the juvenile and criminal justice systems. This program implements and expands evidence-based treatment services and supports for young adults in transition (YATs) with serious emotional disturbance (SED) or serious mental illness (SMI), including the Wraparound Model and Transition to Independence Process (TIP), which are developmentally appropriate; YAT-driven; and involve family and community members. YATs will be offered specialized services and supports that are developmentally and appropriate towards their specific needs which can include, but are not limited to Case Management, Peer Recovery Support Services, Individual Placement and Support Services (IPS), Therapy, Group Therapy, Rehab, and Medication Clinic.

Youth Diversion. The Youth and Young Adult Diversion initiative focuses on providing relevant services and supports to communities in providing treatment, crisis and support services to the 16- to 25-year-old population. This initiative plans and implements outreach, referral and engagement efforts to educational institutions, healthcare, child welfare, juvenile justice, and correction institution, to identify young adults in transition with untreated SED/SMI.

Clinical High Risk For Psychosis (CHR-P). CHR-P is a specialized program for early intervention designed to identify and support young people ages 16-25, showing early warning signs of psychosis. This program aims to support youth and young adults in resuming age-appropriate social, academic, and/or vocational activities, improve symptoms and behavioral functioning (that may be related to early onset of psychosis), Delay or prevent the onset of psychosis and minimize the duration of untreated psychosis for those who develop psychotic symptoms. This program implements and expands evidence-based treatment services and supports for young adults in transition (YATs) at clinical high risk for psychosis including the Wraparound Model, Transition to Independence Process (TIP), Recovery Oriented Cognitive Therapy (CT-R), and Cognitive Behavioral Therapy for Psychosis (CBTp). YATs who may be at Clinical High Risk for Psychosis will be referred for screening of psychosis risk via administering the PRIME Early Psychosis Screener. YATs with positive screenings will be referred for further assessment of psychosis risk via administering the Structured Interview for Psychosis-Risk Syndromes (Mini SIPS or SIPS assessment) and offered specialized, stepped model of care services, and supports appropriate to their assessment results which can include, but are not limited to Case Management, Peer Recovery Support Services, Therapy, Group Therapy, Rehab, and Medication Clinic.

Partnerships. ODMHSAS and OKDHS have several partnerships around access to treatment for youth in the child welfare system. ODMHSAS facilitate consultation calls with DHS staff and mental health service providers to establish and monitor mental health services. Oklahoma also has 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.

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.

Other Activities Leading to a Decrease in 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. CCBHCs are 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.

Crisis. As a part of the decrease in 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.

Oklahoma has 6 Children and Youth Crisis Stabilization Units (CSUs). These units provide crisis stabilization services usually lasting 3-7 days. All youth are referred for outpatient services upon discharge. Currently in Oklahoma there are a total of 8 child and adolescent Urgent Recovery Centers (URCs) open across Oklahoma. 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. One URC and CSU in Creek County specializes in serving children and youth intellectual and developmental disabilities. More information on Crisis Stabilization Centers and URC's can be found in Section 9 (Crisis) of the Environmental Factors and Plan Section.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
(Priority Populations: SMI Older Adults, Individuals with SMI/SED in rural areas and homeless)
Information about Older Adults with SMI and individuals with SMI/SED in rural areas is located at the end of this document as Older Adults with SUD and individuals with SUD who live in rural and frontier areas is also a recommended population for the SUPTRS BG.

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 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". Oklahoma also leads the nation in access to disability income through SSI/SSDI Outreach, Access, Recovery (SOAR). ODMHAS works 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 two housing programs through our partner, Mental Health Association Oklahoma (MHAO). One program, ION (Intensive Outreach and Navigation), is for those discharging from ODMHSAS crisis stabilization units and inpatient facilities and scattered site apartments offer support services. More information on Homeless Services for SMI can be found in Section 6, Criterion 4 of the Statutory Criterion for MHBG, of the Environmental Factors and Plan.

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.

Criterion 5: Management Systems:
Throughout this application, ODMHSAS describes the various things listed for this criterion. Financial resources can be found in the Planning Tables. Staffing and training (professional development) is addressed in Question 2 of Planning Step 1. Plans for how ODMHSAS intends to expend the SAMHSA Block Grants are throughout this application, both in the Planning Steps as well as the Environmental Factors and Plan.

Substance Use Prevention, Treatment, and Recovery Services Block Grant
(SUPTRS BG)

Criterion 1: Statewide Plan for Substance Use Primary Prevention, Treatment and Recovery Services for Individuals, Families and Communities
(Priority Populations: Individuals with Co-occurring MH and SUD, Persons in Need of Recovery Support Services for SUD, and Persons Experiencing Homelessness)
(Recommended Population: Youth)
Throughout this application, ODMHSAS furnishes or describes the various things listed for this criterion. Funding agreements

and assurances are attached to this application. This application and its accompanying documents will be submitted to SAMHSA, via WebBGAS, by the predetermined due date. Financial resources can be found in the Planning Tables. The ODMHSAS purposes and activities in spending the SUPTRS BG is outlined throughout the application. Goals and objectives can be found in the Plan Table 1: Priority Area and Annual Indicators section and a description of planned expenditures can be found in the Planning Tables.

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 five CCARCs throughout the state. CCBHCs are also able to render substance use disorder treatment services.

Co-occurring Treatment for Adults and Youth. 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 substance use disorder treatment is required of all providers.

Medication for Substance Use Disorder and Medication for Opioid Use Disorder. This type of treatment, formerly known as MAT, is provided through the CCBHCs, CCARCs, and OTPs (Opioid Treatment Programs). This is discussed more in-depth in Question 1 of the Planning Step 1 section.

Youth (Adolescent Substance Use Disorder Treatment). The ODMHSAS currently has 11 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 one adolescent substance use disorder and one co-occurring residential program. 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.

Recovery Support. Certified Peer Recovery Support Specialists (PRSSs) are also heavily utilized by our substance use disorder treatment providers. PRSS's have been addressed within Question 1 of Planning Step 1 and also within the Section 10 (Recovery) of the Environmental Factors and Plan section.
Recovery Housing. Another essential component of the recovery system is the state's partnerships for recovery housing. Using State Opioid Response Grant funds, the ODMHSAS contracts with the Oklahoma Alliance of Recovery Resources (OKARR) to certify recovery housing that is medication assisted treatment (MAT) friendly. OKARR is the state affiliate of the National Alliance for Recovery Residences (NARR) and is the leading advocacy group for those in recovery in the state providing certification of recovery housing, recovery community organizations, recovery friendly workplaces in addition to training and technical assistance in recovery support services. Two hundred and eighty-two recovery residences with over 1,919 beds have been certified in Oklahoma as of Dec 2024 and are following best practices within the social model of recovery.

The Oklahoma City Housing Authority, in collaboration with the ODMHSAS, provides sober-living environment for women in recovery, allowing them to focus on healing while maintaining custody of and strengthening bonds with their dependent children. Residents are required 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. Oxford House will be addressed later in this document.

Criterion 2: Primary Prevention (Priority Population):
ODMHSAS sets aside a minimum of 20% of each SUPTRS BG award for substance use primary 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: 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: 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 (SPF) 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.

Criterion 3: Pregnant Women and Women with Dependent Children
(Priority Population)

ODMHSAS does follow the preference and admittance to treatment facilities in the following order: first pregnant women who inject drugs, then pregnant women, then persons who inject drugs, and then all others. However, 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 the waitlist that they had previously used, which followed the preferential order given above.

Pregnant Women with SUD. 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.

All pregnant women assessed as needing outpatient substance use disorder services can be admitted into any outpatient program of their choice in the state. Pregnant women assessed at a higher level and needing 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 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 also implemented the Oklahoma Families First Project, a SAMHSA-funded initiative (2019–2023), which enhanced

outpatient services across ten counties (Creek, Cherokee, Tulsa, Okmulgee, Wagoner, Muskogee, Rogers, Washington, Kay, and Osage). This project focused on improving parenting and attachment, expanding case management, and strengthening family-oriented treatment approaches. The lessons learned from this project informed the development of the HOPE Initiative and supported the ongoing expansion of Family Treatment Courts.

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.

In 2024, ODMHSAS was awarded the State Pilot Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) grant through SAMHSA. This award supports the launch of the HOPE Initiative (Healthy Outcomes through Prevention and Engagement). The HOPE Initiative is a three-year effort focused on improving maternal and infant health outcomes and expanding access to family-based outpatient and intensive outpatient services for pregnant and postpartum women with a primary diagnosis of SUD. With the HOPE Initiative, there is an emphasis on opioid use disorder. The HOPE Initiative targets Comanche County and surrounding rural areas, which have been designated as a Health Professional Shortage Area (HPSA) and bear a disproportionate burden of maternal substance use, overdose, and child welfare involvement.

The HOPE Initiative features:
• Integrated, trauma-informed, responsive care for pregnant and postpartum women and their children under age 17.
• Services that include motivational interviewing, Parent-Child Assistance Program (PCAP), PRSS, Strengthening Families Program/ Celebrating Families Program!, (SFP/CFP), Circle of Security Parenting, Attachment Biobehavioral Catch-Up, and FDA-approved MOUD options.
• Use of Family Care Plans (FCPs), peer navigation, SBIRT screening, and a mobile app to facilitate warm handoffs, referrals, and care coordination.
• Coordination with tribal nations, birthing hospitals, OB/GYNs, child welfare, housing, and the legal system.
• A continued emphasis on anti-stigma messaging, including expansion of the Tough as a Mother campaign and strategic cross-system training.
• Partnership with The Evolution Foundation to expand outreach, community engagement, and coalition development.

Together, the HOPE Initiative and the work advanced under the original QIC-CCCT and SAFER projects demonstrate Oklahoma's ongoing, layered commitment to building a coordinated, family-centered system of care for pregnant and parenting individuals with substance use disorders—addressing stigma, increasing access to services, reducing maternal mortality, and supporting family preservation.

Women with Dependent Children
(Priority Population)
Oklahoma continues to prioritize expanding access to coordinated, comprehensive, and family-centered care for individuals with behavioral health needs, with a strong emphasis on women with substance use disorders (SUDs) who are pregnant or parenting dependent children. The state has implemented a continuum of residential, outpatient, recovery support, and justice-involved services that promote parenting capacity, family preservation, and long-term recovery.

To address the needs of women with dependent children, Oklahoma contracts with three residential programs and two halfway house programs designed for Women with Children (WWC), and provide integrated behavioral health services, including biopsychosocial assessments for both the parent and child(ren), case management, transportation, and linkages to community-based supports. One halfway house also operates a residential program for women without children, offering a flexible continuum of care as family needs evolve.

All WWC programs are required to prioritize pregnant women and ensure access to:
• Medical services, including prenatal care, well-child visits, and developmental screenings;
• Public benefit assistance (SNAP, Medicaid, TANF, etc.);
• Housing supports, Head Start, and early childhood education;
• Parenting education, employment and training, and mental health services.

These programs are also participants in federally funded initiatives aimed at improving maternal and child outcomes:

• From 2018–2023, Oklahoma operated under the SAMHSA Pregnant and Postpartum Women (PPW) grant to enhance residential treatment models.
• In 2024, Oklahoma received a new PPW-PLT grant from SAMHSA to support the HOPE Initiative (Healthy Outcomes through Prevention and Engagement), focused on expanding outpatient, intensive outpatient, and recovery services in Comanche County and surrounding rural areas for pregnant and postpartum women and their families. The initiative includes parenting interventions such as Circle of Security, Strengthening Families Program, and Celebrating Families Program along with Peer Recovery Support Services, Family Care Plans, contingency management, and the use of a mobile app to enhance referral coordination.
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. They must also 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.
In addition to programmatic and service expansions, Oklahoma is also strengthening infrastructure through workforce development efforts. The ODMHSAS is in the process of implementing a new "Women's Liaison" role at every state-contracted outpatient provider. This designated staff member will be responsible for ensuring that services addressing the needs of women with dependent children—are available, accessible, and coordinated within their agency.

The Women's Liaison will serve as a point person for internal coordination, training, and quality improvement efforts related to women's and family-centered care. ODMHSAS is actively working with providers to:
• Define the scope and responsibilities of the role,
• Identify appropriate staff within each agency to serve in this capacity, and
• Develop mechanisms to track implementation, outcomes, and impact of these roles on service access and engagement.
Together, these initiatives reflect the commitment of ODMHSAS to building a coordinated, trauma-informed, and family-centered system of care for women with substance use disorders and their children. By embedding these practices across all levels of care—from prevention and outpatient treatment to residential services, recovery housing, and court-based interventions—the state is working to ensure that services are responsive to the complex and evolving needs of women and families. These efforts aim not only to promote recovery, but to strengthen family stability, reduce system involvement, and support long-term well-being for the entire household.

Criterion 4: Persons Who Inject Drugs
(Priority Population)
Persons who inject drugs are served by all contracted ODMHSAS substance use disorder service providers, CCBHCs, and state operated facilities. As stated above, there is no longer a waitlist. But, when there was a waitlist, those individuals involved with IDU (injection Drug Use) were afforded priority placement.

Outreach is carried out, by the State, CCBHC's and other contracted entities in many avenues, resulting in contact with various populations. Throughout these outreach activities, contact is made with individuals who inject drugs. Once contact is made, the entities encourage individuals to seek treatment and give them information on how to access treatment.

Criterion 5: Tuberculosis Services
(Priority Population Services for people at risk of TB)
CCBHCs and the ODMHSAS substance use disorder service providers are contractually required to make tuberculosis services available to individuals receiving substance use disorder treatment. As there is no longer a waitlist, there is no need to provide interim services for individuals waiting for admission. The required services include referral to appropriate medical evaluation in the form of screening and treatment when needed, as well as counseling. 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.

Criterion 6: Early Intervention Services Regarding the Human Immunodeficiency Virus (Priority Population Services for people at risk of HIV)
Oklahoma is not an HIV state. 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. Information on HIV related issues is found in the above Criterion 4 Section for Persons Who Inject Drugs.

Criterion 7: Group Homes for Persons in Recovery from Substance Use Disorders
(Priority Population Persons Experiencing Homelessness)
Oxford Houses are another valued partner for recovery housing. Currently, there are 137 Oxford Houses through 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 MOUD and Medication for Substance Use Disorder, resulting in an increase of residents who are able to take advantage of this type of treatment.

Oxford House also operates multiple homes for women with children, as well as two houses—one in Oklahoma City and one in Tulsa—both for men with dependent children.

Criterion 8: Referrals to Treatment:
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 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 weekly 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. 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. Because there is not a waitlist, there is not a need for interim services. For those who are unsure about treatment at a higher level of care, they are offered outpatient services by the contracted provider.

Criterion 9: Independent Peer Review:
Information on the Independent Peer Review is found in Question 2 in Planning Step 1 section.

Criterion 10: Professional Development:
Information on Professional Development is found in Question 2 of the Planning Step 1 section.

Other Populations
Older Adults
(MHBG Priority Population Older Adults with SMI, SUPTRS BG Recommended Population Older Adults with SUD, SUPTRS Priority Population Individuals With a Co-occurring MH and SUD)
The vision of Aging Services is that all Oklahomans have the opportunity to live and age with behavioral health, including physical health, well-being, social connection, and purpose. To advance these outcomes, Aging Services, in collaboration with cross-sector partners, focuses on policy and practice development that strengthens age-informed engagements, services, and care.

Key justification and urgency of this work:
• The older adult population in the U.S. is growing rapidly as is the need for behavioral health services and systems to serve this population.
• As of 2024, eleven states and 45% of U.S. counties had more older adults than children under <18, which is up from three states and 31% of counties in 2020.

In Oklahoma:
• Older adults are projected to surpass the number of children <18 by 2034.
• The number of persons ages =65 served within ODMHSAS has consistently increased since FY 2016 (2021 was an exception), reaching nearly 7,500 in FY 2024; ODMHSAS projects a 32% increase in this age group among persons served within the next five years.

In 2022, in preparation for this demographic shift, ODMHSAS and the new Aging Services partnered with the Oklahoma Mental Health and Aging Coalition (OMHAC) to convene the Oklahoma Behavioral Health Policy Academy. The Academy was initiated by OMHAC and facilitated by the E4 Center of Excellence for Aging. A direct outcome is the Behavioral Health Forum on Aging. The Forum is guided by the Oklahoma Older Adult Behavioral Health State Plan and provides strategic direction to Aging Services.

Utilizing FY25 as a reference, below are key areas of focus for Aging Services:

Behavioral Health Forum on Aging: The Forum, chaired by the OMHAC Director, and Aging Services, work in concert to promote the Division's vision. The Forum convenes six times annually in addition to targeted work by taskforces (e.g. Age-Informed Screening Tools, Aging Our Way Multi-Sector Plan on Aging, CCBHCs, and Communications). One Taskforce highlight is that along with only four other states, Oklahoma was invited to participate in the first SAMHSA Older Adult Suicide Prevention Policy Academy. A direct outcome is the Suicide Prevention Taskforce, which is working to integrate unique aspects of older adult

suicide prevention into the broader State Suicide Prevention Plan.

Age-Informed Training: In aggregate, >950 people completed trainings focused on aging, behavioral health, and the central role of reframing aging. This includes:
o Scheduled sessions geared toward professionals and sessions in response to community requests.
o PEARLS Coach Training, which is an evidence-based depression intervention.
o Not included in this number: 1) people completing PRSS Older Adults, which is co-managed with the PRSS and Wellness Team; 2) Partnership with Oklahoma State Department of Health and CCBHCs to promote training and subsequent delivery of Tai Chi: Moving for Better Balance and Walk with Ease, both Arthritis Appropriate, Evidence Based Interventions.

988 Outreach: Participation with 14 community events to raise awareness of 988 as an age-encompassing resource.

Standing Committees: Aging Services participates in (including member and leadership roles) Aging Our Way, Oklahoma's Multi-Sector Plan on Aging; Areawide Agency on Aging; Edmond CCBHC Advisory Council; National Mental Health and Aging Council; Oklahoma Mental Health & Aging Coalition (MHAC); New View Oklahoma; Regional Food Bank of Oklahoma: Age-Friendly; and Oklahoma State Council on Aging.

Persons with Disabilities
(Recommended Population)
As addressed above, 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. Additionally, all CCBHCs are required to have an MOU, Care Coordination Agreement or Protocols with all Disability Resource Services in their catchment areas, this includes with the Oklahoma Department of Rehabilitation services (DRS). DRS expands opportunities for employment, independent life and economic self-sufficiency by helping Oklahoman's with disabilities succeed in the workplace, school and at home.

CCBHC's IPS programs also are able to receive referrals from the DRS-VR so that those individuals can be served with any and all CCBHC services that they may need.

Rural Areas
(Priority Population Individuals with SMI, SED in Rural Areas; Recommended Population Individuals with SUD 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. Today, ODMHSAS Telehealth Service provides access in all 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 city/county health departments to help rural residents immediately access behavioral healthcare. In calendar year 2024, an average of 60,629 services were provided per month.

Military Personnel and their Families
(Recommended Population)

Military members and their families receive services through the CCBHCs as well as the other contracted facilities. In addition to this, 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.

Individuals Involved in the Criminal or Juvenile Justice Systems
(Recommended Population)
The ODMHSAS collaborates with various partners within criminal justice and law enforcement to provide a variety of services. Many of these areas were discussed in Question 2 of the Planning Step 1.

Jail Screening. Jail 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 jail and prison-alternative sentences that best meet the offender's needs and increase the likelihood of successful diversion. This is discussed more in depth in Question 2 of the Planning Step 1.

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

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Footnotes:

11-6-25: Made changes to this section to come into alignment with the current administration and SAMHSA's current stance on acceptable verbiage.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of 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 should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, 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, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

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, 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 MH Block Grant application for FFYs 2026-2027.

The ODMHSAS performs needs assessments routinely and collects needs assessment data, from several sources, on an on-going basis. Obtaining this data allows ODMHSAS to not only determine if current services are adequate, it also allows ODMHSAS to identify the gaps in care deliver and the areas that need to be focused on, in terms of treatment and workforce. Below are needs assessments whose data was examined to identify which areas need to be addressed.

Certified Community Behavioral Health Clinic (CCBHC). Each CCBHC is required to complete a comprehensive community needs assessment at least once every three years. The timing of each assessment depends on when the organization was initially certified as a CCBHC, as that start date determines their individual three-year cycle.

Oklahoma has 13 CCBHCs. Below is a grid of when each performed a needs assessment and turned it into the ODMHSAS.

CCBHC Year Needs Assessment Completed
Family & Children's Services Inc. 2025

Grand Mental Health Center, Inc. 2025
Jim Taliaferro Community Mental Health Center 2025
North Oklahoma County Mental Health Center, Inc. 2025
Carl Albert Community Mental Health Center 2024
Central Oklahoma Community Mental Health Center 2024
Green Country Behavioral Health Services, Inc. 2024
Hope Community Services, Inc. 2024
Northwest Center for Behavioral Health 2024
Red Rock Behavioral Health Services 2024
Lighthouse Behavioral Wellness Centers 2023
Creoks Mental Health Services, Inc. 2022
Counseling and Recovery Services of Oklahoma 2022

In Oklahoma, 59 of the 77 counties are considered rural or frontier. Because of this, it is imperative to be able to gather data about the needs of those areas. Because there are CCBHCs located in rural and/or frontier areas, their needs assessments capture this information very well. The CCBHCs pull information for their needs assessments from many different sources. Examples of sources of data are the National Survey on Drug Use and Health (NSDUH), U.S. Bureau Census Data, SAMHSA, National Institute of Health (NIH), Centers for Disease Control (CDC), University of Wisconsin's Population Health Institutes, The Child & Adolescent Health Measurement Initiative, Oklahoma State Department of Health (OSDH), and internal facility data. Additional information is obtained through focus groups, advisory work groups and surveys that the facilities conduct. Surveys conducted are CCBHC Staff Surveys, CCBHC Community Surveys, and Caregiver and Consumer Satisfaction Surveys.

State Opioid Response Grant. The ODMHSAS received the fourth State Opioid Response Grant in 2024. As it is used to address the critical public health crisis posed by opioid and other stimulant misuse, the ODMHSAS refers to it as the SOS (State Opioid and Stimulant) III Initiative. A requirement of receiving this grant was that a comprehensive needs assessment needed to be performed. This was done in 2024. In completing this information was compiled from the following sources: the Oklahoma State Department of Health, both from the division of Injury Prevention Service and Center for Health Statistics National Vital Statistics System, Healthcare Cost and Utilization data, NSDUH, and Oklahoma Healthcare Authority.

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

Key data have been provided by the Oklahoma State Epidemiological Outcomes Workgroup (STEOW). The STEOW 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 STEOW 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.

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 comprised of representatives from tribes, tribal organizations, government agencies, non-profit organizations, and universities 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).

