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# FFY 2026-2027 Combined Block Grant Application Guide

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Community Mental Health Services Block Grant (MHBG)

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 2026-2027 Block Grant Application Guide

### I. INTRODUCTION

The FFY 2026-2027 Combined Block Grant Application Guide contains the template and instructions for the Substance Abuse and Mental Health Services Administration's (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)), are 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). States that do not choose to apply for the MHBG or SUPTRS BG will have their funds redirected to other states as provided for in statute (42 U.S.C. § 300x-54).<sup>1</sup>

The SUPTRS BG provides funding for a total of 60 grantees representing 50 states, the District of Columbia (D.C.), five U.S. Territories, three freely associated states, and one Indian Tribe while the MHBG provides funding for a total of 59 grantees representing 50 states, D.C., five U.S. Territories and three freely associated states. Throughout this document, the word "state" is used to describe all of these grantees.

The FFY 2026-2027 Combined Block Grant Application Guide includes four major sections: Introduction; Submission of application and plan time frames; Mental and substance use disorder (M/SUD) assessment and plan; and a Reporting Requirements section.

#### **SAMHSA Overview**

The United States faces unprecedented and interrelated 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 COVID-19 pandemic, rates of depression and anxiety were increasing. The grief, trauma, and physical and social isolation experienced with the pandemic continue to impact people and communities across the country and exacerbate issues of mental health and substance use for many. Drug overdose deaths have reached historic levels, devastating individuals, families, and communities. In 2022, 107,941 Americans died from a drug overdose<sup>2</sup>, and 49,449 Americans died by suicide<sup>3</sup>. The COVID-19 pandemic also revealed significant disparities in access to health and behavioral health services leading to poorer outcomes for historically underserved communities. Finally, long COVID has been associated with the development and worsening of mental health disorders, including, depression, anxiety, psychosis, obsessive compulsive disorder, and posttraumatic stress disorder.

SAMHSA is actively working to address these interrelated crises and impacts of the COVID-19 pandemic, by strengthening system capacity, connecting more Americans to care, and creating a continuum of prevention and support that aims to transform the nation's health and social

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

<sup>2</sup> [https://www.cdc.gov/nchs/products/databriefs/db491.htm#Key\\_finding](https://www.cdc.gov/nchs/products/databriefs/db491.htm#Key_finding)

<sup>3</sup> [https://www.cdc.gov/suicide/facts/data.html?CDC\\_AAref\\_Val=https://www.cdc.gov/suicide/suicide-data-statistics.html](https://www.cdc.gov/suicide/facts/data.html?CDC_AAref_Val=https://www.cdc.gov/suicide/suicide-data-statistics.html)

services infrastructure to address behavioral health holistically and equitably. The MHBG and SUPTRS BG are key levers towards realizing these goals.

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance use, 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 disorders receive care, achieve well-being and thrive. SAMHSA has articulated its mission and vision in its [2023-2026 Strategic Plan](#)<sup>4</sup>. To achieve its mission, SAMHSA has identified five key priority areas and four guiding principles to better meet the behavioral health care needs of individuals, families, communities, and service providers.

The five priority areas are:

1. Preventing Substance Use and Overdose
2. Enhancing Access to Suicide Prevention and Mental Health Services
3. Promoting Resilience and Emotional Health for Children, Youth and Families
4. Integrating Behavioral and Physical Health Care
5. Strengthening the Behavioral Health Workforce

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

1. Equity
2. Trauma-Informed Approaches
3. Recovery
4. Commitment to Data and Evidence

SAMHSA encourages states to incorporate activities that advance these priorities when developing each block grant application, as further described below under Section C - SAMHSA's Priorities and Principles.

In addition to addressing the annual MHBG and SUPTRS BG appropriations, this application includes sections on planned expenditures for the American Rescue Plan (ARP) Supplemental Funding of MHBG and SUPTRS BG and Bipartisan Safer Communities Act (BSCA) for MHBG. The BSCA (P.L. 117-159), which was enacted into law on June 25, 2022, provides supplemental funds to state mental health authorities (SMHAs) through the MHBG 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 complex presentations.

SAMHSA recommends that opportunities for work in substance use disorder treatment and recovery follow best practices. All decisions regarding work should be predicated on an individual's choice, specific needs, and the required level of support necessary. A person-centered, individualized, and strength-based approach will ensure that an individual's

<sup>4</sup> <https://www.samhsa.gov/about-us/strategic-plan>

preferences, strengths, needs, and goals are at the center of decision making. For the SUPTRS BG, best practices involve conducting assessments of the appropriateness of each individual’s participation in work, education, training, or volunteer opportunities. The BG specifically requires that grantees and subrecipients adhere to SAMHSA best practice guidance regarding work in recovery housing. This guidance is outlined in a publication titled, [Best Practices for Recovery Housing. Publication No. PEP23-10-00-002. Rockville, MD: Office of Recovery, SAMHSA, 2023.](#) SAMHSA policies require recovery housing programs supported by the SUPTRS BG to be free from any form of resident abuse or neglect, and free from any form of forced or coerced labor.

## **A. Background**

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 states<sup>5</sup> 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 areas (e.g., populations of focus) 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.<sup>6</sup>). 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 information and instructions included in the FFY 2026-2027 Block Grant Application furthers SAMHSA’s efforts to have states use and report on the opportunities offered under various federal initiatives. The combined Block Grant application process allows states to submit one application for both MHBG and SUPTRS BG funds.

The information in this application includes a request for additional information on coordinated and integrated care, along with a focus on improving services for persons with mental and substance use disorders. This information will be used to inform and tailor SAMHSA’s technical assistance to support state efforts.

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 and SUD and for adults with SMI and children with SED.

