#	Date Received	Commenter/ Organization	Comment/Question	Disposition of Comment/ Rationale
1	12/24/2016	Barry Lovgren	The proposed application for SAPT Block Grant funds is woefully inadequate. It doesn't require the State to submit the State Plan required by statute (42 USC 300x *et seq*) and regulation (45 CFR, Part 96, subpart L). It needs to be revised to require that the application includes a State Plan which meets each of the requirements specified by 45 CFR 96.122(g). Until this is done, SAMHSA is failing to meet its duty to ensure compliance with federal law relating to the Block Grant. The format for application for 2018-19 funding needs to be revised to require that the application includes each of the State Plan requirements specified by 45 CFR 96.122(g).	SAMHSA does not agree. The proposed plan and report provides states and jurisdictions with sufficient guidance to reasonably implement the statutory and regulatory performance requirements applicable to pregnant women and women with dependent children. In the event that a Substance Abuse Prevention and Treatment Block Grant (SABG) recipient, i.e., state or jurisdiction, submits a plan which does not adequately demonstrate compliance with the statutory and regulatory requirements as described above, SAMHSA requires the state or jurisdiction to revise and resubmit its plan. Further, all SABG sub-recipients are required to make their respective biennial plans available in a manner to facilitate comments from the public while the plan is under development by the sub-recipients and while the biennial plans are being reviewed by SAMHSA.
2	1/13/17	VT Department of Health	We appreciate SAMHSA's responsiveness to states' requests for guidance and examples of Block Grant use in cost sharing and co-pays coverage (page 5).	SAMHSA appreciates the comment.
3	1/13/17	VT Department of Health	Vermont supports the recommendation for states to adopt PHAB criteria by public health authorities as	SAMHSA appreciates the comment.

			well as to pursue accreditation. Vermont was accredited in 2014. (Section B. Strategic Partnerships, pages 6-7).	
4	1/13/17	VT Department of Health	This 2018-2019 application sets out the four main purposes of the Block Grant, which is very clear and helpful (page 11).	SAMHSA appreciates the comment.
5	1/13/17	VT Department of Health	Vermont appreciates the structure and information provided in Section III. Behavioral Health Assessment and Plan, Sub-section A. Framework for Planning. This section provides very clear descriptions of the criterion and priority populations that must be addressed in the planning steps, including legislative citation. This will help further focus our planning efforts and application responses (pages 15–18).	SAMHSA appreciates the comment.
6	1/13/17	VT Department of Health	Under Section B. Planning Steps, SAMHSA adds the newly required SABG Needs Assessment Tables (Table A: Treatment Needs Assessment Summary Matrix, and Table B: Treatment Needs by age, sex, race/ ethnicity). Table A and Table B involve reporting at a "sub-state planning area level" which will be challenging for small states to complete. Data points may either be too small to be meaningful and/or the data collection systems may not be existent in all areas for statewide reporting (pages 20-21).	Under the Cures Act, these Needs Assessment Tables have been eliminated.
7	1/13/17	VT Department of Health	Vermont values greatly that "system improvement" is an allowable strategy supported under the Block Grant, and can include invaluable investments such as linkages to primary care, peer-based services, TA to support comprehensive community planning,	SAMHSA appreciates the comment.

			services for people with disabilities, benefit management for high cost services, etc. (page 25).	
8	1/13/17	VT Department of Health	Vermont appreciates every effort by SAMHSA to simplify the application process year after year. This year we appreciate the outline of the application at the beginning, the clearer definitions and streamlining of Table 5 (old Table 6a). Most importantly the streamlined the narrative sections under Section IV. Environmental Factors with formal Yes/No check box and then a text box for the state to describe a promising or innovative practice or describe a technical assistance need (pages 39-94) is efficient and provides clarity on what information SAMHSA is seeking. It is also likely these short responses will allow SAMHSA to develop a clearer picture of our system nationally.	SAMHSA appreciates the comment.
9	1/13/17	VT Department of Health	Vermont appreciates the enhanced emphasis on prevention throughout the application as reflected in the required populations (e.g., Persons in need of primary prevention), the requirement of the State Behavioral Health Planning Council narrative to address questions on planning for substance misuse planning, and integration of the with the primary health care system and EHRs.	SAMHSA appreciates the comment.
10	1/13/17	VT Department of Health	The WebBGAS structure provides an invaluable tool in Vermont's planning processes to help our cross-disciplinary teams better envision how the program concepts and strategies relate to the financials, deliverables and other outcome measures. Therefore, Vermont requests that the structure of WebBGAS be	SAMHSA appreciates the comment.

