FFY 2022-2023 Block Grant Application

Community Mental Health Services Block Grant (MHBG)
Plan and Report

Substance Abuse Prevention and Treatment Block Grant (SABG)
Plan and Report

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Table of Content

S

1.   Required Forms
        a. Face Page—Community Mental Health Services Block Grant
        b. Face Page—Substance Abuse Prevention and Treatment Block Grant
        c. Funding Agreements/Certifications—Community Mental Health Services Block Grant
        d. Funding Agreements/Certifications—Substance Abuse Prevention and Treatment
            Block Grant
        e. Assurances

FFY 2022-2023 Block Grant Application

I. INTRODUCTION

This is an application for SAMHSA's Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) as authorized by sections 1911-1920 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.CF.§§ 300x-300x-9) and sections 1921-1935 of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C.§ 300x-21-35), respectively, and sections 1941-1956 of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§§ 300x-51-66). This block grant application includes four major parts: introduction; submission of application and plan time frames; Mental and Substance Use Disorder (M/SUD) assessment and plan; and report requirements. These sections include discussions and planning around the following policy topics: access to care, integration, and care coordination; health disparities; innovations in purchasing decisions; evidence-based practices for early intervention (e.g., serious mental illness (SMI)); person centered planning (PCP); program integrity; tribes; primary substance use disorder prevention, statutory criteria for MHBG; substance use disorder treatment; quality improvement; trauma; criminal and juvenile justice; medication-assisted treatment; crisis services; recovery; community living and Olmstead; children and adolescents M/SUD services; suicide prevention; support of state partners; state planning/advisory council; and public comment. It also includes the planned expenditures for FY 2022-23 Consolidated Appropriations Act (COVID-19 Relief) Supplemental Funding and the FY 2022-23 American Rescue Plan (ARP) Supplemental Funding of MHBG and SABG grantees.

A. Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees two major block grants: The Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG). These block grants give states[1] maximum flexibility to address the M/SUD needs of their populations. The MHBG and SABG differ in a number of their practices (e.g., targeted populations) and statutory authorities (e.g., method of calculating maintenance of effort (MOE), stakeholder input requirements for planning, set-asides for specific populations or programs, etc.[2]). As a result, information on the services and clients supported by block grant funds varies by block grant and by state.

SAMHSA believes it is vital to collect, report, and analyze data at the state and federal levels to ensure the nation's M/SUD system provides access to high quality and cost-effective treatment and services. State block grant expenditures should be based on the best possible evidence; program quality and outcomes should be carefully tracked so that data can inform improvements.

Better alignment of the MHBG and SABG applications will help block grant recipients improve

---

[1] The term "state" means each of the several states, the District of Columbia and each of the territories of the United States. The term "territories of the United States" means each of the Commonwealth of Puerto Rico, Virgin Islands, American Samoa, Commonwealth of the Northern Marianas Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and the Republic of Palau.

[2] In addition to statutory authority, SABG is detailed by comprehensive regulation.
http://www.samhsa.gov/grants/block-grants/laws-regulations

data collection and coordination between programs. In fiscal year (FFY) 2011, SAMHSA redesigned the FFY 2012-2013 MHBG and SABG applications to better align with the current federal/state environments and related policy initiatives, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Tribal Law and Order Act (TLOA).

The FFY 2022-2023 Block Grant Application furthers SAMHSA's efforts to have states use and report the opportunities offered under various federal initiatives. The FFY 2022-2023 Block Grant Application allows states to submit a combined application for both MHBG and SABG funds and requires a biennial plan for the MHBG while allowing a biennial plan for the SABG. This Application also reflects the health care system's strong emphasis on coordinated and integrated care along with the need to improve services for persons with mental health and substance use disorders. In addition, questions about identified needs allow SAMHSA to better design technical assistance to support state efforts.

In accordance with the Consolidated Appropriations Act, 2021 [P.L. 116-260], SAMHSA received supplemental appropriations in the sum of $3.3 billion ($1.65 billion each) to the Mental Health and Substance Abuse Block Grants to combat behavioral health impacts of the COVID-19 pandemic across the nation. This additional funding will affect how states pay for and provide services as along with who will be the recipients of said services. The COVID-19 funding maintains that states must appropriate no less than 20 percent of their allotment for primary prevention services, however, allows for waiver on other programmatic requirements of the block grant. States were given some leeway as to allowable activities so long as they could attribute them to M/SUD. New planning and reporting requirements are required to account for these additional funds and allowable activities. The expenditure period for this funding is March 15, 2021 to March 14, 2023.

Further supplemental appropriations were provided through the American Rescue Plan Act (ARP), 2021 [P.L. 117-2] in the sum of $3 billion ($1.5 billion each) to the block grants. SAMHSA, through guidance received regarding this funding, asks states to improve and enhance their mental health and substance use service array. To address the issue of healthcare equity, states must address treatment and recovery needs of people in rural areas and underserved populations through this round of supplemental funding. States are encouraged to base these new services on the mental health and substance abuse issues exacerbated by the COVID-19 pandemic and heightened by social inequities present in the healthcare system. An additional requirement for this funding was preparation for a potential set aside for recovery-based services. The timeline for funding planning and expenditure is from September 1, 2021 to September 30, 2025, which necessitates changes to several years of block grant planning and reporting requirements.

B. Impact on State Authorities and Systems

SAMHSA seeks to ensure that State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) are prepared to address the priorities discussed throughout this document. By addressing these factors, SMHAs and SSAs will enhance their ability to increase access to evidence-based services.

The block grant authorizing legislation and implementing regulations prohibit the provision of financial assistance to any entity other than a public or nonprofit entity and require that the funding be used only for authorized activities.[3] SAMHSA Guidance on the use of block grant funding for co-pays, deductibles (including high deductible health plans), 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 that choose to do this will need to develop specific policies and procedures for ensuring compliance with this guidance.

States leverage their block grant funding and strive to diversify funding sources.

When developing strategies for purchasing services, SMHAs and SSAs should identify other state and federal sources available to purchase services. States should assist providers in the development of better financial strategies that will allow providers to be less dependent on SMHA and SSA funding only. Funding available from the Centers for Medicare & Medicaid Services (CMS), such as CHIP, Medicaid, and Medicare may play an important role in the states' financial strategy. There are also national demonstration projects and programs (e.g., Health Homes, Clinical Practice Transformation, Innovation Accelerator Program, State Innovation Models, Comprehensive Community Behavioral Health Centers, and Financial Alignment Initiative for Medicare-Medicaid Enrollees) that support efforts to provide M/SUD services. In addition, M/SUD services supported through the Health Resources and Services Administration (HRSA) must be considered as states develop these strategies. For example, HRSA has significantly expanded access to health and M/SUD services through its Health Center Program. HRSA has also made available funding and other opportunities to increase and enhance the quality of the M/SUD workforce (e.g., National Health Service Corps, training grants, etc.). Both TRICARE and the Department of Veterans' Affairs (VA) have enhanced their M/SUD services as well. This means that SMHAs and SSAs (as well as public health authorities responsible for prevention) will need to engage and collaborate with these partners at the federal, state and community levels. Persons eligible for such services should be assisted in accessing these services as appropriate.

States should focus on vulnerable and underserved populations.

In addition to populations currently targeted for the block grants, other populations have evolving needs that may be addressed. These populations include military families, youth who need M/SUD services, individuals who experience trauma, people with co-occurring addictions (including opioid use disorder) and disabilities (including intellectual and developmental disabilities), increased numbers of individuals diverted or released from correctional facilities, diverse racial and ethnic minority groups, American Indians and Alaska Natives, Older Adults, and LGBTQ+ individuals.

The context of service delivery has also significantly changed. Services should be delivered in a manner that promotes recovery and resiliency. Individuals who have lived experiences with M/SUD are playing an increasingly important role in the delivery of recovery-oriented services. Services should require the availability of culturally specific content for racial and ethnic minorities. Services should address the unique needs of tribal populations and the role of tribal

---

[3] http://www.samhsa.gov/grants/block-grants/laws-regulations

governments in planning and delivering care.

The use of appropriate technologies may support better access to services. Technology has changed significantly since SAMHSA's inception in 1992. Technology plays an increasing role in how individuals learn about, receive, and experience their health care services. Interactive Communication Technologies (ICT) are being used more frequently to deliver various health care and recovery support services by providers and to report health information and outcomes by individuals.

States continue to design and develop collaborative plans for health information systems. Health care payers will seek to promote electronic health records (EHR) and interoperable health information technology (HIT) systems that allow for the effective exchange and use of health data.

All SAMHSA grantees that provide services to individuals are encouraged to demonstrate ongoing clinical use of a EHR system. A certified EHR is a system that has been tested and certified by an approved Office of the National Coordinator (ONC) certifying body.

Providers of M/SUD services should adopt HIT and systems that meet the standards and certifications required for interoperable health information technology as issued by the ONC.[4] In addition to meeting common standards and certification, these systems should support the privacy and security of patient information across all HIT technologies. Such systems should be used to collect information on provider characteristics, client enrollment, demographics, and treatment. Current laws require these systems to comply with national standards such as national provider numbers, International Classification of Diseases (ICD-10), Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT), normalized names for clinical drugs (RxNorm), Logical Observation Identifiers Names and Codes (LOINC), and Current Procedural Terminology (CPT)/Healthcare Procedure Coding System (HCPCS) codes. The information technology systems will also have to be interoperable with providers across the continuum of care, as well as health information exchanges (HIE), health information organizations (HIOs), and payers (e.g., Medicaid, Medicare, and private insurance plans, etc.). SAMHSA believes it is important for public health purchasers to continue to collaborate and discuss system interoperability, electronic health records, federal information technology requirements, and other related matters. Additional information can be found at SAMHSA https://www.samhsa.gov/section-223/certification-resource-guides/health-information-technology and ONC https://www.healthit.gov/ .

---

[4] Office of the National Coordinator for Health Information Technology (ONC) is at the forefront of the administration's health IT efforts and is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide, standards-based health information exchange to improve health care. ONC is organizationally located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS).

States continue to form strategic partnerships to provide individuals with access to effective and efficient service systems.

SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation depends on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, 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.

State authorities focus their system goals on recovery.

People can and do recover from M/SUD and services and supports must foster this recovery. Recovery benefits both the individual with an M/SUD condition and the community, leading to a healthier and more productive population. SAMHSA is committed to assisting states, providers, and people with M/SUD, families, and others in promoting recovery.

SAMHSA recognizes the importance of recovery support services in the journey of individuals with SUD. Currently there is no requirement to fund recovery services with block grant dollars. Due to this lack of requirement there are only 140 communities that have recovery related organizations across the country. In the FY 2022 Presidential Budget, recovery support services are emphasized as an integral part of the continuum of care. Accordingly, SAMHSA believes that adding a 10 percent set aside for recovery support services will serve to promote recovery initiatives across the nation. This required set aside for recovery services would provide a dedicated and sustainable source for the recovery services community. Changes to both the budget forms and reporting requirements will be necessary to address this proposed new set aside requirement.

State authorities continue to monitor the coverage of M/SUD services offered by Qualified Health Plans (QHPs) and Medicaid to ensure individuals with M/SUD conditions have adequate coverage and access to services.

Some states have contracted with managed care organizations (MCO) or Administrative Services Organizations (ASO) to oversee and provide M/SUD services. State legislatures, state-based marketplace entities, and state insurance commissioners have developed policies and regulations related to Electronic Handbooks. SMHAs and SSAs should be involved in these efforts to ensure that M/SUD services are appropriately included in plans, and M/SUD providers are included in networks.

States should continue to make primary substance use disorder prevention a priority.

To respond to the primary prevention set-aside requirement of the SABG, states should keep in mind that the backbone of a prevention system is an infrastructure with the ability to collect and

analyze epidemiological data on substance use and its associated consequences. The system must also be able to use this data to identify areas of greatest need, and to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in all communities.

State authorities are strategic in leveraging scarce resources to fund prevention services.

