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FFY 2024-2025 Combined Block Grant Application

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

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

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

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FFY 2024-2025 Block Grant Application

I. INTRODUCTION

This is an application for SAMHSA’s Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) (formally known as the 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.C. §§ 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. States that do not choose to apply for the MHBG or SUPTRS BG will have their funds redirected to other states as provided in statute. (42 U.S.C. §300x-54).¹

The United States faces unprecedented mental health and substance use crises among people of all ages and backgrounds. Two out of five adults report symptoms of anxiety or depression, and under-resourced communities are disproportionately impacted. Even before the pandemic, rates of depression and anxiety were increasing. The grief, trauma, and physical and social isolation related to COVID-19 have exacerbated these issues for many. In addition, drug overdose deaths have reached a historic high, devastating individuals, families, and communities. More than 107,600 Americans died due to a drug overdose in 2021. For these reasons, this Administration has prioritized mental health and the overdose epidemic as two of the four pillars of the President’s [Unity Agenda](#)². SAMHSA is actively working to advance this Agenda, which includes strengthening system capacity, connecting more Americans to care, and creating a continuum of support that aims to transform our health and social services infrastructure to address behavioral health holistically and equitably. The MHBG and SUPTRS BG are key levers towards realizing this Agenda.

SAMHSA’s mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. SAMHSA’s vision is that people with, affected by, or at risk for mental health and substance use conditions receive care, thrive, and achieve wellbeing. SAMHSA has articulated its mission and vision in its [Interim Strategic Plan](#)³. In order to achieve its mission, SAMHSA has identified five key priority areas and four core principles to better meet the behavioral health care needs of individuals, communities, and service providers.

The five priority areas are:

- Preventing Overdose
- Enhancing Access to Suicide Prevention and Crisis Care
- Promoting Resilience and Emotional Health for Children, Youth and Families
- Integrating Behavioral and Physical Health Care

¹ <http://www.samhsa.gov/grants/block-grants/laws-regulations>

² <https://www.whitehouse.gov/omb/briefing-room/2022/03/28/fact-sheet-president-bidens-budget-advances-a-bipartisan-unity-agenda/>

³ <https://www.samhsa.gov/about-us/interim-strategic-plan>

- Strengthening the Behavioral Health Workforce

SAMHSA’s work is guided by four core principles that are infused throughout the Agency’s activities. The four core principles are:

- Equity
- Trauma-Informed Approaches
- Recovery
- Commitment to Data and Evidence

As you develop your application, SAMHSA encourages you to discuss how each Block Grant’s funding can be utilized to advance these priorities and principles, as further described below under Section C SAMHSA’s Priorities and Principles.

This application includes sections on 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 SUPTRS BG grantees and Bipartisan Safer Communities Act (BSCA) for MHBG. Additionally, the BSCA (P.L. 117-159) which passed on June 25, 2022 provides supplemental MHBG funds to state mental health authorities (SMHAs) to examine what is needed to address mass shootings and other threats to communities. As the United States works to address the massive disruption and loss of life caused by these crises, as well as other natural and man-made disasters, SAMHSA recommends that states utilize the BSCA funding to strengthen and enhance disaster preparedness and crisis response efforts for those with Serious Mental Illness (SMI) and or Serious Emotional Disturbance (SED). This is a unique opportunity for states to develop sustainable and improved public mental health systems that meet the needs of vulnerable people, including those with more complex presentations.

A. Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees two major block grants: the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Support Services Block Grant (SUPTRS BG). These block grants give states⁴ maximum flexibility to address the mental and substance use disorder (M/SUD) needs of their populations. The MHBG and SUPTRS BG 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.⁵). As a result, information on the services and clients supported by block grant funds has varied by block grant and by state. Please see Appendix A for a side-by-side comparison of required elements for the MHBG and SUPTRS BG.

The FFY 2024-2025 Block Grant Application furthers SAMHSA’s efforts to have states use and report the opportunities offered under various federal initiatives. The FFY 2024-2025 Block Grant Application allows states to submit one application for both MHBG and SUPTRS BG

⁴ 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.

⁵ In addition to statutory authority, SUPTRS BG is detailed by comprehensive regulation: <http://www.samhsa.gov/grants/block-grants/laws-regulations>

funds and requires a biennial plan for the MHBG while allowing a biennial plan for the SUPTRS BG. This Application also reflects a strong emphasis on coordinated and integrated care, along with the need to improve services for persons with mental and substance use disorders. In addition, questions about identified needs will allow SAMHSA to better design technical assistance to support state efforts.

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 its guidance asks⁶ states to use these resources towards improving and enhancing their array of mental health and substance use services. States are required to address the treatment and recovery support service needs of people in rural areas and underserved populations⁷ through this round of supplemental funding, and are encouraged to account for mental health and substance use disorder issues exacerbated by the pandemic and heightened by social inequities in the healthcare system. The timeline for funding planning and expenditure of these supplemental appropriations is from September 1, 2021, to September 30, 2025, which will necessitate changes to several years of block grant planning and reporting requirements.

SAMHSA's MHBG and SUPTRS BG 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 services addressing these needs.

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

1. To fund priority treatment and recovery support services for individuals who are uninsured or underinsured.
2. For SUPTRS BG 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.

B. Impact on State Authorities and Systems

SAMHSA seeks to ensure that 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.⁸ 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->

⁶ <https://www.samhsa.gov/sites/default/files/american-rescue-plan-act-guidance.pdf>

⁷ "Underserved populations" is further defined in Executive Order 13985: <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>

⁸ <http://www.samhsa.gov/grants/block-grants/laws-regulations>

[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.

C. SAMHSA’s Priorities and Guiding Principles

In order to achieve its mission, SAMHSA has identified [five key priority areas and four core principles](#) to better meet the behavioral health care needs of individuals, communities, and service providers.

The five priority areas are:

- Preventing Overdose
- Enhancing Access to Suicide Prevention and Crisis Care
- Promoting Resilience and Emotional Health for Children, Youth and Families
- Integrating Behavioral and Physical Health Care
- Strengthening the Behavioral Health Workforce

SAMHSA’s work is guided by four guiding principles that are infused throughout the Agency’s activities. The four principles are:

- Equity
- Trauma-Informed Approaches
- Recovery
- Commitment to Data and Evidence

Preventing Overdose

The isolation, anxiety, and reduced access to resources experienced by so many during the COVID-19 pandemic have exacerbated the overdose epidemic and contributed to a sharp rise in related deaths. In response, HHS released a new [Overdose Prevention Strategy](#) in October 2021 which outlines four pillars: Primary Prevention, Harm Reduction, Evidence-Based Treatment, and Recovery Support. The Strategy is built on the principles of maximizing health equity by using the best available data and evidence to inform policy and actions, integrating substance use disorder (SUD) treatment services into other types of health care and social services, and reducing stigma. It recognizes the full continuum of integrated care and services needed to help prevent substance use, reduce harm, expand quality treatment, and sustain recovery from SUD, all while emphasizing HHS’ commitment to helping historically under-resourced populations.

SAMHSA’s contributions to these efforts begin upstream with primary prevention programs which are supported through both technical assistance and funding, such as the SUPTRS BG and the Partnerships for Success grant programs. Recognizing that some individuals may have a SUD or need more intensive services, SAMHSA supports a range of more targeted mitigation services, including evidence-based harm reduction approaches such as distribution of naloxone and fentanyl test strips to those at high risk for overdose.

SAMHSA’s treatment and recovery support programs include a range of evidence-based services such as the State Opioid Response, Harm Reduction and Building Communities of Recovery grants. These types of services specifically aim to link people with SUDs and those who have experienced an overdose to low threshold medication, non-pharmacologic treatment options, and peer support services to reduce repeat overdoses. Together, these efforts help address mental

health and substance use conditions by meeting people wherever they are on the behavioral health continuum, through targeted services and supports that are evidence-based, culturally responsive, and driven by public health data.

States are encouraged to use their Block Grant funds to strengthen overdose prevention efforts and further develop their primary prevention programs by leveraging the SUPTRS BG 20 percent set-aside for primary prevention.

Enhancing Access to Suicide Prevention and Crisis Care

Enhancing access to suicide prevention and crisis care is a key priority for SAMHSA, and by improving the nation's efforts in this area, individuals experiencing suicidal ideation and other behavioral health crises can thrive and achieve well-being.

Suicide is a preventable cause of premature mortality and a leading cause of death for adults and youth, there have been significant increases in suicidal behaviors among young people during the COVID-19 pandemic.⁹ In 2020, death by suicide was the second leading cause of death for youth ages 10-14 and the third leading cause of death among individuals between the ages of 15-24 in the United States.¹⁰ The [2021 National Survey on Drug Use and Health \(NSDUH\)](#) data estimate that the number of adults with serious thoughts of suicide was 12.3 million, those with plans for suicide was 3.5 million, and those who attempted suicide was about 1.7 million. Comprehensively addressing suicide involves preventive public health interventions as well as clinical workforce improvements so that all providers can consistently identify and provide basic management or evidence-based treatment of those at risk for suicidal ideation and suicidal behaviors. Individuals at risk include those who have indicated plans to complete suicide and those considering attempting suicide as well as individuals who have attempted suicide.

As [SAMHSA's 2020 National Guidelines for Behavioral Health Crisis Care](#) indicate, comprehensive crisis care systems include several core services, such as crisis contact centers, mobile crisis teams, and crisis receiving and stabilizing facilities. More robust, culturally relevant, and responsive systems will be essential to meeting crisis care needs effectively and equitably across the nation. SAMHSA envisions a day when everyone across our country has someone to call, someone to respond, and a safe place to receive help. To help achieve this goal, on July 16, 2022, the National Suicide Prevention Lifeline transitioned to the [988 Suicide and Crisis Lifeline](#). Services provided through this number include direct contact with a trained counselor and referral to services. For situations in which risk is imminent or the crisis is ongoing, a responder such as a mobile crisis response unit can go where the caller is and/or identify a place the caller can go for help. SAMHSA also continues to invest in key suicide prevention efforts such as the Garrett Lee Smith youth suicide prevention and Zero Suicide programs, the Suicide Prevention Resource Center and other needed technical assistance to the field.

States are encouraged to use their Block Grant funds to strengthen suicide prevention efforts for

⁹ Yard E RL, Ballesteros MF, Sheppard M, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12-25 Years Before and During the COVID-19 Pandemic - United States, January 2019-May 2021. *Morb Mortal Wkly Rep.* 2021;70(24):888-894.

¹⁰ National Institute of Mental Health. Suicide. National Institute of Mental Health. Available at: https://www.nimh.nih.gov/health/statistics/suicide#part_2585. Accessed August 15, 2022.

those with SMI and SED and further develop the crisis care system in the state. In particular, States are encouraged to leverage the MHBG's crisis set-aside to provide evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. States may use some or all of the set aside for a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, and regional or State-wide crisis call centers coordinating in real time.

Promoting Resilience and Emotional Health for Children, Youth and Families

Most people with mental health and substance use conditions first manifest signs in childhood, adolescence, and young adulthood. In fact, half of all mental illnesses emerge by the time a child turns 14, and nearly 75% by the time a person is 24 years old¹¹. There is also a significant correlation between adverse childhood experiences (ACEs), which are potentially traumatic events that occur in childhood, as well as aspects of the child's environment that can undermine their sense of safety, stability, and bonding, and negative physical and behavioral health outcomes in adulthood.