First Name Last Name Organization
Kristi Allen CARECG
Jennifer Newton CARECG
Stacy Potter CARECG
Chelsey Russell CARECG
Brady Garrett Cherokee Nation
Melissa Foreman Cherokee Nation
Sam Bradshaw Cherokee Nation Behavioral Health
Coleman Cox Cherokee Nation Behavioral Health
Chuck Lester Oklahoma State University, Community Wellness
Jessica McGuire Oklahoma Bureau of Narcotics and Dangerous Drugs
Josh DeBartolo Oklahoma Department of Mental Health and Substance Abuse Services - Partnerships
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
Miranda Murdock Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Division
Carrie Daniels Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Division
Lauren Kidwell Oklahoma Department of Mental Health and Substance Abuse Services - Prevention Division
Vi Pham Oklahoma Department of Mental Health and Substance Abuse Services – Prevention Division
Paul Harris Oklahoma Highway Safety Office
Claire Nguyen Oklahoma State Department of Health - Injury Prevention Service
Avy Doran-Redus Oklahoma State Department of Health - Injury Prevention Service
Marvin Smith Oklahoma State Department of Health - Injury Prevention Service
Naresh Bhandari Oklahoma State Department of Health - Injury Prevention Service
Thad Burk Oklahoma State Department of Health - Maternal Child Health Assessment
Bailey Harris 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
Meredith Wyatt Oklahoma State University-Center for Health Sciences
Deborah Jones-Saumty Osage Nation
Dana Lott Osage Nation Prevention
J.T. Neuzil Southern Plains Tribal Health Board
Michael Logan Southern Plains Tribal Health Board
Cassidy Raphael Southern Plains Tribal Health Board
Luis Ambrosio Southern Plains Tribal Health Board
Charmel Holland 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 Wilson Southern Plains Tribal Health Board
Dr. 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
Raven Helmrick Tulsa County Health Department
Cassidy Raphael Oklahoma City Indian Clinic
Clayton Tselee Neighbors Building Neighborhoods
Carlos Martinez Tribal Consultant

In addition to the means discussed above, data is also pulled regularly throughout the year for different purposes, such as applying for grants, writing reports, or performing research for presentations. Accessing this data routinely assists not only with identifying needed areas to work on but also with seeing if areas, need to continue to be addressed. Sites that are routinely checked for data include NSDUH, Treatment Episode Data Set (TEDS), CDC mortality data, National Institute on Drug Abuse (NIDA), NIH, and Oklahoma state sites, such as the Oklahoma Department of Health.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

MENTAL HEALTH
A Mental Health America report showed that Oklahoma is ranked 47th in overall mental health in 2024 and 47th in adult mental health1. This ranking is based on a higher prevalence of mental illness and lower rates of access to care. The 2021-2022 National Survey on Data Use and Health (NUSDA) indicates that Oklahoma is slightly below the national rate on any mental illness in the past year (21.62%, 21.79%, respectively), the rate is increasing when compared to the rate of 18.3% in the 2013-2014 results. The State is higher on serious mental illness (6.57%) than the national rate (5.86%) and major depressive episode in the past year with a state rate of 9.86% compared to the US rate of 8.63%.
Children's Mental Health
The COVID 19 pandemic's impact on young people's mental health is multifaceted, encompassing disruptions to education, social isolation, increased family stress, and heightened exposure to trauma and loss.2,3. The transition to remote learning presented additional challenges, including incommensurate access to technology, decreased engagement, and a lack of personalized support4. Social isolation, coupled with the cancellation of extracurricular activities and social interactions, further deprived young people of opportunities for crucial social connection5. These challenges have exacerbated existing contrasts, disproportionately affecting vulnerable children and adolescents who already face significant hardships6.
The CDC reports that in 2021, more than a third of Oklahoma high school students reported poor mental health during the

COVID-19 pandemic. Forty-four percent said they "persistently felt sad or hopeless during the past year," nearly 20% had seriously considered suicide, and 9% attempted suicide.

In Oklahoma and across the country, emergency departments have recorded a significant rise in pediatric mental health emergencies. One large hospital system in the State reported that there was a 117% increase in inpatient pediatric admissions stemming from suicide-related ER visits in 20217.

Early Psychosis Intervention (EPI)

Psychosis tends to emerge during the mid-to-late teenage years and early twenties, an important developmental stage for young people in terms of their identity, independence, relationships, educational, and long-term vocational plans8. A key rationale for early intervention in psychosis is to limit disruptions to the young person's important developmental stages, in addition, to reduce distress and suffering the symptoms that can cause the young person and those close to them.

Evidence-based EPI interventions not only achieve symptomatic recovery, but also functional recovery. Symptomatic refers to symptoms of psychosis and functional recovery refers to such things as a return to school or work, family, and other social relationships, having a place to live, and addressing physical health needs.

Incidence estimates based on putative cases were 126 per 100,000 per year among those aged 15 to 29 and 107 per 100,000 among those aged 30–599.

Suicide

A recent study looked at suicide trends in Oklahoma from 2013-202210. For nearly two decades, Oklahoma has had a higher suicide rate than the national average among the top 10 highest in the country, according to the most recent data available.

While suicide rates have climbed across the U.S. in recent years, this increase has been even more dramatic in Oklahoma.

Suicide rates have risen faster in Oklahoma than in the U.S. Higher rates of suicide are seen in rural areas than in urban ones and among American Indians and white Oklahomans.

The factors behind suicide are complex. Over half of Oklahomans who died by suicide had a history of mental illness or substance use, and about a third had a problem with an intimate partner that appeared to contribute to their death. A physical health problem appeared to be a factor in about 1 in 5 suicide deaths.

Children and youth have lower rates of suicide compared to adults, but suicidality is highest among young Oklahomans. About 1 in 7 adolescents in Oklahoma had serious thoughts of suicide, and about 4% attempted suicide.

Suicidality is costly. In 2022, suicide-related emergency room visits and hospitalizations in Oklahoma cost about $139 million. Early and upstream care is not only compassionate, but it is also significantly more cost-effective.

Most suicides in Oklahoma are gun deaths. Men and boys were far likelier to use a firearm as a means for suicide, which in turn makes them less likely to survive a suicide attempt.

Behavioral health diagnoses among Oklahomans who died by suicide, 2013 – 2022.

- 32.5% mental health diagnosis
- 12.1% substance use disorder diagnosis
- 10.5% Co-occurring mental health and substance use disorder
- 45.0% no mental health or substance use disorder diagnosis

COMMUNITIES IN NEED OF ASSISTANCE

Homelessness

Homelessness significantly impacts mental health, leading to higher rates of mental illness, chronic stress, and emotional challenges among individuals experiencing housing instability. Individuals experiencing homelessness have mental illness rates that are more than twice that of the general population11. Approximately 20-25% of the homeless population suffers from severe mental illness, compared to about 6% of the general public. Conditions such as schizophrenia, bipolar disorder, and major depressive disorder are particularly prevalent among this group.

Homeless women, for instance, have a 47% rate of major depressive disorder, which is double that of women in general12. Children and adolescents facing homelessness also experience developmental challenges, including delays in language and social skills, which can adversely affect their emotional and cognitive development.

The number of individuals experiencing homelessness in Oklahoma increased 17.6% in 2024 when compared to 2023. The number of individuals experiencing homelessness in 2024 increased 29.5% when compared to 200713,14.

In 2024, there were approximately 5,497 Oklahomans experiencing homelessness. Of those, 3,251 were sheltered homelessness (2,599 in emergency shelter and 652 in transitional housing) and 2,216 were unsheltered homelessness. In this population, 22.2% had a severe mental illness, 17.8% had a chronic substance use disorder, 304 were veterans, 35 had HIV/AIDS, and 611 were victims of domestic abuse13.

Older adults

As the baby boom cohort continues to age, the number of older adults in the United States continues to grow, now making up over 20 percent of the general population16. SAMHSA conducted a study based on the results from the 2021 and 2022 National Surveys on Drug Use and Health (NSDUH) and found that substance use and mental health are major public health concerns among older adults17. As adults age, social isolation, bereavement, or health problems associated with aging can contribute to the development of mental disorders18. Stigma surrounding mental illness and substance use can create a difficulty for older adults to seek treatment for mental or substance use disorders. Older adults also can have difficulty accessing behavioral health treatment because of cost, transportation, and challenges in navigating the healthcare system. Consequently, older adults who might benefit from such treatment often do not receive appropriate diagnosis and care18.

- There were 10.0 million older adults (12.8%) who engaged in binge drinking in the past month, including 2.5 million (3.2%) who engaged in heavy drinking.
- There were 9.5 million older adults who used illicit drugs in the past year, including 7.7 million who used marijuana (9.9%) and 1.8 million who misused opioids (2.3%).

• There were 7.1 million older adults who had a substance use disorder (SUD) in the past year (9.1%), including 4.4 million who had an alcohol use disorder (AUD) (5.6%) and 3.2 million who had a drug use disorder (DUD) (4.1%).
• An estimated 9.8 million older adults had any mental illness (AMI) in the past year (12.5%), including 1.5 million (1.9%) who had serious mental illness (SMI).
• About 1 in 50 older adults had serious thoughts of suicide in the past year. Similar percentages of older adult females and males had suicidal thoughts.

Veterans

According to the American Addiction Centers, veteran populations are at increased risk for using alcohol or drugs in problematic ways. This is due to a variety of experiences linked directly to military service. Military culture, exposure to stressors and trauma related to service or combat, the development of mental health disorders including post-traumatic stress disorder (PTSD), and chronic pain or physical health issues can influence substance use.

Approximately 11% of veterans who visit a medical facility run by the Department of Veterans Affairs (VA) for the first time have a substance use disorder (SUD)19. Binge drinking, or consuming a lot of alcohol in a short time, is one of the more common issues that veterans face20, 21. Veterans may abuse substances in response to mental health disorders, to cope with readjusting to civilian life, or to manage pain. Substance use has been linked to trauma, homelessness, mental health disorders, physical health issues, increased risk of suicide, and problems in relationships and at work19,20. Statistics on substance abuse in veterans show that among those who have SUDs:22

• More than 80% (nearly 900,000) abuse alcohol.
• Nearly 27% (about 300,000) abuse illegal drugs.
• About 7% (almost 80,000) abuse both alcohol and illegal drugs.

The presence of mental illness and SUDs, also known as co-occurring disorders, is especially common in veterans19,20. Mental illness such as depression, anxiety, and PTSD can lead to substance use. Efforts to self-medicate symptoms or manage stress make vets more prone to developing SUDs19,20. In addition, these mental health diagnoses can result from any combination of factors: genetic predisposition, the stresses of being deployed, exposure to combat and traumatic events, injuries, and the challenges of reintegrating into civilian society19,23.

Between 82-93% of veterans who served in Afghanistan and Iraq with an SUD had at least one co-occurring disorder20.

Veterans who have an SUD are 3-4 times more likely to be diagnosed with depression20.

Approximately 37-50% of veterans who served in Afghanistan and Iraq were diagnosed with at least one mental illness19.

Nearly 10% of veterans have symptoms of anxiety, while about 11% have symptoms of depression24.

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• Veterans who have an SUD are 3-4 times more likely to be diagnosed with depression20.
• Approximately 37-50% of veterans who served in Afghanistan and Iraq were diagnosed with at least one mental illness19.
• Nearly 10% of veterans have symptoms of anxiety, while about 11% have symptoms of depression24.

Post-traumatic stress disorder (PTSD) is a diagnosis that results from exposure to traumatic events such as combat, having your life threatened, or sexual trauma—all of which can occur while in the military23,25. Symptoms can be long-lasting and affect many different life areas, including sleep, employment, social relationships, driving, and the ability to participate in some activities25. Veterans with PTSD may start drinking or using drugs to try and relieve symptoms21,22. If you already have an issue with substance use, it may worsen if you develop PTSD19.

• Nearly 25% of veterans have PTSD26,27.
• Veterans who have an SUD are 3 to 4 times more likely to be diagnosed with PTSD19,20.
• Among veterans with SUDs who served in Afghanistan and Iraq, 63% also had PTSD19,20.
• More than 20% of veterans diagnosed with PTSD have co-occurring disorders21.

Suicide rates among veterans are higher than that of civilians27. This has been linked to a variety of factors that can be interrelated: substance abuse, homelessness, mental health issues, medical concerns, and chronic pain. Veteran suicide rates have been increasing since 2005. Both male and female veterans are at increased risk for suicide than the general population28.

In 2017, there was an average of nearly 17 veteran suicides each day, for a total of 6,139 veterans28. In 2017, veterans were 1.5 times more likely to commit suicide than civilians.

• Nearly 71% of male veterans and more than 43% of female veterans used firearms to commit suicide in 2017.
• About 30% of veterans who commit suicide had abused substances beforehand20.
• Almost 20% of veterans have thought about suicide, and nearly 15% have tried to commit suicide27.

Rural Oklahomans

According to the United Health Foundation, 35.8% of Oklahomans live in a rural area in 2023. Rural areas experience a lack of access to and availability of the full range of behavioral health care services, challenges with mental health care workforce recruitment and retention, and technology difficulties impacting telehealth visits29. These challenges contribute to a more vulnerable and resource-poor rural population compared to urban peers. As of March 31, 2021, 122 million Americans (37 percent of the population) lived in a mental health professional shortage area30. Two-thirds of mental health professional shortage areas are rural, for example, 96.4 percent of the population of Wyoming versus 0.4 percent of New Jersey residents live in a mental health professional shortage area31. This lack of access and availability of mental health workforce results in rural residents not obtaining treatment as easily, readily, or frequently as their urban peers.

Geographic differences impact the availability of mental health services. Chronic mental health care provider shortages

disproportionately impact rural communities, with fewer mental health providers serving rural communities compared to urban areas. An incommensurate distribution of health care providers exists among psychiatrists, psychologists, psychiatric nurse practitioners, and social workers, with a significantly higher percentage of providers located in urban counties compared to rural counties32,33.

Rural residents travel significantly farther than their urban peers to access health services, including mental health care34, 37. Lack of public transportation or limited access to private transportation – including having a reliable vehicle, driver's license, fuel, and time – are important hurdles to accessing health services35,36. The costs associated with mental health care are a burden for rural residents, who often have lower income than urban residents, which can result in individuals forgoing care38. Insufficient insurance coverage, which is also more common in rural areas, results in high patient costs and low reimbursement rates or restrictive policies by insurance providers can impact health care providers' abilities to offer services. Limited broadband coverage in rural areas may limit rural residents' access to advancements designed to increase access to health care services, such as telehealth. Rural households have fallen behind urban in access to broadband services, computers, and other technology. Despite expansion in telehealth infrastructure and reimbursement during the COVID-19 pandemic, technology limitations persistently impede access to mental health services in rural communities.

People are less likely to access mental health care when stigma and health literacy issues are present38. Higher rates of mental health stigma in rural areas inhibits help-seeking behavior. Limited health literacy, also a challenge in rural communities, impacts individuals' awareness of mental health conditions and treatment options. Lack of privacy is a common hurdle to mental health care cited by rural residents. Individuals are reluctant to seek treatment when anonymity is at risk. This concern can be particularly prevalent in small communities with interconnected social networks. The need for competent, appropriate health care is a concern among residents of rural areas. It is important that individuals can choose health care providers and treatments that align with their preferences, beliefs, practices, language, and backgrounds. There is a demand for mental health providers who recognize the unique and different needs of rural Americans. Additionally, rural areas of the country have grown more different, amplifying the need for appropriate mental health care in rural communities.

While rates of mental illness are similar in rural areas compared to urban areas, there is a higher risk of suicide in rural communities, with nearly twice as many suicides in the most rural counties compared to urban29. In 2018, data from the National Vital Statistics System reported male and female rural and urban differences, with the rural male suicide rate (30.7 per 100,000) higher than the urban male suicide rate (21.5 per 100,000) and the rural female suicide rate (8.0 per 100,000) higher than the urban rate (5.9 per 100,000)30.

Pregnant and Parenting Women

According to the CDC, opioid use among pregnant women is a significant public health concern39. From 2010 to 2017, the number of women with opioid-related diagnoses at delivery hospitalization increased by 131%40. Opioid use disorder during pregnancy has been linked with serious negative health outcomes. These include preterm birth, stillbirth, maternal mortality, and neonatal abstinence syndrome41.

Figures from the most recently-published report from the National Survey of Drug Use and Health state that, of pregnant women aged 15–44, 9.4% reported current alcohol use, 2.6% reported binge drinking, and 0.4% reported heavy drinking42. Of pregnant women aged 15–44, 5% report current illicit drug use, a proportion not significantly different than in the previous study year. The rate of illicit drug use varies widely with the woman's age. Teenaged pregnant women have the highest rates of illicit drug use (15–17, 20.9%), followed by young adult women (18–25, 8.2%) and adult women (26–44, 2.2%). There are no reliable nationwide estimates of the annual number of infants born after prenatal substance exposure. For example, the CDC website reports that the rate of Fetal Alcohol Syndrome (FAS) is 0.2-1.5 cases per 1,000 live births43, although this estimate appears to be based on research from the 1990s. A recent study found the rate of FAS in one Midwestern community to be 6–9 per 1,000 children, and more general Fetal Alcohol Spectrum Disorder (FASD) as high as 24–48 per 1,000 children44. Some infants prenatally exposed to opioids exhibit symptoms of Neonatal Abstinence Syndrome (NAS), including hyperirritability and dysfunction of the nervous system, gastrointestinal tract, and respiratory system45. Between 2000 and 2009, the incidence of NAS among hospital-born newborns increased from 1.20 to 3.39 per 1,000 live births per year. Total hospital charges for NAS during this time period are estimated to have increased from $190 million to $720 million, adjusted for inflation46. While it is possible that some of the increase in NAS diagnoses could be attributed to growing recognition of NAS symptoms and increased surveillance of pregnant women, it appears that prenatal exposure to substances is a significant public health problem47.

In the United States, between 59-70% of women in substance use treatment programs have children47, and women involved in substance use treatment programs are steadily increasing due to the high prevalence of substance use among reproductive-age women in general48, and among pregnant women specifically47. In addition to stressors and unique needs associated with parenting, women in substance use treatment programs have a high prevalence of co-occurring negative physical health and mental health outcomes, including anxiety, depression, and posttraumatic stress disorder49,50; as well as histories of physical or sexual abuse, relationship problems, negative support systems, family substance use problems, and inadequate income51. Further, substance-using women display a higher likelihood of severe psychopathology and personality disorders that can significantly impact their emotional and cognitive ability to serve as effective parents.

SUBSTANCE USE DISORDER (SUD)

Great strides have been made to reduce prescription opioid-related overdoses in Oklahoma, yet a drug overdose crisis remains. Methamphetamine and illicit fentanyl are currently the leading substances involved in drug overdoses (prevalence numbers below). The number of overdoses has more than doubled in the last five years of reported data, from 14.3/100,000 in 2019 to 32.7/100,000 in 202352. Of the individuals who died from an overdose in 2023, 81% had a history of substance use and 28% had a history of mental illness. The total number of individuals discharged from a hospital due to a non-fatal overdose was 4,434 for a rate of 109.4/100,000.

Oklahoma is above the national average for substance use disorder in the past year for age 12 and older (18.43%, 17.19%,

respectively) with the greatest difference in 18+ (19.58% vs. 18.05%)53.
Oklahoma is also above the national average for opioid misuse in the past year for ages 12 and older (4.02%, 3.15%, respectively). This is true for all age groups (12-17, 2.1% vs. 1.90%; 18-25, 3.28% vs. 2.86%; and 26+, 4.41% vs. 3.34%.).
The state also has a higher rate of methamphetamine use in the past year for ages 12 and older (1.46%, .94%, respectively). While the youth rate of use is the same as the national rate, the adult state rates are higher (18-25, .67% vs. .39%; 26+, 1.77% vs. 1.12%).
Pain reliever use disorders are also higher in the State than nationally (2.43%, 1.93%, respectively). This holds true for all age groups (12-17, 1.39% vs. 1.13%; 18-25, 1.35% vs. 1.17%; and 26+, 2.76% vs. 2.14%).

Persons Who Inject Drugs (PWID)
In the United States, injection is an increasingly common route of administration for opioids and other substances54.
Persons who inject drugs are at risk for a number of unwanted health issues that affect their bodies and their overall health55. 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 PWIDs do not seek medical attention.
In 2023, Oklahoma had the highest rate of Hepatitis C according to the Centers for Disease Control at 145.5/100,00056. This is concerning with the U.S. rate of 36.2/100,000. Further, Oklahoma is one of seven states in the US with the highest burden of HIV57.
One metanalysis estimated that 24.8% of people who inject drugs globally had experienced recent homelessness or unstable housing, 58.4% had a lifetime history of incarceration, and 14.9% had recently engaged in sex work58.

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3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Goal 1: Expand access for Rural and Older Adult with SMI and Co-occurring populations.

ODMHSAS will work on this by increasing services for mental health disorders and co-occurring issues by increasing the number of residential care facility beds available for individuals requiring that level of care. Work will also be done to increase targeted outreach to individuals most in need by enhancing quality measures for CCBHCs.

Goal 2: Increase number of consumers served through coordinated specialty care programs.

This will be accomplished by increasing coordinated specialty care services to more rural areas of the catchment areas that are already being served by the RA1SE Navigate program. There will also be an increase in the number of people served by beginning to serve those with affective disorders who are also experiencing First Episode Psychosis.

Goal 3: Decrease mental health related emergency department utilization.

The ODMHSAS will work on this by improving the efficiency and quality of Urgent Recovery Centers (URCs) and Crisis Stabilization Units (CSUs) by updating associated rules including standardized admission and exclusion criteria. Existing mobile crisis teams will also be optimized to increase coverage and responsiveness by implementing enhanced contract and metric monitoring, increased partnerships, and providing technical assistance when needed. Crisis diversion programs will be enhanced, to better reduce hospital admissions, by funding a 988/911 Liaison with the Oklahoma Office of Emergency Management to increase the number of 911 Public Safety Answering Points (PSAPs) diverting to Oklahoma's 988 Contact Center, when appropriate.

Goal 4: Reduce the statewide youth suicide death rate.

The ODMHSAS will work to reduce the statewide youth suicide death rate by improving 988 Suicide and Crisis Lifeline responsiveness and by increasing the number of calls answered within 20 seconds. We will also work to reduce the suicide death rate by implementing prevention strategies throughout the state. The ODMHSAS will also work on this by optimizing Mobile Response and Stabilization Services (MRSS) availability and quality for youth and families by integrating the two child call centers into the state's primary 988 contact center. More information on the work being done in suicide prevention can be found in Planning Step One.

Goal 5: Increase number reached through direct and indirect prevention practices and programs.