States need to make the most efficient use of funds for primary substance use disorder prevention and be prepared to report on the outcomes of these efforts. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data-driven primary substance use disorder prevention system. Specifically, SAMHSA recommends that states align the 20 percent set-aside for primary prevention of the SABG with other federal, state, and local funding that will aid the state in developing and maintaining a comprehensive primary substance use disorder prevention system, as well as collaborate with and assure that behavioral health is part of the state's larger public health prevention activities.

State authorities use evidence of improved performance and outcomes to support their funding and purchasing decisions.

SMHAs and SSAs are well positioned to understand and use the evidence regarding various M/SUD services as critical input for making purchasing decisions and influencing coverage offered in their state through commercial insurers and Medicaid. In addition, states may also be able to use this information to educate policymakers and to justify their budget requests or other strategic planning efforts. States may also want to consider undertaking a similar process within their state to review local programs and practices that expand treatment technologies and show promising outcomes.

State authorities ensure that they comport with changes in quality reporting.

The National Behavioral Health Quality Framework (NBHQF) provides a mechanism for states to examine, prioritize, and report on approaches to prevention, treatment, and recovery processes through the block grant as well as discretionary and formula grantees.

States authorities ensure that individuals with M/SUD conditions are receiving the mandated coverage and access in accordance with the federal parity law.

Plans and issuers subject to MHPAEA[5] that offer M/SUD coverage as part of the overall health benefits packages must comply with the requirements regarding coverage of M/SUD benefits in relation to medical/surgical benefits. Parity requires that the plans that offer M/SUD benefits do so at the same level of benefit as for physical conditions; it does not require a plan to offer M/SUD benefit. M/SUD services are among the ten categories of service elements that serve as

---

[5] *S.4388 - Mental Health Equity Act of 2020*. (2020, July 30). Retrieved July 22, 2021, from https://www.congress.gov/bill/116th-congress/senate-bill/4388/text?r=1&s=1

components of the essential health benefits package required by the Affordable Care Act. Whether it is federal or state-level parity, continued efforts for education are instrumental in increasing awareness of the benefits of mental health and addiction services and open the door to appropriate services, especially for potential first-time users. Some states have taken steps to enforce parity and are building on lessons learned. This active involvement to increase awareness helps to ensure that consumers receive quality M/SUD prevention, treatment, and recovery services within their state and are aware of what protections and resources exist in their state should their claim be denied inappropriately by insurance companies.

State authorities are key players in M/SUD integration activities.

Strong partnerships between SMHAs and SSAs and their counterparts in health, public health, and Medicaid 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 their Medicaid 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 Medicaid agency 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.

In addition, states play a key role in developing strategies for reducing smoking among individuals with behavioral health conditions. States should strongly consider implementing strategies for reducing smoking, including moving towards tobacco-free M/SUD facilities and grounds, and screening, referring, and/or treating tobacco use.

Population changes in many states have created a demographic imperative to focus on improving M/SUD prevention, treatment, and recovery for diverse populations with the goal of reducing disparities.

States are increasingly recognizing the value in addressing health disparities, realizing that

failure to act results in continued excess costs and spending and lost lives. States have developed plans to address these disparities through incentives in health insurance plans, training initiatives and requirements for language access, targeted quality improvement and cost containment plans, cost and impact estimates for the most vulnerable populations, and tracking mechanisms to evaluate progress in improving health equity[6]. Few of these plans, however, have focused specifically on M/SUD services. SSAs and SMHAs need to better track access, service use, and outcomes for these subpopulations to develop targeted outreach, engagement, enrollment, and intervention strategies to reduce such disparities.

State authorities ensure that their states have a system of care approach to children and adolescents' M/SUD services.

The success of the systems of care approach has shown that interagency coordination centered on serving the unique needs of children, youth, and families is critical. Facilitating and sustaining this approach at the local level requires a parallel effort at the state level. As states adopt a system of care approach, they should address state policies that can support local efforts, identifying financing mechanisms, and enabling a family and youth input to policy at the state level. In addition to identifying the resources needed for services, states will need to develop a realistic planning process for enabling systems of care that includes the necessary staff time and administrative resources.

C. Block Grant Programs' Purposes

SAMHSA's MHBG and SABG provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities affected by substance use disorders and for adults with SMI and children with SED. The purpose of the block grant programs is to support these service needs.

In order to assure that the block grant program continues to support the necessary services for the target population, SAMHSA has indicated that the block grants may be used:

1. To fund priority treatment and support services for individuals who are uninsured or underinsured.
2. For SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities.
3. To collect performance and outcome data for mental health and substance use, determine the effectiveness of promotion/SUD primary prevention, and treatment and recovery supports.

II. SUBMISSION OF APPLICATION AND PLAN TIMEFRAMES

Statutory Deadlines

While the statutory deadlines and block grant award periods remain unchanged, SAMHSA encourages states to turn in their Application as early as possible to allow for a full discussion

---

[6] http://www.samhsa.gov/behavioral-health-equity

and review by SAMHSA. Applications for the MHBG are due no later than September 1, 2021. Applications for SABG are due no later than October 1, 2021. Single Applications for MHBG and SABG are due no later than September 1, 2021. MHBG and SABG Reports are due December 1, 2021. In addition, for the SABG, the Annual Synar Report is due no later than December 31, 2021.

The FFY 2022-2023 MHBG and SABG Application(s) include(s) a two-year Mental and Substance Use Disorder Systems Assessment and Plan (Plan) as well as projected expenditure tables, certifications, and assurances. The Plan will cover a two-year period aligning with states'

FY budget cycle for SFY 2022-2023. States will have the option, but will not be required to amend their Plans when they submit their FFY 2023 Application.

States should submit their respective MHBG and SABG Application(s) for FFYs 2022 and 2023 based on the guidance provided in this document. The Plan provides a consistent framework for SMHAs and SSAs to assess the strengths and needs of their systems and to plan for system improvement, which is consistent with the strategic planning framework currently used by SAMHSA for various grants. The unique statutory and regulatory requirements of the specific block grants are described in the State Plan section.

The FFY 2022-2023 Plan seeks to collect information from states regarding their activities in response to federal laws, initiatives, changes in technology, and advances in research and knowledge. The FFY 2022-2023 Plan has sections that are required and other sections where additional information is requested, but not required. The requested information is necessary for a full understanding of the design of the state system of care and provides a benefit to both the states and SAMHSA. There will be no penalty assessed to states that provide only information that is required.

Required Sections and Tables

The FFY 2022-2023 Application requires states to submit a M/SUD assessment and plan; expenditure, performance, and utilization reports; executive summary; and funding agreements, assurances, and certifications. States are strongly encouraged to respond to each section so that SAMHSA understands the totality of states' efforts and how the block grant funding fits into the states' overall goals and constraints. Section III.B, Planning Steps, requires states to undertake a needs assessment as part of their plan submission. This section identifies four key steps: (1) assess the strengths and needs of the service system; (2) identify unmet service needs and critical gaps; (3) prioritize state planning activities to include the required target populations and other priority populations (e.g. youth with substance use disorders); and (4) develop goals, objectives, strategies, and performance indicators. Section III.B, Plan Table 1 (Priority Area and Annual Performance Indicators) and Plan Table 2 (State Agency Planned Expenditure) and Plan Table 6 (Non-Direct Services/System Development Activities Planned Expenditures) are required for both MHBG and SABG. For the SABG, Plan Table 3 (SABG Persons in need/receipt of treatment), Table 5a (SABG Primary Prevention Planned Expenditures) and Table 5b (SABG Planned Primary Prevention Targeted Priorities) are also required.

The application requests information on state efforts on certain policy, program, and

technology advancements in physical and M/SUD prevention, treatment, and recovery. MHBG statute requires a description of the state's comprehensive system of care for individuals with SMI and SED (42 U.S.C. §300x–1 (b) (1) (A)[7]) and MHBG funds must be used for allowable activities based on MHBG statute. This information will help SAMHSA understand the whole of the applicant state's efforts and identify how SAMHSA can assist the applicant state in meeting its goals. In addition, this information will identify states that are models and assist other states with areas of common concern.

Application Requirements and Award

For the Secretary of HHS, acting through the Assistant Secretary for Mental Health and Substance Use, to make an award under the programs involved, states must submit an application(s) sufficient to meet the requirements described in SAMHSA's block grant authorizing legislation and implementing regulations sufficient for SAMHSA to monitor the states' compliance efforts regarding the obligation and expenditure of MHBG and SABG funds. The funds awarded will be available for obligation and expenditure[8] to plan, carry out, and evaluate activities and services for children with SED and adults with SMI; primary substance use disorder prevention; youth and adults with a SUD; adolescents and adults with co-occurring disorders; and the promotion of recovery among persons with SED, SMI, or SUD.

A grant may be awarded only if a state's application(s) include(s) a State Plan[9],[10] in the proper format containing information including, but not limited to, detailed provisions for complying with each funding agreement for a grant under section 1911 of Title XIX, Part B, Subpart I of the PHS Act (42 U.S.C. § 300x-1) or section 1921 of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-21) that is applicable to a state. The State Plan must include a description of the manner in which the state intends to obligate the grant funds, and it must

include a report[11] in the proper format containing information that the Secretary determines to be necessary for securing a record and description of the purposes for which both the MHBG and SABG were expended. States have the option of updating their plans during the two-year planning cycle.

MHBG statute requires states to provide services to those with SMI and SED as described in the state's plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs) and community mental health centers which meet the criteria as described in 42 USC §300x-2 (c).

---

[7] State plan for comprehensive community mental health services for certain individuals, Subchapter XVII—Block Grants U.S.C. § 42 U.S. Code § 300x–1 (Oct. 17, 2020). https://www.law.cornell.edu/uscode/text/42/300x-1

[8] Title XIX, Part B of the PHS Act, http://www.samhsa.gov/grants/block-grants/laws-regulations

[9] Section 1912 of Title XIX, Part B, Subpart I of the PHS Act (42 U.S.C. § 300x-2), http://www.samhsa.gov/grants/block-grants/laws-regulations

[10] Section 1932(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-32(b)), http://www.samhsa.gov/grants/block-grants/laws-regulations

[11] Section 1942(a) of Title XIX, Part B, Subpart III of the PHS Act (42 U.S.C. § 300x-52(a)), http://www.samhsa.gov/grants/block-grants/laws-regulations

States are encouraged to submit a combined MHBG and SABG application. If a state is submitting separate MHBG and SABG plans, it should clarify which system is being described in this section (e.g., mental health, substance misuse prevention, SUD treatment, or recovery).

III.   MENTAL AND SUBSTANCE USE DISORDER ASSESSMENT AND PLAN

SAMHSA values the importance of a thoughtful planning process that includes the use of available data to identify the strengths, needs, and service gaps for specific populations. By identifying needs and gaps, states can prioritize and establish tailored goals, objectives, strategies, and performance indicators. In addition, the planning process should provide information on how the state will specifically spend available block grant funds consistent with the statutory and regulatory requirements, environment, and priorities described in this document and the priorities identified in the state's plan.

Meaningful input of stakeholders in the development of the plan is critical. Evidence of the process and input of the Planning Council required by section 1914(b) of the PHS Act (42 U.S.C. § 300x-4(b)) for the MHBG must be included in the application that addresses MHBG funds. States are also encouraged to expand this Planning Council to include prevention and SUD stakeholders and use this mechanism to assist in the development of the state plan for the SABG application. States must also describe the stakeholder input process for the development of both the SABG plan and the MHBG plan, as mandated by section 1941 of the PHS Act (42 U.S.C.§ 300x-51[12]), which requires that the state plans be made available to the public in such a manner as to facilitate public comment during the development of the plan (including any revisions) and after the submission of the plan to the Secretary through SAMHSA. This description should also show involvement of persons who are service recipients and/or in recovery, families of individuals with M/SUD, providers of services and supports, representatives from racial and ethnic minorities, sexual and gender minority populations, persons with co-existing disabilities, and other key stakeholders. Evidence of meaningful consultation with federally recognized tribes where tribal governments or lands are located within the boundaries of the state are strongly encouraged for both MHBG and SABG.