To assure that the block grant program continues to support the needed and necessary services for the populations of focus, 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

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<sup>5</sup> The term “state” means the 50 states, the District of Columbia, the United States Territories, Freely Associated States (FAS), and the Red Lake Band of Chippewa Indians. The United States Territories include the Commonwealth of Puerto Rico, Virgin Islands, American Samoa, Commonwealth of the Northern Marianas Islands, and Guam. The FAS include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

<sup>6</sup> In addition to statutory authority, SUPTRS BG is detailed by comprehensive regulation: <http://www.samhsa.gov/grants/block-grants/laws-regulations>

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 of Block Grants 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 statute](#) 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.<sup>7</sup> SAMHSA guidance on the use of block grant funding for co-pays, deductibles (including high deductible health plans), and premiums can be found at <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States that choose to take advantage of this provision 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 guiding principles](#) to better meet the behavioral health care needs of individuals, families, communities, and service providers. SAMHSA is asking states to incorporate these priority areas and guiding principles in formulating their planned responses to community needs.

The five priority areas are:

1. Preventing Substance Use and Overdose
2. Enhancing Access to Suicide Prevention and Mental Health Services
3. Promoting Resilience and Emotional Health for Children, Youth and Families
4. Integrating Behavioral and Physical Health Care
5. Strengthening the Behavioral Health Workforce

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

1. Equity
2. Trauma-Informed Approaches
3. Recovery
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### **Preventing Substance Use and Overdose**

In October 2021, HHS released a new [Overdose Prevention Strategy](#) 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, addressing upstream prevention and root drivers of

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<sup>7</sup> <http://www.samhsa.gov/grants/block-grants/laws-regulations>



substance use, integrating harm reduction and 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, policies, and practices which are supported through both technical assistance and funding, such as the SUPTRS BG and the Strategic Prevention Framework - Partnerships for Success grant programs. Recognizing that some individuals may have a SUD or need more intensive services and given the lethality of the current illicit drug supply, SAMHSA supports a range of more focused mitigation strategies and services, including evidence-based overdose prevention and harm reduction approaches such as distribution of naloxone and other opioid overdose reversal medications and fentanyl and xylazine test strips to those at high risk for overdose.

SAMHSA grant programs support a range of treatment and recovery support services, including through the State Opioid Response grant program, the Building Communities of Recovery, Recovery Community Services Program grants, and the Tribal Opioid Response grant program. These grants support different types of services aimed at linking people with SUDs and those who have experienced an overdose to low threshold medication treatment, behavioral treatment interventions, and peer support services to reduce repeat overdoses and overdose death, while improving overall health and wellbeing. Through addressing overdose in the community, these grants also aim to support individuals in their path to maintaining or achieving recovery. Together, these efforts strive to meet people wherever they are on the behavioral health continuum, through focused services and supports that are evidence-based, culturally informed, trauma-informed, recovery-oriented, and driven by public health data.

### **Enhancing Access to Suicide Prevention and Mental Health Services**

The continuum of mental health services includes mental health promotion and early intervention, crisis care, suicide prevention, treatment, and recovery support services. Individuals with any mental health disorder, including serious mental illness (SMI), too often lack timely access to care. Additionally, mental health services are often fragmented such that transitions from one level of care to another are challenging for people moving between them and providers alike. Many communities experience service gaps across the continuum such that persons are not able to receive what they need, when they need it. 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.<sup>8</sup> In 2022, 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

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<sup>8</sup> 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.

States.<sup>9</sup> The [2023 National Survey on Drug Use and Health \(NSDUH\)](#) data estimate that the number of adults with serious thoughts of suicide was 12.8 million, those with plans for suicide was 3.7 million, and those who attempted suicide was about 1.5 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 for those at risk for suicidal ideation and suicidal behaviors. While there are many factors that contribute to suicide risk, key risks include having a plan to complete suicide, considering attempting suicide, as well as a previous suicide attempt. More information can be found in the 2024 [National Strategy for Suicide Prevention](#).

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 the country has someone to contact, 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 to 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 State/Tribal 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 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, least-restrictive crisis care programs addressing the needs of adults with serious mental illnesses and children with serious mental and emotional disturbances. States may use some or all of the funds set aside for a set of core crisis care service components including: crisis contact centers, 24/7 mobile crisis services, and crisis receiving and stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by the State, with referrals to inpatient or outpatient care. SAMHSA encourages States to fund 988 Suicide & Crisis lifelines and/or collaborate with 988 to ensure that their crisis contact centers are coordinated. States are also encouraged to use the MHBG crisis set-aside to fund all aspects of their crisis continuums – including mobile crisis services and crisis stabilization programs.

### **Promoting Resilience and Emotional Health for Children, Youth and Families**

Most people with mental health and substance use disorders commonly first manifest signs of these conditions in childhood, adolescence, and young adulthood. In fact, half of all mental illnesses emerge by the time a child turns 14, and nearly 75 percent by the time a person is 24

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<sup>9</sup> Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database. Data are from the final Multiple Cause of Death Files, 2018-2021, and from provisional data for years 2022-2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/mcd-icd10-provisional.html> on Feb 6, 2024. .

years old<sup>10</sup>. There is also a significant link between adverse childhood experiences (ACEs) – potentially traumatic events that occur in childhood and 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 disorder and 1 in 10 had a serious emotional disturbance that negatively impacted their ability to function at home, in school, or in the community<sup>11 12</sup>. Unfortunately, many young people are not exposed to effective prevention strategies nor receive the treatment and recovery supports they need. According to the 2023 NSDUH, an estimated 4.5 million adolescents aged 12 to 17 had a past year major depressive episode (MDE). Of these adolescents with a past year MDE, 43.2 percent did not receive mental health treatment in the past year. Additionally, an estimated 2.9 million adolescents needed substance use treatment in the past year; however, only 38.9 percent reported receiving it.<sup>13</sup> The pandemic exacerbated this situation with depression and anxiety doubling in youth compared to pre-pandemic levels,<sup>14</sup> and over 215,000 U.S. children left to deal with the grief of losing a primary or secondary caregiver to COVID-19. This loss disproportionately impacted children of black, indigenous, and other people of color.<sup>15 16</sup> The overdose crisis has also had a profound impact on our nation’s children and youth. A recent study found that more than 321,000 children lost a parent to drug overdose between 2011 and 2021 – further underscoring the multigenerational impacts of this crisis.<sup>17</sup>

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 prevention and promotion strategies and increases 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

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<sup>10</sup> 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.

