First of all, we would like to say that we welcome the changes to the block grant that reflect SAMHSA's growing emphasis on integration of mental health and substance abuse prevention and treatment. Unifying these block grants will send a message to states to better coordinate the care for youth with co-occurring mental health and substance use disorders, who have unique needs that are not being adequately addressed by the system as it is today.

We also know that many states use the majority of their mental health dollars on residential treatment for youth, so we hope that the new block grants will also encourage states to move towards funding home and community-based services and supports for children and youth with mental, emotional and/or behavioral health needs. Requiring states to assess their behavioral health needs will force them to see that such an overwhelming emphasis on residential treatment under serves the families who would be better served with home or community-based services. Not to mention the huge financial burden it places on states. Home and community-based services are less expensive, preventative, and produce more positive outcomes in the long term. The emphasis on recovery support should also help to bring more funds away from out-of-home placement.

A key theme in our comments is the need for families to be more included in the development of the states' block grant applications. The adult consumer voice is well supported, however the voice of children is not as strong. Especially for young children, their parents and caregivers are their voice. SAMHSA has relied on the National Federation over the years to engage parents and their system partners nation-wide to define the evolving role parents and youth play in designing, administering and sustaining programs and systems that work. This has moved the Children's Mental Health Initiative GFA language from "family centered" in 1997 to "family involvement" in 1999 to "family-driven" in 2005. Unfortunately, the family-driven principle has not spread very far outside of the programs administered by SAMHSA's Child, Adolescent and Family Branch.

For the past decade SAMHSA's Statewide Family Networks have been supporting families and youth to use their experiential expertise to advocate for themselves. Therefore, in our below comments where we further explain different sections where family input is necessary, please consider how the Statewide Family Networks are well-poised to provide that input to the states as they develop their plans for the block grant funds.

Our comments below are in response to the question of ways to enhance the quality, utility, and clarity of the information to be collected.

The plans that SMHAs and SSAs develop should address not only bi-directional integration of behavioral health and primary care services, but also the bi-directional integration of public and private behavioral health delivery. This is important for example in the case where a child has been receiving outpatient mental health services through a private insurance company, but then needs to go to a residential treatment center. After 30 days, the maximum amount of days that the private insurance company will pay for the residential, the child can stay at the residential treatment center because s/he becomes eligible for Medicaid under out-of-home placement. At that time the residential center is required to report to the state, but while the youth was receiving services through the
private insurance company the residential center was not required to report to the state. This makes coordinating of services very difficult.

In Step One, states should address the strengths and needs of the service system to address the specific populations in conjunction with family members of children from that population and in conjunction with youth and adult consumers from that population.

Under Information on Activities that Support Individuals in Directing the Services, SAMHSA should also ask States to provide information about policies and programs that allow custodial parents of children with mental illness and/or substance use disorders to direct their children's care.

Under Process for Comment on State Plan, SAMHSA should ask States to describe their efforts and procedures to obtain public comment from consumers and family members of children consumers, use of electronic media for posting of the draft plan and solicitation of comments on the development of and draft State plan.

Under Description of Processes to Involve Individuals and Families, SAMHSA should more than request that States describe their efforts, it should be required of states and supported by a budget line item. This is necessary because we have seen too often State governments fail to adequately involve family members. Requiring States to do this will force States to make family involvement a higher priority.

Under Description of the Use of Technology, we would like to see SAMHSA include asking States how they plan to use ICTs for not only health care services, but also support services. Many of these support services are necessary for children's resilience.

Under Description of State Behavioral Health Advisory Council, we would like to see SAMHSA also strongly encourage States to use the council to advise and consult regarding issues and services for children through the voice of parents with children with or at risk of behavioral (including substance use) or mental health disorders as well.

Under Information on Data and Information Technology, SAMHSA should require that states include disaggregated data by race, ethnicity and language in all of the reports. This information is critical to informing us of where there are health disparities among certain populations.