A. *Framework for Planning—Mental Health and Substance Use Prevention and Treatment*

States should identify and analyze the strengths, needs, and priorities of their M/SUD system. The strengths, needs, and priorities should consider specific populations that are the current focus of the block grants and the changing health care environment.

The MHBG program is designed to provide comprehensive community mental health services to adults with SMI or children with SED. For purposes of block grant planning and reporting,

---

[12] Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

SAMHSA has clarified the definitions of SED and SMI. States may have additional elements that are included in their specific definitions, but the following provides a common baseline definition. Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; who (1) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Section 1912(b) of the Public Health Act (42 USC § 300x-1) establishes five criteria that must be addressed in state mental health plans. States must describe these in the planning steps. The criteria are defined below:

- *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 M/SUD. States must have 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 individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

- *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 3: Children's Services:* Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

- *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 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.

States must submit a plan on how they will utilize the 10 percent set-aside funding in the MHBG to support appropriate evidence-based programs for individuals with Early Serious Mental

1

Illness (ESMI) including psychosis. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than the services/principles components of Coordinated Specialty Care (CSC) approach developed via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. In consultation with National Institute of Mental Health (NIMH), as needed, either the proposals will be accepted or requests for modifications to the plan will be discussed and negotiated with the state. This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow. Please note that the MHBG funds cannot be used for primary substance use disorder prevention or preventive intervention for those at risk of SMI or SED.

The Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260] requires states to set-aside not less than 5 percent of their total MHBG allocation amount for each fiscal year to support evidence-based crisis care programs addressing the needs of individuals with SMI and children with serious mental and emotional disturbances. The set-aside must be used to fund some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or state-wide crisis call centers coordinating in real time.

The SABG program provides primary substance use disorder prevention, SUD treatment and recovery services, (and certain related activities) to at-risk individuals or persons in need of SUD treatment. See 42 U.S.C. §§ 300x-300x-66.

Section 1921 of the PHS Act (42 U.S.C.§ 300x-21) authorizes the States to obligate and expend SABG funds to plan, carry out and evaluate activities and services designed to prevent and treat SUD. Section 1932(b) of the PHS Act (42 U.S.C. § 300x-32(b)) established the criterion that must be addressed in the State Plan.

- *Criterion 1*: Statewide Plan for Primary Substance Use Disorder Prevention, Treatment and Recovery Services for Individuals, Families and Communities (42 U.S.C. § 300x-21 and 45 CFR § 96.122)

- *Criterion 2*: Primary Prevention (42 U.S.C. § 300x-22(a) and 45 CFR § 96.125). The authorizing legislation and implementing regulation established a 20 percent set-aside for primary substance use disorder prevention programs, defined as programs for individuals who do not require treatment for substance use disorders. States must utilize this set-aside to implement the six strategies and to carry out Section 1926 –Tobacco activities. States may also utilize funds for non-direct services.

- *Criterion 3*: Pregnant Women and Women with Dependent Children (42 U.S.C. § 300x-

1

22(b); 42 U.S.C. § 300x-27; 45 CFR § 96.124(c)(e); and 45 CFR § 96.131). The authorizing legislation and implementing regulation established a 5 percent set-aside that was applicable to the FFY 1993 and FFY 1992 SABG Notices of Award. For FFY 1994 and subsequent fiscal years, states have been required to comply with a performance requirement that the states are required to obligate and expend funds for SUD treatment services designed for such women in an amount equal to the amount expended in FFY 1994.

- *Criterion 4*: Persons Who Inject Drugs (42 U.S.C. § 300x-23 and 45 CFR § 96.126). The authorizing legislation and implementing regulation established two performance requirements related to persons who inject drugs: (1) Any programs that receive SABG funds to serve persons who inject drugs must comply with the requirement to admit an individual requesting admission to treatment within 14 days and not later than 120 days; and (2) outreach to encourage persons who inject drugs to seek SUD treatment Additionally, subject to the annual appropriation process, states may authorize such programs to obligate and expend SABG funds for elements of a syringe services program (SSP) pursuant to guidance developed by the HHS Office of HIV/AIDS an Infectious Disease Policy (OHIDP) .

- *Criterion 5*: Tuberculosis Services (42 U.S.C. § 300x-24(a) and 45 CFR § 96.127). The authorizing legislation and implementing regulation require any programs that receive SABG funds to, directly or through arrangements with other public and non-profit entities, routinely make available tuberculosis services to each individual receiving SUD treatment services.

- *Criterion 6*: Early Intervention Services Regarding the Human Immunodeficiency Virus (42 U.S.C. § 300x-24(b) and 45 CFR § 96.128). The authorizing legislation and implementing regulation require designated states to set-aside five percent of the SABG to establish 1 or more projects to provide EIS/HIV at the site(s) at which individuals are receiving SUD treatment services.

- *Criterion 7*: Group Homes for Persons in Recovery from Substance Use Disorders (42 U.S.C. § 300x-25 and 45 CFR § 96.129). The authorizing legislation and implementing regulation provide states with the flexibility to establish and maintain a revolving loan fund for the purpose of making loans, not to exceed $4,000, to a group of not more than six individuals to establish a recovery residence.

- *Criterion 8*: Referrals to Treatment (42 U.S.C. § 300x-28(a) and 45 CFR § 96.132(a) and Coordination of Ancillary Services (42 U.S.C. § 300x-28(c) and 45 CFR § 96.132(c). The authorizing legislation and implementing regulation require states to promote the use of standardized screening and assessment instruments and placement criteria to improve patient retention and treatment outcomes.

- *Criterion 9*: Independent Peer Review (42 U.S.C. § 300x-58(a) (1) (A) and 45 CFR § 96.136). The authorizing legislation and implementing regulation require states to assess the quality, appropriateness, and efficacy of M/SUD treatment services.

1

- *Criterion 10*: Professional Development ([42 U.S.C. § 300x-28(b)](#) and [45 CFR § 96.132(b)](#). The authorizing legislation and implementing regulation requires any programs that receive SABG funds to ensure that prevention, treatment and recovery personnel operating in the state's SUD system have an opportunity to receive training on an ongoing basis concerning recent trends in substance use in the state, improved methods and evidence-based practices for providing primary substance use disorder prevention and treatment services, performance-based accountability, data collection and reporting requirements, and any other matters that would serve to further improves the delivery of primary substance use disorder prevention and treatment services within the state.

MHBG Children's Set Aside: Verification of Minimum Spending Level

States are required to provide services for children with SED. Each year the state shall expend not less than the amount expended in FY 1994. If there is a shortfall in funding available for children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the state is providing an adequate level of comprehensive community mental health services for children with SED, as indicated by comparing the number of children in need of such services with the services actually available within the state.

MHBG Maintenance of Effort (MOE)

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory maintenance of effort (MOE) requirements.[13] MOE information is necessary to document that the state has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the 2-year period preceding the fiscal year for which the state is applying for the grant. The state shall only include community mental health services expenditures for individuals that meet the federal or state definition of SMI adults and SED children. States that received approval to exclude funds from the MOE calculation should include the appropriate MOE approval documents.

At a minimum, the plan should address the following populations as appropriate for each block grant.
(**Populations that are marked with an asterisk are required to be included in the state's needs assessment for the MHBG or SABG. To the extent that the other listed populations fall within any of the statutorily covered populations, states must include them in the plan*)

1. (MHBG) Comprehensive community-based mental health services for adults with SMI and children with SED:

---

[13]   Title XIX, Part B, Subpart II, of the Public Health Service Act, as amended by the Children's Health Act of 2000 (P.L.106-310) Title 42 U.S.C. § 42 U.S. Code § 300x–4 (Oct. 17, 2020).

- Children with SED and their families*
- Adults with SMI*
- Older Adults with SMI*
- Individuals with SMI or SED in the rural and homeless populations, as applicable*
- Individuals who have ESMI (10 percent MHBG set aside);
- Individuals in need of behavioral health crisis services (5 percent MHBG set aside)

2. (SABG) Services for persons with SMI/SED or persons with or at risk of having substance use disorder:
   - Persons who inject drugs*
   - Adolescents with substance use and/or mental health problems.
   - Children and youth who are at risk for mental, emotional, and behavioral disorders including, but not limited to, addiction, conduct disorder, and depression.
   - Women who are pregnant and have a substance use and/or mental disorder*
   - Parents with substance use and/or mental disorders who have dependent children*
   - Military personnel (active, guard, reserve, and veteran) and their families
   - American Indians/Alaska Natives

3. (SABG) Services for persons with or at risk of contracting communicable diseases:
   - Individuals with tuberculosis* and other communicable diseases
   - Persons at risk for HIV/AIDS who may be unaware of the infection status and persons living with HIV/AIDS who need mental health or substance use early intervention, treatment, or prevention services*[14]
   - The National HIV/AIDS Strategy (NHAS) for the United States and NHAS Implementation Plan [15]
   - Prevention of HIV among persons who inject drugs; substance use is associated with a greater likelihood of acquiring HIV infection. HIV screening and other comprehensive HIV prevention services should be coupled with SUD treatment programs

4. (SABG) Services for individuals in need of primary substance use disorder prevention*

5. In addition to the targeted/required populations and/or services required in statute,

---

[14] For the purpose of determining the states and jurisdictions which are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137),). SAMHSA relies on the HIV Surveillance Report produced by the CDC, National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention. The HIV Surveillance Report, Volume 25, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV, which provided any state that was a "designated state" in any of the 3 years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state whose AIDS case rate is below 10 or more such cases per 100,000 and meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

[15] https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update

states are encouraged to consider the following populations, and/or services:

- Individuals with M/SUD who experience homelessness or are involved in the criminal or juvenile justice systems
- Individuals with mental and/or substance use disorders who live in rural areas
- Underserved racial and ethnic minority and LGBTQ++ populations
- Persons with disabilities
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family, and business norms through laws, policy and guidelines and enforcement
- Community settings for universal, selective, and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies

In addition, states should consider linking their *Olmstead* planning work in the block grant application, identifying trend data on individuals who are institutionalized or at risk of institutionalization. There is a need generally for data that will help the state address housing and related issues in their planning efforts. To the extent that such data are available in a state's *Olmstead* Plan, it should be used for block grant planning purposes.

B. *Planning Steps*

For each of the populations and common areas, states should follow the planning steps outlined below:

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

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of primary substance use disorder prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the 11 SABG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal* Government, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American person, Asian Americans, and Pacific Islanders), members of religious minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ++) persons; persons with disabilities; persons who live in rural

areas; and persons otherwise adversely affected by persistent poverty or inequality. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the SABG priority populations: Pregnant Women, Person Who Inject Drugs, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Use Disorder Prevention, and, for FY 2022 HIV-designated states or a state designated in any of the prior three FY and opted to use SABG funds for early intervention services for HIV (EIS/HIV), Persons at Risk for HIV. See Appendix A for a list of the FY 2022 HIV-designated states.

Step 2: Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Abuse Treatment Services (N-SSATS), the Behavioral Health Barometer, Behavioral Risk Factor Surveillance System (BRFSS) , Youth Risk Behavior Surveillance System (YRBSS), the Uniform Reporting System (URS) and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Person Who Inject Drugs, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Use Disorder Prevention, and, for HIV-designated states, Persons at Risk for HIV. Moreover, a discussion of the unmet service needs and critical gaps in the current system regarding diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American person, Asian Americans, and Pacific Islanders), members of religious minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ++) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality must be included.

Step 3:   Prioritize state planning activities

Prioritize state planning activities that will include MHBG and SABG. The priorities must include the core federal block grant goals and aims of the MHBG and SABG programs, as well as state programs with a focus on target populations (those required in legislation and regulation for each block grant) and other priority populations described in the document. States should list priorities in Plan Table 1 and indicate the priority type: substance use prevention (SAP),

substance use disorder treatment (SAT), or mental health services (MHS).