			as closely aligned with the application instructions as possible, as well as be available to the states for opening and use as soon as possible after the application is formally posted. In the past, WebBGAS unfortunately wasn't available for viewing or use by the states until our planning stages were well underway, creating some confusion and often requiring our sub-teams to duplicating much of our planning and application drafting processes.	
11	01/09/17	PASMI Action	Prevention and Recovery language in this document does not pertain to Serious Mental Illness, which can neither be 'prevented,' nor 'recovered from,' any more than Alzheimer's can be 'prevented' or 'recovered from.' This is old language which contradicts and undermines the stated goal of 21st Century Cures Act and Helping Families In Mental Health Crisis Act, to prioritize and better serve people with Serious Mental Illness.	SAMHSA appreciates the comment. SAMHSA encourage states to provide comprehensive services to address prevention. This include activities and efforts in reducing suicide, recurrence of mental disorders, attempts to reduce symptoms, minimize mental health crises and decreasing the impact of illness in the affected person, their families and the society. There is extensive evidence that people can and do recover from Serious Mental Illness. While there are indivduals who are at different levels of their recovery, the document is not implying that individuals can be "cured" of their symptoms with one approach or the other. The lives of individuals with mental illness can be greatly improved with evidence-based medical treatment

				and services that are critical for recovery. Also, Section 8001 of the 21st Century Cures Act requires states to submit a description of their recovery and recovery support services.
12	01/09/17	PASMI Action	If the new scope and purpose of the Community Mental Health Services Block Grant is to better serve people with Serious Mental Illness, then this discrete population must be targeted based on their specific needs and profile, which does not in any way coincide with the needs and profile of those with primary Substance Abuse disorders. Serious Mental Illness is biological, neurological and cannot be 'prevented,' recovered from,' or, by its nature, 'peer-supported.' If we are to fund initiatives which truly serve this population, grants must be updated, particularized and based in medical research and medical treatments which are evidence and research-based.	SAMHSA appreciates the comments. The Block Grant Application provides overall guidance to states, however states has the ability to develop and implement services and supports for individuals with SMI/SED based on their local needs and resources. Data shows that a very high percentage of people with mental illness also have a substance use disorder. SAMHSA encourages states to provide services that are integrated. While there are indivduals who are at different levels of their recovery, the document is not implying that individuals can be "cured" of their symptoms. Peer support for people with serious mental illness has been shown to have efficacy. SAMHSA acknowledges the importance of evidence-based medical treatments

				and services as critical to recovery .
13	01/09/17	PASMI Action	Prevention of Substance Abuse and Mental Illness: Separate Substance Abuse and Mental Illness: Separate Language For Substance Abuse and Mental Illness-Substance Abuse can be 'prevented' however, Serious Mental Illness cannot. There is no prevention for SMI 'by maximizing opportunities to create environments,…. etc. for SMI. This is non-sensical and non-factual.	See above comments
14	01/09/17	PASMI Action	Health Care and Health Systems Integration: 'Increasing Access to appropriate high-quality prevention, treatment, recovery and wellness services and supports' is not a realistic target for SMI population. Many persons with SMI need to be 'compelled,' rather than 'encouraged' to receive adequate healthcare services. SMI have brain-based neurological thinking and perceptual deficits that cannot be overcome by 'encouragement.' Many SMI are fearful, avoidant, or paranoid regarding hospitals, doctors, and healthcare settings based on bad experiences, and brain-based denial of medical needs, or conditions (anosognosia). The only way to 'reduce disparities' is to offer integrated healthcare services through long-term residential, or inpatient settings. ie. State Hospitals and long-term residential settings for SMI should provide on-grounds integrated healthcare services, or doctor/nurse regular Home Visits and home-based medical care to all	SAMHSA agrees that, according to state statutes, an individual may warrant the need for involuntary treatment. We also acknowledge that most people with serious mental illness can and do benefit from increasing access to high quality care and that the vast majority of individuals with SMI seek care voluntarily. While residential and hospital settings can provide integrated healthcare services, there are extensive evidence that these same services can be provided in community based services with excellent outcomes. SAMHSA continue to work with our State-partners in developing these resources.