The ODMHSAS will work on this by strengthening the capacity of local prevention coalitions, community organizations, and school districts by providing technical assistance and training. We will also enhance public education campaigns focused on substance misuse and mental health awareness through education and information dissemination efforts. Also, we will use data-driven approaches to target prevention resources efficiently. Oklahoma will also enact new organizational policies related to substance misuse and will provide direct prevention services to schools and communities through evidence-based strategies such as Botvin Life Skills, PAX Good Behavior Games, and 3rd Millennium.

Goal 6: Increase outpatient substance use disorder (SUD) recovery and retention at 90 days.

The ODMHSAS will work to increase outpatient SUD recovery and retention, at 90 days, by increasing the number of SUD providers trained in evidence-based therapies, such as Cognitive Behavioral Therapy, Strengthening Families and Celebrating Families.

Goal 7: Develop infrastructure and capacity for Women's Liaison roles at all ODMHSAS-contracted outpatient providers.

The ODMHSAS will do this by defining the role and responsibilities for the Women's Liaison role. Then, we will identify designated staff within each provider agency and will develop and launch the initial training. Additional work will be done in this area, but these are the preliminary steps identified to be developed and implemented.

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Footnotes:

11-6-25: Removed wording in an attempt to come into alignment with the current administration and SAMHSA's current stance on acceptable verbiage.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Access for Rural and Older Adult SMI and Co-ocurring Populations

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Expand Access for Rural and Older Adult SMI and Co-occurring Populations

Strategies to attain the goal:

1. Increase services for mental health disorders and co-occurring issues by increasing the number of residential care facility beds available for individuals requiring that level of care.
2. Increase targeted outreach to individuals most in need by enhancing quality measures for CCBHCs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: increase in service utilization among Rural and Older Adult SMI and Co-ocurring Populations

Baseline measurement (Initial data collected prior to and during 2026): 52,753

First-year target/outcome measurement (Progress to the end of 2026): 52,760

Second-year target/outcome measurement (Final to the end of 2027): 52,775

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 #: 2

Priority Area: Access to treatment for ESMI population

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

Increase number of consumers served through coordinated specialty care programs.

Strategies to attain the goal:

1. Increase coordinated specialty care services to more rural areas of the catchment areas that are already being served by the RA1SE Navigate program.
2. Increase the number of people served by beginning to serve those with affective disorders who are also experiencing First Episode Psychosis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of consumers served through coordinated specialty care programs

Baseline measurement (Initial data collected prior to and during 2026): 27

First-year target/outcome measurement (Progress to the end of 2026): 30

Second-year target/outcome measurement (Final to the end of 2027): 35

Data Source:

Provider reports

Description of Data:

Admission to treatment data compiled by provider

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Mental Health Related Emergency Department Utilization

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Decrease Mental Health Related Emergency Department Utilization by .5% over the next two years.

Strategies to attain the goal:

1. Improve the efficiency and quality of Urgent Recovery Centers (URCs) and Crisis Stabilization Units (CSUs) by updating associated rules including a standardized admission and exclusive criteria.
2. Optimize existing mobile crisis teams to increase coverage and responsiveness by implementing enhanced contract and metric monitoring, increased partnerships, and providing technical assistance when needed.
3. Enhance crisis diversion programs to better reduce hospital admissions by funding a 988/911 Liaison with the Oklahoma Office of Emergency Management to increase the number of 911 Public Safety Answering Points (PSAPs) diverting to Oklahoma's 988 contact center, when appropriate.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: % reduction in mental health related ED visits statewide

Baseline measurement (Initial data collected prior to and during 2026): 2.95%

First-year target/outcome measurement (Progress to the end of 2026): decrease by .25%

Second-year target/outcome measurement (Final to the end of 2027): decrease by .25%

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 #: 4

Priority Area: Suicide

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Reduce the statewide youth suicide death rate over the next two years

Strategies to attain the goal:

1. Reduce suicide death rate by improving 988 Suicide & Crisis Lifeline responsiveness and by increasing the number of calls answered within 20 seconds.
2. Reduce suicide rate by implementing prevention strategies throughout the state.
3. Optimize Mobile Response and Stabilization Services (MRSS) availability and quality for youth and families by integrating the two child call centers into the state's primary 988 contact center.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: decrease in youth suicide deaths

Baseline measurement (Initial data collected prior to and during 2026): 87

First-year target/outcome measurement (Progress to the end of 2026): 86

Second-year target/outcome measurement (Final to the end of 2027):

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 #: 5

Priority Area: Increase Reach of Prevention Efforts

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Increase number reached through direct and indirect prevention practices and programs

Strategies to attain the goal:

1. Strengthen capacity of local prevention coalitions, community organizations, and school districts by providing technical assistance and training.
2. Enhance public education campaigns focused on substance misuse and mental health awareness through education and information dissemination efforts.
3. Use data-driven approaches to target prevention resources efficiently.
4. Enact new organizational policies related to substance misuse.
5. Provide direct prevention services to schools and communities through evidence-based strategies such as Botvin Life Skills, PAX Good Behavior

Games, and 3rd Millennium.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of people trained or directly reached through evidence-based prevention programs or practices

Baseline measurement (Initial data collected prior to and during 2026): 185,491

First-year target/outcome measurement (Progress to the end of 2026): 187,346

Second-year target/outcome measurement (Final to the end of 2027): 189,201

Data Source:

Prevention Reporting System (PRS), ODMHSAS training/program attendance records

Description of Data:

Number of people reached by EBPs are reported by subrecipients in the PRS and compiled by project evaluators.

Data issues/caveats that affect outcome measures:

Individuals can be reached by more than one population-based strategy and can be reached more than one times. Therefore, estimates for population-based strategies cannot be deduplicated. *Increases are dependent on availability of commensurate funding for prevention practices and programs.

Indicator #: 2

Indicator: Number of people indirectly reached through population level evidence-based prevention practices

Baseline measurement (Initial data collected prior to and during 2026): 25,760,525

First-year target/outcome measurement (Progress to the end of 2026): 26,018,130

Second-year target/outcome measurement (Final to the end of 2027): 26,275,736

Data Source:

Prevention Reporting System (PRS), ODMHSAS training/program attendance records

Description of Data:

Number of people reached by EBPs are reported by subrecipients in the PRS and compiled by project evaluators.

Data issues/caveats that affect outcome measures:

Individuals can be reached by more than one population-based strategy and can be reached more than one times. Therefore, estimates for population-based strategies cannot be deduplicated. *Increases are dependent on availability of commensurate funding for prevention practices and programs.

Priority #: 6

Priority Area: SUD Recovery and Retention

Priority Type: SUT

Population(s): PRSUD

Goal of the priority area:

Increase Outpatient SUD Recovery and Retention

Strategies to attain the goal:

Increase outpatient SUD recovery and retention by increasing the number of SUD providers trained in evidence-based therapies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: % of clients retained in treatment at 90 days

Baseline measurement (Initial data collected prior to and during 2026): 50%

First-year target/outcome measurement (Progress to the end of 2026): 52%

Second-year target/outcome measurement (Final to the end of 2027): 53%

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 #: 7

Priority Area: Access to Treatment for High Risk Population of pregnant women and women with dependent children

Priority Type: SUR

Population(s): PWWDC

Goal of the priority area:

Embed a Women's Liaison at contracted providers to ensure that services addressing the needs of women with dependent children are available, accessible and coordinated.

Strategies to attain the goal:

1. Define role and responsibilities for the Women's Liaison role
2. Identify designated staff within each provider agency
3. Develop and launch initial training

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Designation of Women's Liaison role and completion of initial training & onboarding tools

Baseline measurement (Initial data collected prior to and during 2026): New project. No baseline established

First-year target/outcome measurement (Progress to the end of 2026): Role defined, staff designated in 75% of agencies, training launched

Second-year target/outcome measurement (Final to the end of 2027): Training developed and launched

Data Source:

ODMHSAS contracts and implementation tracker

Description of Data:

Internal designation documentation, training attendance logs

Data issues/caveats that affect outcome measures:

Varying agency capacity or staffing shortages may affect rollout.

Footnotes:

11-6-25: Removed wording in an attempt to come into alignment with the current administration and SAMHSA's current stance on acceptable verbiage.

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$26,278,852.00		$26,311,966.00	$29,851,416.00	$133,757,854.00	$0.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$488,152.00		$0.00	$2,692,046.00	$2,416,552.00	$0.00	$0.00	
b. All Other	$25,790,700.00		$26,311,966.00	$27,159,370.00	$131,341,302.00	$0.00	$0.00	
2. Recovery Support Services[c]	$821,200.00		$0.00	$0.00	$1,332,082.00	$0.00	$0.00	
3. Primary Prevention[d]	$7,342,002.00		$0.00	$14,103,840.00	$9,161,972.00	$0.00	$0.00	
4. Early Intervention Services for HIV[e]	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
5. Tuberculosis	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$2,020,484.00		$0.00	$0.00	$0.00	$0.00	$0.00	
13. Administration[g]	$1,797,140.00		$0.00	$0.00	$8,280,076.00	$0.00	$0.00	
14. Total	**$38,259,678.00**		**$26,311,966.00**	**$43,955,256.00**	**$152,531,984.00**	**$0.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] 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.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Column C Medicaid: portion is 100%.

Column E: The exact amount is $13,155,983.00.

Row 3: Regarding the 20% Prevention set-aside reflected on this table, the $3,671,001.00 (above) is from Table 5a. The remaining 20% is reflected in Table 6 SUPTRS BG, Column C ($154,967.00). With those two amounts together, the sum is $3,825,968.00 which is the 20% Prevention set-aside. (Row 12 on this table has the sum of ALL of Table 6 SUPTRS BG, not just Prevention.)

Row 4: Oklahoma is not an HIV state.

Row 5: In Oklahoma, the Tuberculosis services are provided through local Oklahoma State Department of Health Facilities or through other community health care programs, i.e. an FQHC. However, all of our substance use disorder service providers are contractually required to make tuberculosis services available to individuals receiving substance use disorder treatment. They do this via referral to the above entities.

Column A doubled on 10-22-25.

On 10-27-25 Columns C-E were doubled to reflect 2 years of planned expenditures. 2-2(a) The state's planned budget for State Funds (Column E: $152,531,984.00) demonstrates an intent to meet the State's Maintenance of Effort (MOE) obligations over the next two years. 2-3

The State's planned budget for PWWDC (Sum of Row 1a, Columns (A & E) [$2,904,704.00] demonstrates an intent to meet the state's Women's Maintenance of Effort (MOE) obligations.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$2,218,875.00	$0.00	$0.00	$0.00	$0.00	$0.00	$69,905.00
7. State Hospital			$51,152,082.00	$0.00	$106,020,702.00	$0.00	$0.00	
8. Other Psychiatric Inpatient Care			$0.00	$0.00	$0.00	$0.00	$0.00	
9. Other 24-Hour Care (Residential Care)		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
10. Ambulatory/Community Non-24 Hour Care		$17,751,001.00	$302,468,174.00	$11,611,712.00	$576,304,862.00	$0.00	$0.00	$594,193.00
11. Crisis Services (5 percent Set-Aside)[c]		$1,109,438.00	$0.00	$0.00	$0.00	$0.00	$0.00	$34,953.00
12. Other Capacity Building/Systems Development								
13. Administration		$1,109,438.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
14. Total		**$22,188,752.00**	**$353,620,256.00**	**$11,611,712.00**	**$682,325,564.00**	**$0.00**	**$0.00**	**$699,051.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Regarding Row 11 (Crisis services), the amounts reported are for the MHBG setaside, as well as the crisis setasides from BSCA 3 and BSCA 4. The project period for BSCA 3 is 9/30/24-9/29/26 and so that is why BSCA 3 is included in these amounts.

Regarding Column H (BSCA), BSCA 3 and BSCA 4 is reflected in the amounts. BSCA 3's award was $699,051.00 and BSCA 4's award was also $699,051.00.

11-7-25 MHBG Table 2 doubled.

3-25-26 Final allocation revision.

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **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 B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	2395	153
Women with Dependent Children	14300	198
Individuals with a co-occurring M/SUD	110016	17458
Persons who inject drugs	45562	6061
Persons experiencing homelessness	4648	5752

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.
Row 1: NIDA (https://nida.nih.gov/publications/research-reports/substance-use-in-women/substance-use-while-pregnant-breastfeeding#:~:text=Estimates%20suggest%20that%20about%205,one%20or%20more%20addictive%20substances.&text=Regular%20use%20of%20some%20drugs,goes%20through%20withdrawal%20upon%20birth.) Row 2: Women in Admitted for SA Treatment that are Pregnant: 198 Admissions An estimated 47,000 births occur each year in Oklahoma. It is estimated that 19.66% of adults in Oklahoma have a substance abuse disorder each year which would result in approximately 9,200 new mothers with a substance abuse disorder annually. It is estimated that 10.83% of adults in Oklahoma have an alcohol use disorder each year which would result in approximately 5,100 new mothers with an alcohol use disorder annually. Estimated in Need: 14,300. Row 3-SAMHSA (https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders) Row 4-NIH (https://pubmed.ncbi.nlm.nih.gov/35791261/) Row 5-EndHomelessness.Org (https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards/?State=Oklahoma)
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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$13,139,425.00	
2 . Recovery Support Services[b]	$410,600.00	
3 . Substance Use Primary Prevention[c]	$3,671,001.00	
4 . Early Intervention Services for HIV[d]	$0.00	
5 . Tuberculosis Services	$0.00	
6 . Other Capacity Building/Systems Development[e]	$1,010,242.00	
7 . Administration[f]	$898,570.00	
8. Total	$19,129,838.00	$0.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]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.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

In Oklahoma, the Tuberculosis services are provided through local Oklahoma State Department of Health Facilities or through other community health care programs, i.e. an FQHC. However, all of our substance use disorder service providers are contractually required to make tuberculosis services available to individuals receiving substance use disorder treatment. They do this via referral to the above entities. Also, Oklahoma is not an HIV state.

Regarding the 20% Prevention set-aside reflected on this table, the $3,671,001.00 (above) is from Table 5a. The remaining 20% is reflected in Table 6 SUPTRS BG, Column C ($154,967.00). With those two amounts together, the sum is $3,825,968.00 which is the 20% Prevention set-aside. (Row 6-above-has the sum of ALL of Table 6 SUPTRS BG, not just Prevention.)

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	
1b. Crisis Services for Adults	1043155.00
1c. CSC/ESMI program for Adults	
1d. Other outpatient/ambulatory services for Adults	12083626.00
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	13126781.00
3. Services for Children	
3a. EBPs for Children	
3b. Crisis Services for Children	66283.00
3c. CSC/ESMI program for Children	2218875.00
3d. Other outpatient/ambulatory services for Children	4906855.00
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	7192013.00
5. Other Capacity Building/Systems Development[a]	760520.00
6. Administrative Costs[b]	1109438.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**22188752.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

3-31-26: Table revised following final allocation.

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Information Dissemination	Universal	$890,600	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$890,600**	**$0**
2. Education	Universal	$323,113	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$323,113**	**$0**
3. Alternatives	Universal	$19,823	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$19,823**	**$0**
4. Problem Identification and Referral	Universal	$0	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$0**	**$0**
	Universal	$890,599	
	Selective	$0	

5. Community-Based Processes	Indicated	$0	
	Unspecified	$0	
	Total	**$890,599**	**$0**
6. Environmental	Universal	$1,416,703	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$1,416,703**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$130,163	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$130,163**	**$0**
8. Other	Universal	$0	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$0**	**$0**
Total Prevention Budget		**$3,671,001**	
Total Award [a]		**$19,129,838**	
Planned Primary Prevention Percentage		**19.19%**	

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

The Prevention total is $3,825,968.00. However, after subtracting the $154,967.00 allocated on Table 6 (SUPTRS BG, Column C), the total is now $3,671,001.00. ($3,671,001.00 (Table 5a total) + $154,967.00 (Table 6 SUPTRS BG, Column C) = $3,825,968.00. The percentage at the bottom is not 100% because it is not factoring in the Prevention amount in Table 6 SUPTRS BG, Column C.

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Universal Direct		
2. Universal Indirect		
3. Selective		
4. Indicated		
5. Column Total	**$0**	
6. Total SUPTRS Award[a]	**$19,129,838**	
7. Primary Prevention Percentage	**0.00%**	

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Not applicable. Completed in Table 5a.

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
Alcohol	☑	☐
Tobacco/Nicotine-Containing Products	☑	☐
Cannabis/Cannabinoids	☑	☐
Prescription Medications	☑	☐
Cocaine	☐	☐
Heroin	☐	☐
Inhalants	☐	☐
Methamphetamine	☑	☐
Fentanyl or Other Synthetic Opioids	☑	☐
Other	☐	☐
Priority Populations		
Students in College	☑	☐
Military Families	☑	☐
American Indian/Alaska Native	☑	☐
African American	☑	☐
Hispanic	☑	☐
Persons Experiencing Homelessness	☑	☐
Native Hawaiian/Pacific Islander	☑	☐
Asian	☑	☐
Rural	☑	☐

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026			FFY 2027		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$25,000.00	$0.00	$100,000.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$25,000.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$100,000.00	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$360,000.00	$0.00	$10,000.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$10,000.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$360,000.00	$0.00	$0.00	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$65,000.00	$0.00	$19,967.00	$0.00	$0.00	$0.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$65,000.00	$0.00	$19,967.00	$0.00	$0.00	$0.00
7. Training and Education	$396,275.00	$9,000.00	$25,000.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$25,000.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$396,275.00	$9,000.00	$0.00	$0.00	$0.00	$0.00
8. Total	**$846,275.00**	**$9,000.00**	**$154,967.00**	**$0.00**	**$0.00**	**$0.00**

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Footnotes:

Table 6 SUPTRS BG, Column C + Table 4, Row 3= the 20% Prevention setaside.

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	FFY 2026 MHBG[1]	FFY 2026 BSCA Funds[2]	FFY 2027 MHBG[3]
1. Information Systems	$20,000.00	$20,000.00	
2. Infrastructure Support	$0.00	$0.00	
3. Partnerships, Community Outreach, and Needs Assessment	$599,720.00	$0.00	
4. Planning Council Activities	$0.00	$0.00	
5. Quality Assurance and Improvement	$0.00	$0.00	
6. Research and Evaluation	$0.00	$0.00	
7. Training and Education	$140,800.00	$0.00	
8. Total	**$760,520.00**	**$20,000.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

[3] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [**July 1, 2026 – June 30, 2027**, for most states].

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

11-12-25: Amount corrected and items doubled to reflect 2 years.

3-25-26: With final allocation, no changes to this table.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **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 health 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: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

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 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 details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

a. & l. Adults with serious mental illness (SMI)
The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is actively working to enhance access to care for individuals with mental health needs, including adults with Serious Mental Illness (SMI). A key component of this effort is the expansion of the Certified Community Behavioral Health Clinics (CCBHC) model across the state.

Beginning October 1, 2025, all 13 Oklahoma CCBHCs will operate under a Centers for Medicare and Medicaid Services (CMS)-approved State Plan Amendment, previously Oklahoma operated under the SAMHSA CCBHC Demonstration. This transition represents a significant advancement in the sustainability and delivery of comprehensive, community-based mental health and substance use services.

As mandated by the Substance Abuse and Mental Health Services Administration (SAMHSA), all CCBHCs are required to conduct a comprehensive needs assessment at the time of implementation and every three years thereafter. These assessments are critical to identifying and addressing difficulties that may limit access to care. Key areas evaluated include transportation challenges, income levels, clinic hours, and workforce capacity.

CCBHCs are designed to ensure that services are accessible, available, and responsive to the needs of the communities they serve. To this end, CCBHCs in Oklahoma must provide: Service times and settings that are convenient and responsive to community needs, service delivery in locations where clients live and feel comfortable, timely intake and rapid engagement in services, access to robust crisis services available 24/7, and options for both in-person and telehealth services when appropriate.

By implementing these standards, the state aims to reduce difficulties to accessing care, increase service capacity, and improve outcomes for adults with SMI, particularly those who also face co-occurring substance use disorders or other complex challenges.

b. Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)
Oklahoma recognizes the complex needs of adults living with both Serious Mental Illness (SMI) and co-occurring Intellectual and Developmental Disabilities (I/DD). This population often faces significant hurdles to accessing care, including limited provider capacity, diagnostic overshadowing, and challenges accessing integrated, person-centered services. The ODMHSAS and The ODMHSAS Care Coordination Team both work collaboratively with state partners, including the Oklahoma Department of Human Services Developmental Disabilities Services (DDS), to improve service coordination, cross-system training, and referral pathways. Efforts include enhancing provider training on dual diagnoses, expanding access to behavioral health services that are tailored for individuals with I/DD, and supporting community-based care models that promote encompassing all, independence, and dignity. ODMHSAS is committed to ensuring access to comprehensive care for this vulnerable population through systems integration, stakeholder collaboration, and ongoing evaluation of service gaps.

c. All pregnant women assessed as needing outpatient substance use disorder services can be admitted into any outpatient program of their choice in the state. Pregnant women assessed at a higher level and needing 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 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.

In 2018, ODMHSAS was awarded the Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) initiative to improve outcomes for substance-using pregnant and postnatal women and their newborns.. This initiative laid the foundation for strategic training and education around plans of safe care and the importance of prenatal and postnatal treatment . Although the QIC-CCCT project ended in April 2021, it opened the door for Oklahoma to expand services and support for pregnant and parenting individuals with substance use disorders (SUDs). In March of 2020, the ODMHSAS and partner agencies were selected to receive 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), continuing he progress initiated under QIC-CCCT. Through this collaboration, a cross-system effort was launched to improve the continuum of care for pregnant and parenting families impacted by substance use and/or co-occurring disorders. Building on that momentum, Oklahoma launched a statewide, multi-agency collaborative originally known as SAFER (Safely Advocating for Families Engaged in Recovery). While the SAFER name is no longer used, the initiative continues under the leadership of The Evolution Foundation, a long-standing statewide nonprofit organization with deep expertise in behavioral health systems, peer-led services, and family engagement. The Evolution Foundation has worked in close partnership with ODMHSAS for over two decades and serves as the state's lead family engagement entity supporting behavioral health and child-serving systems. Their mission to "provide hope for Oklahoma's children, youth, and families, one community at a time" is reflected in their work building community coalitions, offering technical assistance, and delivering trauma-

informed training and navigation support to families. Under their leadership, this statewide initiative continues to focus on improving the continuum of care for pregnant and parenting people, including those with co-occurring mental health and substance use disorders. The initiative brings together state and local agencies to identify hurdles, enhance early access to care, promote family-centered recovery supports, and reduce involvement in the child welfare and justice systems.