Step 4:   Develop goals, objectives, performance indicators, and strategies

For each of the priorities, states should identify the relevant goals, measurable objectives, and at least one-performance indicator for each objective for the next two years. For each objective, the state should describe the specific strategy that will be used to achieve the objective.

These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance use and mental health treatment, substance use prevention activities, and system improvements that will address the objective.

Strategies to consider and address include:

- Strategies that are targeted for children and youth with SED or SUD. States should use a system of care approach that has been well established for children with SED and co-occurring SUD. This approach should be used statewide, coordinating care with other state agencies (e.g., schools, child welfare, juvenile justice, primary care, etc.) to deliver evidence-based treatments and supports through a family-driven, youth-guided, culturally competent, individualized treatment plan. For adolescents with SUD and SED, this approach should be used in conjunction with evidence-based interventions for substance use or dependence.

- Strategies targeted for adults with SMI/SUDs that will identify and intervene early, connect with, or provide the best possible treatment, and design and implement recovery-oriented services.

- Strategies that will promote integration and inclusion into the community. This includes housing models that integrate individuals into the community instead of long-term care facilities or nursing homes and other settings that fail to promote independence and inclusion. This also can include strategies to promote competitive and evidenced-based supported employment in the community, rather than segregated programs.

- Strategies on how technology, especially interactive communication technologies (ICT) will be used to engage individuals and their families into prevention, treatment, and recovery supports. Almost 40 percent of uninsured individuals are under the age of 30 and use technology as a substantial, if not primary, mode of communication.

- Strategies that result in developing recovery support services (e.g., peer support services, recovery housing, permanent housing and supportive employment or education for persons with M/SUD). This includes how local authorities will be engaged to increase the availability of housing, employment, and educational opportunities, and how the state will develop services that will wrap around these individuals to obtain and maintain safe and affordable housing, employment, and/or

education.

- Strategies that will enable the state to document the diversity of its service population and providers and to specify the development of an array of culture-specific interventions and providers to improve access, engagement, quality, and outcomes of services for diverse ethnic and racial minorities and LGBTQ+ populations. States will be encouraged to refer to the IOM reports, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*[16] and *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*[17] in developing this strategy.

- Strategies that will build the state and provider capacity to provide evidence-based, trauma-specific interventions in the context of a trauma-informed delivery system. Recognizing trauma as a critical factor in the development of M/SUD, states should build provider competence in using effective trauma treatments. States should ensure that these treatments are provided in systems that understand the impact of trauma on their service population and work to eliminate organizational practices and policies that may cause new or exacerbate existing trauma. SAMHSA has developed "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach" to provide states with a framework for incorporation of trauma informed care into its system.

- Strategies that increase the use of person-centered planning, self-direction, and participant-directed care. This includes measures to help individuals or caregivers (when appropriate) identify and access services and supports that reinforce recovery or resilience. These strategies should also include how individuals or caregivers have access to supports to facilitate participant direction, including the ability to manage a flexible budget to address recovery goals; identifying, selecting hiring and managing support workers and providers; and ability to purchase goods and services identified in the recovery or resilience planning process.

- As specified in 45 CFR § 96.125(b), states shall use a variety of evidence-based programs, policies and practices in their prevention efforts that include funding all six prevention strategies that are listed below:
    - Information dissemination.
    - Education.
    - Alternatives that decrease alcohol, tobacco, and other drug use.
    - Problem identification and referral to education.
    - Community based programming; and,
    - Environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

---

[16] Institute of Medicine. (2009). *Race, Ethnicity, and Language Data: Standardization for Healthcare quality Improvement.* Subcommittee on Standardization Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Board on Healthcare Services. Cheryl Ulmer, Bernadette McFadden, and David R. Nerenz, Editors, Washington, DC: The National Academies Press

[17] IOM (Institute of Medicine). 2011. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK64806/

2

Prevention strategies should also be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking[18], Evidence Based Practices Resource Center and/or other materials documenting their effectiveness. For the education prevention strategy, evidence based repositories may be used to find appropriate programs that align with statutory requirements of the SABG and the parameters of the specific populations that are being served (e.g. Blueprints for Healthy Youth Development).
These strategies include:

- Strategies that target tobacco use prevention and tobacco-free facilities that are supported by research and encompass a range of activities including policy initiatives and programs.
- Strategies that engage schools, workplaces, and communities to establish programs and policies to improve knowledge about alcohol and other drug problems, denote effective ways to address the problems, and enhance resiliency.
- Strategies that implement evidence-based and cost-effective models to prevent SUD in young people in a variety of community settings, e.g., families, schools, workplaces, and faith-based institutions, consistent with the current science.
- Strategies that follow the Surgeon General's *Call to Action to Prevention and Reduce Underage Drinking,* and Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health which focus on policy and environmental programming to change the community's norms around, and parental acceptance of, underage alcohol use; and offer the latest science and research on prevention, treatment and recovery.
- Strategies that address harder-to-reach racial/ethnic minority and sexual and gender minority communities that experience a cluster of risk factors that make them especially vulnerable to substance use and related problems.

SABG primary prevention set-aside funds can only be used to fund strategies that prevent substance use.

- System improvement activities may be included as a strategy to address issues identified in the needs assessment. System improvement activities should:
  - Allow states to position their providers to increase access, retention, adoption, or adaptation of EHRs, or to develop strategies to increase workforce numbers. These system improvement activities should use federal and state resources currently available and those proposed for the planning period to enhance the competency of the M/SUD workforce. System improvements that seek to expand the workforce should build upon existing efforts to increase M/SUD skill development in a wide range of professions as well as increase the role of people in recovery from M/SUD in the planning and delivery of services.
  - Support providers to participate in networks that may be established through managed care or administrative service organizations (including accountable care organizations (ACOs)). This may include assistance to develop the necessary

---

[18] https://www.ncbi.nlm.nih.gov/books/NBK44360/

infrastructure (e.g., electronic billing and EHRs) and reporting requirements to participate in these networks.

- Encourage the use of peer specialists or recovery coaches to provide needed recovery support services, which are already delivered by volunteers and paid staff. Peers are trained, supervised, and regarded as staff and operate out of a community-based or recovery organization. A state's strategy should allow states to support peer and other recovery support services delivered under either model. The infrastructure, including paid staff, to coordinate and encourage the use of volunteer-delivered or run services should also be supported.

- Increase links between primary, specialty, emergency and rehabilitative care and M/SUD providers working with M/SUD provider organizations for expertise, collaboration, and referral arrangements, including the support of practitioner efforts to screen patients for M/SUD. Activities should also focus on developing model contract templates for reciprocal health and M/SUD integration and identifying state policies that present barriers to reimbursement. This would include efforts to implement dual eligible products, ACOs, and medical homes.
- Develop support systems to provide communities with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other resources to foster the development of comprehensive community plans to improve mental, emotional, and M/SUD outcomes.
- Fund auxiliary aids and services to allow people with disabilities to benefit from the M/SUD services and language assistance services for people who experience communication barriers to access.
- Develop benefit management strategies for high-cost services (e.g., youth out of home services and adult residential services). SAMHSA believes that states should align their care management to guarantee that individuals get the right service at the right time in the right amount. These efforts should ensure that decisions made regarding these services are clinically sound.

Planning Tables

States should describe specific performance indicators that will be used to determine if the goals for that priority area were achieved. For each performance indicator, the state must describe the data and data source that has been used to develop the baseline for FFY 2022 and how the state proposes to measure the change in FFY 2023. States must use the template (Plan Table 1: Priority Areas by Goal, Strategy, and Performance Indicators) below. As a reminder, these population performance indicators should reflect the unmet need listed in Planning Step 2 and discussed above under Step 3 and Step 4.

Plan Table #1. Priority Area and Annual Performance Indicators

States should follow the guidelines presented above in Framework for Planning – Mental Health and Primary Substance Use Disorder Prevention and Treatment Planning Steps to complete Plan Table 1. States are to complete a separate table for each state priority area to be included in the MHBG and SABG. Please include the following information when entering

into WebBGAS:

1. *Priority area* (based on an unmet service need or critical gap: After this information is completed for the first priority area, another table will appear so additional priorities can be added.
2. *Priority type:* From the drop-down menu, select **SAP –** primary substance use disorder prevention, **SAT –** substance use disorder treatment, or **MHS --** mental health service.
3. *Targeted/required populations*: Indicate the population(s) required in statute for each block grant as well as those populations encouraged, as described in IIIA *Framework for Planning—Mental Health and Substance Abuse Prevention and Treatment*. States must include at least one priority for each required population. For example, at least one priority and indicator must be denoted SAP and PP. From the drop-down menu select:

    a) **SMI**–Adults with SMI,
    b) **SED**–Children with an SED,
    c) **ESMI**--Individuals with ESMI including psychosis,
    d) **PWWDC**–Pregnant women and women with dependent children,
    e) **PP**–persons in need of primary substance use disorder prevention,
    f) **PWID**–Persons who inject drugs (formerly known as intravenous drug users (IVDU)),
    g) **EIS/HIV**–Persons with or at risk of HIV/AIDS who are receiving SUD treatment services,
    a) **TB**–Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or
4. **Other**- Specify (Refer to section IIIA of the Assessment and Plan).
   Goal of the priority area. Goal is a broad statement of general intention. Therefore, provide a general description of what the state hopes to accomplish.
5. *Objective*: Objective should be a concrete, precise, and measurable statement.
6. *Strategies to attain the objective*. Indicate program strategies or means to achieve the stated objective.
7. *Annual Performance Indicators* to measure success on a yearly basis. Each indicator must reflect progress on a measure that is impacted by the block grant. After indicator is completed with the information for the first indicator below, the table will expand to enter additional indicators. For each performance indicator, specify the following components:

    a) Baseline measurement from where the state assesses progress;
    b) First-year target/outcome measurement (Progress to the end of SFY 2022);
    c) Second-year target/outcome measurement (Final to the end of SFY 2023);
    d) Data source;
    e) Description of data; and
    f) Data issues/caveats that affect outcome measures.

Plan Table 1: Priority Area and Annual Performance Indicators

1. Priority Area:
2. Priority Type (SAP, SAT, MHS):
3. Population(s) (SMI, SED, ESMI, PWWDC, PP, PWID, EIS/HIV, TB, OTHER):
1. Goal of the priority area:
2. Objective:
3. Strategies to attain the objective:
7. Annual Performance Indicators to measure achievement of the objective: Indicator #1:
Plan Table 1: Priority Area and Annual Performance Indicators, continued
a)   Baseline measurement (Initial data collected prior to and during SFY 2022):
b)   First-year target/outcome measurement (Progress to the end of SFY 2022):
c)   Second-year target/outcome measurement (Final to the end of SFY 2023):
d)   Data source:
e)   Description of data:
f)   Data issues/caveats that affect outcome measures:

SAMHSA will work with states to monitor whether they are meeting the goals, objectives and performance indicators established in their plans, and to provide technical assistance as needed. SAMHSA staff will work with states during the year to discuss progress, identify barriers, and develop solutions to address these barriers.

If a state is unable to achieve its goals and objectives as stated in its application(s) approved by SAMHSA, the state will be asked to provide a description of corrective actions to be taken. If further steps are not taken, SAMHSA may ask the state for a revised plan, which SAMHSA will assist in developing, to achieve its goals and objectives. States that do not choose to apply for the MHBG or SABG will have their funds redirected to other states as provided in statute.[19]

---

[19] http://www.samhsa.gov/grants/block-grants/laws-regulations

Plan Table 2: State Agency Planned Expenditures MHBG

Table 2 addresses funds to be expended during the 24-month period of July 1, 2021 through June 30, 2023. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP Supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period (7/1/21-6/30/23). Please document the use of COVID-19 Relief Supplemental and ARP Supplemental funds in the footnotes.

*Please note that MHBG and SABG now have two separate Table 2 submissions.