Even before the COVID-19 pandemic, the nation's youth were experiencing significant mental health and substance use challenges. Nearly 1 in 5 young people had a diagnosable mental health condition, and 1 in 10 had a serious emotional disturbance that negatively impacted their ability to function at home, in school, or in the community^{12 13}. Unfortunately, many young people do not receive the treatment supports they need. Over half of children/youth with mental health needs did not receive services, and over 96% of young adults with a SUD did not receive appropriate treatment^{14 15}. The pandemic has made this situation even worse with depression and anxiety doubling in youth compared to pre-pandemic levels¹⁶, and more than 215,000 U.S. children have experienced the death of a primary or secondary caregiver due to COVID-19, with children of black, indigenous, and people of color disproportionately impacted^{17 18 19}. The

¹¹ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. Jun 2005;62(6):593-602.

¹² Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children - United States, 2013-2019. *MMWR Suppl*. Feb 25 2022;71(2):1-42.

¹³ Williams NJ, Scott L, Aarons GA. Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis. *Psychiatr Serv*. Jan 1 2018;69(1):32-40

¹⁴ Center for Behavioral Health Statistics and Quality. <https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables>. Available at: <https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables>. Accessed August 15, 2022.

¹⁵ American Academy of Child and Adolescent Psychiatry Committee on Health Care Access and Economics Task Force on Mental Health. Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics*. Apr 2009;123(4):1248-1251.

¹⁶ Racine N, McArthur BA, Cooke JE, Eirich R, Zhu J, Madigan S. Global Prevalence of Depressive and Anxiety Symptoms in Children and Adolescents During COVID-19: A Meta-analysis. *JAMA Pediatr*. Nov 1 2021;175(11):1142-1150.

¹⁷ National Institute on Drug Abuse. COVID-19 & Substance Use. Available at: <https://nida.nih.gov/research-topics/comorbidity/covid19-substance-use>. Accessed September 15, 2022.

¹⁸ Substance Abuse and Mental Health Services Administration. Peer Support. Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peer-support-2017.pdf. Accessed August 15, 2022.

¹⁹ Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. May 1998;14(4):245-258.

Centers for Disease Control and Prevention also released data indicating that 1 in 3 high school students experienced poor mental health during the pandemic and nearly half of students felt persistently sad or hopeless^{20 21}.

SAMHSA’s vision is that all children, youth, young adults, and their families thrive in their homes and communities. SAMHSA encourages states to achieve this through a tiered public health approach that expands access to effective interventions and matches each child with the right service at the right time through a comprehensive and integrated system of care. States can use implementation science, and evidence- and measurement-based approaches to promote wellness and prevention, focus on early identification, and implement quality services and supports to improve the health and well-being of children, youth, young adults, and families.

States are encouraged to use their Block Grant funds to strengthen their systems of care approaches and leverage the MHBG funding dedicated to the system of integrated services for children with SED and the SUPTRS BG primary prevention set-aside in service of this priority.

Integrating Behavioral and Physical Health Care

According to the 2021 NSDUH, 43.7 million people ages 12 and older in the United States needed substance use treatment in the past year; however, only 6.3% reported receiving any. Close to 58 million adults ages 18 or older reported having any mental illness in the past year; while 27.6% of them perceived having an unmet treatment need. People with serious mental illness and SUDs have shorter life expectancies compared to their peers without these conditions. Mortality from mental illness and SUD often stems from the conditions themselves but is regularly compounded by co-occurring physical health conditions.

A key to achieving SAMHSA’s vision is advancing the bi-directional integration of behavioral health with all other health care services and systems. SAMHSA’s integration efforts provide support in areas integral to its mission, including grant programs, technical assistance, training resources, and policy activities. These efforts also include the education and training of primary care providers to better promote prevention, screening, and early behavioral health interventions as well as investing in models that connect individuals with behavioral health issues to needed physical health screening and associated care. SAMHSA is working hard to eliminate the barriers that providers encounter when trying to deliver holistic health care and supports. These barriers are especially profound when serving communities disproportionately affected with co-morbid infectious disease conditions.

States are encouraged to use their Block Grant funds in support of integrated systems of care, with special attention to the physical health care needs of individuals with M/SUD.

Strengthening the Behavioral Health Workforce

The nation’s workforce of mental health and SUD providers is critical to providing Americans

²⁰ Centers for Disease Control and Prevention. Adolescent Behaviors and Experiences Survey (ABES). Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/healthyyouth/data/abes.htm>. Accessed August 15, 2022

²¹ Jones SE, Ethier KA, Hertz M, et al. Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic - Adolescent Behaviors and Experiences Survey, United States, January-June 2021. *MMWR Suppl.* Apr 1 2022;71(3):16-21.

with access to essential health care services. Prior to the pandemic, there was already a projected shortage of behavioral health care providers, with acute shortages predicted for psychiatrists and addiction counselors through 2030. The supply of these providers is likely to be further reduced due to the negative impact of COVID-19 and burnout. At the same time, a higher demand for services is predicted due to increased prevalence of depressive and anxiety disorders and substance use related to COVID-19. Recognizing that a strong behavioral health workforce is critical to providing services to best meet people's needs where they are, the 21st Century Cures Act directed SAMHSA to work with states and other stakeholders to develop and support recruitment and retention efforts specific to addressing mental health and substance use disorders.

This is particularly important considering lack of diversity in the workforce is a systemic issue that contributes to poor health outcomes for racial, ethnic, sexual and gender minorities. The use of telehealth among behavioral health providers is also a promising strategy that can help increase access to mental health and SUD treatment by addressing workforce shortages which are often more pervasive in certain geographic areas.

States are encouraged to use their Block Grant funds towards strengthening the behavioral health workforce by focusing on training and technical assistance, expanding the use of paraprofessionals (i.e., peers), and focusing on increased diversity and cultural competency.

Equity

Behavioral health equity is the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; veterans and military service members; older adults; lesbian, gay, bisexual, transgender, queer/questioning and intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

As population demographics continue to evolve, behavioral health care systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to care, promoting quality programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, SAMHSA will ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, ACEs, and food and housing insecurity, and increasing the usage of culturally and linguistically appropriate services.

In service of [Executive Order 13985](#) (Advancing Racial Equity and Support for Underserved Communities Through the Federal Government), SAMHSA encourages States to better track access, service use, and outcomes for these communities to develop prioritized outreach, engagement, enrollment, and intervention strategies to reduce such disparities.

Recovery

SAMHSA's working definition of recovery is described as a process of change through which

individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. This definition is operationalized through the four major dimensions of recovery: 1) health: overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional wellbeing; 2) home: having a stable and safe place to live; 3) purpose: conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and 4) community: having relationships and social networks that provide support, friendship, love, and hope.

The concept of recovery signals a dramatic shift in the expectation for individuals who experience mental and/or substance use conditions to one in which we expect them to thrive. SAMHSA envisions not only individuals achieving recovery, but also supports developing and sustaining recovery-oriented systems of care and creating recovery facilitating environments. Today, when people with mental health and/or SUD seek help, they are met with the knowledge and belief that anyone can recover and/or manage their conditions successfully.

SAMHSA encourages states to leverage block grant resources to promote individual, program, and system-level approaches that foster health and resilience; increase housing services to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.

Trauma-Informed Approaches

Trauma is a widespread and costly public health problem that occurs as a result of violence, abuse, neglect, loss, disaster, war, pandemic, and other emotionally harmful events. For those with mental health and substance use conditions, trauma is an almost universal experience.

Research has documented the relationships among exposure to traumatic situations, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical and/or behavioral health disorders. Many people who experience trauma may overcome it, with some becoming stronger and more resilient; but for others, trauma can be overwhelming and disruptive. It is also important to recognize that whole communities can share trauma and can be profoundly shaped by traumatic experiences and history.

Trauma-informed approaches recognize and intentionally respond to the lasting adverse effects of experiencing traumatic events. A trauma-informed approach is defined through six key principles: 1) safety: participants and staff feel physically and psychologically safe; 2) peer support: peer support and mutual self-help as vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their lived experience; 3) trustworthiness and transparency: decisions are conducted with the goal of building and maintaining trust; 4) collaboration and mutuality: importance is placed on partnering and leveling power differences; 5) cultural, historical, and gender issues: culture and gender-responsive services are offered while moving beyond stereotypes/biases; and 6) empowerment, voice and choice: organizations foster a belief in the primacy of the people who are served to heal and promote recovery from trauma. It is critical that linkages to recovery and resilience for those individuals and families impacted by trauma are promoted.

Commitment to Data and Evidence

Leveraging data and evidence strengthens SAMHSA’s activities. As the country continues to recover and heal from the collective traumas of COVID-19 and other impactful events such as natural disasters and the overdose epidemic, it is vital that data and evaluation inform policies and determine the impact of programs on mental health and substance use conditions. SAMHSA is steadfast in its efforts to advance the health of the nation while also promoting equity for under-resourced and historically marginalized communities.

Timely, high-quality, ongoing, and specific data help public health officials, policymakers, community practitioners, and the public to understand mental health and substance use trends and how they are evolving; inform the development and implementation of targeted evidence-based interventions; focus resources where they are needed most; and evaluate the success of response efforts. SAMHSA is streamlining and modernizing data collection efforts, while also coordinating evaluation across the agency to ensure funding and policies are data driven. A key objective is to decrease the burden on stakeholders while expanding and improving data collection, analysis, evaluation, and dissemination.

The backbone of a strong behavioral health system is an infrastructure with the ability to collect and analyze epidemiological data on M/SUD and its associated consequences. States must 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 improve health and well-being in all communities. SAMHSA encourages states to leverage block grant resources in support of enhancing data collection, analysis, evaluation, and dissemination.

Evolving Priorities

SAMHSA also recognizes a number of evolving priorities where states may want to focus their efforts.

Alcohol Use Disorder

According to the 2020 NSDUH Annual National Report²², 50.0% of people aged 12 or older (or 138.5 million people) used alcohol in the past month (i.e., current alcohol users), 18.7 percent used a tobacco product, and 13.5 percent used an illicit drug. 40.3 million people aged 12 or older had an SUD in the past year, including 28.3 million who had alcohol use disorder, 18.4 million who had an illicit drug use disorder, and 6.5 million people who had both alcohol use disorder and an illicit drug use disorder. Among people aged 12 or older in 2020, 22.2 percent (or 61.6 million people) were binge alcohol users in the past month. Among the 138.5 million current alcohol users aged 12 or older in 2020, 44.4 percent were past month binge drinkers. Among past month binge drinkers, 17.7 million people (28.8 percent of current binge drinkers and 12.8 percent of current alcohol users) were past month heavy drinkers. Among people aged 12 to 20 in 2020, 16.1 percent were past month alcohol users. Estimates of binge alcohol use and heavy alcohol use in the past month among underage people were 9.2 percent and 1.8 percent, respectively.