			residents.	The goal of the *Community* Mental Health Block Grant is to provide to the extent possible quality, evidence based treatment and services to individuals with serious mental illness to avoid hospitalization, incarceration, homelessness, and other negative outcomes.. This is keeping with the June 22, 1999 United States Supreme Court decision in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.
15	01/09/17	PASMI Action	Recovery Support: People with SMI cannot 'recover' any more than people with Alzheimer's can 'recover.' The language of 'Recovery' which fits for Substance Abuse, therefore, does not make sense for SMI. SMI and Substance Abuse should not be grouped together, as they are two separate and distinctly different conditions.	See above comments. Data suggests that the prevalence of substance use among individuals with SMI is very high and SAMHSA encourages states to use evidence based coordinatedtreatment to promote

				recovery from both SMI and substance abuse in an integrated manner.
16	01/09/17	PASMI Action	Health Information Technology: If SMI are to 'fully participate with general healthcare delivery system in the adoption of health information technology' then this technology must be available in residential and long-term inpatient settings.	SAMHSA appreciates the comments.
17	01/09/17	PASMI Action	Workforce Development: Should include the addition of recruitment of licensed BCBA's (Board Certified Behavior Analysts) for the SMI and SMI with comorbid Autism Spectrum Disorder population. People with high functioning autism (HFA) are the fastest growing segment of the population of Seriously Mentally Ill currently being served by Department of Mental Health. Applied Behavioral Analysis implemented by a trained, licensed BCBA- is the only evidence-based intervention for people with Autism and Serious Mental Illness.	SAMHSA appreciates the comment. SAMHSA has no authority to instruct states on the kind of professionals they license and hire. States determine who provide services to individuals with SMI/SED.
18	01/09/17	PASMI Action	Separate Serious Mentally Ill from Substance Abuse populations. They are substantively different populations and should not be placed under the same umbrella, or category. A 'High quality, self-directed, and satisfying life' is beyond the scope and ability of most Seriously Mentally Ill, who, due to the biological impact of their illness, suffer cognitive impairment. They are not any more able to be 'self-directed' than senior citizens with Alzheimer's or dementia. Seriously Mentally Ill need and deserve life-long residential care and support, either in long-term state hospital, or other residential settings where they are provided with activities, medical treatment and supervision.	The 21st Century Cures Act allows states to submit a joint application ("SEC 1958). Data suggests that the prevelance of substance use among individuals with SMI are very high and evidence based integrated services provides excellent outcomes. While SAMHSA agress that there are individuals with SMI who are determined to have serious cognitive deficits, evidence shows that the vast majority of individuals with serious mental illness are able to live successfully in the community with appropriate treatments and supports.

19	01/09/17	PASMI Action	Further, Peer Support goals are unrealistic and superfluous. We do not fund 'peer-support' programs for other biological, brain-based neurological disorders such as Alzheimer's, or dementia, as the absurdity of such programs would be obvious, -as it should be with Serious Mental Illness.	See response to comment #12
20	01/09/17	PASMI Action	If FFY 201802019 Block Grant Application remains as written, the goals of passage of 21st Century Cures Act to improve treatment and direct funding and resources to our Seriously Mentally Ill, have been completely undermined and obliterated.	SAMHSA appreciates this comment. Provisions and language from the 21st Century Cures Act has been incorporated into the 2018-19 Block Grant Application.
21	01/19/2017	Elizabeth Glitter, Ohio Department of Mental Health & Addiction Services	**Add space for footnotes or comments to each Environmental Factor section to briefly explain or clarify answers, and limit length of footnotes or comments in WebBGAS.** This will provide SAMHSA with clarifying information, and avoid some problems created by some questions. (Example: #9. Statutory MHBG Requirements, Criterion #1. Most state Mental Health & Addiction Agencies do not provide all of these services directly----so a "Yes" choice is problematic for some services (e.g. education, employment, housing) without space for a brief explanation that these services are provided through coordination with other organizations. If the state answers, "No," the concern is that it will be out of compliance. The same is true for #10 SABG Criterion on some items.	SAMHSA agrees with the comment and will include an additional box for comments.
22	01/19/2017	Elizabeth Glitter, Ohio Department of	**For MHBG Report Table 2b State Agency First Episode Psychosis (FEP) Expenditure Report, please eliminate non-Block Grant fund reporting.**	SAMHSA will add language that indicates that the category for "local funds" be optional.