<sup>11</sup> 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.

<sup>12</sup> 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

<sup>13</sup> Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>

<sup>14</sup> 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.

<sup>15</sup> 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.

<sup>16</sup> 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](https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peer-support-2017.pdf). Accessed August 15, 2022.

<sup>17</sup> Jones CM, Zhang K, Han B, Guy GP, Losby J, Einstein EB, Delphin-Rittmon M, Volkow ND, Compton WM. Estimated Number of Children Who Lost a Parent to Drug Overdose in the US From 2011 to 2021. *JAMA Psychiatry*. 2024 May 8:e240810. doi: 10.1001/jamapsychiatry.2024.0810. Epub ahead of print. PMID: 38717781; PMCID: PMC11079787.

early identification, and implement quality services and recovery 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 prevention and care approaches. This includes leveraging 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 2023 NSDUH, 54.2 million people ages 12 and older in the United States needed substance use disorder treatment in the past year; however, only 23.6 percent reported receiving any. Nearly 59 million adults aged 18 or older reported having any mental illness in the past year, however, slightly less than half (27.1 million people) did not receive mental health treatment in the past year. Of the 27.1 million adults, 23.8 percent perceived an unmet need for mental health treatment in the past year. People with serious mental illness and SUDs have shorter life expectancies compared to their peers without these conditions. Early mortality rates for people with mental health and substance use disorders often stem from the conditions themselves but also contribute to and are regularly compounded by co-occurring physical health conditions.

Integrated care takes a whole-person approach, considering all the needs of an individual across their behavioral, physical health, and social determinants of health needs. Considering and addressing this complement of needs in a holistic way gives people the opportunity to improve their health from different angles and in the least burdensome manner. Integrated care provided in the community may also have system-level financial benefits by reducing inappropriate and costly use of emergency departments, especially for people from underserved populations who are less likely to seek care due to stigma, unfamiliarity, or mistrust.

A key to achieving SAMHSA's vision is advancing the bi-directional integration of behavioral health with all other health care services and systems, including community health workers and systems navigators. 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 support. Access and integration barriers are especially profound when serving communities disproportionately affected with co-morbid infectious disease conditions, for those experiencing homelessness, and for individuals involved with the justice system.

### **Strengthening the Behavioral Health Workforce**

The nation's workforce of mental health and SUD providers is critical to providing Americans with access to essential health care services. There is a projected shortage of specialty behavioral health care providers, with acute shortages predicted for psychiatrists and addiction counselors through 2030. The COVID-19 pandemic exacerbated behavioral healthcare

workforce shortages that existed prior to the pandemic and has continued at a time of increased need for services. 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 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.

The use of peer support specialists – including family support providers – has emerged as an evidence-based practice that fosters recovery of people who experience mental health and substance use disorders (<https://www.samhsa.gov/resource/ebp/what-are-peer-recovery-support-services>.) SAMHSA recently released [national model standards for peer support](#) certification.

The Block Grants are also a critical source of funding that supports the behavioral health workforce. 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 peer support specialists and peer recovery coaches, prevention specialists, and focusing on increased diversity and cultural competency in the existing workforce and in emerging new roles in behavioral health.

## **Equity**

Behavioral health equity is the right to access high-quality and affordable health care services and support for all populations, including historically underserved Black, Latino, Indigenous and Native American persons, Asian Americans, Native Hawaiians, 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 and the epidemiology of substance use and mental health continue to evolve, behavioral health care systems will need to expand their capacity to meet the growing needs of a diverse population. By improving access to care, promoting quality programs and practices, and reducing persistent disparities in mental health and substance use services for underserved 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 identify underserved communities, develop culturally informed and culturally appropriate outreach and engagement strategies including partnerships with community leaders and trusted entities, and

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 (<https://www.samhsa.gov/find-help/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 disorders (M/SUD) 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, such as peer operated centers and services. Today, when people with M/SUD seek help, they are met with the knowledge and belief that anyone can recover and/or manage their conditions successfully.

[A range of recovery support services](#) have emerged to provide critical whole health approaches such as Recovery Community Organizations, peer specialist services, warm lines, and peer respites.

SAMHSA encourages states to leverage block grant resources for the population of focus 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 disorders, 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 conditions. Many people who experience trauma may overcome it, with some becoming stronger and more resilient; but for others, trauma can be overwhelming and disruptive with long lasting impacts. It is also important to recognize that whole communities can share trauma and can be profoundly shaped by traumatic experiences and history.

Trauma-informed and trauma responsive 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 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.

SAMHSA encourages states to support system wide trauma-informed and trauma responsive approaches for the population of focus that prevent and address trauma and work toward avoiding re-traumatization of individuals including working to eliminate the use of seclusion and restraint in care settings. CMHS leads the [Interagency Task Force on Trauma-Informed Care](#) to develop best practices for trauma-informed identification, referral, and support and offers several resources on trauma informed care on its [webpage](#) including [Practical Guide for Implementing a Trauma-Informed Approach](#). Additional resources available on SAMHSA's [Trauma and Violence](#) webpage.