The Drug Abuse Warning Network (DAWN): Findings from Drug-Related Emergency Department (ED) Visits, 2021,²³ found that the top five drugs involved in drug-related ED visits

²² <https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report>

²³ <https://store.samhsa.gov/sites/default/files/pep22-07-03-002.pdf>

in 2021 were alcohol (41.70% of all drug-related ED visits), opioids (14.79%), methamphetamine (11.29%), marijuana (11.19%), and cocaine (4.77%). Alcohol was the most common additional drug involved in methamphetamine-, marijuana-, and cocaine-related polysubstance ED visits. And the CDC's [Alcohol-Related Disease Impact \(ARDI\) application](#), found that excessive alcohol use was responsible for more than 140,000 deaths in the United States each year during 2015–2019, or more than 380 deaths per day. Each year, deaths from excessive drinking:

- Shortened the lives of those who died by an average of 26 years, for a total of nearly 3.6 million years of potential life lost.
- Usually involved adults aged 35 or older and males.
- Were mostly due to health effects from drinking too much over time, such as various types of cancer, liver disease, and heart disease.
- Led to premature deaths. Deaths from drinking too much in a short time (from causes such as motor vehicle crashes, poisonings involving substances in addition to alcohol, and suicides) accounted for more than half of the years of potential life lost.

Altogether, these findings reiterate the urgent and longstanding need to connect individuals at risk for or diagnosed with alcohol use disorder and provide training, mentoring, and ongoing support for clinical sites and practitioners seeking to implement comprehensive screening and pharmacological interventions for AUD.

Harm Reduction

Harm reduction²⁴ is an important part of SAMHSA's comprehensive public health approach to addressing substance use disorders, where individuals who use substances set their own goals. Harm reduction is critical to keeping people who use drugs alive and as healthy as possible, and is a key pillar in HHS' overdose prevention strategy.

Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services. Harm reduction approaches incorporate a spectrum of strategies that meet people "where they are" on their own terms, and may serve as a pathway to additional prevention, treatment, and recovery services. Harm reduction works by addressing broader health and social issues through improved policies, programs, and practices.

Harm reduction services save lives by being available and accessible in a manner that emphasizes the need for humility and compassion toward people who use drugs. Harm reduction plays a significant role in preventing drug-related deaths and offering access to healthcare, social services, treatment, and recovery. These services decrease overdose fatalities, acute life-threatening infections related to unsterile drug injection, and chronic diseases such as HIV/HCV.

A comprehensive public health and risk reduction strategy, harm reduction is part of the continuum of care. Harm reduction approaches have proven to prevent death, injury, disease, overdose, and substance misuse. Harm reduction is effective in addressing the public health

²⁴ Guidance on harm reduction services/supplies that are allowable costs which may be covered with SAMHSA funds can be found here: <https://www.samhsa.gov/find-help/harm-reduction>.

epidemic involving substance use as well as infectious disease and other harms associated with drug use. Specifically, harm reduction services can:

Connect individuals to overdose education, counseling, and referral to treatment for infectious diseases and substance use disorders.

- Distribute opioid overdose reversal medications (e.g., naloxone) to individuals at risk of overdose, or to those who might respond to an overdose.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections.
- Reduce infectious disease transmission among people who use drugs, including those who inject drugs by equipping them with accurate information and access to resources.
- Reduce overdose deaths, promote linkages to care, facilitate co-location of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders
- Promote a philosophy of hope and healing by engaging those with lived experience of recovery in the management of harm reduction services, and connecting those who have expressed interest to treatment, peer support workers and other recovery support services.

Health Information Technology

The use of technologies may support better access to services. Certainly, health information technology (HIT) played a crucial role through COVID-19 towards ensuring individuals retained or had access to behavioral health services. Technology is playing a growing role in how individuals learn about, receive, and experience their behavioral 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. Where necessary and appropriate to meet programmatic expectations, SAMHSA grantees that provide clinical or other indicated services to individuals are encouraged to demonstrate ongoing clinical use of an 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.

States can leverage block grant dollars towards adoption of HIT and systems for providers that serve that targeted population and that meet the standards and certifications required for interoperable health information technology as issued by the Office of the National Coordinator for Health Information Technology (ONC).²⁵ 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 services delivered. Current laws will require these systems to comply with national standards such as national provider numbers, International Classification of Diseases, 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

²⁵ 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).

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 SAMHSA²⁶ and ONC²⁷.

States should 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.

Criminal Justice

SAMHSA strongly encourages state behavioral health authorities to continue to work closely with their state courts to ensure the best coordination of services and outcomes, in light of pervasive health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. This includes establishing effective partnerships between state behavioral health systems, providers, and state courts. Unfortunately, for many individuals and their families experiencing SMI, SED, and/or SUD, the state and local justice system is at times the entry point for obtaining treatment and services. Courts and criminal justice systems are a referral source for behavioral health treatment, and jails and detention centers are often major providers of behavioral health services requiring coordination with broader community behavioral health systems. Creating effective partnerships between state and local behavioral health and justice system leaders and agencies to develop and support systems to divert individuals with mental and substance use disorders from the criminal justice system, including jail diversion teams, police crisis intervention teams, police drop off assessment centers, certified community behavioral health clinics, the 988 effort, and court-based programs, are essential elements of all state plans.

Climate Change

Increasingly, climate related environmental changes are impacting, directly and indirectly, individuals, providers, caregivers, and communities experiencing behavioral health conditions. For instance, climate change may increase the likelihood of extreme weather events, such as heatwaves, that adversely impact persons with psychiatric conditions. Hurricanes may exacerbate suffering for those with behavioral health conditions. As well, growing numbers of youth and others are experiencing heightened anxiety related to current and potential impacts of climate change. Emergencies and disasters such as hurricanes also can disrupt access to and participation in substance use disorder treatment. SAMHSA is actively collaborating with a wide range of governmental and non-governmental partners to foster preparedness including the Administration for Strategic Preparedness and Response (ASPR), the Federal Emergency Management Agency (FEMA), and the HHS Office of Climate Change and Health Equity (OCCHE) to ensure inclusion of behavioral health needs in federal, state, local, tribal, and territorial emergency and disaster planning.

SAMHSA similarly encourages SMHAs and SSAs to foster collaboration among governmental

²⁶ <https://www.samhsa.gov/section-223/certification-resource-guides/health-information-technology>

²⁷ <https://www.healthit.gov/>

and non-governmental partners to strengthen community resilience, preparedness, response, and recovery in situations of emergencies and disasters. SAMHSA notes that underserved populations may be among those more vulnerable to emergencies and disasters and urges that Block Grant recipients consider especially the needs of such populations. SAMHSA also notes that underserved populations and persons with behavioral health conditions face increased risks from climate change, the COVID-19 public health emergency and other ongoing and potential future challenges. Taking all of this into account, in situations where State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) have identified environmental factors where climate related events are part of community and/or individual mental health and substance use conditions, the State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) may incorporate climate-informed approaches in clinical and non-clinical mental health and substance use treatment and prevention.

Parity

Many health plans must comply with requirements regarding parity in coverage of M/SUD benefits in relation to medical/surgical benefits under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008²⁸. Generally, MHPAEA requires that the financial requirements (such as deductibles, copayments, or coinsurance) and treatment limitations imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to most physical health benefits.

States play an important role in the implementation and enforcement of parity protections, particularly in the oversight of Medicaid plans and private health plans that are subject to parity protections. States also have a role in working with providers and individuals and families that access mental health and substance use disorder services to ensure that people are aware of parity protections and know where to go if they feel that they may have experienced a violation of federal or state parity laws and regulations. State agencies (including SMHAs and SSAs, Medicaid, and departments of insurance) can work in partnership to ensure that their citizens are able to access the behavioral health benefits and services that they are entitled to under parity requirements.

SAMHSA published “[The Essential Aspects of Parity: A Training Tool for Policymakers](#),” which provides state regulators and behavioral health staff an overview of mental health and substance use disorder parity and how to implement and comply with the federal parity law regarding employee-sponsored health plans and group and individual health insurance.

Sustainability

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 strategies that allow providers to leverage existing funding, promote sustainability, and be less dependent on SMHA and SSA funding. 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, Accountable Care Organizations, Certified Community Behavioral Health Centers, the Value in Opioid Use Disorder Treatment Program,

²⁸ <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>

Integrated Care for Kids (InCK) Model, and Financial Alignment Initiative for Medicare-Medicaid Enrollees) that support efforts to provide M/SUD services. States may also find the [Medicare-Medicaid-Coordination Office](#) a helpful resource in serving people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals. CMS recently released guidance on [mobile crisis services](#) and [behavioral health services for children and youth](#) amongst other guidance available on mental health and substance use treatment services, integrated services, and collaborative care, available here: <https://www.medicicaid.gov/federal-policy-guidance/index.html>.

In December 2016, the 21st Century Cures Act was signed into law. Through this Act (Public Law 114-255), the [Interdepartmental Serious Mental Illness Coordinating Committee](#) (ISMICC) was established to make recommendations for actions that federal departments can take to better coordinate the administration of mental health services for adults with a serious mental illness or children with a serious emotional disturbance. This committee has been chaired by the Assistant Secretary of Mental Health And Substance Use and works to coordinate programs and policy across the whole of government.

Beyond SAMHSA and CMS, there have been broad investments in access to M/SUD services across the federal government. For example, HHS/Health Resources and Services Administration (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.

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.

SMHAs and SSAs (as well as public health authorities responsible for prevention) should conduct a thorough survey to identify these potential resources, develop a strategy for matching resources to appropriate providers, 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.

II. SUBMISSION OF APPLICATION AND PLAN TIMEFRAMES

Statutory Deadlines

Statutory deadlines and block grant award periods remain unchanged. Applications for MHBG only are due no later than September 1, 2023. Applications for SUPTRS BG only are due no later than October 2, 2023. Combined Applications for MHBG and SUPTRS BG are due no later than September 1, 2023. SAMHSA encourages states to turn in their Application as early as possible to allow for a full discussion and review by SAMHSA. MHBG and SUPTRS BG Reports are due by December 1, 2023. For the SUPTRS BG, the Annual Synar Report is due by

December 31, 2023.

Application	Due Date	Report Deadline
MHBG	September 1, 2023	December 1, 2023
SUPTRS BG	October 2, 2023	December 1, 2023
Annual Synar Report	N/A	December 31, 2023
Combined MHBG & SUPTRS BG	September 1, 2023	December 1, 2023

States should submit their respective MHBG and SUPTRS BG Application(s) for FFYs 2024 and 2025 based on the guidance provided in this document. The FFY 2024-2025 MHBG and SUPTRS BG 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. Please see “Mental and Substance Use Disorder Assessment and Plan” for more details.

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

Application Requirements

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 SUPTRS BG funds. The funds awarded will be available for obligation and expenditure²⁹ to plan, carry out, and evaluate activities and services for children with SED and adults with SMI; substance use primary 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 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 report³⁰ in the proper format containing information that the Secretary determines to be necessary for

²⁹ Title XIX, Part B of the PHS Act, <http://www.samhsa.gov/grants/block-grants/laws-regulations>

³⁰ 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>

securing a record and description of the purposes for which both the MHBG and SUPTRS BG 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, certified community behavioral health clinics, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health consumer-directed programs) which meet the criteria as described in [42 USC §300x-2 \(c\)](#).