In 2024, ODMHSAS was awarded the State Pilot Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) grant through SAMHSA. This award supports the launch of the HOPE Initiative (Healthy Outcomes through Prevention and Engagement), a three-year effort focused on improving maternal and infant health outcomes and expanding access to family-based outpatient and intensive outpatient services for pregnant and postpartum women with a primary diagnosis of SUD, with an emphasis on opioid use disorder. The HOPE Initiative targets Comanche County and surrounding rural areas, which have been designated as a Health Professional Shortage Area (HPSA) and bear a disproportionate burden of maternal substance use, overdose, and child welfare involvement.

The HOPE Initiative features:
• Integrated, trauma-informed, responsive care for pregnant and postpartum women and their children under age 17.

• Services that include motivational interviewing, PCAP, PRSS, SFP/CFP, Circle of Security Parenting, Attachment Biobehavioral Catch -Up, and FDA-approved MOUD options.

• Use of Family Care Plans (FCPs), peer navigation, SBIRT screening, and a mobile app to facilitate warm handoffs, referrals, and care coordination.

• Coordination with tribal nations, birthing hospitals, OB/GYNs, child welfare, housing, and the legal system.

• A continued emphasis on anti-stigma messaging, including expansion of the Tough as a Mother campaign and strategic cross-system training.

• Partnership with The Evolution Foundation to expand outreach, community engagement, and coalition development.

Together, the HOPE Initiative and the work advanced under the original QIC-CCCT and SAFER projects demonstrate Oklahoma's ongoing, layered commitment to building a coordinated, family-centered system of care for pregnant and parenting individuals with substance use disorders—addressing stigma, increasing access to services, reducing maternal mortality, and supporting family preservation.

Additionally, ODMHSAS continues to support the Tough as a Mother campaign, modeled after Colorado's initiative of the same name. This public awareness campaign targets pregnant and parenting individuals with SUDs and aims to reduce stigma, increase public understanding, and connect women to services. Recognizing that stigma and fear of legal consequences can prevent individuals from seeking help, the campaign uses trauma-informed messaging and real-life stories to create a sense of safety and hope. The campaign is promoted through digital media, community partnerships, and provider outreach. More information can be found at Tough As A Mother - Oklahoma Resources (okimready.org)

d. Oklahoma continues to prioritize expanding access to coordinated, comprehensive, and family-centered care for individuals with behavioral health needs, with a strong emphasis on women with substance use disorders (SUDs) who are pregnant or parenting dependent children. The state has implemented a continuum of residential, outpatient, recovery support, and justice-involved services that promote parenting capacity, family preservation, and long-term recovery.

To address the needs of women with dependent children, Oklahoma contracts with three residential programs and two halfway house programs designed for Women with Children (WWC) that provide integrated behavioral health services, including biopsychosocial assessments for both the parent and child(ren), case management, transportation, and linkages to community-based supports. One halfway house also operates a residential program for women without children, offering a flexible continuum of care as family needs evolve.

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 medical services, including prenatal care, mental health services, case management to assist in establishing eligibility for public assistance programs provided by federal, state, or local governments (SNAP, Medicaid, TANF, etc); employment and training programs; education, parenting 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; developmental screening; 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.

These programs are also participants in federally funded initiatives aimed at improving maternal and child outcomes:
• From 2018–2023, Oklahoma operated under the SAMHSA Pregnant and Postpartum Women (PPW) grant to enhance residential

treatment models.
• Oklahoma also implemented the Oklahoma Families First Project, a SAMHSA-funded initiative (2019–2023), which enhanced outpatient services across ten counties (Creek, Cherokee, Tulsa, Okmulgee, Wagoner, Muskogee, Rogers, Washington, Kay, and Osage). This project focused on improving parenting and attachment, expanding case management, and strengthening family-oriented treatment approaches. The lessons learned from this project informed the development of the HOPE Initiative and supported the ongoing expansion of Family Treatment Courts.
• In 2024, Oklahoma received a new PPW-PLT grant from SAMHSA to support the HOPE Initiative (Healthy Outcomes through Prevention and Engagement), focused on expanding outpatient, intensive outpatient, and recovery services in Comanche County and surrounding rural areas for pregnant and postpartum women and their families. The initiative includes parenting interventions such as Circle of Security, Strengthening Families Program, and Celebrating Families!, along with Peer Recovery Support Services, Family Care Plans, contingency management, and the use of a mobile app to enhance referral coordination.

In addition to programmatic and service expansions, Oklahoma is also strengthening infrastructure through workforce development efforts. The ODMHSAS is in the process of implementing a new "Women's Liaison" role at every state-contracted outpatient provider. This designated staff member will be responsible for ensuring that women's services—particularly those addressing the needs of women with dependent children—are available, accessible, and coordinated within their agency.

The Women's Liaison will serve as a point person for internal coordination, training, and quality improvement efforts related to responsive and family-centered care. ODMHSAS is actively working with providers to:
• Define the scope and responsibilities of the role,
• Identify appropriate staff within each agency to serve in this capacity, and
• Develop mechanisms to track implementation, outcomes, and impact of these roles on service access and engagement.
Safe and stable housing is another critical focus area. The Oklahoma City Housing Authority, in collaboration with the ODMHSAS, provides sober-living environment for women in recovery, allowing them to focus on healing while maintaining custody of and strengthening bonds with their dependent children. Residents are required 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. Oxford House also operates multiple homes for women with children, as well as two houses—one in Oklahoma City and one in Tulsa—both for men with dependent children.

Additionally, Family Treatment Courts (FTCs) are a vital component of Oklahoma's strategy to improve access and outcomes for families impacted by substance use and child welfare involvement. FTCs use a collaborative, multidisciplinary approach to provide timely access to family-centered, trauma-informed treatment, parenting services, and wraparound supports—while maintaining judicial oversight to promote accountability and reunification. FTCs directly support Oklahoma's goals to reduce foster care entries and improve child and parent well-being, and align with the HOPE Initiative and statewide family-centered practices.

Together, these initiatives reflect the commitment of ODMHSAS to building a coordinated, trauma-informed, and family-centered system of care for women with substance use disorders and their children. By embedding these practices across all levels of care—from prevention and outpatient treatment to residential services, recovery housing, and court-based interventions—the state is working to ensure that services are responsive to the complex and evolving needs of women and families. These efforts aim not only to promote recovery, but to strengthen family stability, reduce system involvement, and support long-term well-being for the entire household.

e. 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. 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 the waitlist that they had previously used. For residential substance use disorder treatment, Oklahoma has an online tool that is updated weekly, by contracted facilities, which shows which facilities have open beds. People can either access the residential treatment beds by directly contacting the residential facilities or they can go to an outpatient provider or CCBHC and be screened. If their screen shows them as needing a residential level of care and they are amenable to treatment at that higher level of care, the provider then views the online tool and connects the person to the residential treatment facility. Because there are open beds, interim services are not required but can be provided if the person needs some additional time in order to get their affairs in order prior to accessing the residential treatment services. Even though treatment beds are available to all that need them, interim services are required by contract as is the requirement for contractors to meet the 14-120 day standard. Outreach is carried out, by the State, CCBHC's and other contracted entities in many avenues, resulting in contact with various populations. Throughout these outreach activities, contact is made with individuals who inject drugs. Once contact is made, the entities encourage individuals to seek treatment and give them information on how to access treatment.

f. 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.

g. 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). By the end of September, every drug court program in the state will have received training on the Best Practice revisions. In addition, training and technical assistance will be offered throughout FY26 to ensure that all courts are equipped to follow the latest standards. All Oklahoma treatment courts demonstrate tremendous success through outcomes such as a decrease 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. In December 2024, a pilot program was initiated to provide Medications for Opioid Disorders (MOUD) at one female and one male Department of Corrections prison.

h. 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 an effort to empower local prevention efforts, vending machines that can disburse Narcan and Fentanyl test strips have been made available to community partners. The vending machines are not being bought. The community partners will be responsible for buying the machine software, ensuring the power source and stocking the vending machine. After one year, the vending machines will become the property of the community partner.

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) and there are six children and youth Community Based Structured Crisis Centers (CBSCCs). These facilities are more typically referred to as Crisis Stabilization Units (CSUs) as they provide crisis stabilization services usually lasting 3-7 days. All consumers are referred for outpatient services upon discharge. With regards to Urgent Recovery Centers (URCs), there are 20 facilities for adults and there are eight child and adolescent facilities. The child and adolescent facilities 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. One URC and CSU in Creek County specializes in serving children and youth intellectual and developmental disabilities.

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.

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 over 4,000 clinicians in CAMS.

ODMHSAS has also increased training for Colleges and Universities and consultations to provide treatment for the student

population in their college counseling programs for treatment of suicidal and substance abuse issues.

i. 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 five 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.

An essential component of the recovery system is the state's partnerships for recovery housing. Using State Opioid Response Grant funds, the ODMHSAS contracts with the Oklahoma Alliance of Recovery Resources (OKARR) to certify recovery housing that is medication assisted treatment (MAT) friendly. OKARR is the state affiliate of the National Alliance for Recovery Residences (NARR) and is the leading advocacy group for those in recovery in the state providing certification of recovery housing, recovery community organizations, recovery friendly workplaces in addition to training and technical assistance in recovery support services. Two hundred and eighty-two recovery residences with over 1,919 beds have been certified in Oklahoma as of Dec 2024 and are following best practices within the social model of recovery.

Oxford Houses are another valued partner for recovery housing. Currently, there are 137 Oxford Houses through 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.

j. Children and youth with serious emotional disturbances (SED) or substance use disorders-
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, Systems of Care covers all 77 counties in OK. 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 partners with family advocacy and community children's behavioral health development organizations that cover all regions of the state. 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. ODMHSAS is also part of several cross agency planning teams including Cross Systems Hope and Wellbeing, the Council on State Governments Policy Academy, The Children's State Advisory Workgroup and the Interagency Forum for Youth Mental Health Policy. These teams all consist of representatives from the state child serving agencies as well as those with lived experience. ODMHSAS is also contracting with the Oklahoma Commission on Children and Youth to develop a State Youth Advisory Council for recommendations on programming, processes and policy to improve access and quality of behavioral health services for children and youth.

k. ODMHSAS participates in a monthly staffing with Oklahoma Human Services DDSD Division to staff children and youth with SED and co-occurring mental health and I/DD needs. ODMHSAS is also currently working with OHS DDSD Division to develop a plan to improve access to care that best meets the developmental needs of children and youth with SED and co-occurring borderline intellectual functioning. ODMHSAS is also contracting for a specific Child and Family Urgent Recovery Clinic and a Crisis Stabilization that serves the specialty population for children and youth with I/DD that are experiencing a mental health crisis. In 2024, ODMHSAS contracted with the Center for Start Services to train 70 children's crisis providers on how to best provide crisis services to children and youth with co-occurring mental health and I/DD. ODMHSAS will also partner with NASMHPD and NASHP on providing and receiving technical assistance to better serve this population.

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 that began in April 2024. ODMHSAS has and will continue to work with OHCA to ensure managed care entities are in compliance with mental health parity laws.

3. 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.

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. Screening and assessment is performed to determine the presence of mental health, co-occurring or substance use disorders. Care is delivered using an integrated interdisciplinary team that addresses physical health needs, as well as mental health needs, or substance use or co-occurring needs, appropriate treatment. 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).

a. Please describe how this system differs for youth and adults.

Children and youth have access to the same services and supports as named above, because those services are across the lifespan. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities in addition to behavioral health concerns, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Oklahoma prioritizes integrated treatment for individuals with co-occurring mental health and substance use disorders, as well as those with co-occurring SMI/SED and I/DD. CCBHCs utilize integrated, person-centered care plans and interdisciplinary teams to ensure that the full range of behavioral, substance use, and physical health needs are addressed in a coordinated fashion. Staff are trained in co-occurring disorder treatment, and services are delivered using evidence-based practices tailored to individuals with complex needs. Collaborative relationships with developmental disability service providers help bridge gaps and support continuity of care for individuals with co-occurring SMI and I/DD. Through the CCBHC model, Oklahoma is advancing a comprehensive and sustainable framework for integrated care that improves outcomes for individuals across the behavioral health spectrum.

One of the evidenced based practices utilized by CCBHCs are Programs of Assertive Community Treatment (PACT). These are self-contained clinical program that assure the fixed point of responsibility for providing treatment, rehabilitation and support services to consumers with serious mental illnesses. They use an integrated service approach to merge clinical and rehabilitation staff expertise, such as psychiatric, substance abuse, employment, within one service delivery team, supervised by a qualified program director. Accordingly, there shall be a minimal referral of consumers to other program entities for treatment, rehabilitation, and support services. The PACT staff is responsible to ensure services are continuously available in natural settings for the consumer in a manner that is courteous, helpful and respectful.

c. How many IT-COD teams do you have? Please explain.

There are 13 CCBHCs. CCBHCs operate on a model of team-based care. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers, (14) behavioral health aid (for children) (15) wellness coaches.

There are also 9 PAC teams. With the exception of one, all of the PACT teams operate inside a CCBHC.

d. Do you monitor fidelity for IT-COD? Please explain.

Fidelity, both to the CCBHC and to the PACT model, is conducted in two different ways. The ODMHSAS created a fidelity review monitoring tool based on the SAMHSA criteria for CCBHCs and these reviews are conducted on an annual basis. PACT fidelity reviews are conducted in conjunction with the CCBHC reviews. Monitoring also takes place via the certification process, which can occur anywhere between every 1-3 years. Both CCBHCs and PACT programs must acquire and sustain certification with the ODMHSAS in order to be able to render services.

e. Do you have a statewide COD coordinator? (●) Yes ( ) No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. 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

    d) How the state provides integrated treatment for individuals with co-occurring disorders

Oklahoma has made significant strides in supporting integrated behavioral health and primary health care for individuals with mental health disorders, substance use disorders (SUD), co-occurring mental and substance use disorders, and individuals with co -occurring Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and Intellectual and Developmental Disabilities (I/DD). As a Certified Community Behavioral Health Clinic (CCBHC) state, Oklahoma has leveraged the CCBHC model to promote whole-person, coordinated care. CCBHCs are required to offer a full array of behavioral health services and support for the populations they serve. Building on the foundational principles of Health Homes, Oklahoma's CCBHCs have expanded efforts to integrate behavioral health with primary care, acute care, and long-term services and supports for individuals with chronic and complex health conditions.

a) Access to behavioral health care facilitated through primary care providers-To improve access, CCBHCs ensure that every enrollee is aligned with a primary care provider (PCP). This alignment facilitates integrated care planning and service coordination. Care coordination activities include referrals from PCPs to behavioral health services, bidirectional communication between behavioral and primary care providers, and joint care planning efforts.

b) Efforts to improve behavioral health care provided by primary care providers- CCBHCs engage in ongoing collaboration with PCPs to support improved behavioral health service delivery in primary care settings. This includes shared use of health information exchanges (HIEs), consultation between behavioral health and medical providers, and the use of population health management platforms. These efforts enable early identification of behavioral health needs and improve care continuity.

c) Efforts to integrate primary care into behavioral health settings- Integration of primary care into behavioral health settings is achieved through interdisciplinary care teams that address mental health, SUD treatment, and physical health needs. CCBHCs develop clinical pathways for common medical conditions, provide monitoring of physical health follow-up care, and participate in transitional care planning. CCBHCs are required to maintain formal relationships with key primary care-related entities, including Federally Qualified Health Centers (FQHCs), inpatient psychiatric and acute care hospitals, Veterans Affairs facilities, hospital outpatient clinics, Health Management Programs (HMPs), and Health Access Networks (HANs).

d) How the state provides integrated treatment for individuals with co-occurring disorders- Oklahoma prioritizes integrated treatment for individuals with co-occurring mental health and substance use disorders, as well as those with co-occurring SMI/SED and I/DD. CCBHCs utilize integrated, person-centered care plans and interdisciplinary teams to ensure that the full range of behavioral, substance use, and physical health needs are addressed in a coordinated fashion. Staff are trained in co-occurring disorder treatment, and services are delivered using evidence-based practices tailored to individuals with complex needs. Collaborative relationships with developmental disability service providers help bridge gaps and support continuity of care for individuals with co-occurring SMI and I/DD. Through the CCBHC model, Oklahoma is advancing a comprehensive and sustainable framework for integrated care that improves outcomes for individuals across the behavioral health spectrum.

5. 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 (SMI)

    b) Adults with substance use disorders

    c) Adults with SMI and I/DD

    d) Children and youth with serious emotional disturbances (SED) or substance use disorders

    e) Children and youth with SED and I/DD

Care coordination is a foundational component of Oklahoma's Certified Community Behavioral Health Clinic (CCBHC) model and a critical mechanism for ensuring individuals receive timely, appropriate, and integrated care across systems. In Oklahoma, care coordination is funded through the Prospective Payment System (PPS) associated with the CCBHC model. CCBHCs are required to provide care coordination services that are intentionally organized around the individual's needs and delivered across all relevant care settings. These services are tailored based on the seriousness and complexity of behavioral health needs, ensuring a person-centered approach across all populations served. CCBHCs are required to maintain formal relationships with a wide array of care settings to ensure comprehensive care coordination, including: Federally Qualified Health Centers (FQHCs), Rural Health Clinics, inpatient psychiatric facilities, substance use disorder treatment providers (outpatient and residential), schools, child welfare agencies, juvenile and criminal justice systems, Indian Health Services, child placing and therapeutic foster care agencies, Veteran's Affairs facilities, inpatient acute care hospitals, hospital outpatient clinics, Health Management Programs (HMPs), and Health

Access Networks (HANs). These partnerships enable effective coordination across behavioral health, physical health, and social service domains, ensuring a truly integrated system of care for all Oklahomans.

a. Adults with SMI- For adults with Serious Mental Illness (SMI), care coordination focuses on ensuring seamless transitions across levels of care, managing co-occurring physical health needs, connecting individuals to housing, employment, and social services, and supporting community tenure. Intensive care coordination is available for high-risk individuals, including those in the "Most In Need" (MIN) population—defined by frequent use of crisis or inpatient services. A dedicated state-level Care Coordination Team (CCT) supports this work by monitoring real-time data alerts when MIN individuals access elevated levels of care. The CCT collaborates with inpatient providers and outpatient CCBHCs to coordinate warm handoffs, conduct joint staffing meetings when needed, monitor discharge planning, and track outpatient follow-up to ensure continuity of care.

b. For adults with Substance Use Disorders (SUD), care coordination emphasizes timely access to detoxification, residential, and outpatient treatment services, as well as linkages to life-saving overdose prevention and response programs, medication-assisted treatment (MAT), peer recovery supports, and social determinants of health services. Coordination efforts also include partnering with courts, law enforcement, and community supports to engage individuals involved with the justice system.

c. Adults with SMI and I/DD For adults with co-occurring SMI and Intellectual and Developmental Disabilities (I/DD), care coordination is customized to address complex behavioral and developmental needs. CCBHCs work in collaboration with ODMHSAS Care Coordination Team and Oklahoma Department of Human Services Developmental Disabilities Services (DDS) to align service plans and ensure integrated care that respects individual preferences and communication styles. Teams receive specialized training in dual diagnosis and person-centered planning for this population.

d. Children with SED or SUD - Children and Youth receive two types of care coordination with service coordination for children and youth with lower level needs and Care Coordination using the Wraparound Model for children and youth with high level needs whose families want to participate in that high level care coordination. Care Coordination including Wraparound is funded through the CCBHC model. Children and youth with substance use disorders have access to care coordination through their providing agency whether that is a stand alone substance use organization or a CCBHC. Providers work with our other child serving state agencies to ensure care coordination is accessible to children and youth in child welfare and the juvenile justice system. 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. ODMHSAS support children and youth in child welfare who meet criteria for therapeutic foster care by providing Wraparound services to foster families serving these children and youth through a program in OHS called Enhanced Foster Care.

e. This would be the same as (c) above. However, we do have an urgent recovery center and a crisis unit that is specific for children and youth with I/DD.

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

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Oklahoma supports a comprehensive and integrated approach to serving individuals, across the lifespan, with co-occurring mental health disorders and intellectual and developmental disabilities (I/DD) through its Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs are required to provide outpatient primary care screening and monitoring for a wide range of physical and behavioral health indicators. These screenings are critical to identifying co-occurring conditions and include, but are not limited to: body mass index (BMI) and weight assessments, blood pressure, tobacco use and cessation support, depression and alcohol use screening with follow-up planning, diabetes and metabolic screenings for individuals on antipsychotic medications, cardiovascular health screenings, and adherence monitoring for medications commonly used in treating schizophrenia, bipolar disorder, and depression. For children and adolescents, CCBHCs ensure delivery of developmentally appropriate screenings and preventive interventions tailored to the child's age and health risk profile.

In addition to health screening, CCBHCs conduct comprehensive, trauma-informed assessments that evaluate for co-occurring I/DD and behavioral health conditions. This includes identifying developmental delays, communication challenges, and adaptive functioning deficits alongside mental health symptoms. CCBHCs are trained to recognize and address diagnostic overshadowing—when I/DD symptoms mask or are mistaken for behavioral health conditions—and to provide or coordinate referrals for formal I/DD diagnostic evaluations when indicated.

Integrated, person-centered, and family-driven care planning is central to service delivery. Each individualized care plan incorporates behavioral health, medical, developmental, and prevention needs, and is developed collaboratively with the individual (and family or guardian, as appropriate). For individuals with co-occurring I/DD and behavioral health disorders, care plans are adapted to ensure accessibility, including the use of visual supports, simplified communication methods, and coordination with I/DD service systems.

For adults with co-occurring SMI and I/DD, integrated services are coordinated in partnership with Oklahoma's Developmental Disabilities Services (DDS). This collaboration ensures alignment between behavioral health and developmental disability supports, such as supported employment, community living, and habilitation services. CCBHCs, in partnership with ODMHSAS CCT, may engage in joint service planning with DDS case managers and leverage multidisciplinary care teams trained in dual diagnosis to ensure comprehensive and coordinated care.

For children and youth with SED and co-occurring I/DD, services are more family-focused and often involve coordination with schools, early intervention programs, and child welfare or juvenile justice systems. Care coordination emphasizes developmental supports, school-based accommodations, family education, and transition planning for youth aging out of pediatric systems. CCBHCs work to ensure that youth with complex needs receive early and appropriate interventions that support both emotional development and functional life skills.

Oklahoma's approach to integrating behavioral health and I/DD services reflects a commitment to whole-person care that is balanced, accessible, and responsive to the needs of individuals and families across the lifespan.

8. Please indicate areas of **technical assistance needs** related to this section.

Oklahoma is in the early stages of formally addressing the needs of individuals with co-occurring Serious Mental Illness (SMI) and Intellectual and Developmental Disabilities (IDD). We would greatly appreciate technical assistance to strengthen and expand these efforts.

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Footnotes:

11-6-25: Removed wording in an attempt to come into alignment with the current administration and SAMHSA's current stance on acceptable verbiage.
12-3-25: Further wording removed.