### **Commitment to Data and Evidence**

To support the SAMHSA mission and strengthen SAMHSA's activities across its five priority areas, the agency has developed the [SAMHSA 2023-2026 Data Strategy](#). States are encouraged to draw from SAMHSA's data strategies to enhance their ability to collect, analyze, and disseminate high-quality data, from both quantitative and qualitative sources, while also leveraging that data and evidence to inform programs and policies. Leveraging data and evidence strengthens SAMHSA's activities. It is vital that data and evaluation inform policies and determine the impact of programs on mental health and substance use disorders. SAMHSA is steadfast in its efforts to advance the health of the nation while also promoting equity for underserved 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 focused 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 and based on the best available evidence and impact 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 mental health and substance use disorders and their associated consequences across states and territories of the United States. States must use these data to identify areas of greatest need (at a state level, not local geographic level) 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.

In alignment with SAMHSA’s 2023-2026 goal<sup>18</sup> to enhance the agency’s ability to collect, capture, and maintain high-quality data, SAMHSA requires that state Block Grant data aligns with requirements at the Federal level, this includes recent revisions to the classification of race and ethnicity. On March 29, 2024, the Office of Management and Budget (OMB), under the Executive Office of the President, issued revisions to [Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity \(SPD 15\)](#). The revised SPD 15 replaces and supersedes OMB’s 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The revisions made under SPD 15 are intended to result in more accurate and useful race and ethnicity data across the Federal government. Specifically, all Federal agencies must begin reporting race and ethnicity as follows:

|   |
|---|
| <p><b>American Indian or Alaska Native</b></p> <ul style="list-style-type: none"> <li>Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya</li> </ul> |
| <p><b>Asian</b></p> <ul style="list-style-type: none"> <li>Individuals with origins in any of the original peoples of Central or East Asia, Southeast Asia, or South Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.</li> </ul>  |
| <p><b>Black or African American</b></p> <ul style="list-style-type: none"> <li>Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.</li> </ul>   |
| <p><b>Hispanic or Latino</b></p> <ul style="list-style-type: none"> <li>Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.</li> </ul>   |
| <p><b>Middle Eastern or North African</b></p> <ul style="list-style-type: none"> <li>Individuals with origins in any of the original peoples of the Middle East or North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli.</li> </ul>  |
| <p><b>Native Hawaiian or Pacific Islander</b></p>   |

<sup>18</sup> SAMHSA 2023-2026 Data Strategy. Available online at: <https://www.samhsa.gov/sites/default/files/2023-2026-data-strategy.pdf>



|   |
|---|
| <ul style="list-style-type: none"> <li>Individuals with origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands, including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese.</li> </ul> |
| <p><b>White</b></p> <ul style="list-style-type: none"> <li>Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish.</li> </ul>                                 |

As a result, all states will eventually be required to begin reporting race and ethnicity to align with these revised SPD 15 requirements. SAMHSA recognizes that these changes will be time intensive and carry an initial burden to states and state data collection systems. **Therefore, while no changes will be implemented at this time, SAMHSA will be actively working with states and their partners during the FY2026/2027 MHBG and SUPTRS BG award cycle to aid in the adoption of these changes.** Robust technical assistance will be made available during the course of the two-year cycle to ensure states will be able to meet these federal reporting requirements by the FY 2028/2029 MHBG and SUPTRS BG application and report, with the expectation that states will be able to begin collecting data using race and ethnicity as described above beginning in State Fiscal Year (SFY) 2027. For additional information regarding the new SPD 15 revisions, please visit: <https://spd15revision.gov/>.

Additional Areas for Consideration within Strategic Priorities

SAMHSA recognizes a number of additional topical areas that fall under the above priorities where states may want to focus their efforts.

*Excessive Alcohol Use and Alcohol Use Disorder*

According to the [2023 NSDUH Annual National Report](#), 47.8 percent of people aged 12 or older (or 134.7 million people) used alcohol in the past month, with 61.4 million reporting past-month binge drinking and 16.4 million reporting past-month heavy drinking. Estimates of binge alcohol use and heavy alcohol use in the past month among underage people (those aged 12-20 years old) were 8.6 percent and 1.7 percent, respectively. Of the 48.5 million people aged 12 or older with an SUD in the past year, 28.9 million had alcohol use disorder, 27.2 million had a drug use disorder, and 7.5 million people had both alcohol use disorder and drug use disorder.<sup>19</sup>

The Drug Abuse Warning Network (DAWN): Findings from Drug-Related Emergency Department (ED) Visits, 2022,<sup>20</sup> found that the top five drugs involved in drug-related ED visits in 2022 were alcohol (45 percent of all drug-related ED visits), opioids (12.7 percent), marijuana (11.9 percent), methamphetamine (8.2percent), and cocaine (5.8 percent). Further, alcohol was the most common additional substance involved in methamphetamine-, marijuana-, and cocaine-

<sup>19</sup> Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>

<sup>20</sup> Substance Abuse and Mental Health Services Administration. (2022). Drug Abuse Warning Network: Findings from Drug-Related Emergency Department Visits, 2021 (HHS Publication No. PEP22-07-03-002). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/sites/default/files/pep22-07-03-002.pdf>

related polysubstance ED visits. Excessive alcohol use and alcohol use disorder contribute to increased mortality, reductions in life expectancy, and worsening physical health. According to the [latest CDC estimates](#), approximately 178,000 lives are lost each year due to excessive alcohol use.<sup>21</sup> Excessive alcohol use is also linked to increased risk for suicide, various forms of violence, and other chronic health impacts, and often co-occurs with other substance use and mental health challenges.<sup>22</sup>