The MHBG portion of the statute requires the states expend the grant funds only for the purpose of providing community mental health services for adults with SMI and children with SED. In addition, states may use the funds to evaluate programs and services carried out under the plan; and for planning, administration, and educational activities related to providing services under the plan.

Restrictions of use payments for MHBG funds include, inpatient services, cash payments to intended recipients of health services, purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase of major medical equipment, and to use the MHBG to satisfy any requirement of expenditure of non-federal funds as a condition for the receipt of federal funds, and to provide financial assistance to any entity other than a public or nonprofit private entity.

The SUPTRS BG portion of the statute requires that the States will expend the grant only for the purpose of carrying out the plan developed in accordance with the statute, and for planning, carrying out, and evaluating activities to prevent and treat substance use disorders and for related activities authorized in the statute ([42 U.S.C. §300x-21 \(b\)](#)).

The SUPTRS BG contains certain spending restrictions, including not expending funds for inpatient hospital services except as provided for in the regulations; prohibits cash payments to clients; disallows the purchase, construction, or improvement of land or buildings; and other categories, including a limitation of up to 5% of SUPTRS BG for SSA expenditures related to the administration of the grant.

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 \(b\) \(1\) \(A\)](#)³¹) and MHBG funds must be used for those activities that are allowable based on statute. The SUPTRS BG portion of the statute provides for the application for the grant, and approval of a State plan that includes a comprehensive description of the State's system of care, the establishment of goals and objectives for the period of the plan, and a description of how the State will comply with each funding agreement for the grant, including a description of the manner in which the State intends to expend grant funds ([42 U.S.C. §300x-32 \(b\) \(1\) \(A\)-\(C\)](#)). 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

³¹ 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>

its goals. In addition, this information will identify states that are models and assist other states with areas of common concern.

Required Sections and Tables

The FFY 2024-2025 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; and (4) develop goals, objectives, strategies, and performance indicators.

Section III.B, Plan Table 1 (Priority Area and Annual Performance Indicators), 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 SUPTRS BG. For the SUPTRS BG, Plan Table 3 (SUPTRS BG Persons in need/receipt of treatment), Table 5a (SUPTRS BG Primary Prevention Planned Expenditures) and Table 5b (SUPTRS BG Planned Primary Prevention Prioritized Priorities) are required.

III. MENTAL AND SUBSTANCE USE DISORDER ASSESSMENT AND PLAN

The Plan provides a framework for SMHAs and SSAs to assess the strengths and needs of their systems and to plan for system improvement. The unique statutory and regulatory requirements of the specific block grants are described in the State Plan section. The Plan will cover a two-year period aligning with states' budget cycle for SFY 2024-2025. States will have the option to update their Plans when they submit their FFY 2025 Application.

The FFY 2024-2025 Plan seeks to collect information from states regarding their activities in response to federal laws, initiatives, changes in technology, and advances in research, implementation of innovative practices, and knowledge. The FFY 2024-2025 Plan has sections that are required and other sections that list SAMHSA priorities. The SAMHSA priority sections are 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 the information that is required.

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 substance use disorder stakeholders and use this mechanism to assist in the development of the state block grant plan for the SUPTRS BG application. States must describe the stakeholder input process for the development of both the SUPTRS BG and the MHBG plan, as mandated by section [1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#)³², which requires that the state block grant 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 in recovery, families of individuals with M/SUD, providers of services and supports, representatives from underserved communities (as defined under [EO 13985](#)), 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 SUPTRS BG.

A. Framework for Planning

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

MHBG Framework

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, 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 MHBG plans. 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, inclusive of the crisis services, provided with federal, state, and other public and private resources, in order to enable such individuals to function outside of inpatient or

³² 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.

residential institutions to the maximum extent of their capabilities.

- *Criterion 2: Mental Health System Data Epidemiology:* Contains a state-level estimate of the incidence and prevalence of SMI among adults and SED among children; and includes 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 for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include social services; child welfare services; educational services, including services provided under the Individuals with Disabilities Education Act; juvenile justice services; substance use disorder 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 for 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.

The MHBG Plan must include the following elements:

Element 1: 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 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 the National Institute of Mental Health (NIMH), as needed, 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.

Element 2: The MHBG statute 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 serious mental illnesses 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, and regional or State-wide crisis call centers coordinating in real time.

Element 3: States are required to provide services for children with SED and their families or other caregivers. 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.

Element 4: States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory maintenance of effort (MOE) requirements. 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 maintenance of effort calculation should include the appropriate MOE approval documents.

SUPTRS BG Framework

The SUPTRS BG program provides substance use primary prevention, SUD treatment and recovery support 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 SUPTRS BG funds to plan, carry out and evaluate activities and services designed to prevent and treat substance use disorders. 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 Substance Use Primary 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 substance use primary prevention programs, defined as programs for individuals who do not require treatment for substance use disorders. States must utilize this set-aside to implement at least one of the six strategies and to carry out Section 1926 –Tobacco activities. States may utilize funds for non-direct services also.
- *Criterion 3: Pregnant Women and Women with Dependent Children* ([42 U.S.C. § 300x-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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds for elements of a syringe services program (SSP) pursuant to guidance developed by the HHS' Office of HIV/AIDS and Infectious Disease Policy ([OHIDP](#)).
- *Criterion 5: Tuberculosis Services* ([42 U.S.C. § 300x-24\(a\)](#) and [45 CFR § 96.127](#)). In accordance with §96.127, the state is required to make identified tuberculosis (TB) services available to each individual receiving SUD treatment services from the state's SUPTRS BG approved SUD treatment providers. The state is required to assure that the SUPTRS BG sub-recipients' activities being provided with these SUPTRS BG funds are limited to those §96.121 SUPTRS BG defined Tuberculosis Services and that the grantee's expenditure of SUPTRS BG funds for such services has been the "payment of last resort" in accordance with §96.137 Payment Schedule. Services include counseling, testing, and referral to appropriate medical evaluation and treatment.
- *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 SUPTRS BG 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.
- *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 SUPTRS BG funds to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder 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 substance use primary prevention and treatment services, performance-based

accountability, data collection and reporting requirements, and any other matters that would serve to further improve the delivery of substance use primary prevention, treatment, and recovery support services within the state.

The SUPTRS BG Plan must include a variety of other elements, as well:

Element 1: The authorizing legislation and implementing regulations for the SUPTRS BG includes a specific SUPTRS BG State MOE Expenditure Requirement. A state must maintain its state expenditures for certain SUD prevention, treatment, and recovery support activities at a level that is no less than the state's average expenditures for the previous two state fiscal years. State required MOE contribution for SFY 2021 was \$3.3 billion and actual state expenditures exceeded \$3.4 billion. States that do not meet the MOE requirement due to extenuating circumstances are given options to resolve their MOE deficiencies through a request for a waiver from the Assistant Secretary for Mental Health and Substance Use under the applicable statute and regulations.

Element 2: Beginning in FY 1995 and subsequent fiscal years, states are required to "expend for such services for such women not less than an amount equal to the amount expended in by the state for fiscal year 1994." Therefore, for FY 1995 and subsequent fiscal years, the Women's Services MOE became a performance requirement that provides states with the flexibility to expend a combination of SUPTRS BG and state funds to support treatment services for pregnant women and women with dependent children. The SFY 21 SUPTRS BG MOE 1994 Baseline Requirement for Women's Services reported required contributions for states and territories as totaling \$197,203,799, and actual or estimated expenditures totals as \$281,194,421. As a result of a shortfall in the Women's Services MOE Expenditure Requirement, a state may submit and receive approval for a related waiver from the Assistant Secretary under the applicable statute and regulations.

Element 3: 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 at least one of the six prevention strategies: Information dissemination; Education; Alternatives that decrease alcohol, tobacco, and other drug use; Problem identification and referral; 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 misuse of alcohol, tobacco, and other drugs used in the general population. SUPTRS BG primary prevention set-aside funds can only be used to fund strategies that prevent substance misuse.

Prevention efforts should 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](#)³³ and [Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health](#), SAMHSA's [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 SUPTRS BG and the parameters of the specific populations that are being served (e.g. [Blueprints for Healthy Youth Development](#)).

³³ <https://www.ncbi.nlm.nih.gov/books/NBK44360/>

These prevention efforts can include: tobacco use prevention and tobacco-free facilities that are supported by research and encompass a range of activities including policy initiatives and programs; engaging 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; implement evidence-based and cost-effective models to prevent substance use disorders in young people in a variety of community settings, e.g., families, schools, workplaces, and faith-based institutions, consistent with the current science; 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; and addressing underserve communities that experience a cluster of risk factors that make them especially vulnerable to substance use and related problems.

Populations Served

At a minimum, the plan should address the following populations as appropriate for each block grant. (**Populations marked with an asterisk are required to be included in the state's needs assessment for the MHBG or SUPTRS BG. 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:
 - 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 an Early Serious Mental Illness (ESMI) (10 percent MHBG set aside)
 - Individuals in need of behavioral health crisis services (BHCS) (5 percent MHBG set aside)

2. (SUPTRS BG) Services for persons with or at risk of having substance use disorder:
 - Persons who inject drugs*
 - Adolescents with a substance use disorder or a substance use disorder with a co-occurring mental health problems.
 - Children and youth who are at risk for substance misuse or addiction, which may include a co-occurring conduct disorder, anxiety, depression, or other mental, emotional, and behavioral disorders.
 - Women who are pregnant and have a substance use disorder or a substance use disorder with a co-occurring mental disorder*
 - Parents with a substance use disorder who have dependent children*
 - Military personnel (active, guard, reserve, and veteran) and their families
 - American Indians/Alaska Natives and other underserved populations, per EO 13985.

3. (SUPTRS BG) Services for persons with SUD who are at risk of contracting communicable diseases:
 - Individuals with, or at risk for, 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 are in need of substance use disorder early intervention, treatment, recovery support, or prevention services*³⁴
 - The National HIV/AIDS Strategy (NHAS) for the United States and NHAS Implementation Plan ³⁵
 - 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. (SUPTRS BG) Services for individuals in need of substance use primary prevention*

5. (MHBG and SUPTRS BG) In addition to the prioritized/required populations and/or services referenced in statute, states are strongly encouraged to consider the following populations, and/or services:
 - Individuals with mental and/or substance use disorders who experience homelessness or 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 LGBTQI+ populations
 - Persons with disabilities
 - Members of religious minorities
 - 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
 - Individuals new in their recovery who require additional recovery support services,

³⁴ 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 section 45 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 AtlasPlus HIV data report produced by the CDC, National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention (NCHHSTP). The HIV Surveillance Report, Volume 25, most current NCHHSTP AtlasPlus HIV data report will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SUPTRS BG 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG 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 SUPTRS BG funds for EIS/HIV if they chose to do so, and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

³⁵ <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update>

as appropriate, to maintain their recovery.

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

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

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, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-

SSATS), the Behavioral Health Barometer, [Behavioral Risk Factor Surveillance System \(BRFSS\)](#) , [Youth Risk Behavior Surveillance System \(YRBSS\)](#), the [Uniform Reporting System \(URS\)](#), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under [EO 13985](#). States are encouraged to refer to the [IOM reports, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement](#) and [The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding](#)³⁶ in developing this narrative.