MHBG: Include *public mental health services provided by mental health providers or funded by the state mental health agency by source of funding* ***)**

Planning Period- From: To:										
ACTIVITY (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary prevention [e]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) [d]										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
ACTIVITY (See instructions for using Row 1.)	A. Substance	B. Mental	C. Medicaid (Federal,	D. Other Federal Funds (e.g., ACF	E. State funds	F. Local funds (excluding local	G. Other	H. COVID-19 Relief Funds	I. COVID-19 Relief Funds	J. ARP Funds (MHBG)[b]

	Abuse Block Grant	Health Block Grant	State, and local)	(TANF), CDC, CMS (Medicare) SAMHSA, etc.)		Medicaid)		(MHBG)[a]	(SABG)	
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program / provider level) MHBG and SABG must be reported separately										
10. Crisis Services (5% set-aside) [f]										
13. Total	$	$	$	$	$	$	$	$	$	$

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2022 – June 30, 2024, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2022 – June 30, 2024, for most states."

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

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

[e] Per statute, Administrative expenditures cannot exceed 5 percent of the fiscal year award.

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

Plan Table 2: State Agency Planned Expenditures SABG

ONLY include funds expended by the executive branch agency administering the SABG

ACTIVITY (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other	H. COVID-19-19 Relief Funds (MHBG) [a]	I.COVID-19-19 Relief Funds (SABG) [a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention and Treatment	$		$	$	$	$	$		$	$
a. Pregnant Women and Women with Dependent Children*										
a. All Other										
2. Primary Prevention	$		$	$	$	$	$		$	$
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[f]										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										

ACTIVITY (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) [a]	I. COVID-19 Relief Funds (SABG) [a]	J. ARP Funds (SABG) [b]
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program / provider level) MHBG and SABG must be reported separately g										
10. Crisis Services (5 percent set-aside)[h]										
12. Total	$	$	$	$	$	$	$	$	$	$

a. The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SABG. Per the instructions, the standard MHBG/SABG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2020 – June 30, 2021, for most states.

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

c. Prevention other than primary prevention

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

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

f. Column 3B should include Early Serious Mental Illness programs funded through MHBG set-aside. Per statute, administrative expenditures cannot exceed 5 percent of the fiscal year award.

g. Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

Plan Table 3: SABG Persons in need/receipt of SUD treatment

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

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

Plan Table 3 SABG Persons in need/receipt of SUD treatment		
State Identifier:		
	Aggregate number estimated in need	**Aggregate number in treatment**
1. Pregnant Women		
2. Women with Dependent Children		
1. Individuals with a co-occurring M/SUD		
2. Persons who inject drugs		
3. Persons experiencing homelessness		

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

Plan Table 4: SABG Planned Expenditures.

States must project how they will use SABG funds to provide authorized services as required by the SABG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2022 and FFY 2023 SABG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Plan Table 4	SABG Planned Expenditures					
State Identifier:						
Expenditure Category	**FFY 2022 SABG Award**	**COVID-19 Award** [1]	**ARP Award** [2]	**FFY 2023 SABG Award**	**COVID-19 Award** [1]	**ARP Award** [2]
1. **Substance Use Disorder Prevention**[3] **and Treatment**	$	$	$	$	$	$
2. **Primary Substance Use Disorder Prevention**	$	$	$	$	$	$
3. **Early Intervention Services for HIV**[4]	$	$	$	$	$	$
4. **Tuberculosis Services**	$	$	$	$	$	$
5. **Administration (SSA level only)**	$	$	$	$	$	$
6. **Total**	$	$	$	$	$	$

1.   The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the planning period for the standard SABG expenditures for the FFY 2021 SABG Award is October 1, 2020 - September 30, 2021. For purposes of this table, all COVID-19 Relief Supplemental expenditures between March 15, 2021 and September 30, 2021 should be entered in this column.
2.   The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2021 "standard" SABG, which is October 1, 2020 - September 30, 2021. The planned expenditures for the period of September 1, 2021 - September 30, 2021 should be entered here.
3.   Prevention other than Primary Prevention
4.   For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and

Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report 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 SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Plan Table 5a: Primary Prevention Planned Expenditures

States must spend no less than 20 percent of their SABG allotment on substance use disorder primary prevention strategies. The state must spend the majority of the funds implementing the six substance use disorder primary prevention strategies.   These strategies are directed at individuals not identified to need treatment. To report on their primary prevention planned expenditures, states must complete Table 5a.

Table 5a SABG Primary Prevention Planned Expenditures by Strategy and IOM Category

The state's primary prevention program must include, but is not limited to, the six primary prevention strategies defined below. On Table 5a, states should list their FFY 2022 and FFY 2023 SABG planned expenditures for each of the six primary prevention strategies. Expenditures within each of the six strategies should be directly associated with the cost of completing the activity or task; for example, information dissemination should include the cost of developing pamphlets, the time of participating staff or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other" in Table 5a.

In most cases, the total SABG amount should equal the amount reported on Plan Table 4, Row 2, Primary Substance Use Disorder Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non-Direct Services/System Development activities. The total on Table 6 prevention column combined with the total on Table 5a should equal to expenditure Table 4, Row 2 in most instances.

Primary Prevention Planned Expenditures by IOM Category

Information Dissemination– This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education - This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

Alternatives - This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and drugs through these activities.

Problem Identification and Referral to Education - This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person needs treatment.

Community-based Process - This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

Environmental - This strategy establishes, or changes written and unwritten community standards, codes, and attitudes; thereby, influencing alcohol and other drug use by the general population.

Other - States that plan their primary prevention expenditures using the IOM model of universal, selective, and indicated should use Table 5a to list their FFY 2022 and FFY 2023 SABG planned expenditures in each of these categories.

Institute of Medicine Classification: Universal, Selective, and Indicated:

Prevention strategies may be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by the population targeted. Definitions for these categories appear below:

Universal: Activities targeted to the public or a whole population group that have not been identified based on individual risk.

Universal Direct. Row 1 - Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after-school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).

Universal Indirect. Row 2 - Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not meeting diagnostic levels (Adapted from The Institute of Medicine). States that are able to report on both the strategy type and the population served (universal, selective, or indicated) should do so. If planned expenditure information is only available by strategy type, then the state should report planned expenditures in the row titled Unspecified (for example, Information Dissemination Unspecified).

Section 1926 - Tobacco: Costs Associated with the Synar Program. Per January 19, 1996, 45 CFR Part 96 Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants; Final Rule (45 CFR § 96.130), states may not use the Block Grant to fund the enforcement of their statute, except that they **may expend funds** from their primary prevention set aside of their block grant allotment under 45 CFR § 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections.

Public Law 116-94, signed on December 20, 2019, supersedes this legislation, and increased the minimum age for tobacco sales from 18 to 21. SAMHSA revised its guidance to clarify that the prevention set-aside may be used to fund revisions to states' Synar program to comply with PL 116-94. These funds should be reported in the appropriate columns.

Plan Table 5a: SABG Primary Prevention Planned Expenditures							
State Identifier:							
Report Period- From:			To:				
	A	B			C		
Strategy	IOM Target	FFY 2022			FFY 2023		
		SABG	COVID-19 [1]	ARP [2]	SABG	COVID-19 [1]	ARP [2]
1. Information Dissemination	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
2. Education	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
3. Alternatives	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
4. Problem Identification and Referral to Education	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
5. Community-Based Processes	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
6. Environmental	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
7. Section 1926 (Synar)- Tobacco	Universal	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						

8. Other	Universal Direct	$			$		
	Universal Indirect	$			$		
	Selected	$			$		
	Indicated	$			$		
	Unspecified	$			$		
		SABG	COVID-19 [1]	ARP [2]	SABG	COVID-19 [1]	ARP [2]
	Total						
9. Total Prevention Expenditures		$			$		
Total Award [3]		$			$		
Planned Primary Prevention Percentage		%			%		

The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.
The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.
[3] Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Plan Table 5b: SABG Planned Primary Prevention Targeted Priorities (Required)

States should identify the categories of substances the state block grant plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award C	COVID-19 Award[1]	ARP Award[2]
	Targeted Substances		
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Marijuana	☐	☐	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐

	SABG Award	C	COVID-19 Award[1]	ARP Award[2]
Methamphetamine	[?]		[?]	[?]

Targeted Populations			
Students in College	[?]	[?]	[?]
Military Families	[?]	[?]	[?]
LGBTQ+	[?]	[?]	[?]
American Indians/Alaska Natives	[?]	[?]	[?]
African American	[?]	[?]	[?]
Hispanic	[?]	[?]	[?]
Homeless	[?]	[?]	[?]
Native Hawaiian/Other Pacific Islanders	[?]	[?]	[?]
Asian	[?]	[?]	[?]
Rural	[?]	[?]	[?]
Underserved Racial and Ethnic Minorities	[?]	[?]	[?]

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

Footnotes:

1. The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.
2. The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

Plan Table 6: Categories for Expenditures for System Development/Non-Direct-Service Activities

Please note there is a separate table for MHBG. Only complete this table if the state plans to fund expenditures for non-direct services/system development with MHBG, SABG, COVID-19, and/or ARP dollars.

Expenditures for these activities may be direct expenditures (involving the time of state or sub-state personnel, or other state or sub-state resources) or be through funding mechanisms with independent organizations. Expenditures may come from the administrative funds and/or program funds (but may not include the HIV set-aside funds). These include state, regional, and local personnel salaries prorated for time spent and operating costs such as travel, printing, advertising, and conducting meetings related to the categories below.

Non-direct services/system development activities *exclude* expenditures through funding mechanisms for providing treatment or mental health "direct service" and primary prevention efforts themselves. Instead, these expenditures provide support to those activities.

Please utilize the following categories to describe the types of expenditures your state supports with BG funds. Although the states may use a different classification system, please use these categories to describe the types of expenditures your state supports with BG funds, when the preponderance of the activity fits within a category.

Information systems – This includes collecting and analyzing treatment data as well as prevention data under the SABG in order to monitor performance and outcomes. Costs for EHRs and other health information technology also fall under this category.

Infrastructure Support – This includes activities that provide the infrastructure to support services but for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, and respite services.

Partnerships, community outreach, and needs assessment – This includes state, regional, and local personnel salaries prorated for time and materials to support planning meetings, information collection, analysis, and travel. It also includes the support for partnerships across state and local agencies, and tribal governments. Community/network development activities, such as marketing, communication, and public education, and including the planning and coordination of services, fall into this category, as do needs-assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps.

Planning Council Activities – This includes those supports for the performance of a Mental Health Planning Council under the MHBG, a combined Behavioral Health Planning Council, or (OPTIONAL) Advisory Council for the SABG.

Quality assurance and improvement - This includes activities to improve the overall quality of services, including those activities to assure conformity to acceptable professional standards, adaptation, and review of implementation of evidence-based practices, identification of areas of technical assistance related to quality outcomes, including feedback. Administrative agency contracts to monitor service-provider quality fall into this category, as do independent peer-review activities.

Research and evaluation - This includes performance measurement, evaluation, and research, such as services research and demonstration projects to test feasibility and effectiveness of a new approach as well as the dissemination of such information.

Training and education - This includes skill development and continuing education for personnel employed in local programs as well as partnering agencies, as long as the training relates to either SUD service delivery (prevention, treatment and recovery) for SABG and services to adults with SMI or children with SED for MHBG. Typical costs include course fees, tuition, and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.

Plan Table 6: Categories for Expenditures for System Development/Non-Direct-Service Activities MHBG

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

Non-Direct-Services/System Development						
MHBG Table 6						
MHBG Planning Period- From:	**To:**					
Activity	**A. FFY 2022 Block Grant**	**B. FFY 2022 COVID-19 Funds[1]**	**C. FFY 2022 ARP Funds[2]**	**D. FFY 2023 Block Grant**	**E. FFY 2023 COVID-19 Funds[1]**	**F. FFY 2023 ARP funds[2]**
1. Information Systems						
2. Infrastructure Support						
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education						
8. Total	$	$	$	$	$	$

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2022 – June 30, 2024, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2022 – June 30, 2024, for most states."