Altogether, these findings reiterate the urgent and longstanding need to prioritize comprehensive alcohol prevention and treatment efforts at the state and community level. Of paramount importance in these efforts is screening, identification, and connecting individuals at risk for or diagnosed with alcohol use disorder to effective interventions and treatment, including medications for alcohol use disorder (MAUD). It also reinforces the need for the broader provision and uptake of training, mentoring, and ongoing support for clinical sites and practitioners seeking to implement comprehensive screening and interventions, including MAUD. Moreover, multiple prevention strategies have been demonstrated to be effective in preventing and reducing excessive alcohol use, in particular among underage individuals, underscoring the opportunity that exists to expand prevention policies, programs, and practices in an effort to drive down alcohol-related morbidity and mortality.

SAMHSA encourages states to support system wide prevention and treatment strategies, including using Block Grant funding, to address the significant challenge of excessive alcohol use and alcohol use disorder in the U.S.

### *Harm Reduction*

Harm reduction<sup>23</sup> is an important part of SAMHSA’s comprehensive public health approach to addressing substance use and use disorders, where individuals who use substances set their own goals.<sup>24</sup> 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.

SAMHSA defines harm reduction as a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (PWUD) and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them.<sup>25</sup>

<sup>21</sup> Esser MB, Sherk A, Liu Y, Naimi TS. Deaths from Excessive Alcohol Use — United States, 2016–2021. *MMWR Morb Mortal Wkly Rep* 2024;73:154–161. DOI: <http://dx.doi.org/10.15585/mmwr.mm7308a1>

<sup>22</sup> Liu GS, Nguyen BL, Lyons BH, et al. Surveillance for Violent Deaths — National Violent Death Reporting System, 48 States, the District of Columbia, and Puerto Rico, 2020. *MMWR Surveill Summ* 2023;72(No. SS-5):1–38.

<sup>23</sup> 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>.

<sup>24</sup> Substance Abuse and Mental Health Services Administration: Harm Reduction Framework. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2023. <https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf>

Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and overdose related deaths as well as other substance use-related harms. Harm reduction approaches reduce community infectious disease transmission, address the physical, mental, and social risks to 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 that also benefit communities at large.

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 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) and fentanyl and xylazine test strips 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.

SAMHSA supports states in building on evidence-based and innovative strategies to advance harm reduction interventions, including through the Naloxone State Policy Academy initiative to expand access to naloxone and other opioid overdose reversal medications throughout communities and among high-risk populations. SUPTRS BG funds can be used to plan, purchase, and distribute these lifesaving medications, such as, purchasing a variety of formulations, developing sustainable distribution policies and programs, or hosting statewide policy academies. SAMHSA supports the range of FDA-approved opioid overdose reversal medications, and recommends that grantees fully assess specific community characteristics, available resources, and interest in different products and delivery routes, when determining the FDA-approved opioid overdose reversal medications to purchase and distribute. In addition, the use of Block Grant funds for the purchase of syringes for the intramuscular administration of naloxone is considered an allowable expense.

In addition, states must note that no federal funding maybe used directly or through subsequent reimbursement of grantees to purchase pipes in safer smoking kits. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia for administering any

illegal drug.

*Health Information Technology (a non-direct service)*

Health information technology (IT) plays a critical role in enhancing behavioral health care by enabling better care coordination, improving information sharing, and supporting prevention, treatment, and recovery efforts. Access to and the exchange and use of behavioral health information as part of routine care enhances continuity of care and promotes progress toward an interoperable health care system across the care continuum. Moreover, leveraging technology in service delivery holds significant promise for reducing disparities in behavioral health care, particularly for underserved and low-resourced communities.

The appropriate use of health IT in clinical care has demonstrated its potential to improve access, maximize efficiency, and reduce both administrative burdens and costs. However, despite these benefits, health IT adoption among behavioral health providers continues to lag behind other healthcare sectors. This disparity is partly due to their ineligibility for health IT incentive programs, such as those offered by the Centers for Medicare & Medicaid Services.

A comparative [analysis](#) of American Hospital Association survey data from 2019 and 2021 revealed that 86% of non-federal, general acute care hospitals had adopted a 2015 Edition certified electronic health record (EHR), compared to only 67% of psychiatric hospitals. Furthermore, SAMHSA [survey data](#) from 2020 indicates that psychiatric hospitals are even further behind in adopting interoperability and patient engagement functions.

This lack of access to advanced health IT capabilities—such as patient portals, real-time notifications, clinical decision support, care planning, data exchange, analytics, and reporting—hampers behavioral health providers’ ability to deliver services through tools like telehealth. It also limits the integration of behavioral health data with primary care and other physical health systems, creating significant barriers to the seamless exchange of data across the care continuum.

To address these challenges, grant recipients can utilize block grant funding to support the adoption of health IT and systems for providers that serve the population of focus and meet national interoperability standards. Investing in health IT infrastructure for providers serving priority populations can enhance care delivery, promote data integration, and drive progress toward a fully interoperable healthcare ecosystem.

In accordance with HHS policy, grant recipients who are implementing, acquiring, or upgrading health IT must agree to the following:

| Where award funding involves:   | Recipients and subrecipients are required to:   |
|---|---|
| Implementing, acquiring, or upgrading health IT for activities by any funded entity | Use health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, if such standards and implementation specifications can support the activity. |

|  |  |
|--|--|
|  | Visit <a href="https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-B">https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-B</a> to learn more.   |
| Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Sections 4101, 4102, and 4201 of the HITECH Act | Use health IT certified under the ONC Health IT Certification Program, if certified technology can support the activity.<br><br>Visit <a href="https://www.healthit.gov/topic/certification-ehrs/certification-health-it">https://www.healthit.gov/topic/certification-ehrs/certification-health-it</a> to learn more. |

Note: If standards and implementation specifications adopted in 45 CFR part 170, Subpart B cannot support the activity, recipients, and subrecipients are encouraged to utilize health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ONC Interoperability Standards Advisory, available at <https://www.healthit.gov/isa/>.