Step 3: Prioritize state planning activities

Prioritize state planning activities that will include MHBG and SUPTRS BG. The priorities must include the core federal Block Grant goals and aims of the MHBG and SUPTRS BG programs, as well as state programs with a focus on target priority 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), substance use disorder recovery (SAR), mental health services (MHS), early serious mental illness (ESMI), and behavioral health crisis services_(BHCS).

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. 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.

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

Strategies to consider and address include:

- Strategies that support successful integration and attention to SAMHSA’s five priorities

³⁶ 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.

(i.e., overdose prevention; enhancing access to suicide prevention and crisis care; promoting resilience and emotional health for children, youth, and families; integrating behavioral and physical health care; and strengthening the behavioral health workforce) and four guiding principles (i.e., equity, trauma-informed approaches, recovery, and a commitment to data and evidence), as outlined above.

- Strategies that will 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 that result in developing recovery support services (e.g., peer support services, recovery housing, permanent housing and supportive employment or education for persons with mental and substance use disorders). 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 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. Strategies should address workforce training in person centered planning and service systems, Shared Decision Making and patient/client reported outcomes.
- Strategies to address system improvement activities, as identified in the needs assessment, which 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 mental and substance use disorders 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 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. 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.

States are encouraged to provide workforce training to non-peer staff supervisors and administrators on the purpose, roles, and activities of peer support specialists/recovery coaches consistent with the code of ethics and scope of practice for peer supports in their locality.

- 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 mental and substance use disorders. 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 2024 and how the state proposes to measure the change in FFY 2025. 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* to complete Plan Table 1. States are to complete a separate table for each state priority area to be included in the MHBG and SUPTRS BG. 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** – substance use primary prevention, **SAT** – substance use disorder treatment, **SAR** – substance use disorder

recovery support, **MHS** – mental health service, **ESMI** – early serious mental illness, or **BHCS** – behavioral health crisis services.

3. *Priority/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*. 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. **BHCS:** Individuals in need of behavioral health crisis services,
 - e. **PWWDC:** Pregnant women and women with dependent children who are receiving SUD treatment services,
 - f. **PP:** persons in need of substance use primary prevention,
 - g. **PWID:** Persons who inject drugs (formerly known as intravenous drug users, IVDU),
 - h. **EIS (Early Intervention Services)/HIV:** Persons with or at risk of HIV/AIDS who are receiving SUD treatment services,
 - i. **TB:** Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or
 - j. **Other-** Specify (Refer to section IIIA of the Assessment and Plan).
4. *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 an indicator is completed within the WebBGAS system for the first indicator, the table will then 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 2024)
 - c) Second-year target/outcome measurement (Final to the end of SFY 2025)
 - 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, SAR, MHS, ESMI, BHCS):
3. Population(s) (SMI, SED, ESMI, BHCS, 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 2024):
b) First-year target/outcome measurement (Progress to the end of SFY 2024):
c) Second-year target/outcome measurement (Final to the end of SFY 2025):
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.

Plan Table 2: State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (7/1/23-6/30/25). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

*Please note that MHBG and SUPTRS BG 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

MHBG Table 2a									
Planning Period:		From:			To:				
State Identifier									
State Agency Planned Expenditures									
Activity	A. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other	G. COVID-19 Relief Funds (MHBG) ^a	H. ARP Funds (MHBG) ^b	I. Bipartisan Safer Communities Funds ^c
1. Mental Health Prevention ^d	\$	\$	\$	\$	\$	\$	\$	\$	\$
2. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award) ^e	\$	\$	\$	\$	\$	\$	\$	\$	\$
3. State Hospital		\$	\$	\$	\$	\$	\$	\$	\$
4. Other Psychiatric Inpatient Care		\$	\$	\$	\$	\$	\$	\$	\$
5. Other 24-Hour Care (Residential Care)	\$	\$	\$	\$	\$	\$	\$	\$	\$
6. Ambulatory/Community Non-24 Hour Care	\$	\$	\$	\$	\$	\$	\$	\$	\$
7. Crisis Services (5 percent Set-Aside) ^f	\$	\$	\$	\$	\$	\$	\$	\$	\$

Table 2a (Cont.)	A.	B.	C.	D.	E.	F.	G.	H.	I.
Activity	Mental Health Block Grant	Medicaid (Federal, State, and Local)	Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.)	State Funds	Local Funds (excluding local Medicaid)	Other	COVID-19 Relief Funds (MHBG) ^a	ARP Funds (MHBG) ^b	Bipartisan Safer Communities Funds ^c
8. Administration (Excluding Program and Provider Level) ^g	\$	\$	\$	\$	\$	\$	\$	\$	\$
9. 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. Columns G should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

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

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

^e Column 2A should include Early Serious Mental Illness programs funded through MHBG set aside.

^f Row 7 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

^f Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

Plan Table 2b. State Agency Planned Expenditures

SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG

ACTIVITY (See instructions for using Row 1.)	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SUPTRS BG) ^a	J. ARP Funds (SUPTRS BG) ^b
1. Substance Use Prevention and Treatment	\$		\$	\$	\$	\$	\$		\$	\$
a. Pregnant Women and Women with Dependent Children*										
b. Recovery Support Services										
a. All Other										
2. Primary Prevention	\$		\$	\$	\$	\$	\$		\$	\$
a. Substance Use 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. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State funds	F. Local funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SUPTRS BG) ^a	J. ARP Funds (SUPTRS BG) ^b
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program / provider level) MHBG and SUPTRS BG must be reported separately g										
10. Crisis Services (5 percent set-aside) ^h										
12. Total	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

^aThe 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the standard MHBG/SUPTRS BG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2023 – June 30, 2025, for most states. Please enter SUPTRS BG COVID-19 planned expenditures for the period of 7/1/23 through 6/30/25.

^bThe expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of 7/1/23 through 6/30/25.

^cPrevention other than primary prevention

^dThe 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

^eWhile 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

^fColumn 3B should include Early Serious Mental Illness programs funded through MHBG set aside. Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

^gRow 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: SUPTRS BG Persons in need/receipt of SUD treatment

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

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

Plan Table 3 SUPTRS BG 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: SUPTRS BG Planned Expenditures

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

Plan Table 4 SUPTRS BG Planned Expenditures						
State Identifier:						
Expenditure Category	FFY 2024 SUPTRS BG	COVID-19 Award ¹	ARP Award ²	FFY 2025 SUPTRS BG	COVID-19 Award ¹	ARP Award ²
1. Substance Use Disorder Prevention³ and Treatment	\$	\$	\$	\$	\$	\$
2. Substance Use Primary Prevention	\$	\$	\$	\$	\$	\$
3. Early Intervention Services for HIV⁴	\$	\$	\$	\$	\$	\$
4. Tuberculosis Services	\$	\$	\$	\$	\$	\$
5. Recovery Support Services⁵						
6. Administration (SSA level only)	\$	\$	\$	\$	\$	\$
7. Total	\$	\$	\$	\$	\$	\$

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the planning period for the standard SUPTRS BG expenditures for the FFY 2024 SUPTRS BG Award is October 1, 2023 - September 30, 2024. For purposes of this table, all COVID-19 Relief Supplemental planned expenditures between 10/1/23 and 9/30/24 should be entered in this first COVID-19 column, and all COVID 19 Relief Supplemental planned expenditures between 10/1/24 and 9/30/25 should be entered in the second COVID-19 column.

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

entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column

²Prevention other than Primary Prevention

⁴For the purpose of determining which states and jurisdictions are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP).. The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

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

Table 5a: Primary Prevention Planned Expenditures

States must spend no less than 20 percent of their SUPTRS BG award on substance use primary prevention strategies. The state must spend the majority of the funds implementing a comprehensive primary prevention approach that includes at least one of the six substance use primary prevention strategies, as applicable. These strategies are directed at individuals not meeting the diagnostic criteria for a SUD or identified to not be in need of treatment. To report on their primary prevention planned expenditures, states must complete Table 5a.

States need to make the most efficient use of funds for substance use primary 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 substance use primary prevention system. Specifically, SAMHSA recommends that states align the 20 percent set-aside for primary prevention of the SUPTRS BG with other federal, state, and local funding that will aid the state in developing and maintaining a comprehensive substance use primary prevention system, as well as collaborate with and assure that behavioral health is part of the state's larger public health prevention activities.

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

The state's primary prevention program must include at least one of the six primary prevention strategies defined below. On Table 5a, states should list their FFY 2024 and FFY 2025 SUPTRS BG planned expenditures within the six primary prevention strategies, depending on capacity and other factors. Expenditures within 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 SUPTRS BG amount should equal the amount reported on Plan Table 4, Row 2, Substance Use Primary 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, misuse, 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 - 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 is in need of 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 2024 and FFY 2025 SUPTRS BG 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 prioritized. Definitions for these categories appear below:

Universal: Activities prioritized 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 policies regarding alcohol, tobacco, and other drugs (ATOD), modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

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

Indicated: Activities prioritized 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 Use 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: SUPTRS BG Primary Prevention Planned Expenditures							
State Identifier:							
Report Period- From:				To:			
Strategy	A IOM Target	B FFY 2024			C FFY 2025		
		SUPTRS BG	COVID-19 ¹	ARP ²	SUPTR S BG	COVID- 19 ¹	ARP ²
1. Information Dissemination	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						
2. Education	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						
3. Alternatives	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						
4. Problem Identification and Referral	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						

5. Community-Based Processes	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						
6. Environmental	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						
7. Section 1926 (Synar)-Tobacco	Universal	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
	Total						
8. Other	Universal Direct	\$			\$		
	Universal Indirect	\$			\$		
	Selective	\$			\$		
	Indicated	\$			\$		
	Unspecified	\$			\$		
		SUPTRS BG	COVID-19 ¹	ARP ²	SUPTRS BG	COVID-19 ¹	ARP ²
	Total						
9. Total Prevention Expenditures		\$			\$		
Total Award ³		\$			\$		
Planned Primary Prevention Percentage		%			%		

¹The 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” SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025, for most states.

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

³Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures Plan Table 5b: SUPTRS BG Planned Primary Prevention Priorities (Required) States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards. Planning Period Start Date: 10/12023

Planning Period End Date: 9/30/2025

	SUPTRS BG Award	COVID-19 Award¹	ARP Award²
Prioritized Substances			
Alcohol			
Tobacco			
Marijuana			
Prescription Drugs			
Cocaine			
Heroin			
Inhalants			
Methamphetamine			
Fentanyl			

Priority Populations			
Students in College			
Military Families			
LGBTQI+			
American Indian/Alaska Native			
African American			
Hispanic			
Persons Experiencing Homelessness			
Native Hawaiian/Pacific Islander			
Asian			
Rural			

Priority Populations			
Other Underserved Racial and Ethnic Minorities			

Footnotes:

¹The 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” SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025, for most states.

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

Plan Table 6

Categories for Expenditures for System Development/Non-Direct-Service Activities

Please note there are separate tables for MHBG and SUPTRS BG. Only complete this table if the state plans to fund expenditures for non-direct services/system development with MHBG, SUPTRS BG, COVID-19, BSCA, 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 SUPTRS BG 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 or substance use disorder “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, and if the preponderance of the activity fits within a category. 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 SUPTRS BG 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 SUPTRS BG.