		Mental Health & Addiction Services	Many large states have county administration of behavioral health systems and multiple funding sources for these programs, and will have great difficulty reporting on non-Block Grant funds for FEP clients. Ohio's FEP providers have multiple provider, county-board and state data systems that don't "talk" to each other. FEP providers use multiple EHR and accounting systems, the providers do not report centralized client level expenditure data. While OhioMHAS has a data warehouse that includes client level Behavioral Health Medicaid and state funded services, it does not collect client level data on private health insurance and local county-tax levies. (From conversations with FEP providers, we know that about 40% of the FEP clients have private health insurance.) Additionally, OhioMHAS did not require providers to report expenditures of non-Block Grant funds in its competitive RFP (Request for Proposal) for SFY 2017 FEP funds, so it would be problematic to request this data from providers after the fact-----especially since many of them may not have data systems that will allow reporting of these categories.	
23	1/23/2017	NASMHPD	NASMHPD's members feel that the changes made by SAMHSA this year represent marked improvements on previous versions of the block grant application, guidance, and instructions and they express their appreciation for those improvements and the reduction in administrative burden they will achieve.	SAMHSA appreciates the comment.
24	1/23/2017	NASMHPD	In the Table of Contents, on page 2, "Table 2a" is referenced as "Table 2". On page 6, under *Performance Indicators and Accomplishments*, Table 19a (*Adults with Serious Mental Illnesses*	SAMHSA agrees and will make the recommended changes.

			and Children with Serious Emotional Disturbances Receiving Evidence Based Services for First Episode Psychosis) should probably be highlighted as a new table.	
25	1/23/2017	NASMHPD	On page 8 of the instructions, in MHBG Table 2a (*MHBG State Agency Expenditure Report*), a new Row 3, *Evidence-Based Practices for First Episode Psychosis (FEP)*, has been added. While adding a row to capture information on FEP services may be useful in this table, we suggest this mental health-related service should be moved to the other mental health-related expenditures (Rows 5 through 8) rather than co-mingled with substance-use disorder services (Rows 1 through 5). In addition, if the Row 3 FEP expenditures are to be removed from Row 7 (Ambulatory/Community Non-24-Hour Care), specific instructions to the states need to be added to avoid double counting, since instructions for Row 7 indicate that all community mental health expenditures should be reported in that row and Coordinated Specialty Care (CSC) services are generally part of the community system.	SAMHSA agrees and will make the recommended changes.
26	1/23/2017	NASMHPD	Also in Table 2a, the entire Row 5 (*State Hospital Expenditures*) has been blacked out. Only the Mental Health Block Grant (MHBG) box on that row should be blacked out since MHBG funds cannot be used for inpatient	SAMHSA agrees and will make the recommended changes.

			expenditures, but states have been reporting other expenditures for state hospitals on this row in previous years.	
27	1/23/2017	NASMHPD	On page 9, in new Table 2b (*MHBG State Agency First Episode Psychosis Expenditure Report*), SAMHSA should consider that, because not all states received sufficient funds in their MHBG set- aside to fund a full CSC model program, SAMHSA approved those states providing evidence-based practices that are components of an FEP program but not full CSC services. We suggest splitting Row 1 into two rows, one for reporting CSC model services funded through the MHBG set-aside and other expenditures, and a second row for reporting the use of the MHBG-set-aside and other expenditures for FEP component services. Without the inclusion of a category for components in Table 2b, the total expenditures for FEP (as reported in Table 2A, Item 3) will not match with Table 2a.	SAMHSA agrees and will make the recommended changes.
28	1/23/2017	NASMHPD	For Table 3 (*Set-Aside for Children's Mental Health Services)*, there is a discrepancy between what the BGAS instructions say on Maintenance of Effort and what the table itself instructs. Under the 2017 instructions, states are to spend no less than in FY 2008, but the Table itself states that "States and jurisdictions are required not to spend less than the amount expended in FY 1994."	SAMHSA appreciates the comment. The current instructions in webBGAS are based on FY16/17 application. The instructions for FY18/19 application will include the statutory language sated in Table 3.

29	1/23/2017	NASMHPD	On page 10, MHBG Table 4 (*Profile of Community Mental Health Block Grant Expenditures for Non- Direct Service Activities*) is an earlier version of a table that was modified and updated by a SAMHSA/NASMHPD/NASADAD workgroup led by Anne Herron. The updated table is included in the new FY 2018-2019 Block Grant Application as Plan Table 5, but the version of the table in the MHBG Report uses the old format. Both the Application and Report should use the same, revised table (Plan Table 5 in the Application).	SAMHSA agrees and will make the recommended change.
30	1/23/2017	NASMHPD	In the same Table 4, the field for *Report Year* has been changed to *Report Period From/To*, but this change has not consistently been made across all tables. If the preference is to get the start- and end-dates of the state's reporting period, this change should be made to all tables. The same applies on page 11, in Table 5 (*Profiles of Agencies Receiving Block Grant Funds Directly from the State MHA*, and in Tables 10A and 10B (*Profile of Clients by Type of Funding Support*) on pages 23 and 26 respectively. In Table 5, new column H is titled *Non-Direct Services*, presumably for the reporting of expenditures on non-direct services. However, non-direct service expenditures are also being collected in Table 4, and the instructions for Table 5 (URS Table 10) specifically instruct	SAMHSA agrees and will make the recommended changes.