Additional information can be found on the [SAMHSA](#) and the Assistant Secretary for Technology Policy/ [Office of the National Coordinator for Health Information Technology](#) websites, including information related to joint initiatives on behavioral HIT.<sup>26</sup>

*Justice Involved Populations*

SAMHSA strongly encourages state behavioral health authorities to continue to work closely with their state courts and other components of the justice system 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 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 justice systems are a referral source for M/SUD treatment, and jails and detention centers are often major providers of M/SUD services requiring coordination with broader community behavioral health systems, particularly as individuals leave incarceration and return to their communities. Importantly, research consistently shows that the period of re-entry after incarceration is an extraordinarily high-risk period for overdose and other substance use-related harms. 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 also essential elements of all state plans.

*Older Adults*

The aging population is growing significantly due to the large baby boomer generation. In 2030,

<sup>26</sup> Tripathi M, Delphin-Rittmon ME. (6 February 2024). SAMHSA and ONC launch the behavioral health information technology initiative. Retrieved online: <https://www.samhsa.gov/blog/samhsa-onc-launch-behavioral-health-information-technology-initiative>

older Americans will make up 21 percent of the population, up from 15 percent today. The provisional data from the Centers for Disease Control and Prevention indicates the 75+ age group had the highest suicide rate for any age group (43.7 per 100,000)<sup>27</sup> in 2022. Additionally, SAMHSA's 2023 National Survey on Drug Use and Health (NSDUH) indicates that approximately 2.9 million adults 50 or over reported having a serious mental illness, while 16.9 million individuals reported having any mental illness. In addition, the 2023 NSDUH found that 16.3 percent of those 50 or older reported using illicit drugs in the past year, 16.9 percent reported binge drinking in the past month, and 5.0 percent reported heavy alcohol use. Overdose deaths among older adults have also risen in recent years.<sup>28</sup>

SAMHSA encourages states to address the growing population of older adults across the nation with behavioral health needs. This includes partnering with state aging agencies to integrate care delivery systems and promote evidence-based prevention, treatment, and recovery support services to older adults. Consideration should be given to including veterans, LGBTIQ+ individuals, racial/ethnic minority elders, and their family caregivers in designing, developing, and implementing programs when considering the older adult population for services. When developing services for the older adult population, issues such as social isolation, loneliness, cognitive health, and chronic health conditions should also be taken into consideration.

#### *Climate Change and Emergency Preparedness*

Increasingly, climate related environmental changes are impacting, directly and indirectly, individuals, providers, caregivers, and communities experiencing M/SUD. For instance, climate change may increase the likelihood of extreme weather events, such as heatwaves and hurricanes, that adversely impact persons with M/SUD, exacerbating suffering and disrupting care. Growing numbers of youth and others are experiencing heightened anxiety related to current and potential impacts of climate change. 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 and non-governmental partners to strengthen community resilience, preparedness, response, and recovery in situations of emergencies and disasters. For example, recommendations from the [National Advisory Committee on Seniors and Disasters \(NACSD\), May 2023](#) include reviewing, updating, and broadly disseminating trauma-informed care approaches and disaster behavioral health training (e.g., Psychological First Aid (PFA), Skills for Psychological Recovery (SPR), particularly for those involved in disaster response. 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

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<sup>27</sup> Curtin SC, Garnett MF, Ahmad FB. Provisional estimates of suicide by demographic characteristics: United States, 2022. Vital Statistics Rapid Release; no 34. November 2023. DOI: <https://doi.org/10.15620/cdc:133702>.

<sup>28</sup> Spencer, M.R., Garnett, M. F., Minino, A. M. (March 2024). Drug overdose deaths in the United States, 2002-2022. Centers for Disease Control and Prevention, retrieved online: <https://www.cdc.gov/nchs/data/databriefs/db491.pdf> .



that underserved populations and persons with MH/SUD face increased risks from climate change, disasters and emergencies 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 disorders, 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.

### *Insurance Parity*

Many health plans must comply with requirements regarding parity in coverage of mental and SUD benefits in relation to medical/surgical benefits under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.<sup>29</sup> 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, including opioid settlement dollars that are flowing into states and localities. 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 Clinics, the Value in Opioid Use Disorder Treatment Program, Integrated Care for Kids (InCK) Model, and Financial Alignment Initiative for Medicare-Medicaid Enrollees, Innovation in Behavioral Health (IBH) Model) that support efforts to provide behavioral health services.

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<sup>29</sup> <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>

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 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.medicaid.gov/federal-policy-guidance/index.html>.

Beyond SAMHSA and CMS, there have been broad investments in access to behavioral health 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 behavioral health services, as well.

Some states have contracted with managed care organizations (MCO) or Administrative Services Organizations (ASO) to oversee and provide behavioral health 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 behavioral health services are appropriately included in plans, and mental health and 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 their partners and counterparts in public health and Medicaid at the state level, and work with all partners at the federal, state and community levels.