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
RA1SE Navigate	1.00
eSMI Outreach	13.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,095,763.00	1,095,763.00

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

RA1SE Navigate Treatment services are billed fee for service. If the client has private insurance, then insurance is the payor. 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 is a service that we have approval for, then ODMHSAS pays.

eSMI Outreach is paid on a fixed 1/12 monthly amount through the CCBHC.

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

RA1SE NAVIGATE is a Coordinated Specialty Care model that is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family, as active participants. This comprehensive early treatment model is focused on helping young people 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), Case Manager, PRSS, and a Psychiatrist. In addition to this, because the Raise Navigate team is located at a Certified Community Behavioral Health Clinic (CCBHC), Raise Navigate has access to all of the other services that the CCBHC has to offer, such as Wellness services, medication clinic services, and crisis services.

EBP: RA1SE NAVIGATE
(Previously, Oklahoma has had 2 RA1SE Navigate teams. At the end of September 2025, one of the Navigate teams will be ending their contract. Oklahoma will still have one Navigate team. Moving forward, Oklahoma will be looking at expanding coordinated specialty care (CSC) teams, possibly in the Navigate form.

• 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.

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

EBP: Trainings for Cognitive Behavioral Therapy (CBT), Recovery Oriented Cognitive Therapy (CT-R), and Cognitive Behavioral Therapy for Psychosis (CBTp) are being offered throughout Oklahoma. They are offered free of charge to all clinicians and have CEU's. This is to done to increase competence in rendering this modality for all clinicans as this population may not always seek or be able to seek services at a CCBHC.

Statewide, eSMI outreach programs are provided through 13 CCBHC service areas to develop and maintain collaborative relationships with local higher education institutions (colleges and vo-techs) 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 or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

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

The 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 services that the CCBHC offers, including 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 in FY2026 and FY2027 for your state's ESMI programs.

ODMHSAS has received the Chronic High Risk for Psychosis (CHR-P) grant and has partnered with the University of Oklahoma, in Cleveland County, as well as the CCBHC in that county, Central Oklahoma Community Mental Health Center (COCMHC). College staff personnel are 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. COCMHC staff have been trained on these concepts as well as on how to administer the screening and assessment. Individuals who are screened and are not in need of CHR -P services are offered whatever services might be most needed. Individuals who screen and assess as in need of CHR-P services, are offered a scaled up, more wraparound type of treatment services. Individuals who screen and assess as needing a higher level of services, are referred to Navigate.

In addition to the trainings already discussed above, a whole Navigate training is being planned. This training will offer information to newly hired Navigate staff, increasing their competence and will serve as a refresher for those Navigate staff that would benefit from attending. Navigate staff receive monthly Navigate consulting from our Navigate consultants. Additionally, Navigate staff are able to submit taped Individual Resiliency Training (IRT) sessions to our Navigate consultants, who then score it for fidelity, offer corrections and follow up to ensure that those corrections are implemented.

Continued work will be done with the current Navigate site to encourage them to begin reaching out to more rural portions of their service area to render Navigate services. Until recently, ODMHSAS had operated under the assumption that it was required for a community to have a population of 550,000 in order to justify having a Navigate site. Upon meeting with SAMHSA, it was relayed that this was outdated information. The next step would be to develop more coordinated specialty care teams (possibly Navigate) throughout Oklahoma. Additionally, the Navigate program will begin treating consumers with Bipolar Disorder with FEP. This will also expand their reach.

Continued work will also be done with those sites conducting eSMI outreach. eSMI outreach staff is already rendering outreach to hospitals, vo-techs and colleges and they are beginning to reach out to other settings in which this population's age range and possible symptomology may be encountered, such as vocational schools (cosmetology, welding, horseshoeing) as well as urgent cares.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

Our NAVIGATE program is 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). They will also soon be treating those with Bipolar Disorder with FEP.

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

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

2,507

11. What is the state's plan to outreach and engage those experiencing ESMI 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. Also, the CHR-P grant will continue through 2027, which will enable those clients who are experiencing chronic high risk of psychosis to be served, as well as identifying and referring those in higher need of services to Navigate treatment.

12. Please indicate area of technical assistance needs related to this section.

NA

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process 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. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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

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

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances 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). 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.

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.

Additionally, 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 **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.

6. Please indicate areas of technical assistance needs related to this section.

N/A.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic 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. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based 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 behavioral health 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

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

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

   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 Division Director of Provider Certification, Compliance and Assistance reports directly to the Chief of Policy and Provider Regulation. This function monitors contract compliance and performance for provisions related to SABG and MHBG funded treatment services.

4. Please indicate areas of technical assistance needs related to this section.

   N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders on individuals families and communities.
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6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve 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):

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

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

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

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (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)

• 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)
• 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)
• 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)
• Alcohol outlets (number and rate per population) (Source: Oklahoma Alcoholic Beverages Laws Enforcement (ABLE) Commission)
• Marijuana dispensaries (number and rate per population) (Source: Oklahoma Medical Marijuana Authority)
• Opioid dispensing (number and rates) (Source: Oklahoma Bureau of Narcotics)
• High dose opioid dispensing (number and rates) (Source; Oklahoma Bureau of Narcotics)

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) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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

High need counties are identified by analyzing and compiling common consumption and/or consequence indicators, calculating Z-scores for the individual indicators, calculating final Z-scores based on the sum of the individual Z-scores, and then ranking these counties by score. These rankings are then included in the decision-making process regarding which counties to fund. Total population and square miles of the prioritized counties are allocated through a formula incorporating total population and square miles of the county.

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

Narratve Question

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

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use 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. Linking and coordinating the Substance Abuse Prevention Strategic Plan with state and local prevention initiatives
4. Planning strategic prevention initiatives at the community level that are comprehensive, community specific, evidence-based, and data-driven
5. 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 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.

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 WebBGAS

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?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

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)** [x] Outcome indicators
- **f)** [ ] 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

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) 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.
*Please find attached the EB Criteria Scoring Tool

Narratve Question

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

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)

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 marijuana 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, marijuana, 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) Yes (if so, 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.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 WebBGAS

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)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **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)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ 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)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol 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):

Community norms

Footnotes:

11-6-25: In attempting to come into compliance with the current administration and SAMHSA's current stance on acceptable verbiage, the previously attached Strategic Plan, Evaluation Plan, and Criteria Scoring Tool has been removed.

12-3-25: Further wording was removed.

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The statewide network of CCBHC is primarily responsible for comprehensive services for adults with serious mental illness (SMI) and children/adolescents with serious emotional disturbance (SED) and their families. CCBHCs also treat co-occurring and substance use/misuse disorders. There are 13 CCBHCs located throughout Oklahoma.

Systems of Care is the preferred approach to coordinate services for children and their families. Sometimes CCBHCs and SOCs are one and the same and sometimes are collaborating partners. 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.

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.

In addition to the above, Oklahoma's crisis continuum works to enable individuals to function outside of inpatient/residential institutions. Oklahoma has 6 Children and Youth Crisis Stabilization Units. These units provide crisis stabilization services usually lasting 3-7 days. All youth are referred for outpatient services upon discharge. Currently in Oklahoma there are a total of 8 Child and Adolescent Urgent Recovery Centers (URCs) open across Oklahoma. 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. One URC and CSU in Creek County specializes in serving children and youth intellectual and developmental disabilities.

Oklahoma has 13 Adult Crisis Stabilization Units. These units provide crisis stabilization services usually lasting 3-7 days. Consumers are referred for outpatient services upon discharge. There are currently 20 Urgent Recovery Centers (URCs) open across Oklahoma.

In recent years, the CCBHC system has also intentionally expanded to proactively support diversion from the criminal justice system. Initiatives within this realm include 35 mental health courts, 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 managers, and community-based re-entry intensive care coordination teams.

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 use prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	● Yes	○ No
i)	Recovery 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 (Crisis Stabilization Units) provide short term stays and stabilization in lieu of placement in inpatient facilities. Urgent Care Centers 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. For adults with Serious Mental Illness (SMI), care coordination focuses on ensuring seamless transitions across levels of care, managing co-occurring physical health needs, connecting individuals to housing, employment, and social services, and supporting community tenure. Intensive care coordination is available for high-risk individuals, including those in the "Most In Need" (MIN) population—defined by frequent use of crisis or inpatient services. A dedicated state-level Care Coordination Team (CCT) supports this work by monitoring real-time data alerts when MIN individuals access elevated levels of care. The CCT collaborates with inpatient providers and outpatient CCBHCs to coordinate warm handoffs, conduct joint staffing meetings when needed, monitor discharge planning, and track outpatient follow-up to ensure continuity of care. 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.

5. Please indicate areas of technical assistance needs related to this section.

N/A

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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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	5.4%	17.34%
2.Children with SED	9%	13.42%

2. 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 number of new cases of SMI/SED as defined by Oklahoma in SF2024 that were not in SY2023.

3. Please indicate areas of technical assistance needs related to this section.

N/A

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	◉ Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

N/A

[1] *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.*

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 tailored services to rural population with SMI/SED. See the federal **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 77 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 all 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.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

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 eviction prevention, working with housing authorities, fair housing, and HUD's continuum of care with coordinated entry.

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.

Listed below are programs that ODMSHAS is currently involved in, as well as plans for the coming years.

Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH)-The PATH allocation for Oklahoma for grant year 09/01/2024 – 08/31/2025 is $ 459,773.00. PATH programs are 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 advocacy and 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.

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.

ODMHSAS funds one supervised transitional living program which provides 24/7 on-site staff supervision and support for individuals transitioning from higher levels of care, such as inpatient or residential treatment, into independent living. This site focuses on life skills development and behavioral health support.

ODMHSAS funds two supported transitional living sites. One site offers semi-independent housing with staff support available to assist individuals working toward stable, long-term housing. Residents receive help with mental health needs, employment, and daily living skills. The other site is designed for individuals with behavioral health needs. It offers structured housing with access to counseling, case management, and recovery support while promoting gradual independence. Both sites are for ages 18 and up.

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 18-24 through supported transitional living, and subsidized rapid-re housing. We also partner with Sisu to provide emergency shelter for young adults who are experiencing challenges with mental health and substance use.

One other facility offers transitional housing in the form of short-to medium term housing with therapeutic services and case management that is designed to help individuals with mental illness transition to independent community living.

ODMHSAS also funds a permanent supportive housing and long-term supportive program which combines affordable housing with case management and supportive services. Designed for individuals with serious mental illness or co-occurring disorders. Housing Navigation helps participants locate and maintain stable housing.

The state funds The ION Housing Program (Bridge Transitional Living) that offers master lease and tenant based transitional housing and supportive services for individuals 18 and older with serious mental illness or substance use disorders who are exiting psychiatric hospitalization and lack stable housing. The program helps participants develop independent living skills, engage in treatment and recovery, and work toward long-term housing stability by supporting their transition into permanent housing.

In State Fiscal Year 2026, the state plans to release a competitive bid for Mental Health Block Grant (MHBG) funding to support housing-focused outreach services targeting individuals experiencing serious mental illness (SMI) and/or substance use disorders (SUD) who are currently street-dependent or unsheltered. The selected providers will be responsible for delivering comprehensive, person-centered outreach and engagement services aimed at helping these individuals identify and access stable permanent or transitional housing options. In addition to securing housing, providers will deliver intensive case management and supportive services tailored to address behavioral health needs, improve housing readiness, and promote long-term housing stability. Funded programs will also be expected to provide at least 90 days of follow-along aftercare support post-placement, ensuring continuity of care, linkage to community-based services, and assistance in addressing any difficulty in maintaining housing.

We intend to utilize Mental Health Block Grant (MHBG) funds in the upcoming fiscal year to continue funding our three peer-run drop-in centers and three clubhouses. These programs serve as critical access points for individuals living with serious mental illness, including those experiencing homelessness or housing instability. By offering low-barrier, peer-led support, these centers help individuals engage in recovery, build trust, and connect with essential resources. Services provided promote housing stability through linkage to case management, housing navigation, and basic needs support, while also fostering pathways to employment by offering vocational skill-building, social support, and structured daily activities in a recovery-oriented environment.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

The vision of Aging Services is that all Oklahomans have the opportunity to live and age with behavioral health, including physical health, well-being, social connection, and purpose. To advance these outcomes, Aging Services, in collaboration with cross-sector

partners, focuses on policy and practice development that strengthens age-informed engagements, services, and care.

Key justification and urgency of this work:
• The older adult population in the U.S. is growing rapidly as is the need for behavioral health services and systems to serve this population.
• As of 2024, eleven states and 45% of U.S. counties had more older adults than children under <18, which is up from three states and 31% of counties in 2020.

In Oklahoma:
• Older adults are projected to surpass the number of children <18 by 2034.
• The number of persons ages =65 served within ODMHSAS has consistently increased since FY 2016 (2021 was an exception), reaching nearly 7,500 in FY 2024; ODMHSAS projects a 32% increase in this age group among persons served within the next five years.

In 2022, in preparation for this demographic shift, ODMHSAS and the new Aging Services partnered with the Oklahoma Mental Health and Aging Coalition (OMHAC) to convene the Oklahoma Behavioral Health Policy Academy. The Academy was initiated by OMHAC and facilitated by the E4 Center of Excellence for Aging. A direct outcome is the Behavioral Health Forum on Aging. The Forum is guided by the Oklahoma Older Adult Behavioral Health State Plan and provides strategic direction to Aging Services.

Utilizing SFY 2025 as a reference, below are key areas of focus for Aging Services:

Behavioral Health Forum on Aging: The Forum, chaired by the OMHAC Director, and Aging Services, work in concert to promote the Division's vision. The Forum convenes six times annually in addition to targeted work by taskforces (e.g. Age-Informed Screening Tools, Aging Our Way Multi-Sector Plan on Aging, CCBHCs, and Communications). One Taskforce highlight:
Along with only four other states, Oklahoma was invited to participate in the first SAMHSA Older Adult Suicide Prevention Policy Academy. A direct outcome is the Suicide Prevention Taskforce, which is working to integrate unique aspects of older adult suicide prevention into the broader State Suicide Prevention Plan.
Age-Informed Training: In aggregate, >950 people completed trainings focused on aging, behavioral health, and the central role of reframing aging. This includes:
o Scheduled sessions geared toward professionals and sessions in response to community requests.
o PEARLS Coach Training, which is an evidence-based depression intervention
o Not included in this number: 1) people completing PRSS Older Adults, which is co-managed with the PRSS and Wellness Team; 2) Partnership with Oklahoma State Department of Health and CCBHCs to promote training and subsequent delivery of Tai Chi: Moving for Better Balance and Walk with Ease, both Arthritis Appropriate, Evidence Based Interventions.

988 Outreach: Participation with 14 community events to raise awareness of 988 as an age-encompassing resource.

Standing Committees: Aging Services participates in (including member and leadership roles) Aging Our Way, Oklahoma's Multi-Sector Plan on Aging; Areawide Agency on Aging; Edmond CCBHC Advisory Council; National Coalition on Mental Health and Aging; OMHAC; New View Oklahoma; Regional Food Bank of Oklahoma: Age-Friendly; and Oklahoma State Council on Aging.

d. Please indicate areas of technical assistance needs related to this section.

N/A

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

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.

Criterion 5

1. 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 Behavioral Health Policy and Provider Regulation, Certification Training, Quality, Prevention, Housing & IPS, Clinical Programs, MAT, OPTs, Opiate & Women's Treatment Services, Family/Youth and Civil Diversion Programs, Crisis Services, Children's Outpatient and School Based Programs, Treatment and Recovery Services, Decision Support Services, Human Resources Management, Governmental Affairs/ Communications/Public & Community Partnerships, Finance, Reimbursement, Legal, Program Enhancement & Grant Oversight, Hospital Enterprise & Operations, Justice Services. All leadership and management structures are organized under the ODMHSAS Interim Commissioner and his executive staff including the Deputy Commissioner of Hospitals, Chief of Policy and Provider Regulation, Chief of Compliance and Accountability, Chief of Clinical Programs, Chief of Programs and Education, Chief Technology Officer, Chief Management Officer, Chief of Operations, Chief of Justice Services, and General Counsel.

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).

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 two major conferences each year, the Children's Behavioral Health Conference and the Momentum Conference (which covers Prevention, Justice, and Recovery topics.) The ODMHSAS Human Resources Development training programs recorded combined audiences of over 51,553 participants from all areas of Oklahoma in the state fiscal year 2025. E-learning and the telehealth infrastructure continue to be integral to the training of the behavioral health workforce.

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 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 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 federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. 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 CY2024, an average of 60,629 services were provided per month.

3. Please indicate areas of technical assistance needs related to this section.

N/A

Footnotes:

11-6-25: Changes have been made to Table 6 to bring it into alignment with the current administration and SAMHSA.

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for 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 (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	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. Does your state 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)** 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, 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 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?

○ Yes ○ No

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

Hypodermic Needle Prohibition

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 for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?

● Yes ○ No

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 members, veterans, tribal entities, older adults, persons experiencing homelessness)? ( ) Yes (●) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered 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 system, adult criminal justice system, 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

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 eight providers will participate in the Independent Peer Review Process during FFY2026/2027: approximately four (4) 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

If the answer is No to any of the above, please explain the reason.

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[1] (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) SMI Adviser ( ) Yes (●) No

c) Addiction TTC? (●) Yes ( ) No

d) State Opioid Response Network? (●) Yes ( ) No

e) Strategic Prevention Technical Assistance Center (SPTAC) (●) Yes ( ) No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ( ) Yes (●) No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

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.

Here is a link to the Oklahoma Administrative Rules governing certification for alcohol and drug treatment agencies.
https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/policy/provider-certification/administrative-rules/2023/PC--Chapter-18-Final-effective-9-15-23.pdf

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Here is a link to the Oklahoma Administrative Rules governing certification for alcohol and drug treatment agencies. https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/policy/provider-certification/administrative-rules/2023/PC--Chapter-18-Final-effective-9-15-23.pdf

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 the waitlist that they had previously used. For residential substance use disorder treatment, Oklahoma has an online tool that is updated weekly which shows which facilities have open beds. People can either access the residential treatment beds by directly contacting the residential facilities or they can go to an outpatient provider or CCBHC and be screened. If their screen shows them as needing a residential level of care and they are amenable to treatment at that higher level of care, the provider then views the online tool and connects the person to the residential treatment facility. Because there are open beds, interim services are not required but can be provided if the person needs some additional time in order to get their affairs in order prior to accessing the residential treatment services.

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

The ODMHSAS data collection and reporting system collects both demographic and treatment-related data and is linked with claim data for all clients receiving publicly funded behavioral health services except for clients in managed care. Data is at the client level.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

We are the State Mental Health Authority and the Single State Agency for Substance Use Disorder. We collect all the demographic

and treatment data on the clients we serve in our system and the claims all go through Medicaid MMIS. We have access to all our claims in the MMIS.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

   Our data system is combined with the Medicaid System. We currently can link our data to the Department of Corrections data, Office of the Medical Examiner, and the Oklahoma Employment Security Commission. We have a data sharing agreement with 10 other state agencies for ad hoc data sharing projects.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

   We can report EBP outcome data at the client-level.

5. Briefly describe the limitations of the SMHA 's existing data system.

   We will not have all the demographic and treatment-related data on clients enrolled in managed care but do have the claims data for this population.

6. What strategies are being employed by the SMHA to enhance data quality?

   We have a helpdesk to train and work with providers on data submission. We also have many front-end edits and run routine reports to check for incorrect or incomplete data.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

   We have been submitting data to the federal government for many years and do not foresee any future barriers.

8. Please indicate areas of technical assistance needs related to this section.

   We have been collecting client-level data for over 30 years. We do not anticipate any technical assistance needs.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within 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 evidence-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 fund 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 expending 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 has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, 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 services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, 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 the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Oklahoma's crisis system follows the national model of "Someone to Contact, Someone to Respond, and Somewhere to Go." All Oklahomans have access to the 988 Suicide and Crisis Lifeline (call, text, and chat) through a state-funded, in-state contact center operating 24/7. 911 Public Safety Answering Points (PSAPs) can divert appropriate calls directly to Oklahoma's contact center utilizing a first responder line. This is happening in multiple municipalities in Oklahoma with more to come. Law enforcement is also able to request mobile crisis response to assist them in the community when appropriate. The contact center centrally dispatches Mobile Crisis Teams available statewide, with a focus on youth and adults experiencing behavioral health crises. These teams provide in-person community-based responses in all regions.

Crisis receiving and stabilization services are available statewide through Urgent Recovery Centers (URCs), Crisis Stabilization Units (CSUs), and Crisis Centers (URC and CSU), which accept walk-ins, drop-offs from law enforcement, transfers from Emergency Rooms, and mobile team referrals, operating under a no wrong door policy. These facilities provide under 24-hour observation (URCs) and over 24-hour longer-term stabilization (CSUs) for individuals in crisis, ensuring immediate access to care across urban and rural areas.

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 published 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 published 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.*

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 contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

Someone to talk to (Someone to contact)- ODMHSAS has full implementation of the someone to talk to through our in-state 988 contact center. Oklahoma will be integrating its youth mobile response line with our in-state 988 contact center. We monitor utilizing dashboards, reports from the contact center, ODMHSAS generated reports and the dashboard and reports from the lifeline administrator Vibrant. We also are receptive and appreciate stakeholder feedback when provided.

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.

Place to go (Safe place to be) – The ODMHSAS operates, contracts, certifies, and supports Urgent Recovery Clinics and Crisis Stabilization Units Statewide. ODMHSAS is continually reviewing data to determine need and sustainability in communities.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth 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. ODMHSAS has established its primary 988 call center with all of the air traffic control type functions described by SAMHSA, created dedicated 988 mobile crisis teams, and has expanded 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 to all law enforcement officers who will accept, 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. 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. ODMHSAS will be integrating its Youth Mobile Response Crisis Line with its 988 Contact Center for more efficiency and cost-effectiveness.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 3
   ii. Not in the suicide lifeline network: 13
b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: 3

ii. Not in the suicide lifeline network: 13

c. Estimated percent of 911 calls that are coded out as BH related: 0

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 public safety first responder structures (police, paramedic, fire): 77

b. Integrated with public safety first responder structures (police, paramedic, fire): 2

c. Number that utilizes peer recovery services as a core component of the model: 77

Safe place to be

a. Number of Emergency Departments: 132

b. Number of Emergency Departments that operate a specialized behavioral health component: 132

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 27

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The ODMHSAS anticipates utilizing the 5% crisis set aside to support a funding gap in the increased cost of our 988 contact center due to increase in 988 utilization in the state and integration of our youth mobile response with our state 988 contact center. We will also use the funding to support direct crisis services in our Urgent Recovery Clinic and Crisis Stabilization Units.

7. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

I wanted to add a footnote to clarify some of the components above.
-For the number of locally based crisis call centers in the state (in the 988 suicide and crisis lifeline network), there are currently 1 primary and 2 in-state backup centers but we will be discontinuing the in-state back-up due to high call answer rate with the primary and funding.
-There is not data available at this time for the estimated percent of 911 calls that are coded out as BH related.
-For someone to respond, there are 77 counties, that have mobile behavioral health crisis mobile capacity independent of public safety first responder structures (police, paramedic, fire).
-With regards to safe place to be, there are a total of 132 emergency departments throughout Oklahoma. There are several counties that lack an emergency department.
-With regards to safe place to be, all emergency departments are designated and able to provide behavioral health emergency crisis evaluations and there are many throughout the state that also operate inpatient behavioral health beds as part of their system.

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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 funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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."

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 has incorporated the Family Support Provider role within the Peer Recovery Support Specialist certification. Family Support Providers are now named "Family Peer Recovery Support Specialists" (F-PRSS). An F-PRSS is an individual who has lived experience as a caregiver of a child, youth or young adult who has mental health or behavioral health challenges and is certified by ODMHSAS to offer family peer support services. Family Peers use their lived experience to ensure engagement and active participation of the family throughout the treatment process and assist family members in developing knowledge and skills to promote their family member's recovery.

• This change will expand access to recovery support services to children and their families and allow Family Peers to be reimbursed at the level of current youth and adult PRSS providers
For those who become F-PRSS', the following competencies will be introduced:
• F-PRSS within Recovery/Systems of Care
• F-PRSS Roles and Responsibilities
• Effective Story Telling: Yours and Supporting Families
• Skills helpful for working within family systems
• Self-Care- Importance, Resources, Practice
• Stages and Cycle of Support to enhance self-efficacy
• Respite

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 2,212 actively certified Peer Recovery Support Specialists working across programs and providers.

• Expansion of the peer support services has helped increase engagement of special populations. Currently, there are tracts for Peers to specialize in youth and young adults, criminal justice, Domestic Violence, Crisis care, Older Adults, gambling, 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' 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.

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."

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).

• Additionally, the ODMHSAS has incorporated the Family Support Provider role within the Peer Recovery Support Specialist certification. Family Support Providers are now named "Family Peer Recovery Support Specialists" (F-PRSS). An F-PRSS is an individual who has lived experience as a caregiver of a child, youth or young adult who has mental health or behavioral health challenges and is certified by ODMHSAS to offer family peer support services. Family Peers use their lived experience to ensure engagement and active participation of the family throughout the treatment process and assist family members in developing knowledge and skills to promote their family member's recovery.

• This change will expand access to recovery support services to children and their families and allow Family Peers to be reimbursed at the level of current youth and adult PRSS providers.
For those who become F-PRSS', the following competencies will be introduced:

• F-PRSS within Recovery/Systems of Care
• F-PRSS Roles and Responsibilities
• Effective Story Telling: Yours and Supporting Families
• Skills helpful for working within family systems
• Self-Care- Importance, Resources, Practice
• Stages and Cycle of Support to enhance self-efficacy
• Respite

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, criminal justice, crisis care, domestic violence, methamphetamine use, older adults, and Peer administration/leadership/supervision. a mentoring program to support the navigation of workplace norms by Peer Recovery Support Specialists. A 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.

• 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

along with the Senior Manager of Peer Services and Program Manager of the state's Employee Assistance. 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.

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, methamphetamine use, criminal justice, Domestic Violence, gambling, group facilitation skills, Crisis Care. 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. Up until recently, it was a contractual requirement for providers to ensure those supervising peer support staff receive the supervisory training. The training is still strongly recommended.

• 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 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 2024, those discharging from inpatient or crisis services: 85% had follow up within 7 days, 91% did not re-admit to inpatient/crisis within 6 months and 80% were engaged in treatment within 45 days.

6. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

11-6-25: Removed wording in an attempt to come into alignment with the current administration and SAMHSA's current stance on acceptable verbiage.

Environmental Factors and Plan

11. 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 disorder 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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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 on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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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 use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: 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**

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 use 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 Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Oklahoma Systems of Care, as the catalyst for integration and change, improves outcomes for children, youth, young adults, and

families. OKSOC uses a Wraparound model that serve anyone 0 up to 25 with mental health or substance use disorder regardless of system involvement. This model is primary for youth who are identified as SED who may or may not have a co-occurring disorder. This is through a statewide system approach.

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 253+ school district in Oklahoma.

ODMHSAS and OKDHS have several partnerships around access to treatment for youth in the child welfare system. ODMHSAS facilitate consultation calls with DHS staff and mental health service providers to establish and monitor mental health services.

ODMHSAS and OJA are continuing to partner around juvenile re-entry. The identification of juveniles who are discharge at an OJA institution for the purpose of coordinating the behavioral health treatment for those identified with a MH or SU disorder.

ODMHSAS provides Infant and Early Childhood Mental Health (IECMH) services through a collaborative System of Care. By partnering with sectors like child welfare, early education, and health services, ODMHSAS delivers family-centered, trauma-informed care that addresses developmental and mental health needs. Services include mental health consultation in childcare, home visiting, cross-sector training, and wraparound support for families. The Safe Babies Program focuses on infants and toddlers involved in child welfare, promoting early intervention and family reunification. Overall, the initiative aims to reduce adverse childhood experiences, support caregiver well-being, and foster long-term mental health and resilience.

ODMHSAS supports transition age youth (ages 13–25) through developmentally appropriate services that address mental health, substance use, co-occurring disorders, and early intervention for psychosis. Key touchpoints include:
• Wraparound/TIP(Transition to Independence Process) Model: Youth-driven planning and support focused on wellness, life goals, and building formal/natural supports.
• Providing intensive services for youth with serious emotional or mental health conditions, including case management, peer support, therapy, and employment assistance.
• Early intervention for youth at clinical high risk for psychosis using evidence-based screenings and treatments (e.g., CBT-p, CT-R).
• School & College Partnerships: Mental health training and referral systems for K-12 staff; engagement with colleges to address depression, anxiety, suicide, and substance use.
• Youth Diversion: Outreach and treatment for youth at risk of justice or child welfare involvement.
These programs aim to reduce system involvement, promote recovery, and support youth in achieving long-term stability and success.

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 8 Child and Adolescent Urgent Recovery Centers (URCs) open across Oklahoma. 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. 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 URCs have a Family Peer Support provider as a member of the team.
Oklahoma has 6 Children and Youth Crisis Stabilization Units (CSUs). These units provide crisis stabilization services usually lasting 3-7 days. All youth are referred for outpatient services upon discharge.

One URC and CSU in Creek County specializes in serving children and youth intellectual and developmental disabilities.

8. Please indicate areas of technical assistance needs related to this section.

Areas of technical assistance desired would be the following:
-Problematic Sexual Behavior
-How to Best Serve the ID/DD population with Behavioral Health Concerns
-Aggressive Behavior in the Inpatient Setting
-Intensive Outpatient Treatment Models for High Acuity and Complex Needs

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Footnotes:
12-3-25: Wording was removed.

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

The State of Oklahoma is committed to providing the highest standard of care when it comes to suicide prevention and treatment. One of the key approaches used across the state is the Collaborative Assessment and Management of Suicidality (CAMS), a nationally recognized method that focuses on working closely with individuals to understand and directly address suicidal thoughts and behaviors.

In addition to CAMS, mental health professionals throughout the state are trained in proven, evidence-based therapies such as Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy (CBT). These therapies have been shown to be especially effective in helping people manage suicidal thoughts, regulate emotions, and build coping skills.

To ensure safety from the very first point of contact, all state-operated and state-contracted mental health agencies are required to screen individuals for suicide risk during intake and whenever someone is admitted to an inpatient hospital or outpatient treatment facility. Two of the primary tools used for this are the Columbia Suicide Severity Rating Scale (C-SSRS) and the Patient Health Questionnaire-9 (PHQ-9). These tools help mental health professionals quickly and accurately assess a person's level of risk.

Importantly, these assessments aren't just used once—they are repeated as needed, especially if there are changes in a person's condition or risk level. This ongoing monitoring helps ensure that individuals receive the right support at the right time, with care that is both responsive and personalized.

Oklahoma remains dedicated to using the most effective tools and treatments available to protect and support those at risk of suicide—because every life matters.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation 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 2024 - 2025 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is committed to ensuring that individuals at risk of suicide receive high-quality, effective care—wherever they seek help. To achieve this, ODMHSAS has extended its suicide prevention initiatives to include all private, nonprofit, state-operated, and state-contracted mental health agencies that serve individuals experiencing suicidal thoughts or who have survived a suicide attempt.

Recognizing the unique needs of young adults, ODMHSAS has also expanded efforts to reach college and university counseling centers across the state. This includes specialized training and consultation services tailored to the needs of college student populations, addressing both suicidality and co-occurring substance use issues.

Oklahoma continues to lead the nation in implementing the Collaborative Assessment and Management of Suicidality (CAMS)—a life-saving, evidence-based approach to suicide prevention. This model is now being used in all 77 counties and has helped improve how clinicians understand and respond to suicidal thoughts and behaviors.

To date, over 4,000 clinicians across Oklahoma have been trained in CAMS, strengthening the network of professionals equipped to deliver specialized, person-centered care. ODMHSAS will continue to offer CAMS training statewide during the upcoming federal Block Grant cycle, ensuring that even more providers are prepared to help save lives. During the 2025 year, we introduce an intensive CAMS course to further enhance our clinicians understanding, use of CAMS, and treatment of consumers.

Together, we're building a stronger, safer Oklahoma—where no one faces a mental health crisis alone.

6. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, 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 justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- 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.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. 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 and 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.

4. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

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, letter from the Council Chair 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. I have attached a copy of February's meeting minutes that shows where the Block Grant Reports were discussed during PAC. I have also attached emails where the Block Grant Reports were sent out. There were no comments for the Block Grant Reports. I have attached a copy of April's PAC meeting minutes which discusses the previous year's PAC application being sent out for feedback and it also shows that the (performance indicators) priority 3 measures were discussed at this meeting. The PAC application will be reviewed prior to the August meeting, via email beforehand and during the August meeting. I will also attach copies of the email being sent out to PAC group members and the public that routinely attends; however, I will not be able to attach the August PAC meeting minutes as those will not be approved by the PAC group until our meeting in October. Comments on the Block Grant Application are available upon request. A letter of support from the PAC group is also attached.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — ( ) Yes (●) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use 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.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. 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 32 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. Not only is meaningful input received from those in recovery and their family members, meaningful input is also derived from our providers and state agency members who, in some cases, are either in recovery themselves or have family members. The roles on our PAC group are not siloed to one "designation". Because people are multidimensional, one person can have experience in many of the roles that SAMHSA wants to see reflected within the PAC group.

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. In addition to this, we receive legislative information on mental health and substance use disorder matters. Receiving this information allows PAC members to advocate both on a large scale with legislators as well as on a personal level, with family, friends and acquaintances. We have also held an advocacy training for our PAC group and the public that attends these meetings that has given information and pointers on how to advocate effectively.

7. Please indicate areas of technical assistance needs related to this section.

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Comments and questions about the block grant application have been attached. There have not been any questions about the block grant reports.
12-3-25: Comments on the block grant application have been removed and are available upon request.

Emails Regarding Block Grant Reports being sent out

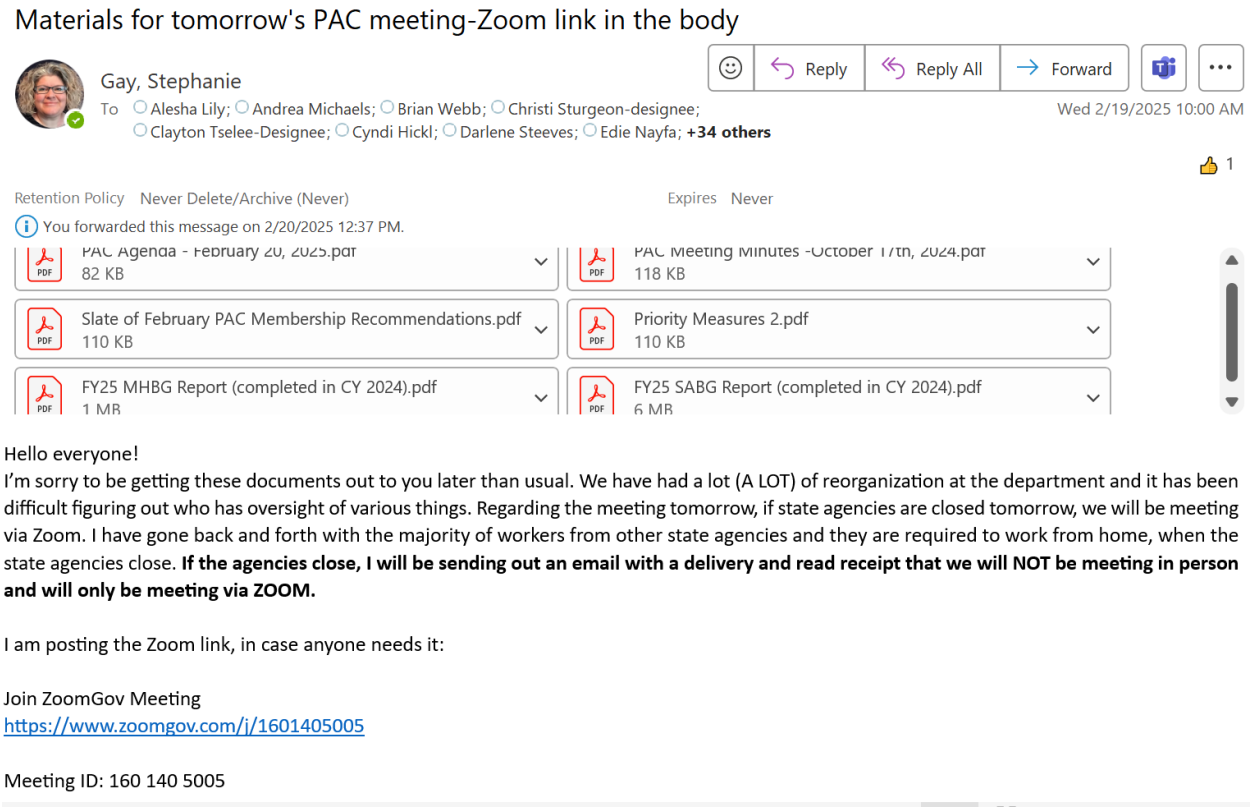
From: Gay, Stephanie
Sent: Thursday, December 19, 2024 9:20 AM
To: Alesha Lily <alesham@health.ok.gov>; Andrea Michaels <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon-designee <christi.sturgeon@sde.ok.gov>; Clayton Tselee-Designee <ctselee@nbn-nrc.org>; Cyndi Hickl <Cynthia-Hickl@ouhsc.edu>; Darlene Steeves <darlene.Steeves@ohfa.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Elisa Thompson <Elisa.Thompson@odmhsas.org>; Gina Olheiser <golheiser@wmpn.org>; Jami Ledoux <Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <Janna.morgan@doc.state.ok.us>; Janys Esparza <dirtx@latinoagencyokc.org>; Jeff Dismukes <jeff@dbsaok.org>; Jeff Tallent <jefftallentz@aol.com>; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Kadedra Smith <Kadedra.Smith@odmhsas.org>; Kelli Litsch <Kelli.Litsch@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Lisa Webb <llwebb@hopecsi.org>; Lorna Palmer-Designee <lorna@namioklahoma.org>; Louann Wiseman <llwiseman@yahoo.com>; lroberts <lroberts@nbn-nrc.org>; Lyndi Seabolt <LSeabolt@spthb.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <mbunch@okdrs.gov>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez-OSDE <Rachael.hernandez@sde.ok.gov>; Rosalind Goodlow-Designee <rosalind.goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Terrence Spain <terrence.spain@odmhsas.org>; Tyler Ross <tyler@ocarta.org>; Young Onuorah <YOnuorah@odmhsas.org>; Alisa West Cahill <AlisaWest.Cahill@odmhsas.org>; Amanda Coldiron <amandac@gethelp.com>; Bethaney Myers <Bethaney.Myers@samhsa.hhs.gov>; Catherine Roberson <Catherine.Roberson@chickasaw.net>; Dedra Hansbro <dedra.hansbro@odmhsas.org>; Elizabeth Stewart <estewart@healthwellnessok.com>; Jeannie Russell Roberts <Jeannie.Russell@okhca.org>; Josh DeBartolo <Joshua.DeBartolo@odmhsas.org>; Karen Orsi <karen.orsi@northcare.com>; Kristen Bradley <Kristen.bradley@northcare.com>; Lauren Craig-Telligen <lcraig@telligen.com>; matthewm@red-rock.com; McEntire, Malissa <MMcEntire@odmhsas.org>; Nola Harrison <Nola.Harrison@ssmhealth.com>; Ray Bottger <Ray.Bottger@odmhsas.org>; Sanders, Penny <Penny.Sanders@odmhsas.org>; Sheamekah Williams <sheamekah@live.com>; Suzanne Williams <suzannew@okarr.org>; Teresa

Stephenson <teresas@okarr.org>
Subject: Block Grant Reports

Hello everyone!

I wanted to send out the Block Grant Reports that were finalized and submitted on December 1st. I will be sending these out again prior to our February PAC meeting date. If there are any questions, please let me know and I will either answer them or get them answered for you. Have a great Holiday!

Stephanie Gay, LPC | SAMHSA Block Grant



Hello everyone!
I'm sorry to be getting these documents out to you later than usual. We have had a lot (A LOT) of reorganization at the department and it has been difficult figuring out who has oversight of various things. Regarding the meeting tomorrow, if state agencies are closed tomorrow, we will be meeting via Zoom. I have gone back and forth with the majority of workers from other state agencies and they are required to work from home, when the state agencies close. **If the agencies close, I will be sending out an email with a delivery and read receipt that we will NOT be meeting in person and will only be meeting via ZOOM.**

I am posting the Zoom link, in case anyone needs it:

Join ZoomGov Meeting
https://www.zoomgov.com/j/1601405005

Meeting ID: 160 140 5005

Meeting Minutes
State Planning and Advisory Council to the ODMHSAS
2000 N. Classen Blvd, 6th floor Conference Room, Hope 4
Thursday, February 20th, 2025 10:00 a.m. to 12:00 p.m.
https://www.zoomgov.com/j/1601405005

Voting Members/Designees Present:

Andrea Michaels	Jeff Dismukes	Lisa Webb
Alesha Lily	Brian Webb	Cindy Hickl
Darlene Steeves	Edie Nayfa	Janelle Bretten
Jana Morgan	Janys Esparza	Jeff Tallent
Josh Cantwell	Keitha Wilson	Kelly Willingham
Louann Wiseman	Lyndi Seabolt	Mary Ann Dimery
Melinda Bunch	Gina Olheiser	Rachael Hernandez
Rose Horsechief	Sarah Rachel Smith	Tyler Ross
Young Onuorah	Kelly Earles (Designee)	

Members Absent:

Jeni Dolan	Lindsey Roberts	Stephanie Dixon

Guest/Public:

Stephanie Gay	Terrence Spain	Alisa West-Cahill
Melanie Mikelson	Penny Sanders	Ray Bottger
Karen Orsi	Meadow Hazelhoff	Lauren Craig
Mark Wallace	Andrea Hamor-Edmondson	

- **Call to Order and Recording of Members Present and Absent** ……. Andrea Michaels
- **Welcome Remarks and Introduction of Attendees** ……..……..…… Andrea Michaels
- **Vote on Minutes from the October 17th, 2024, PAC Meeting** ……..... Andrea Michaels

  Andrea Michaels asked if there were any that would abstain or would vote to not pass. Alesha Lily and Kelly Earles abstained. A motion to approve was made by Edie Nayfa and was seconded by Jeff Tallent. There were none that voted against this. All others were in agreement to approve. Because of this, the issue was declared unanimously passed.

- **Vote on Prospective PAC Members** ……..……... Andrea Michaels

  The slate contained the prospective member had been previously sent to the PAC group. Lisa Webb made a motion to move the slate forward to the Commissioner for her determination of appointment and this was seconded by Josh Cantwell. Alesha Lily and Kelly Earles abstained from the vote. There were none that voted against this, and all others were in agreement. Andrea declared the slate should be moved forward to the Commissioner.

- **Vending Machines & Narcan Update** ……. Andrea Hamor-Edmondson

  Andrea gave an update on the status of the vending machines and also discussed various ways to access Narcan/Fentanyl test strips.

- **Legislative Report**

  There were no legislative updates given. We are hoping that we will have a legislative liaison at the next meeting.

- **Agency Reports**

Department of Rehabilitation Services (DRS)

Melinda put a link in the chat for People with Disabilities Awareness Day which is coming up on March 11th. It will be held at the Oklahoma History Center from noon to 4:00. A lot of exhibitors and resources will be there so come out and join them. Also, Melinda put another link into the chat for the Oklahoma APSE (Association of People Supporting Employment First) Employment Conference which will be held on the April 1st and 2nd, in OKC at the Springlake Metro Tech Campus. On the DRS website, there is a lot of information for anyone that is interested in attending, like the agenda and keynotes. It is all about supporting people with finding employment. As far as things happening with the agency, they've had a lot of meetings cancelled due to weather.

There were a lot of links put in the chat from the DRS website to give people resources. DRS also has a resources page and Melinda stated that, if anyone wanted their agency on the DRS resources page, then email her and let her know. DRS has made progress with filling some of their vacancies which is good news because it means that they have people on staff to serve their individuals. The biggest event coming up now is the Disabilities Awareness Day. However, other events to mention are that the Oklahoma School for the Deaf recently won the Great Plains Football Championship and the Oklahoma School for the Blind has a lot of events going on as well. They have the Braille contest that they do yearly. There are a lot of different things happening with DRS.

State Department of Health (OSDH)

There is not a report today, other than to say that there have been a lot of changes at OSDH.

Office of Juvenile Affairs (OJA)

There is not much to report. They are continuing their work with evidence-based programming in their secure care facility in Tecumseh. Janelle may have some legislative updates by next meeting. She did want to highlight that they are looking to expand their career tech center at their Central Oklahoma Juvenile Center in Tecumseh. They do offer career tech opportunities there, but they will have STEM, auto mechanics, carpentry, and welding. They are looking to expand their space to be able to enhance their programming.

Oklahoma Human Services (OHS)

DHS has had some changes as well since the last meeting. Deborah Smith has moved up as a Deputy Director underneath their Chief Team and now oversees Child Support, Childcare and Adult Family Service Division. We also have new directors for the Adult Family Service Division, Sondra Shelby, and they have hired someone for Childcare as well, Jaesha Quarrels. Their Child Welfare Services Director, Tricia Howell, retired at the beginning of this month and so their interim is the assistant child welfare director, Andrea Buck, until they can hire someone.