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 substance use disorder service delivery (prevention, treatment and recovery) for SUPTRS BG 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.

Table 6a: Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

Non-Direct-Services/System Development								
MHBG Table 6a								
State Identifier:								
MHBG Planning Period		From:			To:			
Activity	A. FY24Block Grant	B. FY24 COVID Funds ¹	C. FY24ARP Funds ²	D.FY24 BSCA Funds ³	E. FY25 Block Grant	F. FY25 COVID Funds ¹	G. FY25ARP funds ²	H. FY25 BSCA Funds ³
1. Information Systems	\$	\$	\$		\$	\$	\$	
2. Infrastructure Support	\$	\$	\$		\$	\$	\$	
3. Partnerships, community outreach, and needs assessment	\$	\$	\$		\$	\$	\$	
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	\$	\$	\$		\$	\$	\$	
5. Quality assurance and improvement	\$	\$	\$		\$	\$	\$	
6. Research and Evaluation	\$	\$	\$		\$	\$	\$	
7. Training and Education	\$	\$	\$		\$	\$	\$	
8. Total	\$	\$	\$		\$	\$	\$	

¹The 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, 2023 – June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

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

Table 6b: Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds to be expended for each activity.

SUPTRS BG Table 6b										
Non-Direct-Services/System Development										
	FFY 2024					FFY 2025				
Activity	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated ¹	D. COVID-19 ²	E. ARP ³	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated ¹	D. COVID-19 ²	E. ARP ³
1. Information Systems										
2. Infrastructure Support										
3. Partnerships, community outreach, and needs assessment										
4. Planning Council Activities (MHBG required, SUPTRS BG optional)										
5. Quality assurance and improvement										
6. Research and Evaluation										
7. Training and Education										
8. Total	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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

²The 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" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list COVID-19 planned expenditures for each standard FFY period.

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

C. Environmental Factors and Plan

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

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

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: <https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001>; <https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983>. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.³⁷ Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in an efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity, seriousness, and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental

³⁷ 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. Available at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

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

- a) Adults with serious mental illness
- b) Pregnant women with substance use disorders
- c) Women with substance use disorders who have dependent children
- d) Persons who inject drugs
- e) Persons with substance use disorders who have, or are at risk for, HIV or TB
- f) Persons with substance use disorders in the justice system
- g) Persons using substances who are at risk for overdose or suicide
- h) Other adults with substance use disorders
- i) Children and youth with serious emotional disturbances or substance use disorders
- j) Individuals with co-occurring mental and substance use disorders

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 serious mental illness
 - b) Adults with substance use disorders
 - c) Children and youth with serious emotional disturbances or substance use disorders

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.

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

2. Health Disparities - Required

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)³⁸, [Healthy People, 2020](#)³⁹, [National](#)

³⁸ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

³⁹ <http://www.healthypeople.gov/2020/default.aspx>

[Stakeholder Strategy for Achieving Health Equity](#)⁴⁰, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the [Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS).⁴¹

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.⁴² 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.⁴³ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed

⁴⁰https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴¹<http://www.ThinkCulturalHealth.hhs.gov>

⁴²<https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status>

⁴³ : <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>

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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The [National Center of Excellence for Integrated Health Solutions](#)⁴⁴ offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

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⁴⁴ <https://www.thenationalcouncil.org/program/center-of-excellence/>

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SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,⁴⁶ The New Freedom Commission on Mental Health,⁴⁷ the IOM,⁴⁸ NQF, and the [Interdepartmental Serious Mental Illness Coordinating Committee \(ISMICC\)](#).⁴⁸

⁴⁵ <https://www.thenationalcouncil.org/program/center-of-excellence/>

⁴⁶ 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

⁴⁷ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

⁴⁸ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

One activity of the EBPRC⁴⁹ was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”⁵⁰ SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA’s Treatment Improvement Protocol Series ([TIPS](#))⁵¹ 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 alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵² was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers’ decisions regarding value-based purchase of M/SUD services. 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):

⁴⁹ <https://www.samhsa.gov/ebp-resource-center/about>

⁵⁰ <http://psychiatryonline.org/>

⁵¹ <http://store.samhsa.gov>

⁵² <https://store.samhsa.gov/?f%5B0%5D=series%3A5558>

- 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 individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms but may also improve long-term prognosis.

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

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

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 early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with an 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 24 and FY 25 (only include MHBG funds).

FY2024	FY 2025

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/FEP?

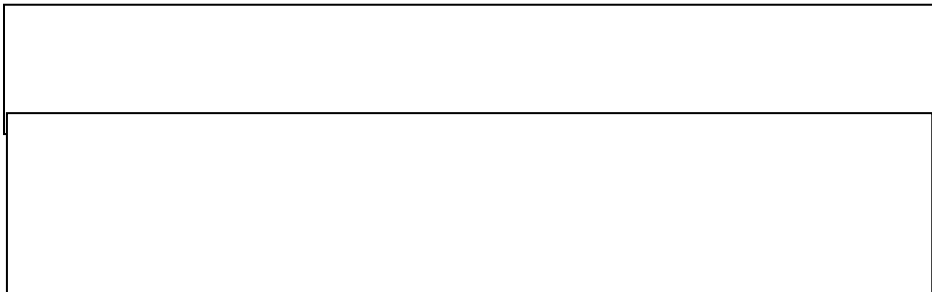
Yes No

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 FY2024 and FY2025 for your state's ESMI/FEP programs.

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

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

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

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



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

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

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

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

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

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.

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

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

6. Program I

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of

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

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

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

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

Please respond to the following:

- 1) Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
- 2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
 Yes No

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

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](#)⁵³ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

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

⁵³

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

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 have 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, SUPTRS BG only

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

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The

program must include, but is not limited to, the following strategies:

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

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

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 SUPTRS BG primary prevention funds?

- a) Yes No

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

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

6. Does your state integrate National CLAS Standards⁵⁴ 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 substance use primary prevention workforce?

⁵⁴ <https://thinkculturalhealth.hhs.gov/clas>

a) Yes (if yes, please describe)

b) No

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary 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 the National CLAS Standards into the capacity building step?

- a) Yes No

i) If yes, 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 substance use primary prevention that was developed within the last five years?

- a) Yes (If yes, please attach the plan in WebBGAS)

- b) No

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

- 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 SUPTRS BG primary prevention funds

- b) Timelines

- c) Roles and responsibilities

- d) Process indicators
- e) Outcome indicators
- f) Cultural competence component (i.e., National CLAS Standards)
- 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 SUPTRS BG 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 SUPTRS BG 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 the National CLAS Standards 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 SUPTRS BG primary prevention funds in a variety of different ways.

Please check all that apply to your state:

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

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

a) Information Dissemination:

b) Education:

c) Alternatives:

d) Referral:

Problem Identification and

e) Community-Based Processes:

f) Environmental:

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

a) Yes (if so, please describe)

b) No

4. Does your state integrate National CLAS Standards 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 substance use primary prevention that was developed within the last five years?

a) Yes (If yes, please attach the plan in WebBGAS)

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 prioritized 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 SUPTRS BG funded prevention services:

a) Numbers served

b) Implementation fidelity

c) Participant satisfaction

d) Number of evidence-based programs/practices/policies implemented

e) Attendance

f) Demographic information

g) Other (please describe)

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

a) 30-day use of alcohol, tobacco, prescription drugs, etc.

b) Heavy 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 the National CLAS Standards 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)

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

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

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.

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

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.

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		

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

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

Criterion 3: Children’s Services

Provides for a system of integrated services for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of ⁵⁵

- a) Social Services
 Yes No
- b) Educational services, including services provided under IDEA
 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 systems
 Yes No

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

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. See SAMHSA’s [Rural Behavioral Health](https://www.samhsa.gov/rural-behavioral-health) page for program resources (<https://www.samhsa.gov/rural-behavioral-health>).

b. Describe your state’s targeted services to people experiencing homelessness. See SAMHSA’s [Homeless Programs and Resources](https://www.samhsa.gov/homeless-programs-resources) for program resources⁵⁶

⁵⁵ A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

⁵⁶ <https://www.samhsa.gov/homelessness-programs-resources>

c. Describe your state’s targeted services to the older adult population. See SAMHSA’s [Resources for Older Adults](#) webpage for resources⁵⁷

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

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.

a. 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

⁵⁷ <https://www.samhsa.gov/resources-serving-older-adults>

implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization’s standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#).

- b.** Describe your state’s current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

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

10. Substance Use Disorder Treatment - Required for SUPTRS BG

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) Withdrawal Management (inpatient/residential)

Yes No

vi) Outpatient

Yes No

vii) Intensive outpatient

Yes No

viii) Inpatient/residential

Yes No

ix) Aftercare/Continuing Care

Yes No

x) Recovery support

Yes No

b) Services for special populations:

Prioritized services for veterans?

Yes No

Adolescents?

Yes No

Older adults?

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?
 Yes **No**
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?
 Yes **No**
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
 Yes **No**
4. Does your state have an arrangement for ensuring the provision of required supportive services?
 Yes **No**
5. Has your state identified a need for any of the following?
 - a) Open assessment and intake scheduling?
 Yes **No**
 - b) Establishment of an electronic system to identify available treatment slots?
 Yes **No**
 - c) Expanded community network for supportive services and healthcare?
 Yes **No**
 - d) Inclusion of recovery support services?
 Yes **No**
 - e) Health navigators to assist clients with community linkages?
 Yes **No**
 - f) Expanded capability for family services, relationship restoration, and custody issues?
 Yes **No**
 - g) Providing employment assistance?
 Yes **No**
 - h) Providing transportation to and from services?
 Yes **No**
 - i) Educational assistance?
 Yes **No**
6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

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?
 Yes No
 - e) Monitoring requirements as outlined in the authorizing [statute](#) and implementing [regulation](#)?
 Yes No
2. Has your state identified a need for any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached?
 Yes No
 - b) Automatic reminder system associated with 14-120 day performance requirement?
 Yes No
 - c) Use of peer recovery supports to maintain contact and support?
 Yes No
 - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?
 Yes No
3. States are required to monitor program compliance related to 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 available tuberculosis services 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 substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?
 Yes **No**
2. Has your state identified a need for any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas?
 Yes **No**
 - b) Establishment or expansion of tele-health and social media support services?
 Yes **No**
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?
 Yes **No**

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances (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 Program?

Yes No

3) Do any of your programs use SUPTRS BG 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 in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?

Yes No

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

a) Workforce development efforts to expand service access?

Yes No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services?

Yes No

c) Establish a peer recovery support network to assist in filling the gaps?

Yes No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, 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) MOUD

(1) Yes No

- ii) Tele-health

(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. H

- 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 substance use disorders in the state?

Yes **No**

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?

Yes **No**

c) Performance-based accountability?

Yes **No**

d) Data collection and reporting requirements?

Yes **No**

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

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

a) A comprehensive review of the current training schedule and identification of additional training needs?

Yes **No**

b) Addition of training sessions designed to increase employee understanding of recovery support services?

Yes **No**

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?

Yes **No**

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?