## II. SUBMISSION OF APPLICATIONS AND PLAN TIMEFRAMES

This section includes the FFY 2026-2027 Combined Block Grant Application’s statutory deadlines, application requirements, planning steps, and plan tables. Additional details for all required parts of the application are further detailed in **Section III. Mental and Substance Use Disorder Assessment and Plan.**

### A. Statutory Deadlines

Statutory deadlines for submission of block grant plan applications and required reports are as follows:

1. Submissions for a Combined MHBG/SUPTRS BG Behavioral Health Assessment and Plan application and the MHBG-only application are due no later than September 1, 2025
2. Submissions for a SUPTRS BG-only application are due no later than October 1, 2025
3. Annual Reports for the MHBG and SUPTRS BG are due by December 1, 2025.
4. The Annual Synar Report is due by December 31, 2025 (SUPTRS BG only).

| Application | Plan Due Date | Report Deadline <sup>a</sup> |
|-------------|---------------|------------------------------|
|-------------|---------------|------------------------------|



|                           |                   |                               |
|---------------------------|-------------------|-------------------------------|
| Combined MHBG & SUPTRS BG | September 2, 2025 | December 1, 2025 <sup>b</sup> |
| MHBG                      | September 2, 2025 | December 1, 2025              |
| SUPTRS BG                 | October 1, 2025   | December 1, 2025              |
| Annual Synar Report       | N/A               | December 31, 2025             |

<sup>a</sup> Annual reports for the most recently completed state fiscal year (SFY)/completed federal fiscal year (FFY) BG awards are required by statute to be submitted in conjunction with the federal fiscal year (FFY) 2026-2027 application.

<sup>b</sup> Separate reports must be submitted for MHBG and SUPTRS BG.

The FFY 2026-2027 MHBG and SUPTRS BG Application(s) submissions must include(s) certifications and assurances (State Information), a two-year Behavioral Health Assessment and Plan (Planning Steps), as well as performance indicators and expenditures (Planning Tables), and supporting forms for service delivery planning and emphasis (Environmental Factors & Plan).

### ***B. Application Requirements***

For the Secretary of HHS, acting through the Assistant Secretary for Mental Health and Substance Use, to make an award under the block grant programs, states must submit an application(s) sufficient to meet the requirements described in SAMHSA’s respective block grant authorizing statute and implementing regulations, as relevant. Information provided in the application(s) must be sufficiently detailed and clear for SAMHSA to monitor the states’ compliance efforts regarding the obligation and expenditure of MHBG and SUPTRS BG funds. Awarded funds will be available for obligation and expenditure<sup>30</sup> to plan, carry out, and evaluate activities and services for children with SED and adults with SMI; substance use primary prevention; treatment services for youth and adults with a SUD, including the provision of preference to treatment admission for pregnant women and persons who inject drugs; 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 that is applicable to a state. Furthermore, plans must meet additional requirements as outlined under Provisions. The State Plan must include a description of the manner in which the state intends to obligate the grant funds. In addition, it must include a report<sup>31</sup> per format containing information that the Secretary determines to be necessary for securing a record and description of the purposes for which both the MHBG and SUPTRS BG were expended. States are required to update their plans during the second year of the two-year planning cycle, in addition to the submission of their annual report.

The MHBG and SUPTRS BG differ in several of their statutory requirements and thus what SAMHSA requires states to reflect in their applications.

### **MHBG Expenditure Requirements and Restrictions**

The MHBG portion of the statute requires states to provide services to those with SMI and SED

<sup>30</sup> Title XIX, Part B of the PHS Act, <http://www.samhsa.gov/grants/block-grants/laws-regulations>

<sup>31</sup> 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>

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 peer and family-operated programs) which meet the criteria as described in [42 USC §300x-2](#) .

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 on the use of payments for MHBG funds include: inpatient services; cash payments to intended recipients of health services; purchase or improvement of land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase of major medical equipment; use of 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.

### **SUPTRS BG Expenditure Requirements and Restrictions**

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, treat, and provide recovery support services for substance use disorders, and for related activities authorized in the statute ([42 U.S.C. §300x-21 \(b\)](#)). Grantees must expend not less than 20% of SUPTRS BG awards on primary prevention of substance use, and those states which are HIV-designated must expend exactly 5% of their total SUPTRS BG award on early intervention services (EIS) for HIV.

The SUPTRS BG contains certain spending restrictions, including not expending funds for inpatient hospital services except as provided for in the regulations; prohibiting cash payments to clients; disallowing 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.

### **Value to SAMHSA of Application Requirements**

The application template requests information on state efforts on certain policy, program, and technology advancements in mental health and SUD prevention, treatment, and recovery. The 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 \(b\)\(1\)\(A\)](#)) 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 helps SAMHSA understand the whole of the applicant state's efforts and identifies how SAMHSA can assist the applicant state in meeting its

goals. In addition, this information helps SAMHSA identify model states and areas of common concern where technical assistance or additional guidance may be needed.

**C. Planning Steps and Plan Tables**

The FFY 2026-2027 MHBG and SUPTRS BG Application(s) include(s) the following sections and accompanying tables:

1. State Information: funding agreements, assurances, and certifications.
2. Planning Steps: a two-year Behavioral Health Assessment and Plan
  - a. assessment of state organizational strengths and capacity (Step 1); and
  - b. identification of service needs and critical gaps, with plan to address needs & gaps (Step 2);

Planning Step 2 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 populations of focus and other priority populations; and (4) develop goals, objectives, strategies, and performance indicators.