Oklahoma Housing Finance Agency (OHFA)

Regarding the 2025 Oklahoma 60th Legislature, currently OHFA has 11 bills that name OHFA specifically.

Regarding OHFA's Homeowner Assistance Fund (HAF) program for homeowners who have experienced financial hardship due to COVID-19, it is winding down as all the funds have either been disbursed or awaiting disbursement once the remaining cases have been processed.

Regarding OHFA's Oklahoma Housing Stability Program (HSP) which provides funding for new construction of single-family homes for purchase, new construction of single-family and multifamily rental homes, and consumer down payment and closing cost assistance for individuals and families purchasing homes as their primary residence in Oklahoma, 53% of the $215 million awarded has been disbursed.

Regarding OHFA's Rental Assistance Programs, the Housing Choice Voucher Program waiting list remains closed due to lack of funding. In addition, there has been a delay in receiving shortfall funding from the US Housing and Urban Development (HUD). However, OHFA has been able to stay current funding existing voucher holders due to authority given by the OHFA Board of Trustees to supplement funding with agency reserves when reimbursement is assured from HUD.

Oklahoma Health Care Authority (OHCA)

Traylor Rains is no longer State Medicaid Director and Melody Anthony has now replaced him as interim Medicaid Director. Member Services now has a call back feature, so members do not have to wait for a call representative.

State Department of Education (OSDE)

OSDE is building out their MTSS Summer Conference. Its's still in the very early planning stages, but they're looking at having that in July. OSDE is continuing their behavior threat assessment training, trying to get all schools trained in this. OSDE was awarded the school based mental health services grant to bring school based mental health programming to four new districts. Those districts include Ardmore, Anadarko, Hinton and Carnegie. OSDE is also working with OHCA to expand Medicaid services to students beyond an IEP for school-based services, including mental health services. They are also continuing to train districts on their student mental health protocol.

Department of Corrections (DOC)

DOC did not have anything to report with regards to DOC services changing. Their staff is working really hard every day and is stretched thin, but they are amazing.

- **Priority 2 Measures** …….……..…… Stephanie Gay

  Priority 2 measures were reviewed and discussed with the PAC group.

- **Block Grant Reports** ……..…….…… Stephanie Gay

  The Block Grant Reports were previously sent out in December and also prior to this meeting. PAC members were encouraged to send any questions to Stephanie, and she would respond with the answer to the entire group. URS reports were also discussed and how that information is ultimately put into the MHBG Report.

- **PAC Member Vacancies** …….……. Stephanie Gay

  The PAC group currently has vacancies in the person in recovery section as well as in the family member section.

- **Next Meeting Agenda Items** …….…….…. Stephanie Gay

  April: There will be a discussion about what CCBHC's and CCARC's are, how they target services and overall awareness about how they support communities. There will also be a

discussion about how the CCBHC's are being trained to use OPNA data to address issues in schools.

June: Other agencies represented on the PAC will share about what their agencies do. Individual and family members can also share about the agency that they are affiliated with.

August: no time for presentation/discussion because we will be going over the block grant application. So, next time available for a discussion would be **October.**

- **Opportunity for Public Comment** ……...…… Stephanie Gay

  PAC members and members of the public discussed upcoming events and resources. Stephanie thanked the new Executive Committee for volunteering to serve.

- **Adjournment** ……..…….…… Andrea Michaels

  Meeting adjourned.

Meeting Minutes
State Planning and Advisory Council to the ODMHSAS
2000 N. Classen Blvd, 6th floor Conference Room, Hope 4
Thursday, April 17th, 2025 10:00 a.m. to 12:00 p.m.
https://www.zoomgov.com/j/1619836832

Voting Members/Designees Present:

Andrea Michaels	Jeff Dismukes	Lisa Webb
Brian Webb	Cindy Hickl	Darlene Steeves
Edie Nayfa	Elisa Thompson	Janelle Bretten
Janys Esparza	Josh Cantwell	Katie Harrison
Keitha Wilson	Louann Wiseman	Lyndi Seabolt
Mary Ann Dimery	Meadow Hazelhoff	Melinda Bunch
Rachael Hernandez	Rose Horsechief	Sarah Rachel Smith
Stephanie Dixon	Young Onuorah	

Members Absent:

Alesha Lily	Clayton Tselee	Janna Morgan
Jeff Tallent	Jeni Dolan	Kelly Willingham
Gina Olheiser	Tyler Ross	

Guest/Public:

Alisa West-Cahill	Angela Wernke	Carrie Daniels
Heather Helberg	Hsiu-Ting	Kadedra Smith
Karen Orsi	Kriston Ahlefeld	Lisa Mears
Lyndi Seabolt	Melanie Mikelson	Nola Harrison
Ray Bottger	Stephanie Gay	Terrence Spain
Tony Stelter		

- **Call to Order and Recording of Members Present and Absent** ……. Andrea Michaels
- **Welcome Remarks and Introduction of Attendees** ……..……..…… Andrea Michaels
- **Vote on Minutes from the February 20th, 2025, PAC Meeting** ……..... Andrea Michaels

  A motion to approve was made by Brian Webb and was seconded by Lisa Webb. There were no abstentions and there were none that voted against this. All others were in agreement to approve. Because of this, the issue was declared unanimously passed.
- **Vote on Prospective PAC Member** ……..……... Andrea Michaels

  The slate contained the prospective member had been previously sent to the PAC group. Josh Cantwell made a motion to move the slate forward to the Commissioner for her determination of appointment and this was seconded by Melinda Bunch. There were no abstentions and there were none that voted against this. All others were in agreement. The slate will be moved forward to the Commissioner.
- **CCBHC & CCARC and OPNA Discussion** … Heather Helberg, Edie Nayfa, Carrie Daniels

  Heather Helberg discussed CCBHC's and Edie Nayfa discussed CCARC's. Carrie Daniels went over the Oklahoma Prevention Needs Assessment information with the PAC group.

- **Legislative Report** ……. Stephanie Gay

  Stephanie Gay gave information on current legislation. This information will also be sent out in the recap, following the meeting. We are hoping that we will have a legislative liaison at the next meeting.

- **Agency Reports**

Department of Rehabilitation Services (DRS)

The biggest event for the Department of Rehabilitation Services (DRS) occurred on March 11th. It was the People with Disability Awareness Day. In the past, it was in the past held at the Capitol, but the attendance grew so big that they had to move it to the History Center. They had over 700 attendees, 71 exhibitors and 90 volunteers and they even had TV coverage there. Melinda reported that if people ever get an opportunity to come to the Disability Awareness Day, they should try to because this event showcases a lot of resources. The Department of Rehabilitation Services works with people who have disabilities, who are seeking employment or need help retaining employment. Maybe they've been involved in an accident or had an illness and so they have to change jobs. They can't continue doing what they had been doing, or they just need help staying in that job. A lot of their events focus on employment.

Regarding Vocational Rehabilitation, their priority group one and two are now open. There's not a waiting list. They still have priority group 3, but that group has a very small number, like two people, on it. So, her department is getting people off the list very rapidly.

DRS does many things to help individuals with education for a career goal or employment, including things like vehicle modifications and housing modifications. Fifteen percent of their budget goes to support people who are of transition age, between 16-24. There are a lot of activities going on with this population. The Transition Coordinator recently told Melinda that they served over 400 students across the state in the camps that they had this past summer. DRS also has the School for the Deaf and the School for the Blind and a lot of things are going on there too. Melinda invited the PAC members to check out their websites for more information and she mentioned that the School for the Deaf was offering free online Asl classes for anyone that was interested.

State Department of Health (OSDH)

Not present.

Office of Juvenile Affairs (OJA)

Janelle had to leave prior to agency reports. She will report at the next meeting.

Oklahoma Human Services (OHS)

The updates from the February meeting are still the same. DHS still has an interim child welfare director and so they are still looking for that replacement. Everything else is as status quo. They are just in the midst of submitting annual federal reports for various funding.

Oklahoma Housing Finance Agency (OHFA)

The Oklahoma Housing Finance Agency (OHFA) has the 2024 Annual Report out on their website. The report covers everything that OHFA is involved in, and it also addresses how many people that they have helped. It is located on the OHFA website at https://www.ohfa.org, just under the News and Features Section.

Oklahoma Health Care Authority (OHCA)

April 1st was the one-year anniversary of when sooner select was implemented, which is the sooner care managed care program. Open enrollment will be from May 1st to June 13th. During open enrollment, they can change their dental plan or health plan or both. If they are happy with their current plan, they do not need to do anything. If they wish to make a change, this can be done either online at MySoonerCare.org or by calling the choice counseling line at (800) 987-7767, option 5. Mary Ann was asked if it might be better to do this online or by calling the phone number. Mary Ann replied that if the member knows their userID, they can do it online. Otherwise, they would be better off calling in.

State Department of Education (OSDE)

The State Department of Education is preparing for their MTSS Summer conference. They are continuing to train schools in behavior threat assessment and are working with the Department of Mental Health to review district mental health crisis protocols.

The State Department of Education is also continuing to train districts on how to be in compliance with House Bill 4106. They are also working on revising the health standards, and then the School-based Mental Health Department will provide a student wellness lens to that committee.

They are also working on building a multi-tiered system to support framework manual for academics, behavior and mental health and building a dashboard within Edplan which will allow districts to collect student data, document processes and measure progress.

Department of Corrections (DOC)

Janna Morgan was unable to attend the meeting but had notified Stephanie Gay that there were no current updates for DOC.

- **Priority 3 Measures** …… Stephanie Gay

  Priority 3 measures were reviewed and discussed with the PAC group.

- **Block Grant Application Discussion** …… Stephanie Gay

  As there is typically a limited time to review and give feedback on the Block Grant Application, it was proposed that the prior year's narrative be sent out to the PAC group so that they could review and give feedback on it. That feedback would then be submitted to Leadership. The PAC group was informed that there was no guarantee that their feedback would result in changes being made to this year's application as there may already be plans in place. This feedback and commenting would be separate from the actual Block Grant Application which will be completed this year and will also be reviewed by the PAC group with feedback sought. There was no dissent voiced to this idea. The narrative will be sent out in the recap, following the meeting.

- **PAC Member Vacancies** …… Stephanie Gay

  The PAC group currently has vacancies in the person in recovery section as well as in the family member section.

- **Next Meeting Agenda Items** …… Stephanie Gay

  June: Other agencies represented on the PAC will share about what their agencies do. Individual and family members can also share about the agency that they are affiliated with.

  August: no time for presentation/discussion because we will be going over the block grant application.

October: It was proposed to hear about the URS Reports. This report information, compiled by Ray Bottger and Sandy Gonterman, is used to fill out much of the MHBG Reports.

- **Opportunity for Public Comment** ……..…… Andrea Michaels

  Brian Webb discussed a recent takeback event in which the Wichita Mountains Prevention Network participated. This takeback event was for medications and sharps. Brian stated that there was a huge need for this as there is not a resource in Stephens County for this. He mentioned one woman brought in 26 two-liter bottles that were full of sharps. He stated that the event accumulated 103 pounds in four hours. He wasn't sure who to turn to for future help. The takeback event had been funded by DEQ.

- **Adjournment** ……..…….…… Andrea Michaels

  Meeting adjourned.

Emails soliciting a review of the Block Grant Application

From: Gay, Stephanie
Sent: Wednesday, July 2, 2025 9:27 AM
To: Alesha J Lilly <AleshaM@health.ok.gov>; andrea <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon <Christi.Sturgeon@sde.ok.gov>; Clayton Tselee <ctselee@nbn-nrc.org>; Darlene Steeves <darlene.Steeves@ohfa.org>; dirtx <dirtx@latinoagencyokc.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Gina Olheiser <golheiser@wmpn.org>; Harrison, Katie <Katie.Harrison@odmhsas.org>; Hickl, Cynthia L. (HSC) <CHICKL@OUHSC.EDU>; Jami Ledoux <Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <janna.morgan@doc.ok.gov>; Jeff Dismukes <jeff@dbsaok.org>; jefftallentz@aol.com; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Keitha Wilson <Keitha.Wilson@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Kriston Ahlefeld <kahlefeld@spthb.org>; Lisa L. Webb <llwebb@hopecsi.org>; lorna@namioklahoma.org; Louann Wiseman <llwiseman@yahoo.com>; Lyndi Seabolt <lseabolt@spthb.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <MBunch@okdrs.gov>; Onuorah, Young <YOnuorah@odmhsas.org>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez <Rachael.Hernandez@sde.ok.gov>; Rosalind Goodlow <Rosalind.Goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Smith, Kadedra <Kadedra.Smith@odmhsas.org>; Spain, Terrence <Terrence.Spain@odmhsas.org>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Thompson, Elisa <Elisa.Thompson@odmhsas.org>; tyler@ocarta.org; Amanda Coldiron <amandac@gethelp.com>; Benefiel, Jennifer <Jennifer.Benefiel@odmhsas.org>; Bethaney Myers <Bethaney.Myers@samhsa.hhs.gov>; Bottger, Ray <Ray.Bottger@odmhsas.org>; Cahill, AlisaWest <AlisaWest.Cahill@odmhsas.org>; Catherine Roberson <Catherine.Roberson@chickasaw.net>; DeBartolo, Joshua <Joshua.DeBartolo@odmhsas.org>; Elizabeth Stewart <estewart@healthwellnessok.com>; Hansbro, Dedra <Dedra.Hansbro@odmhsas.org>; Jeannie Russell Roberts <Jeannie.Russell@okhca.org>; Karen Orsi <karen.orsi@northcare.com>; Kristen Bradley <Kristen.bradley@northcare.com>; Lauren Craig-Telligen <lcraig@telligen.com>; matthewm@red-rock.com; McEntire, Malissa <MMcEntire@odmhsas.org>; Mikelson, Melanie <Melanie.Mikelson.CTR@odmhsas.org>; Nola Harrison <Nola.Harrison@ssmhealth.com>; Sanders, Penny <Penny.Sanders@odmhsas.org>; Sheamekah Williams <sheamekah@evolution-foundation.org>; Stelter, Tony <Tony.Stelter@odmhsas.org>; Suzanne Williams <suzannew@okarr.org>; Teresa

Stephenson <teresas@okarr.org>; Wernke, Angela <Angela.Wernke@odmhsas.org>
Subject: please review and let me know of recommendations

Hi everyone, just a reminder that our next scheduled meeting is on August 21st. At that time, we will go over the block grant application. I am attaching the narrative from the block grant application that was written in 2023. Please review, when you can, and let me know of any feedback/recommendations that you may have for the new application, PRIOR to the meeting.

This email is also being sent out to the public that attends our meetings. If you are part of that category, feedback/recommendations are also welcome from you.

Thank you! Have a great holiday!

Stephanie Gay, LPC

From: Gay, Stephanie
Sent: Friday, August 15, 2025 2:59 PM
To: Alesha J Lilly <AleshaM@health.ok.gov>; andrea <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon <Christi.Sturgeon@sde.ok.gov>; Clayton Tselee <ctselee@nbn-nrc.org>; Darlene Steeves <darlene.Steeves@ohfa.org>; dirtx <dirtx@latinoagencyokc.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Gina Olheiser <golheiser@wmpn.org>; Harrison, Katie <Katie.Harrison@odmhsas.org>; Hickl, Cynthia L. (HSC) <CHICKL@OUHSC.EDU>; Jami Ledoux <Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <janna.morgan@doc.ok.gov>; Jeff Dismukes <jeff@dbsaok.org>; jefftallentz@aol.com; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Keitha Wilson <Keitha.Wilson@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Kriston Ahlefeld <kahlefeld@spthb.org>; Lisa L. Webb <llwebb@hopecsi.org>; lorna@namioklahoma.org; Louann Wiseman <llwiseman@yahoo.com>; Lyndi Seabolt <lseabolt@spthb.org>; Madison Miller <Madison.Miller@odmhsas.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <MBunch@okdrs.gov>; Onuorah, Young <YOnuorah@odmhsas.org>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez <Rachael.Hernandez@sde.ok.gov>; Rosalind Goodlow

<Rosalind.Goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Smith, Kadedra <Kadedra.Smith@odmhsas.org>; Spain, Terrence <Terrence.Spain@odmhsas.org>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Thompson, Elisa <Elisa.Thompson@odmhsas.org>; tyler@ocarta.org
Subject: Materials for August Planning and Advisory (PAC) Group Meeting on August 21st

Hello everyone!

I am sending out the PAC Agenda for next Thursday's meeting and also the minutes from our April meeting. We also have one potential PAC member applicant. I am attaching the slate.

This next meeting (on Thursday) we will go over the PAC application. The last application was 284 pages. This application will be shorter as SAMHSA has cut out some sections; however, there is still a lot to it.

Because of this, I will be breaking the application up into pieces and will be sending it out, in pieces, prior to the meeting. (I don't know about all of you but, for me, receiving a super huge document is SO daunting!)

Have a great weekend!

Stephanie Gay, LPC

From: Gay, Stephanie
Sent: Friday, August 15, 2025 3:32 PM
To: Alesha J Lilly <AleshaM@health.ok.gov>; andrea <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon <Christi.Sturgeon@sde.ok.gov>; Clayton Tselee <ctselee@nbn-nrc.org>; Darlene Steeves <darlene.Steeves@ohfa.org>; dirtx <dirtx@latinoagencyokc.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Gina Olheiser

<golheiser@wmpn.org>; Harrison, Katie <Katie.Harrison@odmhsas.org>; Hickl, Cynthia L. (HSC) <CHICKL@OUHSC.EDU>; Jami Ledoux <Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <janna.morgan@doc.ok.gov>; Jeff Dismukes <jeff@dbsaok.org>; jefftallentz@aol.com; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Keitha Wilson <Keitha.Wilson@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Kriston Ahlefeld <kahlefeld@spthb.org>; Lisa L. Webb <llwebb@hopecsi.org>; lorna@namioklahoma.org; Louann Wiseman <llwiseman@yahoo.com>; Lyndi Seabolt <lseabolt@spthb.org>; Madison Miller <Madison.Miller@odmhsas.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <MBunch@okdrs.gov>; Onuorah, Young <YOnuorah@odmhsas.org>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez <Rachael.Hernandez@sde.ok.gov>; Rosalind Goodlow <Rosalind.Goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Smith, Kadedra <Kadedra.Smith@odmhsas.org>; Spain, Terrence <Terrence.Spain@odmhsas.org>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Thompson, Elisa <Elisa.Thompson@odmhsas.org>; tyler@ocarta.org; Amanda Coldiron <amandac@gethelp.com>; Benefiel, Jennifer <Jennifer.Benefiel@odmhsas.org>; Bethaney Myers <Bethaney.Myers@samhsa.hhs.gov>; Bottger, Ray <Ray.Bottger@odmhsas.org>; Cahill, AlisaWest <AlisaWest.Cahill@odmhsas.org>; Catherine Roberson <Catherine.Roberson@chickasaw.net>; DeBartolo, Joshua <Joshua.DeBartolo@odmhsas.org>; Elizabeth Stewart <estewart@healthwellnessok.com>; Hansbro, Dedra <Dedra.Hansbro@odmhsas.org>; Jeannie Russell Roberts <Jeannie.Russell@okhca.org>; Karen Orsi <karen.orsi@northcare.com>; Kristen Bradley <Kristen.bradley@northcare.com>; Lauren Craig-Telligen <lcraig@telligen.com>; matthewm@red-rock.com; McEntire, Malissa <MMcEntire@odmhsas.org>; Mikelson, Melanie <Melanie.Mikelson.CTR@odmhsas.org>; Nola Harrison <Nola.Harrison@ssmhealth.com>; Sanders, Penny <Penny.Sanders@odmhsas.org>; Sheamekah Williams <sheamekah@evolution-foundation.org>; Stelter, Tony <Tony.Stelter@odmhsas.org>; Suzanne Williams <suzannew@okarr.org>; Teresa Stephenson <teresas@okarr.org>; Wernke, Angela <Angela.Wernke@odmhsas.org>
Subject: 1st piece of application (narrative-Planning Step 1)

Hi everyone,

In preparation of the PAC meeting on Thursday, I will be sending out the SAMHSA block grant application in pieces so that is more easily digestible.

The first piece that I am sending out is the narrative. There are two pieces, Planning Step 1 details our overall mental health and substance use disorder treatment and prevention system. It covers everything, not just what the block grant funds. This is attached.

Planning Step 2 goes over the treatment needs/prevention areas of Oklahoma accompanied by data. This document and the new priority measures will be sent out later. They are still being worked on.

Again, there is a lot of information in this application. If interested, you may want to consider starting with some searches in the documents, if there are some sections that are near and dear to your heart, to see if and how they are covered. Some examples of some searches could be youth or crisis.

We will be going over this and the other pieces of the application during our Thursday meeting but I would encourage you to review what you can and see if there are questions or comments that you have. Those questions/comments can be sent to me either prior to the meeting or given during the meeting.

One last thing to point out. All of the application documents are in the final review stages and so there may be some slight changes made. Everyone will be sent a finalized copy of the application once it is uploaded to SAMHSA. (The due date is September 1st.) However, what you are being given is basically 90% complete.

During the meeting on Thursday, we will vote on whether or not the PAC group would like a letter to be written in support of the application. This letter is written by the Chairperson, to SAMHSA, and is uploaded with the application. This is something that has been routinely done with the applications and the mini applications.