Plan Table 6: Categories for Expenditures for System Development/Non-Direct-Service Activities SABG

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

SABG Table 6										
Non-Direct-Services/System Development										
	FFY 2022					**FFY 2023**				
Activity	**A. SABG Treatment**	**B. SABG Prevention**	**C. SABG Integrated [1]**	**D. COVID-19 [2]**	**E. ARP [3]**	**A. SABG Treatment**	**B. SABG Prevention**	**C. SABG Integrated [1]**	**D. COVID-19 [2]**	**E. ARP [3]**
1. Information Systems										
2. Infrastructure Support										
3. Partnerships, community outreach, and needs assessment										
4. Planning Council Activities (MHBG required, SABG optional)										
5. Quality assurance and improvement										

6. Research and Evaluation										
7. Training and Education										
8. Total	$	$	$	$	$	$	$	$	$	$

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

[2]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023.

C. Environmental Factors and Plan

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

Across the United States, significant percentages of adults with SMI, children and youth with SED, and people with SUD do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, 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. For example, only 7.9 percent of adults with co-occurring M/SUD received treatment for both in 2019.[20]

A venue for states to advance access to care is addressing financing barriers by ensuring that parity protections 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 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 M/SUD are likely to die earlier than those who do not have these conditions.[21] Ensuring that people with M/SUD get 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 or 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 targeted initiatives through the MHBG and SABG 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

---

[20] Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[21] 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

intensity of care coordination support based on the seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with SMI who are at a high risk of institutional placement; and connecting people in recovery from SUD with a range of recovery supports. States should also provide the care coordination necessary to connect people with M/SUD to needed supports in areas like education, employment, and housing.

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

    a)   Adults with SMI

    b)   Adults with SUD

    c)   Children and youth with SED or SUD

    d)   Individuals with co-occurring M/SUD

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.

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

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

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

    c)   Efforts to integrate primary care into behavioral health settings

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

    a)   Adults with SMI

    b)   Adults with SUD

    c)   Children and youth with SED or SUD

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

2.   Health Disparities - Required

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities[22]*, *Healthy People, 2020[23]*, *National Stakeholder Strategy for Achieving Health Equity[24]*, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically

---

[22] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[23] http://www.healthypeople.gov/2020/default.aspx

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

[Appropriate Services in Health and Health Care](http://www.ThinkCulturalHealth.hhs.gov) (CLAS).[25]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[26]

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[27] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[28] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

---

[25] http://www.ThinkCulturalHealth.hhs.gov

[26] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

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

[28] : https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

Please respond to the following items:

1) Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, and age?
      a) race   ☐ Yes ☐ No
      b) ethnicity   ☐ Yes ☐ No
      c) gender   ☐ Yes ☐ No
      d) sexual orientation ☐ Yes ☐ No
      e) gender identity   ☐ Yes ☐ No
      f) age   ☐ Yes ☐ No

2) Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?
      ☐ Yes ☐ No

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

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

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

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

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

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

3. *Innovation in Purchasing Decisions - Requested*

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

Health Care Value = Quality ÷ Cost, **(V = Q ÷ C)**

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape state systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for

individuals with M/SUD, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[29] The New Freedom Commission on Mental Health,[30] the

IOM,[31] NQF, and the [Interdepartmental Serious Mental Illness Coordinating Committee](#)

(ISMICC).[32]   The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[33] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))[34] are best practice guidelines for SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as AOTD disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))[35] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

---

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

[30] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America.* Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[31] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

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

[33]http://psychiatryonline.org/

[34] http://store.samhsa.gov

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

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

Please respond to the following items:

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

2. Which value-based purchasing strategies do you use in your state? (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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

Much of the mental health treatment and recovery service efforts are focused on the later stages

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

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

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

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 with ESMI, 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 the succeeding fiscal year.

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

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

Model(s)/EBP(s) for ESMI/FEP		Number of programs	

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 22 and FY 23 (only include MHBG funds).

FY2022		FY2023	

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

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

5. Does the state monitor fidelity of the chosen EBP(s)?

☐ Yes ☐ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

☐ Yes ☐ No

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

8. Please describe the planned activities in FY2022 and FY2023 for your state's ESMI programs.

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

10. *Please indicate area of technical assistance needed related to this section.*

5. Person Centered Planning (PCP) –Required for MHBG

States must engage adults with SMI or children with SED and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers, and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment,

education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

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

1. Does your state have policies related to person centered planning? ☐Yes   ☐ No

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

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

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

6. Program Integrity - Required

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x–55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, primary substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

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?

```
┌────────────────────────────────────────────────┐
│                                                │
│                                                │
│                                                │
│                                                │
└────────────────────────────────────────────────┘
```

Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

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

```
┌────────────────────────────────────────────────┐
│                                                │
│                                                │
│                                                │
│                                                │
└────────────────────────────────────────────────┘
```

7. Tribes - Requested

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[36] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding.

36

https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs, and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

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

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

┌───┐
│   │
│   │
│   │
│   │
│   │
└───┘

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

┌───┐
│   │
│   │
│   │
│   │
│   │
└───┘

8. Primary Prevention-Required (SABG only)

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to need treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based primary substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities.
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities.
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral to Education**, that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

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

Please respond to the following questions:

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   a) ☐ 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)

3. Does your state collect needs assessment 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) ☐ Cultural/ethnic minorities
   g) ☐ Sexual/gender minorities
   h) ☐ Rural communities
   i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):
   a) ☐ Archival indicators (Please list)

   ┌───┐
   │   │
   │   │
   │   │
   │   │
   └───┘

   b) ☐ National Survey on Drug Use and Health (NSDUH)
   c) ☐ Behavioral Risk Factor Surveillance System (BRFSS)
   d) ☐ Youth Risk Behavior 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 SABG primary prevention funds?
   a) ☐ Yes ☐ No
      i) If yes, (please explain in the box below)

   ┌───┐
   │   │
   │   │
   │   │
   └───┘

      ii) If no, please explain how SABG funds are allocated:

   ┌───┐
   │   │
   │   │
   │   │
   └───┘

6. **Does your state integrate cultural competency into the assessment step?**

a) ☐ Yes ☐ No

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

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

7. **Does your state integrate sustainability into the assessment step?**

a) ☐ Yes ☐ No

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

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

Capacity Building

1. Does your state have a statewide licensing or certification program for the primary substance use disorder prevention workforce?
   a) ☐ Yes (if yes, please describe)

   ```



   ```

   b) ☐ No

2. Does your state have a formal mechanism to provide training and technical assistance to the primary substance use disorder prevention workforce?
   a) ☐ Yes (if yes, please describe mechanism used)

   ```



   ```

   b) ☐ No

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?
   a) ☐ Yes (if yes, please describe mechanism used)

   ```



   ```

   b) ☐ No

4. Does your state integrate cultural competency into the capacity building step?

a) ☐ Yes ☐ No

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

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

5. Does your state integrate sustainability into the capacity building step?

a) ☐ Yes ☐ No

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

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

Planning

1. Does your state have a strategic plan that addresses primary substance use disorder prevention that was developed within the last five years?
   a) ☐ Yes (If yes, please attach the plan in BGAS)
   b) ☐ No

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?

   a) ☐ 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) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) ☐ Timelines
   c) ☐ Roles and responsibilities
   d) ☐ Process indicators
   e) ☐ Outcome indicators
   f) ☐ Cultural competence component
   g) ☐ Sustainability component
   h) ☐ Other (please list)

   i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?

   a) ☐ Yes ☐ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?

   a) ☐ Yes ☐ No
   b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

6. Does your state integrate cultural competency into the planning step?

a) ☐Yes ☐ No

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

[ ]

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

[ ]

7. Does your state integrate sustainability into the planning step?

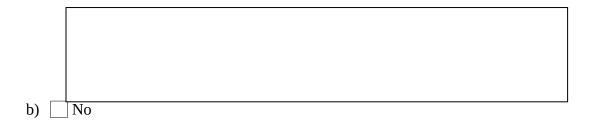a) ☐Yes ☐No

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

[ ]

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

[ ]

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
   a) ☐ SSA staff directly implements primary prevention programs and strategies.
   b) ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) ☐ The SSA funds regional entities that provide training and technical assistance.
   e) ☐ The SSA funds regional entities to provide prevention services.

f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.

g) ☐ The SSA funds community coalitions to provide prevention services.

h) ☐ The SSA funds individual programs that are not part of a larger community effort.

i) ☐ The SSA directly funds other state agency prevention programs.

j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

b) Education:

c) Alternatives:

d) Problem Identification and Referral to Education:

e) Community-Based Processes:

f) Environmental:

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

a) ☐ Yes (if so, please describe)

b) ☐ No

4. **Does your state integrate cultural competency into the implementation step?**

a) ☐ Yes ☐ No

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

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

5. **Does your state integrate sustainability into the implementation step?**

a) ☐ Yes ☐ No

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

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

Evaluation

1. Does your state have an evaluation plan for primary substance use disorder prevention that was developed within the last five years?
   a) ☐ Yes (If yes, please attach the plan in BGAS)
   b) ☐ No

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 targeted benchmarks
   b) ☐ Includes evaluation information from sub-recipients
   c) ☐ Includes SAMHSA 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 SABG 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 SABG funded prevention services:
   a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc.

b) ☐ Heavy use
☐ Binge use
☐ Perception of harm
c) ☐ Disapproval of use
d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
e) ☐ Other (please describe)

```



```

5. Does your state integrate cultural competency into the evaluation step?

a) ☐ Yes ☐ No

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

```



```

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

```



```

6. Does your state integrate sustainability into the evaluation step?

a) ☐ Yes ☐ No

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

```



```

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

9. Statutory Criterion for MHBG (Required for MHBG)

<u>Criterion 1: Comprehensive Community-Based Mental Health Service Systems</u>

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring M/SUD. 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.

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

┌───┐
│   │
│   │
│   │
│   │
│   │
│   │
└───┘

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
   a) Physical health
      ☐ Yes ☐ No
   b) Mental Health
      ☐ Yes ☐ No
   c) Rehabilitation services
      ☐ Yes ☐ No
   d) Employment services
      ☐ Yes ☐ No
   e) Housing services
      ☐ Yes ☐ No
   f) Educational services
      ☐ Yes ☐ No
   g) Substance misuse prevention and SUD treatment services
      ☐ Yes ☐ No
   h) Medical and dental services
      ☐ Yes ☐ No
   i) Support services
      ☐ Yes ☐ No
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)

☐ Yes ☐ No
    k) Services for persons with co-occurring M/SUDs
        ☐ Yes ☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

4. Describe activities intended to reduce hospitalizations and hospital stays.

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.

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI		
2. Children with SED		

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.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for multiple needs. Does your state integrate the following services into a comprehensive system of care?

a) Social Services
☐ Yes ☐ No

b) Educational services, including services provided under IDE
☐ Yes ☐ No

c) Juvenile justice services
☐ Yes ☐ No

d) Substance misuse prevention and SUD treatment services
☐ Yes ☐ No

e) Health and mental health services
☐ Yes ☐ No

f) Establishes defined geographic area for the provision of the services of such system
☐ Yes ☐ No

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.

a. Describe your state's targeted services to rural population.

b. Describe your state's targeted services to the homeless population.

c. Describe your state's targeted services to the older adult population.

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.

Describe your state's management systems.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) or to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard

72

practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

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.