			that, for all reporting years, 'only programs that receive MHBG funds to provide services' should be reported. For these reasons, we question whether it makes sense to add new column H to this table.	
31	1/23/2017	NASMHPD	In Table 8A, on page 19, the cross-reference to "Table 11b" in the column for reporting Hispanic clients served should more accurately be "Table 8B".	SAMHSA agrees and will make the recommended changes.
32	1/23/2017	NASMHPD	In Table 8B, on page 20, the column title "MHBG Table 11" should more accurately be "MHBG Table 8A".	SAMHSA agrees and will make the recommended changes.
33	1/23/2017	NASMHPD	In Table 9, on page 21, the column title "MHBG Table 12" should more accurately be "MHBG Table 9". In the same table, on the following page, the three fields for Comments on Data seem to provide inadequate space for commenting.	SAMHSA agrees and will make the recommended changes.
34	1/23/2017	NASMHPD	In Table 11, on page 28, the header cell should be split into two, with *For Clients in Facility for 1 Year or Less: Average Length of Stay (in Days): Residents at end of year* going into one cell (with its own *average (mean)* and *median* columns, and *For Clients in Facility More than 1 Year: Average Length of Stay (in Days): Residents at end of year* going into the second cell (with its own *average (mean)* and *median* columns	SAMHSA agrees and will make the recommended changes.

35	1/23/2017	NASMHPD	States support the movement from multiple narrative description of activities to more quantitative responses in *Assessment and Planning*, but caution that the emphasis on "integration" or "systemic" work is challenging to quantify. While they support the emphasis on programming and planning to integrate behavioral and physical health, they suggest a move from less narrative to more quantitative data to reflect a "strong connection" will prove challenging	SAMHSA appreciates the comment and will make use of comment boxes whenever it is necessary to explain in text beyond a quantitative measure.
36	1/23/2017	NASMHPD	With regard to *Health Care System - Parity and Integration* reporting, while there is movement away from policy guidance on activities that are not allowable expenditures, states note there remains a significant expectation that such strategies are to be promoted. One state suggested additional guidance or technical assistance on allowable expenditures related to "care coordination" would be of assistance in providing greater clarity.	SAMHSA appreciates the comment and consider this comment an analysis of allowable expenditures. SAMHSA will also consider the suggestion regarding the provision of technical assistance.
37	1/23/2017	NASMHPD	One predominantly rural/frontier state reported that the 10 percent set-aside for evidence-based programs to address FEP has been challenging to implement due to workforce shortages impacting referral base and census/enrollment. They encourage SAMHSA to provide guidance or flexibility in deploying/expending funds on evidence-based practices in rural or frontier areas.	SAMHSA appreciates the comment and agrees that FEP services can be very challenging in rural/frontier areas. SAMHSA has designed a webinar on this topic. This can be found at https://www.nasmhpd.org/content/providing-coordinated-specialty-care-services-first-episode-psychosis-rural-and-frontier

38	1/23/2017	NASMHPD	A second small state, with limited staff resources, research and statistics capacity, data collection systems, and integrated electronic platforms, expresses frustration with how difficult it is to satisfy the extensive data reporting required for the Mental Health Block Grant planning and application process. The state suggests that, given that the Block Grant is noncompetitive, the volume of data on the entire state mental health system collected—some of which, it suggests, has a marginal relationship to the specific programming intended to be addressed by the funding source and is unneeded for administration and oversight of the Block Grant program—is unnecessarily onerous, particularly for a small state with a limited state workforce and data system resources. The state says the volume of data being required for FY 2018-2019 will necessitate it using its block grant funding primarily for administrative purposes rather than the provision of services. That second state asks that any changes to the mental health block grant application include exemptions for small states, based on population and funding thresholds, from a reporting of any data that increases technological costs and/or requires additional staff resources. Given the very limited amounts allocated in the block grants for the Pacific Island territories,	SAMHSA appreciates the comment.

			NASMHPD urges SAMHSA to especially consider such reporting thresholds for those entities.	