Yes **No**

Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers⁵⁸ (TTCs) ?

e) Prevention TTC?

Yes **No**

f) Mental Health TTC?

Yes **No**

g) Addiction TTC?

Yes **No**

h) State Opioid Response?

Yes **No**

Waivers

⁵⁸ <https://www.samhsa.gov/technology-transfer-centers-ttc-program>

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

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations Regarding Women (300x-22(b))
 Yes No
2. Is your state considering requesting a waiver of any requirements related to:
 - a) Intravenous substance use (300x-23)
 Yes No
3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)
 - a) Tuberculosis
 Yes No
 - b) Early Intervention Services Regarding HIV
 Yes No
4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (300x-28)
 - a) Improvement of Process for Appropriate Referrals for Treatment
 Yes No
 - b) Professional Development
 Yes No
 - c) Coordination of Various Activities and Services
 Yes No

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

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 2022-FFY 2023?
 - a) Yes No

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

12. Trauma -Requested

Trauma⁵⁹ is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶⁰ paper.

⁵⁹ 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.*

⁶⁰ *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? Yes No
 2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
 3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? Yes No
 4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
 5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
 6. Does the state use an evidence-based intervention to treat trauma? Yes No
- 5) Does the state have any activities related to this section that it would like to highlight.

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

13. Criminal and Juvenile Justice - Requested

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.⁶¹ Almost two thirds of people in prison and jail meet criteria for a substance use disorder.⁶² As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.⁶³ States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal

⁶¹ Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. *Bureau of Justice Statistics*, 1-16.

⁶² Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. *Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention*.

⁶³ Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. “Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis.” *Journal of the American Academy of Child and Adolescent Psychiatry* 47(3):282–90.

justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts.

SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice_system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

Please respond to the following items:

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- Coordination across mental health, substance use disorder, criminal justice and other systems
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

Yes No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

Yes No

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

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

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

In line with the goals of the Overdose Prevention Strategy and SAMHSA’s priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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

Please respond to the following:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders?
 Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women?
 Yes No
3. Does the state purchase any of the following medication with block grant funds?
 - a) Methadone
 - b) 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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs ?
 Yes No
5. Does the state have any activities related to this section that you would like to highlight?

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

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each

state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

.....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:

- o Crisis call centers*
- o 24/7 mobile crisis services*
- o Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

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

SAMHSA developed [Crisis Services: Meeting Needs, Saving Lives](#), which includes “[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)” as well as an [Advisory: Peer Support Services in Crisis Care](#) and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed “[National Guidelines for Child and Youth Behavioral Health Crisis Care](#)” which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by 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 (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: 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.

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.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be 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 response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization

Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a no-reject 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 crisis facility worker. 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.

Currently, the 988 Suicide and Crisis 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. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 but the , 1-800-273-TALK is still operational. The 988 transition has supported and expanded to the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited 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.

1. Briefly narrate your state’s crisis system. For all regions/areas of your state, 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.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.
 - a) The **Exploration** stage: is the stage when states identify their communities’ needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
 - b) The **Installation** stage: occurs once the state comes up with a plan and the state

begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

- c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.
- d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.
- e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis call Capacity
 - a. Number of locally based crisis call Centers in state
 - i. In the 988 Suicide and Crisis Lifeline network
 - ii. Not in the suicide lifeline network
 - b. Number of Crisis Call Centers with follow up Protocols in place
 - c. Percent of 911 calls that are coded out as BH related
2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)
 - a. Independent of first responder structures (police, paramedic, fire)
 - b. Integrated with first responder structures (police, paramedic, fire)
 - c. Number that employs peers
3. Safe place to go or to be:
 - a. Number of Emergency Departments
 - b. Number of Emergency Departments that operate a specialized behavioral health component.
 - c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to						
Someone to respond						
Safe place to go or to be						

b. Briefly explain your stages of implementation selections here.

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

4. Briefly describe the proposed/planned activities utilizing the 5% set aside.

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

16. Recovery – Required

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to; and coverage for, health care 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 mental disorders and/or substance use disorders.

Recovery is supported through the key components of: *health* (access to quality health and M/SUD treatment); *home* (housing with needed supports), *purpose* (education, employment, and other pursuits); and *community* (peer, family, and other social supports). The principles of 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 interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management 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, 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 and collaborate with existing RCOs and RCCs.

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 such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state 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 of recovery support services?
 Yes No
 - d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state’s 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 substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

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

6. 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home and community-based services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peer support services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employment services.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the state have a plan to transition individuals from hospital to community settings?
 Yes No
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶⁴ 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

⁶⁴ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).

age 24.⁶⁵ For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.⁶⁶

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using substances before the age of 18, one in four will develop an addiction compared to one in 25 who started using substances after age 21.⁶⁷

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children relate to available mental health and/or substance use screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁸

⁶⁵ 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.

⁶⁶ 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.

⁶⁷ The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

According to data from the 2017 Report to Congress⁶⁹ on systems of care, services: reach many children and youth typically underserved by the mental health system.

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

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

- 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 withdrawal management).

Please respond to the following:

1. Does the state utilize a system of care approach to support:
 - a) The recovery of children and youth with SED?
 Yes No
 - b) The resilience of children and youth with SED?
 Yes No
 - c) The recovery of children and youth with SUD?
 Yes No
 - d) The resilience of children and youth with SUD?
 Yes No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs
 - a) Child welfare?
 Yes No
 - b) Health care?
 Yes No
 - c) Juvenile justice?
 Yes No

⁶⁸ 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>

⁶⁹ <https://store.samhsa.gov/sites/default/files/d7/priv/cmhi-2017rtc.pdf>

d) Education?

Yes No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?

Yes No

b) Costs?

Yes No

c) Outcomes for children and youth services?

Yes No

4. Does the state provide training in evidence-based :

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?

Yes No

b) Mental health treatment and recovery services for children/adolescents and their families?

Yes No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?

Yes No

b) for youth in foster care?

Yes No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?

Yes No

d) Does the state have an established FEP program? A CHRP program?

Yes No

e) Is the state providing trauma informed care?

Yes No

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

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.

19. Suicide Prevention – Required for MHBG

Suicide is a major public health concern, it is a leading cause of death nationally, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, and social isolation. Mental illness and substance use 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 the Zero Suicide Initiative?

Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

Yes No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted?

Yes No

If so, please describe the population of focus?

6. Have you conducted any work using the suicide protocol language with your crisis services set-aside?

Yes No

If so, please describe the work?

7. 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 SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state 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 mental and substance use disorders, 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.

- The state’s agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state’s intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?
 Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place?

Yes No

If yes, with whom?

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.

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

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder 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 SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁷⁰

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.

⁷⁰ <https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

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.)

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work?

Yes No

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes No

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

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

Additionally, please complete the Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷¹

⁷¹ 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
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		

Type of Membership	Number	Percentage of Total Membership
Family Members of Individuals in Recovery (to include family members of adults with SMI)		
Parents of children with SED		
Vacancies (individual & family members)		
Others (Advocates who are not State employees or providers)		
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		
Individuals/Family Members from Diverse Racial and Ethnic Populations		
Individuals/Family Members from LGBTQI+ 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).		
Total Membership (Should count all members of the council)		

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 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 diverse audiences (including federal, tribal, or other public agencies, racial, ethnic, sexual and gender minority populations) 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

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

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
BHSIS	Behavioral Health Services Information System
BHCS	Behavioral Health Crisis Services
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	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	<i>The International Statistical Classification of Diseases and Related Health Problems, 10th Revision</i>
ICT	Interactive Communication Technology

IDU	Intravenous Drug User
IMD	Institutions for Mental Diseases
KIT	Knowledge Information Transformation (associated with EBP implementation)
LGBTQI+	Lesbian, gay, bisexual, transgender, queer/questioning and intersex
MAUD	Medications for Alcohol Use Disorder
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
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
SUPTRS BG	Substance Use Prevention, Treatment, and Recovery Services 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 21 st 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 2030 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.
LGBTQI+ Populations	https://www.samhsa.gov/behavioral-health-equity/LGBTQI+	Resources on the LGBTQI+ 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.
TOPIC	LINK	DESCRIPTION

Medications for Addiction Treatment	http://www.samhsa.gov/medication-assisted-treatment	SAMHSA's resources, guides and TIPS
Mental Health and Substance use disorder 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 use disorder Block Grants
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
TOPIC	LINK	DESCRIPTION

<p>SAMHSA’s Evidence-Based Practices Resource Center</p>	<p>https://www.samhsa.gov/resource-search/ebp</p>	<p>The Evidence-Based Practices Resource Center (EBPRC) provides 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 EBPRC contains a collection of resources for a broad range of audiences, including Guidebooks, Advisories, Treatment Improvement Protocols, toolkits, resource guides, and clinical practice guidelines.</p>
<p>National Strategy for Suicide Prevention</p>	<p>http://store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-2012-Goals-and-Objectives-for-Action/PEP12-NSSPGOALS</p> <p>https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf</p>	<p>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)</p> <p>The goal of the Call to Action is to broaden perceptions of suicide, who is affected, and of the many factors that can affect suicide risk. There are a variety of influences at the individual, relationship, community, and societal levels that can increase suicide risk or precipitate a crisis, including social isolation, relationship problems, the loss of a loved one, and legal or financial issues.</p>

RESOURCES	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
The Essential Aspects of Parity: A Training Tool for Policymakers	https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001?referer=from_search_result	This document provides an overview of essential information necessary for understanding mental health and substance use disorder parity and how to implement and comply with federal parity laws. This guide applies to parity laws in employer-sponsored health plans and group and individual insurance.
Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States	https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983?referer=from_search_result	This report offers best practices for implementing the Mental Health Parity and Addiction Equity Act of 2008. It covers processes for implementing parity and collaborating with other organizations. The report also discusses tools for understanding and monitoring compliance.
Prevention of	http://www.ncbi.nlm.nih.gov/books/NBK44360/	The Surgeon General's Call

RESOURCES	LINK	DESCRIPTION
Underage Drinking		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) product on Assertive Community Treatment was developed to.
Substance Use Disorder 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	Links to resources and

RESOURCES	LINK	DESCRIPTION
		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 SUPTRS BG.
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
Trauma & Violence	http://www.samhsa.gov/trauma-violence https://www.nctsn.org/	<p>Includes information around violence and trauma, including the definition and review of trauma informed care.</p> <p>The National Child Traumatic Stress Network (NCTSN) is an unique network of frontline providers, family members, researchers, and national partners is committed to changing the course of children’s lives by improving their care and moving scientific gains quickly into practice across</p>

RESOURCES	LINK	DESCRIPTION
		the U.S.
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	Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships	The White House memorandum regarding the requirements related to tribal consultation