10. Substance Use Disorder Treatment - Required for SABG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services:
   i)   Screening
        ☐ **Yes** ☐ **No**
   ii) Education
        ☐ **Yes** ☐ **No**
   iii) Brief intervention
        ☐ **Yes** ☐ **No**
   iv) Assessment
        ☐ **Yes** ☐ **No**
   v)   Detox (inpatient/social)
        ☐ **Yes** ☐ **No**
   vi) Outpatient
        ☐ **Yes** ☐ **No**
   vii) Intensive outpatient
        ☐ **Yes** ☐ **No**
   viii)   Inpatient/residential
        ☐ **Yes** ☐ **No**
   ix) Aftercare
        ☐ **Yes** ☐ **No**
   x)   Recovery support
        ☐ **Yes** ☐ **No**

b) Services for special populations:
Targeted services for veterans?
☐ **Yes** ☐ **No**
Adolescents?
☐ **Yes** ☐ **No**
Older adults?
☐ **Yes** ☐ **No**
Medication-Assisted Treatment (MAT)?
☐ **Yes** ☐ **No**

Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?
   a) ☐ **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?
   a) ☐ **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?
   a) ☐ **Yes** ☐ **No**
4. Does your state have an arrangement for ensuring the provision of required supportive services?
   a) ☐ **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.

☐

Criteria 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)
1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement?
      ☐ **Yes** ☐ **No**
   b) 14-120 day performance requirement with provision of interim services?
      ☐ **Yes** ☐ **No**
   c) Outreach activities?
      ☐ **Yes** ☐ **No**
   d) Syringe services programs?
      ☐ Y**es** ☐ **No**
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation?
      ☐ **Yes** ☐ **No**

2. Has your state identified a need for any of the following:
   a) Electronic system with alert when 90 percent capacity is reached?
      ☐ **Yes** ☐ **No**
   b) Automatic reminder system associated with 14-120 day performance requirement?
      ☐ **Yes** ☐ **No**
   c) Use of peer recovery supports to maintain contact and support?
      ☐ **Yes** ☐ **No**
   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?
      ☐ **Yes** ☐ **No**

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make tuberculosis services available to individuals receiving SUD treatment and to monitor the service delivery?
   a) ☐ **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.

```



```

Early Intervention Services for HIV (For "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with SUD 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 telehealth and social media support services?
      ☐ **Yes** ☐ **No**
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?
      ☐ **Yes** ☐ **No**

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?
    ☐ **Yes** ☐ **No**

2) Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?
    ☐ **Yes** ☐ **No**

3) Do any of your programs use SABG funds to support elements of a Syringe Services Program?
    a) ☐ **Yes** ☐ **No**
    b) If yes, please provide a brief description of the elements and the arrangement

    ┌───┐
    │   │
    │   │
    │   │
    │   │
    │   │
    └───┘

Criteria 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have an agreement in place to ensure 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, sexual and gender minorities)
        ☐ **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**

f) Explore expansion of services for:

i) MAT

(1) ☐ **Yes** ☐ **No**

ii) Telehealth

(1) ☐ **Yes** ☐ **No**

iii) Social media outreach

(1) ☐ **Yes** ☐ **No**

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

☐ **Yes** ☐ **No**

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services

☐ **Yes** ☐ **No**

b) Establish a program to provide trauma-informed care

☐ **Yes** ☐ **No**

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice 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**

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background?

☐ **Yes** ☐ **No**

Patient Records

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

a) ☐ **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 include the exceptions for disclosure?

☐ **Yes** ☐ **No**

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
   a) ☐ **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

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?
   a) ☐ **Yes** ☐ **No**
   b) **If Yes,** please identify the accreditation organization(s)
      i) ☐ Commission on the Accreditation of Rehabilitation Facilities
      ii) ☐ The Joint Commission
      iii) ☐ Other (please specify) _____

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

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 SUD in the state?
      ☐ **Yes** ☐ **No**
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?
      ☐ **Yes** ☐ **No**
   c) Performance-based accountability?
      ☐ **Yes** ☐ **No**
   d) Data collection and reporting requirements?
      ☐ **Yes** ☐ **No**

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs?
      ☐ **Yes** ☐ **No**
   b) Addition of training sessions designed to increase employee understanding of recovery support services?
      ☐ **Yes** ☐ **No**
   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?
      ☐ **Yes** ☐ **No**
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?
      ☐ **Yes** ☐ **No**

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?
      ☐ **Yes** ☐ **No**

   b) Mental Health TTC?
      ☐ **Yes** ☐ **No**

   c) Addiction TTC?
      ☐ **Yes** ☐ **No**

   d) State Targeted Response TTC?
      ☐ **Yes** ☐ **No**

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations Regarding Women
      ☐ Yes ☐ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus
   a) Tuberculosis
      ☐ Yes ☐ No
   b) Early Intervention Services Regarding HIV
      ☐ Yes ☐ No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment
      ☐ Yes ☐ No
   b) Professional Development
      ☐ Yes ☐ No
   c) Coordination of Various Activities and Services
      ☐ Yes ☐ No

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

┌─────────────────────────────────┐
│   │
│   │
│   │
└─────────────────────────────────┘

11. Quality Improvement Plan- Requested

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

1. Has your state modified its CQI plan from FFY 2020-FFY 2021?
    a)   ☐ Yes ☐ No

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

```
┌─────────────────────────────────────────────────────────┐
│                                                         │
│                                                         │
│                                                         │
│                                                         │
└─────────────────────────────────────────────────────────┘
```

12.   Trauma -Requested

Trauma[37] is a widespread, harmful, and costly public health problem. Causes include violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize these efforts they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems.

---

[37] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[38] paper.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?
    ☐ Yes ☐ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?
    ☐ Yes ☐ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
    ☐ Yes ☐ No

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

---

[38] *Ibid*

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

13.   *Criminal and Juvenile Justice - Requested*

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[39]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment, and recidivism.[40]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

---

[39] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

[40] http://csgjusticecenter.org/mental-health/

Please respond to the following items:

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with M/SUD from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?
   ☐ Yes ☐ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?
   ☐ Yes ☐ No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?
   ☐ Yes ☐ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?
   ☐ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

```

```

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

```

```

14. *Medication Assisted Treatment – Requested (SABG only)*

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with SUD demonstrate that they both have the capacity and staff expertise to use MAT

or have collaborative relationships with other providers to provide the appropriate MAT services clinically needed.

Individuals with SUD who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for SUD for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?
☐ Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?
☐ Yes ☐ No

3. Does the state purchase any of the following medication with block grant funds?
   a) ☐ Methadone
   b) ☐ Buprenorphine; Buprenorphine/naloxone
   c) ☐ Disulfiram
   d) ☐ Acamprosate
   e) ☐ Naltrexone (oral, IM)
   f) ☐ Naloxone

   4.Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance use disorders are used appropriately*?
   ☐ Yes ☐ No

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

>

*Appropriate use is defined as use of medication for the treatment of a SUD, combining psychosocial treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

15.   *Crisis Services – Required for MHBG*

SAMHSA is directed by Congress through the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260], to set aside 5 percent of the MHBG allocation for each state to support evidence-based crisis systems. The appropriation bill includes the following budget language that outlines the new 5 percent set-aside:

> *Furthermore, the Committee directs a new five percent set- aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources.

SAMHSA recently developed [Crisis Services: Meeting Needs, Saving Lives,](#) which includes "[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)" as well as other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. 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 SMI or children with SED. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness, 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 for the system to be optimally effective. These three-core structural or programmatic elements are: Regional Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Regional Crisis Call 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 regional crisis

call center provides an alternative. Regional crisis call centers should be made available statewide, provide real-time access to a live mental health professional on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess 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.

Mobile Crisis Response Team. Once a mental health crisis has been identified and a crisis line has been called, a mobile response is required if the crisis cannot be de-escalated by phone. In the current system, police are often dispatched to the location of the individual in crisis. But in an effective crisis system, two-person teams, including a 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 transported to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In typical systems, 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 individual walk-ins or drop-off 24/7 and should have a no-rejection policy. Particularly when police or EMS are dropping off an individual, the hand-off should be "warm" (welcoming) and efficient, and these facilities provide assessment and address mental health and substance use crisis issues. A warm hand-off establishes an initial face-to-face contact between the client and the behavioral clinician. 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.

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 because either 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 the police department's co-responder team (police officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with police officers who have received Mental Health First Aid and Crisis Intervention Training, including de-escalation methods and behavioral health symptoms; (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 then refer to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Call Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Currently, the National Suicide Prevention Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of professionals and volunteers who are trained to utilize best practices in handling distress calls. Local call centers automatically perform a safety check 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. It will replace the National Suicide Prevention Lifeline's current number, 1800-273-TALK, and provide nationwide ease of access that connects callers in crisis to the Lifeline and Veterans Crisis Line. The 988 transition will provide support and expansion to the current Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide. This bill was signed by President Trump on October 17, 2020.

Building Crisis Services Systems. Most communities across the United States have limited crisis services, but a few have an organized system of services that 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.

- Briefly narrate your state's crisis system. Include a description of access to crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.
- In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to						
Someone						

to respond						
Place to go						

a) The *Exploration* stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

b) The *Installation* stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

c) *Initial Implementation* stage: occurs when the state has the three-core crisis services in place and agencies begin to put into practice the SAMHSA guidelines.

d) *Full Implementation* stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) *Program Sustainability* stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity
   a. Number of locally based crisis call Centers in state
      i. In the Suicide lifeline network
      ii. Not in the suicide lifeline network
   b. Number of Crisis Call Centers with follow up protocols in place
   c. Percent of 911 calls that are coded as MH related
2. Someone to respond: Number of communities that have mobile behavioral health crisis capacity
   a. Independent of first responder structures (police, paramedic, fire)
   b. Integrated with first responder structures (police, paramedic, fire)
   c. Number that employ peers
3. Place to Go:
   a. Number of Emergency Departments
   b. Number of Emergency Departments that operate a specialized behavior health component
   c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hour units that can diagnose and stabilize individuals in crisis)

- Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

```




```

- Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

```



```

16.   Recovery – Required

The performance of recovery supports and services are essential for providing comprehensive, quality M/SUD care. The expansion in access to; and coverage for, health care drives SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with M/SUD.

Recovery is supported through the key components of: *health* (access to quality health and M/SUD treatment); *home* (housing with needed supports), *purpose* (education, employment, and other   pursuits); and *community* (peer, family, and other social supports). The principles of a recovery guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming, and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's M/SUD. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:
- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;

- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported National Technical Assistance and Training Centers. SAMHSA strongly encourages states to take proactive steps to implement and expand recovery support services.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members, and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state M/SUD treatment system.

1. Does the state support recovery through any of the following:
   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
      ☐ Yes ☐ No
   b) Required peer accreditation or certification?
      ☐ Yes ☐ No
   c) Use block grant funding for recovery support services?
      ☐ Yes ☐ No
   d) Involvement of persons in recovery/peers/family members in planning, implementation,   or evaluation of the impact of the state's M/SUD system?
      ☐ Yes ☐ No

2. Does the state measure the impact of your consumer and recovery community outreach activity?
   ☐ Yes ☐ No

3. Provide a description of recovery and recovery support services for

adults with SMI and   children with SED in your state.

4. Provide a description of recovery and recovery support
services for individuals with SUD in your state.

5. Does the state have any activities that it would like to highlight?

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

17.   *Community Living and the Implementation of Olmstead- Requested*

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C*., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's *Olmstead* decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons

with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:
   Housing services provided   ☐ Yes ☐ No
   Home and community-based services ☐ Yes ☐ No
   Peer support services   ☐ Yes ☐ No
   Employment services   ☐ Yes ☐ No

2. Does the state have a plan to transition individuals from hospitals to community settings?
   ☐ Yes ☐ No

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

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

18.　Children and Adolescents M/SUD Services –Required for MHBG, Requested for SABG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with SUD. Each year, an estimated 20 percent of children in the U.S. have a

diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[41] 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.[42] For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[43]

Data show that 11 percent of high school students have a diagnosable SUD involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[44] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment, and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on

---

[41] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).

[42] 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.

[43] 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.

[44] The National Center on Addiction and Substance Abuse at Columbia University. (June 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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.[45]

According to data from the 2015 Report to Congress[46] on systems of care, services:
1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
- residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
      ☐ Yes ☐ No
   b) The recovery and resilience of children and youth with SUD?
      ☐ Yes ☐ No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs
   a) Child welfare?
      ☐ Yes ☐ No
   b) Juvenile justice?