Stephanie Gay, LPC

From: Gay, Stephanie
Sent: Friday, August 15, 2025 3:36 PM
To: Alesha J Lilly <AleshaM@health.ok.gov>; andrea <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon <Christi.Sturgeon@sde.ok.gov>; Clayton Tselee <ctselee@nbn-nrc.org>; Darlene Steeves <darlene.Steeves@ohfa.org>; dirtx <dirtx@latinoagencyokc.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Gina Olheiser <golheiser@wmpn.org>; Harrison, Katie <Katie.Harrison@odmhsas.org>; Hickl, Cynthia L. (HSC) <CHICKL@OUHSC.EDU>; Jami Ledoux <Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <janna.morgan@doc.ok.gov>; Jeff Dismukes <jeff@dbsaok.org>; jefftallentz@aol.com; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Keitha Wilson <Keitha.Wilson@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Kriston Ahlefeld <kahlefeld@spthb.org>; Lisa L. Webb <llwebb@hopecsi.org>; lorna@namioklahoma.org; Louann Wiseman <llwiseman@yahoo.com>; Lyndi Seabolt <lseabolt@spthb.org>; Madison Miller <Madison.Miller@odmhsas.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <MBunch@okdrs.gov>; Onuorah, Young <YOnuorah@odmhsas.org>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez <Rachael.Hernandez@sde.ok.gov>; Rosalind Goodlow <Rosalind.Goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Smith, Kadedra <Kadedra.Smith@odmhsas.org>; Spain, Terrence <Terrence.Spain@odmhsas.org>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Thompson, Elisa <Elisa.Thompson@odmhsas.org>; tyler@ocarta.org; Amanda Coldiron <amandac@gethelp.com>; Benefiel, Jennifer <Jennifer.Benefiel@odmhsas.org>; Bethaney Myers <Bethaney.Myers@samhsa.hhs.gov>; Bottger, Ray <Ray.Bottger@odmhsas.org>; Cahill, AlisaWest <AlisaWest.Cahill@odmhsas.org>; Catherine Roberson <Catherine.Roberson@chickasaw.net>; DeBartolo, Joshua <Joshua.DeBartolo@odmhsas.org>; Elizabeth Stewart <estewart@healthwellnessok.com>; Hansbro, Dedra <Dedra.Hansbro@odmhsas.org>; Jeannie Russell Roberts <Jeannie.Russell@okhca.org>; Karen Orsi <karen.orsi@northcare.com>; Kristen Bradley <Kristen.bradley@northcare.com>; Lauren Craig-Telligen <lcraig@telligen.com>; matthewm@red-rock.com; McEntire, Malissa <MMcEntire@odmhsas.org>; Mikelson, Melanie <Melanie.Mikelson.CTR@odmhsas.org>; Nola Harrison <Nola.Harrison@ssmhealth.com>; Sanders, Penny <Penny.Sanders@odmhsas.org>; Sheamekah Williams <sheamekah@evolution-foundation.org>; Stelter, Tony <Tony.Stelter@odmhsas.org>; Suzanne Williams <suzannew@okarr.org>; Teresa

Stephenson <teresas@okarr.org>; Wernke, Angela <Angela.Wernke@odmhsas.org>
Subject: 2nd piece of application (Environmental Factors & Plan)

I have attached the second section of the SAMHSA Block Grant Application. These various sections of the block grant application go more in depth on specific areas of prevention and treatment.

Stephanie Gay, LPC

From: Gay, Stephanie
Sent: Monday, August 18, 2025 7:30 PM
To: Alesha J Lilly <AleshaM@health.ok.gov>; andrea <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon <Christi.Sturgeon@sde.ok.gov>; Clayton Tselee <ctselee@nbn-nrc.org>; Darlene Steeves <darlene.Steeves@ohfa.org>; dirtx <dirtx@latinoagencyokc.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Gina Olheiser <golheiser@wmpn.org>; Harrison, Katie <Katie.Harrison@odmhsas.org>; Hickl, Cynthia L. (HSC) <CHICKL@OUHSC.EDU>; Jami Ledoux <Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <janna.morgan@doc.ok.gov>; Jeff Dismukes <jeff@dbsaok.org>; jefftallentz@aol.com; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Keitha Wilson <Keitha.Wilson@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Kriston Ahlefeld <kahlefeld@spthb.org>; Lisa L. Webb <llwebb@hopecsi.org>; lorna@namioklahoma.org; Louann Wiseman <llwiseman@yahoo.com>; Lyndi Seabolt <lseabolt@spthb.org>; Madison Miller <Madison.Miller@odmhsas.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <MBunch@okdrs.gov>; Onuorah, Young <YOnuorah@odmhsas.org>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez <Rachael.Hernandez@sde.ok.gov>; Rosalind Goodlow <Rosalind.Goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Smith, Kadedra <Kadedra.Smith@odmhsas.org>; Spain, Terrence <Terrence.Spain@odmhsas.org>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Thompson, Elisa <Elisa.Thompson@odmhsas.org>; tyler@ocarta.org; Amanda Coldiron <amandac@gethelp.com>; Benefiel, Jennifer <Jennifer.Benefiel@odmhsas.org>; Bethaney Myers <Bethaney.Myers@samhsa.hhs.gov>; Bottger, Ray

<Ray.Bottger@odmhsas.org>; Cahill, AlisaWest <AlisaWest.Cahill@odmhsas.org>; Catherine Roberson <Catherine.Roberson@chickasaw.net>; DeBartolo, Joshua <Joshua.DeBartolo@odmhsas.org>; Elizabeth Stewart <estewart@healthwellnessok.com>; Hansbro, Dedra <Dedra.Hansbro@odmhsas.org>; Jeannie Russell Roberts <Jeannie.Russell@okhca.org>; Karen Orsi <karen.orsi@northcare.com>; Kristen Bradley <Kristen.bradley@northcare.com>; Lauren Craig-Telligen <lcraig@telligen.com>; matthewm@red-rock.com; McEntire, Malissa <MMcEntire@odmhsas.org>; Mikelson, Melanie <Melanie.Mikelson.CTR@odmhsas.org>; Nola Harrison <Nola.Harrison@ssmhealth.com>; Sanders, Penny <Penny.Sanders@odmhsas.org>; Sheamekah Williams <sheamekah@evolution-foundation.org>; Stelter, Tony <Tony.Stelter@odmhsas.org>; Suzanne Williams <suzannew@okarr.org>; Teresa Stephenson <teresas@okarr.org>; Wernke, Angela <Angela.Wernke@odmhsas.org>
Subject: 3rd piece of Block Grant Application and priority measures

Hello everyone! I am attaching the third piece of the application. It contains the Planning Step 2 and financial tables.

Please note that question 2 of the Planning Step 2 is still in the works. Also, Table 4 MHBG is still pending as well.

I have attached the new priority measures. The baselines and target dates are still being worked on as well.

Stephanie Gay, LPC

From: Gay, Stephanie
Sent: Tuesday, August 19, 2025 9:50 PM
To: Alesha J Lilly <alesham@health.ok.gov>; andrea <andrea@namioklahoma.org>; Brian Webb <bwebb@wmpn.org>; Christi Sturgeon <christi.sturgeon@sde.ok.gov>; Clayton Tselee <ctselee@nbn-nrc.org>; Darlene Steeves <darlene.Steeves@ohfa.org>; dirtx <dirtx@latinoagencyokc.org>; Edie Nayfa <enayfa@catalystok.org>; Edwina Rose Horsechief <edwina.horsechief@wichitatribe.com>; Gina Olheiser <golheiser@wmpn.org>; Harrison, Katie <Katie.Harrison@odmhsas.org>; Hickl, Cynthia L. (HSC) <Cynthia-Hickl@ouhsc.edu>; Jami Ledoux

<Jami.Ledoux@okdhs.org>; Janelle Bretten <Janelle.Bretten@oja.ok.gov>; Janie Fugitt <JFugitt@okdrs.gov>; Janna Morgan <Janna.morgan@doc.state.ok.us>; Jeff Dismukes <jeff@dbsaok.org>; jefftallentz@aol.com; Jeni Dolan <jdolan@operationaware.org>; Josh Cantwell <jcantwell@glmhc.net>; Keitha Wilson <Keitha.Wilson@okdhs.org>; Kelly Willingham <kelly.willingham@gmail.com>; Kim Hill-Crowell-Designee <khill@glmhc.net>; Kriston Ahlefeld <kahlefeld@spthb.org>; Lisa L. Webb <llwebb@hopecsi.org>; lorna@namioklahoma.org; Louann Wiseman <llwiseman@yahoo.com>; Lyndi Seabolt <LSeabolt@spthb.org>; Madison Miller <Madison.Miller@odmhsas.org>; Mary Dimery <Mary.Dimery@okhca.org>; Meadow Hazelhoff <MHazelhoff@okpca.org>; Melinda Bunch <mbunch@okdrs.gov>; Onuorah, Young <YOnuorah@odmhsas.org>; Patti Stem (Designee) <patti.stem@doc.ok.gov>; Rachael Hernandez <Rachael.hernandez@sde.ok.gov>; Rosalind Goodlow <rosalind.goodlow@ohfa.org>; Sarah Rachel Smith <savingcourtney14@gmail.com>; Shannon Flynn-Designee <Shannon-Flynn@ouhsc.edu>; Smith, Kadedra <Kadedra.Smith@odmhsas.org>; Spain, Terrence <terrence.spain@odmhsas.org>; Stephanie Dixon <stephanie@2cr-oklahoma.org>; Thompson, Elisa <Elisa.Thompson@odmhsas.org>; tyler@ocarta.org; Amanda Coldiron <amandac@gethelp.com>; Benefiel, Jennifer <Jennifer.Benefiel@odmhsas.org>; Bethaney Myers <Bethaney.Myers@samhsa.hhs.gov>; Bottger, Ray <Ray.Bottger@odmhsas.org>; Cahill, AlisaWest <AlisaWest.Cahill@odmhsas.org>; Catherine Roberson <Catherine.Roberson@chickasaw.net>; DeBartolo, Joshua <Joshua.DeBartolo@odmhsas.org>; Elizabeth Stewart <estewart@healthwellnessok.com>; Hansbro, Dedra <dedra.hansbro@odmhsas.org>; Jeannie Russell Roberts <Jeannie.Russell@okhca.org>; Karen Orsi <Karen.orsi@northcare.com>; Kristen Bradley <Kristen.bradley@northcare.com>; Lauren Craig-Telligen <lcraig@telligen.com>; matthewm@red-rock.com; McEntire, Malissa <MMcEntire@odmhsas.org>; Mikelson, Melanie <Melanie.Mikelson.CTR@odmhsas.org>; Nola Harrison <Nola.Harrison@ssmhealth.com>; Sanders, Penny <penny.sanders@odmhsas.org>; Sheamekah Williams <sheamekah@evolution-foundation.org>; Stelter, Tony <Tony.Stelter@odmhsas.org>; Suzanne Williams <suzannew@okarr.org>; Teresa Stephenson <teresas@okarr.org>; Wernke, Angela <angela.wernke@odmhsas.org>
Subject: Last of the financial tables for the Block Grant Application

Attached, please find Table 4 for the MHBG Application.

Stephanie Gay, LPC

NOTICE OF MEETING & AGENDA

Planning and Advisory Council to the ODMHSAS SAMHSA Block Grant

ODMHSAS, 2000 N. Classen Blvd., 6th floor conference room, HOPE 4, OKC, OK, 73106

Thursday, August 21st, 2025 - 10:00 a.m. to Noon

https://www.zoomgov.com/j/1619836832

- **Call to Order and Recording of Members Present and Absent** …….....… Andrea Michaels
- **Welcome Remarks and Introduction of Attendees**..... Andrea Michaels

Items Requiring a Vote

- **Vote on Minutes from April 17th, 2025 Regular Meeting** ……..…..…….. Andrea Michaels
- **Vote on Prospective PAC Members** …….…….. Andrea Michaels

Reports

- **Legislative Report** ……..... Madison Miller
- **Agency Reports** .....Designated Representatives from State Agencies

Dept. of Rehabilitation Services **(Melinda Bunch)**
State Dept. of Health **(Alesha Lily)**
Office of Juvenile Affairs **(Janelle Bretten)**
Dept. of Human Services **(Keitha Wilson)**
OK Housing Finance Agency **(Darlene Steeves)**
OK Health Care Authority **(Mary Ann Dimery)**
State Dept. of Education **(Rachael Hernandez)**
Dept. of Corrections **(Janna Morgan)**

Priority Measures

- **No Priority Measures discussed**

Block Grant

- **Review of Application & Vote on Letter of Support** ……..…. Stephanie Gay

PAC Member Items

- **PAC Member Vacancies for Individual in Recovery and Family Member** ...… Stephanie Gay

Miscellaneous

- **Next Meeting Agenda Items**.....Andrea Michaels
- **Opportunity for Public Comment** ……..……..…… Andrea Michaels

  This opportunity is including, but not limited to, public comments regarding the State's Mental Health, Substance Abuse, and Prevention Block Grant Plan and Implementation Reports in Accordance with Provisions stated in PL 102-321. Copies can be obtained by calling 405-248-9342.

- **Adjournment**.....Andrea Michaels

Next Meeting:
October 16, 2025 (https://www.zoomgov.com/j/1619836832)
10:00am-12:00pm
Other Meeting Dates: 12/18/25

NAMI Oklahoma
National Alliance on Mental Illness

August 22, 2025

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 to the Oklahoma Department of Mental Health and Substance Abuse Services, I have the privilege of submitting this letter of support for the Oklahoma FY2026-2027 Block Grant Application which was reviewed and approved by the PAC group at the August 21st, 2025, meeting.

In addition to continuing treatment for all Oklahomans, our Block Grant Plan moves forward with focusing on increased access and targeted treatment for specific populations. Our Peer Recovery Support Services Division has continued to offer the PRSS Crisis tract, for those rendering crisis services. They are supplementing this tract with virtual bi-monthly support meetings and special support calls for these peers. Our Children's Services Division are working with the Oklahoma Human Services Developmental Disabilities Services Division to develop a plan to improve access to care that best meets developmental needs of children and youth with SED and co-occurring borderline intellectual functioning. In 2024, ODMHSAS contracted with the Center for Start Services to train 70 children's crisis providers on how to best provide crisis services to children and youth with co-occurring mental health and I/DD (intellectual/developmental disabilities). In August 2024, Oklahoma was invited to participate in the first SAMHSA Older Adult Suicide Prevention Policy Academy. A direct outcome was the Suicide Prevention Taskforce, which is working to integrate aspects of older adult suicide prevention in the broader State Suicide Prevention Plan. Additionally, ODMHSAs is in the process of implementing a "Women's Liaison" role at every state-contracted outpatient provider. This designated staff member will be responsible for ensuring that women-specific services, particularly those addressing the needs of women with dependent children, are available, accessible and coordinated within their agency.

Last April, Managed Care began assisting in Serving Oklahoma Medicaid. Growing pains continue to be experienced with Managed Care. However, ODMHSAS continues to partner with providers to ensure that all Oklahomans, who need treatment, are able to receive it.

Sincerely,

Andi Michaels

Andrea Michaels
Chief Operating Officer
NAMI Oklahoma

3009 NW 63rd St, Suite A2, Oklahoma City, OK 73116
Mailing address: PO Box 1306, El Reno, OK 73036
1-800-583-1264 • 405-601-8283 • Fax 405-669-3823
info@namioklahoma.org •www.namioklahoma.org

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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Kriston Ahlefeld	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		9705 Broadway Extension Suite 200 Oklahoma City OK, 73114 PH: 405-869-6309	kahlefeld@spthb.org
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	MBunch@okdrs.gov
Josh Cantwell	Providers	Grand Mental Health	6333 E. Skelly Dr. Tulsa OK, 73109 PH: 918-533-6891	jcantwell@GrandMH.com
Erin Coffee	Parents of children with SED		OK, PH: 918-340-8967	coffeee@aetna.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	Advocates/representatives 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
Stephanie Dixon	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		P.O. Box 162 Duncan OK, 73534 PH: 940-597-0955	stephanie@2cr-oklahoma.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	Latino Community Development Agency	420 SW 10th Street Oklahoma City OK, 73109 PH: 405-236-0701	dirtx@latinoagencyokc.org

Katie Harrison	State Employees	Oklahoma Department of Mental Health and Substance Abuse Services	2000 N. Classen Blvd., Suite 600 Oklahoma City OK, 73106 PH: 405-615-8320	katie.harrison@odmhsas.org
Meadow Hazelhoff	Providers	Meadow Hazelhoff Counseling, LLLC	9524 Conners Way McLoud OK, 74851 PH: 405-219-2271	MHazelhoff@okpca.org
Rachael Hernandez	State Employees	Oklahoma State Department of Education	2500 N. Lincoln Blvd. Oklahoma City OK, 73105 PH: 405-522-0031	Rachael.hernandez@sde.ok.gov
Cindy Hickl	Providers	OU Impact	4444 E. 41st Ste. 2900 Tulsa OK, 74135 PH: 918-660-3150	Cynthia-Hickl@ouhsc.edu
Edwina Horsechief	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		301 W. Broadway Anadarko OK, 73005 PH: 405-247-2425	edwina.horsechief@wichitatribe.com
Alesha Lily	State Employees	Oklahoma State Department of health	1000 NE 10th St. Oklahoma City OK, 73117 PH: 405-271-4477	alesham@health.ok.gov
Andrea Michaels	Advocates/representatives who are not state employees or providers	NAMI of Oklahoma	P.O. Box 1306 El Reno , 73036 PH: 405-456-0312	andrea@namioklahoma.org
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	Catalyst Behavioral Services	3033 N. Walnut Avenue Oklahoma City , 73105 PH: 405-826-0105	enayfa@catalystok.org
Gina Olheiser	Persons in Recovery from or providing treatment for or advocating for SUD services		22 SW D Avenue, Ste 2 Lawton OK, 73501 PH: 580-355-5246	golheiser@wmpn.org
Young Onuorah	State Employees	Oklahoma Department of Mental Health and Substance Abuse Services	2000 N. Classen Blvd., Suite 600 Oklahoma City OK, 73106 PH: 405-626-0411	YOnuorah@odmhsas.org
Tyler Ross	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		2701 W I-44 Service Road Oklahoma City OK, 73112 PH: 405-436-7366	tyler@ocarta.org
Lyndi Seabolt	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		9705 Broadway Extension Suite 200 OK, 73114 PH: 405-620-0500	LSeabolt@spthb.org
Sarah Rachel Smith	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		3009 NW 63rd St. Oklahoma City OK, 73116 PH: 405-642-8270	savingcourtney14@gmail.com

Darlene Steeves	State Employees	Oklahoma Housing Finance Agency	100 NW 63rd Street Oklahoma City OK, 73116 PH: 405-419-8211	darlene.steeves@ohfa.org
Jeff Tallent	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		1620 Ridgecrest Edmond OK, 73013 PH: 405-203-7898	jefftallentz@aol.com
Elisa Thompson	State Employees	Oklahoma Department of Mental Health and Substance Abuse Services	2000 N. Classen Blvd., Suite 600 Oklahoma City OK, 73106 PH: 405-761-2383	Elisa.Thompson@odmhsas.org
Clayton Tselee	Youth/adolescent representative (or member from an organization serving young people)	Neighbors Serving Neighborhoods	207 N. 2nd St. Muskogee OK, 74401 PH: 918-683-4600	ctselee@nbn-nrc.org
Lisa Webb	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		6100 S. Walker Oklahoma City OK, 73139 PH: 405-417-0581	llwebb@hopecsi.org
Brian Webb	Persons in Recovery from or providing treatment for or advocating for SUD services		22 SW D Avenue, Ste 2 Lawton OK, 73501 PH: 580-251-0992	bwebb@wmpn.org
Kelly Willingham	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		4000 N. Lincoln Blvd. Oklahoma City OK, 73105 PH: 405-249-7828	kelly.willingham@gmail.com
Keitha Wilson	State Employees	Oklahoma Department of Human Services	2400 N. Lincoln Blvd. Oklahoma City OK, 73105 PH: 405-215-1362	Keitha.Wilson@okdhs.org
Louann Wiseman	Persons in Recovery from or providing treatment for or advocating for SUD services		725 W. Walnut 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:

Keitha Wilson is a PAC member and represents the Oklahoma Department of Human Services which functions as both a social services agency and also as a child welfare agency.

12-2-2025: 3 co-occurring individuals were moved to SMI status.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	6	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	1	
4. Vacancies (individuals and family members)	7	
5. Total individuals in recovery, family members, and parents of children with SED	**17**	**42.50%**
6. State Employees	11	
7. Providers	4	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**15**	**37.50%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	4	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	2	
13. Advocates/representatives who are not state employees or providers	2	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**8**	**20.00%**
16. Total membership (all members of the council)	**40**	

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Footnotes:

Advocacy agencies, agencies serving youth, people in recovery from SUD and family members of people who have SUD issues are not added into the top section of the grid, since they are not statutorily mandated. However, Oklahoma has a planning and advisory council that comments on a combined mental health and substance use disorder treatment application and so we are in need of individuals in recovery from SUD and family members of those individuals in order to give a real-life perspective on what is working and what is needed for services in Oklahom. Here is the breakdown. The cap on our council is 40. We have 11 state agency members, 3 mental health providers, one SUD treatment provider, and 2 agencies that specifically serve youth. We have 2 mental health advocacy agencies-NAMI of OK and the Depression Bipolar Support Alliance of Oklahoma. For SMI, we currently have 3 people in recovery and 3 family members and we have one family member of an SED child. For SUD, we currently have 4 people in recovery and 2 family members. Although their role in the PAC is not "Representative

from Federally Recognized Tribe" (as that is not a statutorily mandated population for the PAC group), we do have 4 PAC members who are members of Federally Recognized Tribes and can, therefore, speak on tribal matters as it pertains to their tribe. In order to have a full PAC group, we are needing 7 more individuals in the person in recovery or family member category. We seek PAC members through various means. I regularly inform my PAC group of the vacancies that we have and request that tell their friends and others about PAC. I also make sure that PAC is represented at conferences by having PAC applications with me as I speak to the public about PAC. We discuss PAC membership with our treatment agencies and ask them to speak to their consumers and staff about membership. We have the application online so that anyone can access it and fill it out. PAC is not a monetarily reimbursed membership and so it can be difficult to entice people who already have jobs that are not treatment oriented. We find that those in the treatment field typically have employers that are more supportive of taking time out from the day to attend a PAC meeting. In spite of this, our efforts will continue and I will continue to seek more outreach opportunities with the public to speak about PAC and acquire more members. Our timeline to have these vacancies filled would be by November 2026. (12-2-2025) No changes to this as the changes from the previous table (number-wise) are carried over into this table. Our PAC composition will be restructured as current PAC members terms end. We will be soliciting much fewer individuals experiencing SUD and their family members and will also be decreasing our number of providers and advocacy agencies. However, this will have to be done through time as we have some members who have terms through 2026 and 2027. By letting those roles in PAC lapse, we will not have those members in the "non-required but encouraged" group that, with this PAC application, have been added into our total number of PAC composition.

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

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

d) Please indicate areas of technical assistance needs related to this section.

N/A.

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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 been three comments made on the application. Two comments, from the public, had to do with the application that was submitted in 2023 and changes that they wanted to have made in the current application. One PAC member put forth a recommendation on verbiage that they wanted included in the current application, after its review. One PAC member had a question about the contents of the application, after its review. There have been two inquiries that have come through the email where people can send questions about the block grant. One person was wondering how to become a contracted provider and another was looking for an individual grant to help them pay for expenses. Both of those people were assisted with finding appropriate resources. All of this information will be put in the Environmental Factors and Plan #14.

Additionally, the block grant application has been reviewed by the planning and advisory council (PAC) and the public that attends the meetings at multiple times. This was done both prior to the actual PAC meetings and during the PAC meeting and comments were solicited each time.

In addition to posting on the ODMHSAS website and soliciting comment via meetings and emails, 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 is seen by a large number of people.

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

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 SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG 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 SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (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. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. 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 SUPTRS BG 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.

2. 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 SUPTRS BG 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.

3. 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 SUPTRS BG 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 use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

ODMHSAS is not pursuing this, at this time.