Appendix A

Side-by-side comparison of select required elements for the MHBG and SUPTRS BG

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
Biennial Plan	42 USC -6A XVII §300x-1. (b), 300x-6 Criteria for plan and Application for grant	In accordance with subsection (a), a State shall submit to the Secretary a plan every two years... The plan contains requirements for the submission of funding agreements, certification, assurances of compliance, and a description of needs, persons served, services, resources, priorities, goals and objectives.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-32. Application for grant; approval of State Plan (a) In general; (b) State plan	The plan contains requirements for the submission of funding agreements, certification, assurances of compliance, and a description of needs, persons served, services, resources, priorities, goals and objectives.
Joint Application	42 USC 6A, Subchapter XVII, Subpart III, 300x-68 Joint applications	The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall permit a joint application to be submitted for grants under subpart I and subpart II upon the request of a State. Such application may be jointly reviewed and approved by the Secretary with respect to such subparts, consistent with the purposes and authorized activities of each such grant program. A State submitting such a joint application shall otherwise meet the requirements with respect to each such subpart.	42 USC 6A, Subchapter XVII, Subpart III, 300x-68	The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall permit a joint application to be submitted for grants under subpart I and subpart II upon the request of a State. Such application may be jointly reviewed and approved by the Secretary with respect to such subparts, consistent with the purposes and authorized activities of each such grant program. A State submitting such a joint application shall otherwise meet the requirements with respect to each such subpart.
Plan- Tables 1,2,6	42 USC 6A XVII Part B:§300x-1. (b) (1)(B); §300x-1.(b) (2) (d) (1) State plan for comprehensive community mental health services for certain individuals and management services	Table 1 provides information on priority areas and performance indicators. Table 2 requests state agency planned expenditures. Table 6 requests non-direct services/system development	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-32. Application for grant; approval of State Plan (b) State plan; (1) In general	Table 1 provides information on priority areas and performance indicators. Table 2 requests state agency planned expenditures. Table 6 requests non-direct services/system development

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
		activities planned expenditures.		activities planned expenditures.
Plan- Tables 3, 5a, 5b	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-32. Application for grant; approval of State Plan (b) State plan; (1) In general	Table 3 requests a summary of need, and a summary of persons served in SUD treatment. Tables 5a and 5b request a description of planned primary prevention expenditures.
Set-aside for Children	42 USC XVII 6A Part B: §300x-2 (a) Allocation for systems of integrated services for children	The state must demonstrate the amount expended is greater or equal to dollars spent to provide services for children with SED in FY 1994.	N/A	Rather than a specific set-aside for children, the SUPTRS BG requires a 20% Primary Prevention Set-Aside which focuses primarily on children and adolescents, but does not require that all activities be directed to this population.
Maintenance of Effort (MOE)	42 USC XVII 6A Part B: §300x-4. (b) Maintenance of effort regarding State expenditures for mental health	The state must demonstrate the state funds expended for the state community mental health system is at least the average of the two years prior.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-30. Maintenance of effort regarding State expenditures (a) In general; (b) Exclusion of certain funds	The methodology for the calculation for the SUPTRS BG MOE expenditure requirement is based on an average of the state expenditures for the past two state fiscal years, but normally includes only those funds which flow directly through the SSA, so this MOE total may or may not include state Medicaid funds for SUD treatment. CSAT provides states with the option of co-designation of state Medicaid funds managed by another state agency when certain criteria are met.
MOE-Women	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-22. Certain allocations (b) Allocations regarding women (1) In general; (2) Waiver; (3) Childcare and	The state is required to expend on SUD treatment services for pregnant women and women with dependent children an amount not less than the amount expended for such services in FY 1994.

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			prenatal care	
Tuberculosis	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-24. Requirements regarding tuberculosis (a) Tuberculosis (1) In general; (2) Tuberculosis services	The state is required to routinely make available tuberculosis services to each individual receiving substance use disorder treatment services.
Restrictions re inpatient Hospitalization	42 USC 6A XVII Part B: §300x-5 Restrictions on use of payments	A funding agreement for a grant under section 300x of this title is that the State involved will not expend the grant— (1) to provide inpatient services.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-31. Restrictions on expenditure of grant (b) Exception regarding inpatient hospital services (1) Medical necessity as precondition; (2) Rate of payment	The restriction on the use of funds for SUD inpatient hospital services provides for an exception, only if it is determined that an individual cannot be effectively treated in a community-based, non-hospital residential program of treatment.
Prohibit Cash Payments	42 USC 6A XVII Part B: §300x-5 Restrictions on use of payments	A funding agreement for a grant under section 300x of this title is that the State involved will not expend the grant— to make cash payments to intended recipients of health services.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-31. Restrictions on expenditure of grant (a) In general (1) Certain restrictions (B)	A funding agreement for a grant under section 300x of this title is that the State involved will not expend the grant— to make cash payments to intended recipients of health services.
Planning Council	42 USC 6A XVII Part B: 300x-3 State mental health planning council	A funding agreement for a grant under section 300x of this title is that the State involved will establish and maintain a State mental health planning council.	N/A	Requested or recommended item in annual SUPTRS BG Application/Behavioral Health Assessment and Plan, Environmental Factors and Plan, Advisory Council Members, and Advisory Council Composition by Member Type.

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Public Input to Plan	42 USC 6A XVII Part B: 300x-51 Opportunity for public comment on State plans	A funding agreement for a grant under section 300x or 300x-21 of this title is that the State involved will make the plan required in section 300x-1 of this title, and the plan required in section 300x-32 of this title, respectively, public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart iii §300x-51. Opportunity for public comment on state plans	Required item in SUPTRS BG Application/Behavioral Health Assessment and Plan, Form 22. Public Comment on the State Plan.
10% Set-aside for Early SMI	42 USC 6A XVII Part B:300x-9(c) Early serious mental illness	...a State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.	N/A	N/A
Primary Prevention	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-22. Certain allocations (a) Allocation regarding primary prevention programs	The state is required to expend not less than 20% of the SUPTRS BG allocation for persons who do not require treatment for a substance use disorder.
Annual Report	2 USC CHAPTER 6A,	SUPTRS BG and MHBG: The	42 USC CHAPTER 6A,	The state is required to submit to

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	SUBCHAPTER XVII, Part B, subpart iii §300x-52. Requirement of reports and audits by States (a) Report	state is required to submit to the Secretary a report with a description of the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program.	SUBCHAPTER XVII, Part B, subpart iii §300x-52. Requirement of reports and audits by States (a) Report	the Secretary a report with a description of the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program.
Independent Peer Review	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart iii §300x-53. Additional requirements (a) In general	SUPTRS BG and MHBG: The state is required to annually provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart iii §300x-53. Additional requirements (a) In general	The state is required to annually provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved.
Persons who inject drugs (syringe services, etc.)	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-23. Intravenous substance abuse (a) Capacity of treatment programs; (b) Outreach to persons who inject drugs	The state is required to ensure that each SUPTRS BG funding subrecipient maintain an active capacity management system, and to notify the state upon reaching 90% of its capacity to admit individuals to the program. Syringe Services is also a required item in annual SUPTRS BG Application/Behavioral Health Assessment and Plan, Environmental Factors, Form 23. Syringe Services (SSP), and Syringe Services (SSP) Program Information – Table A.
5% set-aside	N/A	N/A	42 USC CHAPTER 6A,	Designated states are required to

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for Early Identification Services (EIS) for HIV			SUBCHAPTER XVII, Part B, subpart ii §300x-24. Requirements regarding human immunodeficiency virus (b) Human immunodeficiency virus	expend 5% of each allocation on HIV services for individuals in SUD treatment who have HIV, or who are at risk for HIV.
Recovery Residences- Revolving Loan Fund	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-25. Group homes for persons in recovery from substance use disorders (a) State revolving funds for establishment of homes	States may establish and maintain the ongoing operation of a revolving loan fund to support group homes for persons in recovery from substance use disorders.
Services for individuals with co-occurring disorders	42 USC 6A XVII, Part B: 300x-66 Services for individuals with co-occurring disorders	States may use funds available for treatment under sections 300x and 300x-21 of this title to treat persons with co-occurring substance use and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.	42 USC 6A XVII, Part B: 300x-66 States may use funds available for treatment under sections 300x and 300x-21 of this title to treat persons with co-occurring substance and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.	States are required under 42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-32. to provide information in the plan on the need for substance use disorder prevention and treatment services in the State, to include individuals with a co-occurring mental health and substance use disorder.
Professional Development	N/A	N/A	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-28. Additional agreements (b) Professional development	The state is required to ensure that prevention, treatment, and recovery personnel operating in the States’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training, on an ongoing basis, on a number of designated

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				topics that would serve to further improve the delivery of substance use disorder prevention and treatment services within the State.
Crisis Services	Consolidated Appropriations and Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260]	Funding was established for states to develop 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.	Requested	Requested or recommended item narrative in annual SUPTRS BG Application/Behavioral Health Assessment and Plan, Environmental Factors and Plan, Form 15. Crisis Services.
Recovery	42 USC 6A: XVII Part B:300x-1. (b) (1)(A) (vii) (IV) Comprehensive community-based health systems	The plan shall provide a description of recovery and recovery support services for adults with a serious mental illness and children with a serious emotional disturbance.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-32. Application for grant; approval of State plan (b) State plan	The state is required to provide a description of the system that is available to provide services by modality, including the provision of recovery support services.
Children's Services	Required 42 USC 6A XVII, Part B:300-1. (b) (1)(C) Children's services	In the case of children with a serious emotional disturbance (as defined pursuant to subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple	N/A	N/A

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		needs (such system to include services provided under the Individuals with Disabilities Education Act).		
Services to rural and homeless populations	42 USC 6A XVII, Part B 300x-1, (b) (1) (D) Targeted services to rural and homeless populations	The plan shall describe the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-32. Application for grant; approval of State Plan (a) In general; (b) State plan	States are required to provide information in the plan on the need for substance use disorder prevention and treatment services in the State, to include persons who are experiencing homelessness.
Suicide Prevention	42 USC 6A: XVII, Part B:300x-1. (b) (1)(A) (vii) (II) Comprehensive community-based health systems	The plan shall provide a description of the activities intended to reduce incidents of suicide for people with SMI and SED using the block grant funds.	N/A	N/A
Support of State Partners	42 USC 6A XVII, Part B:300x-1. (b) (1)(A) (iii) Comprehensive community-based health systems	The plan shall include a description of the manner in which the 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 (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other	42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart ii §300x-28. Additional agreements (c) Coordination of various activities and services	The state is required to coordinate SUD prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services).

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		<p>support services to be provided with Federal, State, and local public and private resources) with other agencies to enable individuals receiving services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act [20 U.S.C. 1400 et seq.].</p>		
Reporting Requirements	<p>42 USC 6A XVII, Part B: 300x-35, (b) (3) Core data set</p>	<p>A State that receives a new grant, contract, or cooperative agreement from amounts available to the Secretary under paragraph (1), for the purposes of improving the data collection, analysis and reporting capabilities of the State, shall be required, as a condition of receipt of funds, to collect, analyze, and report to the Secretary for each fiscal year subsequent to receiving such funds a core data set to be determined by the Secretary in conjunction with the States.</p>	<p>42 USC 6A XVII, Part B: 300x-35, (b) (3) Core data set</p>	<p>A State that receives a new grant, contract, or cooperative agreement from amounts available to the Secretary under paragraph (1), for the purposes of improving the data collection, analysis and reporting capabilities of the State, shall be required, as a condition of receipt of funds, to collect, analyze, and report to the Secretary for each fiscal year subsequent to receiving such funds a core data set to be determined by the Secretary in conjunction with the States.</p>