---

[45] 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
[46] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

☐ Yes ☐ No
c) Education?
☐ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   ☐ Yes ☐ No
   b) Costs?
   ☐ Yes ☐ No
   c) Outcomes for children and youth services?
   ☐ Yes ☐ No

4. Does the state provide training in evidence-based :
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   ☐ Yes ☐ No
   b) Mental health treatment and recovery services for children/adolescents and their families?
   ☐ Yes ☐ No
5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
   ☐ Yes ☐ No
   b) for youth in foster care?
   ☐ Yes ☐ No

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

>

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

>

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

>

19.   *Suicide Prevention – (Required for MHBG)*

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?
   ☐ Yes ☐ No

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

   ```
   
   
   
   
   ```

3. Have you incorporated any strategies supportive of Zero Suicide?
   ☐ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?
   ☐ Yes ☐ No

5. Have you begun any targeted or statewide initiatives since the FFY 2020 - 2021 plan was submitted?
   ☐ Yes ☐ No
   If so, please describe the population targeted?

   ```
   
   
   
   
   ```

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

```



```

20.   Support of State Partners - Required for MHBG

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for M/SUD, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?
   ☐ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place?

   ☐ Yes ☐ No
   If yes, with whom?

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.

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

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[47]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)
   a) What mechanism does the state use to plan and implement substance misuse prevention, treatment, and recovery services?

   ```
   

   ```

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
      ☐ Yes ☐ No

---

[47] https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf

2. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
    ☐ Yes ☐ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

```
┌─────────────────────────────────────────────────────────────────┐
│                                                                   │
│                                                                   │
│                                                                   │
│                                                                   │
│                                                                   │
└─────────────────────────────────────────────────────────────────┘
```

Additionally, please complete the Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[48]

---

[48] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Advisory Council Members

Name	Type of Membership*	Agency or Organization Represented*	Address Phone & Fax	Email Address (If Available)
		**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		
		***State Marketplace Agency		
		***State Child Welfare Agency		
		***State Health Agency		
		***State Agency on Aging		

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

** Required by Statute.

***Requested not required

Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Total Membership		
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED/SUD*		
Vacancies (individual & family members)		
Others (Advocates who are not State employees or providers)		
Total Individuals in Recovery, Family Members and Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ+ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ+ Populations		
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ+ Populations		
Persons in recovery from or providing treatment for or advocating for SUD services		
Representatives from Federally Recognized Tribes		
Youth/adolescent representative (or member from an organization serving young people).		

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

22. *Public Comment on the State Plan- Required*

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states to provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

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:

   If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

   c) Other (e.g., public service announcements, print media)
      ☐ Yes ☐ No

Acronyms

ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
AI	American Indian
AIDS	Acquired Immune Deficiency Syndrome
AN	Alaskan Native
ARP	American Rescue Plan
AOT	Assisted Outpatient Treatment
ATOD	Alcohol, Tobacco and Other Drugs
BHSIS	Behavioral Health Services Information System
CAP	Consumer Assistance Programs
CBHSQ	Center for Behavioral Health Statistics and Quality
CCBHC	Certified Community Behavioral Health Center
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease of 2019
CPT	Current Procedural Terminology
CSC	Coordinated Specialty Care
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EBP	Evidence-Based Practice
EHB	Essential Health Benefit
EHR	Electronic Health Record
EIS	Early Intervention Services (association with Human

	Immunodeficiency Virus (HIV)
ESMI	Early Serious Mental Illness
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus (associated with Early
	Intervention Services)
HRSA	Health Resources and Services Administration
ICD-10	*The International Statistical Classification of Diseases and Related Health Problems*, 10th Revision
ICT	Interactive Communication Technology
IDU	Intravenous Drug User
IMD	Institutions for Mental Diseases
KIT	Knowledge Information Transformation (associated with
	EBP implementation)
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MHBG	Community Mental Health Services Block Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
MOE	Maintenance of Effort
M/SUD	Mental and/or Substance Use Disorder
NAS	National Academies of Science
NBHQF	National Behavioral Health Quality Framework
NHAS	National HIV/AIDS Strategy
NIAAA	National Institute on Alcoholism and Alcohol Abuse
NIDA	National Institute on Drug Abuse
NIMH	National Institute on Mental Health

NOMS	National Outcome Measures
NQF	National Quality Forum
NQS	National Quality Strategy
OCR	Office for Civil Rights
OMB	Office of Management and Budget
PBHCI	Primary and Behavioral Health Care Integration
PBR	Patient Bill of Rights
PCP	Person Centered Planning
PHS	Public Health Service
PPW	Pregnant and Parenting Women
PPWC	Pregnant and Postpartum Women and Children
PWWDC	Pregnant Women and Women with Dependent Children
PWID	Persons Who Inject Drugs
QHP	Qualified Health Plan
RAISE	Recovery After an Initial Schizophrenia Episode
RCO	Recovery Community Organization
RFP	Request for Proposal
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Serious Emotional Disturbance
SFY	State fiscal year
SEOW	State Epidemiological Outcome Workgroup
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SPA	State Plan Amendment
SPF	Strategic Prevention Framework
SSA	Single State Agency
SUD	Substance Use Disorder
TIP	Treatment Improvement Protocol
TLOA	Tribal Law and Order Act

U.S.C. United States Code

VA U.S. Department of Veterans Affairs

Resources

TOPIC	LINK	DESCRIPTION
SAMHSA Block Grants	http://samhsa.gov/grants/block-grants	Description of Block Grant, its purpose, deadlines, laws and regulations and resources
SAMHSA Topic Search	http://www.samhsa.gov/topics	Search SAMHSA's website for resources, information and updates by topic or program
SAMHSA Store	http://store.samhsa.gov/	Search SAMHSA's store to download or order publications and resources
RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE		
TOPIC	LINK	DESCRIPTION
21st Century Cures Act	https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.pdf	Link to the 21st Century Cures Act, which includes the section on Helping Families in Mental Health Crisis Reform Act of 2016
Center for Integrated Health Solutions	http://www.integration.samhsa.gov/	HRSA-SAMHSA Center for Integrated Health Solutions offers resources, trainings, hot topics, and webinars on primary and behavioral health care integration
Characteristics of State Mental Health Agency Data Systems	http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361	Reviews current information technology (IT) systems and technology implementation efforts in state mental health agencies. Reports key findings on IT and structure, client-level and claims-level data, linking to other state data, and electronic health records. (Downloadable report)
Children Mental Health	https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM	Presents program evaluation findings of a federally funded initiative that supports systems of care for community-based mental health services for children, youth, and their families. Reports on FFY2010 data that track service characteristics, use, and outcomes. (Downloadable report)

TOPIC	LINK	DESCRIPTION
Co-Occurring Resources and Models	http://www.samhsa.gov/co-occurring/	SAMHSA's webpage dedicated to co-occurring models and practice. Includes: resources, webinars, public resource links and more.
Health Care Integration	https://www.samhsa.gov/grants/grant-announcements/sm-15-005	Overview of SAMHSA Health Care Integration initiatives and links to resources and information about health care integration
Health Homes	http://www.integration.samhsa.gov/integrated-care-models/health-homes	SAMHSA's description of Health Homes and resources around health homes
Healthy People Initiative	http://www.healthypeople.gov/2020/default.aspx	Government website that reviews the goals of Healthy People 2020 and provides resources to help meet the goals.
Health Financing	https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/health-financing-impact-homelessness	SAMHSA guides, trainings, and technical assistance resources around health reform implementation.
Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT	https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366	Provides practice principles about integrated treatment for co-occurring disorders, an approach that helps people recover by offering M/SUD services at the same time and in one setting. Offers suggestions from successful programs.
LGBTQ+ Populations	https://www.samhsa.gov/behavioral-health-equity/LGBTQ+	Resources on the LGBTQ+ population include national survey reports, agency and federal initiatives, and related behavioral health resources.
Medicaid Policy Guidance	http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html	Searchable database of Medicaid Policy Guidance's; including peer support services, affordable care act, health homes, prescription drugs, etc.
Medication Assisted Treatment	http://www.samhsa.gov/medication-assisted-treatment	SAMHSA's resources, guides, and TIPs on MAT
Mental Health and Substance Abuse Block Grant Laws and Regulations	http://www.samhsa.gov/grants/block-grants/laws-regulations	Links to the laws and regulations that govern the Mental Health and Substance Abuse Block Grants

TOPIC	LINK	DESCRIPTION
Mental Health Crisis	https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427	Presents guidelines to improve services for people with serious mental illness or emotional disorders who are in mental health crises. Defines values, principles, and infrastructure to support appropriate responses to mental health crises in various situations.
National CLAS Standards	http://www.ThinkCulturalHealth.hhs.gov	The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.
National HIV/AIDS Strategy (NHAS) for the United States	https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update	July 2010 PDF of the National HIV/AIDS Strategy for the United States
National Partnership for Action to End Health Disparities	https://www.minorityhealth.hhs.gov/npa/	Offers an overview and resources to help end health disparities
SAMHSA's Evidence-Based Practices Resource Center	https://www.samhsa.gov/resource-search/ebp	This new Evidence-Based Practices Resource Center aims to provide communities, clinicians, policy-makers, and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings. The Resource Center contains a collection of scientifically-based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources.
National Strategy for Suicide Prevention	http://store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-2012-Goals-and-Objectives-for-Action/PEP12-NSSPGOALS	Outlines a national strategy to guide suicide prevention actions. Includes 13 goals and 60 objectives across four strategic directions: wellness and empowerment; prevention services; treatment and support services; and surveillance, research, and evaluation. (Downloadable report)

TOPIC	LINK	DESCRIPTION
Olmstead	https://www.samhsa.gov/sites/default/files/olmstead-policy-academy.pdf	Links to the Olmstead decision document, as well as, a report that offers a basic primer on supportive housing, as well as a thorough review of states' current Olmstead planning efforts in this area
Parity	https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4971_print.pdf	Letter from Medicaid on Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans
Prevention of Underage Drinking	http://www.ncbi.nlm.nih.gov/books/NBK44360/	The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking seeks to engage all levels of government as well as individuals and private sector institutions and organizations in a coordinated, multifaceted effort to prevent and reduce underage drinking and its adverse consequences.
Recovery	https://www.samhsa.gov/brss-tacs	SAMHSA's resources, guides, and technical assistance on recovery
SAMHSA.gov Data Resources	http://www.samhsa.gov/data/	Links to SAMHSA data sets including: NSDUH, DAWN, NSSATS/NMHSS, TEDS, Uniform Reporting System (URS), National and State Barometers, etc.
SAMHSA's Evidenced Based Practice Knowledge Information Transformation (KIT)	http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345	SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[1] were developed to help move the latest information available on effective behavioral health practices into community-based service delivery.
Substance Abuse for Women	https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf	Guidance on components of quality SUD treatment services for women, states can refer to the documents found at this link
Suicide Prevention	https://www.samhsa.gov/suicide-prevention https://www.samhsa.gov/prevention	Links to resources and guides around suicide prevention and other mental and substance misuse prevention topics.
Synar Program	http://samhsa.gov/synar	Description and overview of the SYNAR program, which is a requirement of the SABG.
Telehealth Policy Resource	https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf	Telehealth Medicaid Policy site that provides telehealth laws and reimbursement by state, telehealth policy PDF and a review of pending legislations

TOPIC	LINK	DESCRIPTION
Trauma & Violence	http://www.samhsa.gov/trauma-violence	Includes information around violence and trauma, including the definition and review of trauma informed care.
Criminal & Juvenile Justice	http://www.samhsa.gov/criminal-juvenile-justice	Review of behavioral health services and resources in the criminal justice and juvenile justice systems.
Tribal Consultation	https://obamawhitehouse.archives.gov/the-press-office/memorandum-tribal-consultation-signed-president	The White House memorandum regarding the requirements related to tribal consultation