**3. Planning Tables:**

- a. Priority areas and performance indicators (Table 1, both MHBG and SUPTRS BG; Table 5c, SUPTRS BG only);
  - b. Expenditures (Tables 2, 4 and 6, both MHBG and SUPTRS BG; Table 5a, and 5b SUPTRS BG only);
  - c. Persons in need of and receiving SUD treatment (Table 3, SUPTRS BG only);
- 4. Environmental Factors & Plan:** supporting forms (Forms 1 – 23) for service delivery planning and emphasis

| Required Planning Tables  | MHBG | SUPTRS BG |
|---|------|-----------|
| Table 1: Priority Area and Annual Performance Indicators              | ✓    | ✓         |
| Table 2: Planned State Agency Budget for Two State Fiscal Years (SFY) | ✓    | ✓         |
| Table 3: Persons in need/receipt of treatment                         | --   | ✓         |
| Table 4: Planned Block Grant Award Budget by Planning Period          | ✓    | ✓         |
| Table 5a: Primary Prevention Planned Budget                           | --   | ✓         |

|   |    |   |
|---|----|---|
| Table 5b: Primary Prevention Planned Budget by IOM Category                         | -- | ✓ |
| Table 5c: Planned Primary Prevention Priorities                                     | -- | ✓ |
| Table 6: Planned Budget for Other Capacity Building/ Systems Development Activities | ✓  | ✓ |

### 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 2026-2027. States will have the option to update their Plans when they submit their FFY 2027 Application in a timeframe designated by SAMHSA.

The FFY 2026-2027 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 2026-2027 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-3\(b\)\)](#) for the MHBG and must be included in the application. Although it is not statutorily required, states are also encouraged to expand this Planning Council to include substance use service stakeholders and use this mechanism to assist in the development of the state block grant plan for the SUPTRS BG application. The BG plans should also show the involvement of persons who are service recipients and in recovery, families of individuals with SMI/SED, providers of services and supports, representatives from other state agencies in the Planning Council. It is also encouraged to include individuals in recovery from SUD, representatives from underserved communities (as defined under [EO 13985](#)), tribes, and other key stakeholders.

States must also describe the public input process for the development of the BG plans, as

mandated by section [1941 of the PHS Act \(42 U.S.C. § 300x-51<sup>32</sup>\)](#), 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 and SUPTRS BG.

### **A. Framework for Planning**

States should identify and analyze the strengths, needs, and priorities of their mental health and SUD system. The strengths, needs, and priorities should take into account specific populations that are the current focus of the block grants, the changing epidemiology of mental health and substance use in the U.S., and the changing health care environment.

### **MHBG Framework**

The MHBG program is designed to provide comprehensive recovery-oriented 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 disorders. 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 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, developmentally appropriate 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

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<sup>32</sup> 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.

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 for individuals experiencing ESMI. 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 defined by the MHBG statute including: (A) crisis contact centers; (B) 24/7 mobile crisis services; (C) 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.
- *Element 3:* States are required to provide services for children with SED. Each year the State shall expend not less than the amount expended in FY 1994. If there is a shortfall in funding available for children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the state is providing an adequate level of comprehensive community mental health services for children with SED, as indicated by comparing the number of children in need of such services with the services actually available within the State.
- *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**

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](#)). The authorizing statute and implementing regulations require each grantee to submit an application for each fiscal year containing information that conforms to funding agreements and assurances, and for which the application and report are submitted by the date prescribed by law. The application and report must contain information as is necessary to determine the purposes and the activities of the grantee, for which the Block Grant is expended. This includes, but is not limited to the establishment of, and progress in achieving, meeting prevention, treatment, and recovery support services goals, objectives, activities, and a description of all related expenditures.
- *Criterion 2: Primary Prevention* ([42 U.S.C. § 300x-22\(a\)](#) a). The authorizing statute 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 statute 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 the population of designated women in an amount equal to the amount expended in FFY 1994. Furthermore, providers receiving SUPTRS BG funds for treatment must give preference and admittance to treatment facilities in the following order: first pregnant women who inject drugs, then pregnant women, then persons who inject drugs, and then all others.
- *Criterion 4: Persons Who Inject Drugs* ([42 U.S.C. § 300x-23](#) and [45 CFR § 96.126](#)). The authorizing statute 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 provide screening and identification of tuberculosis (TB) and make 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 statute and implementing regulation require designated states as defined in the statute 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 statute 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\(a\)](#)) *Coordination of Ancillary Services* ([42 U.S.C. § 300x-28\(c\)](#) and [45 CFR § 96.132\(c\)](#)). The authorizing statute 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-53\(a\) \(1\) \(A\)](#) and [45 CFR § 96.136](#)). The authorizing statute and implementing regulation require states to assess the quality, appropriateness, and efficacy of SUD and co-occurring treatment services provided in the State to individuals under the program involved.
- *Criterion 10: Professional Development* ([42 U.S.C. § 300x-28\(b\)](#) and [45 CFR § 96.132\(b\)](#)). The authorizing statute 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:* Authorizing statute (42 U.S.C § 300x-30) and implementation regulations (45 C.F.R. 96.134) for the SUPTRS BG includes a [State Maintenance of Effort \(MOE\) Expenditure Requirement](#). A state plan must include the amount of state expenditures maintained for certain SUD prevention, treatment, and recovery support activities. [Table 2 planned expenditures for state MOE shall be](#) at a level that is no less than the state's average expenditures for the previous two state fiscal years. At the time of reporting actual state expenditures in the annual SUPTRS BG Report, states that do not meet the MOE requirement due to extenuating circumstances have opportunities to remedy this compliance issue. States may request a waiver or determination of material compliance from the Assistant Secretary for Mental Health and Substance Use under the applicable statute and regulations. States may refer to [SAMHSA MOE Primer](#) for additional guidance on procedures for making waiver requests.
- *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 ([45 CFR §96.124\(c\)](#)) 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. States must account for their Women’s Services MOE Expenditure Requirements over the award period in their planned expenditure Table 2. At the time of reporting final actual expenditures on pregnant women and women with dependent children in the annual SUPTRS BG Report, in the event 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 primary prevention efforts that include funding at least one of the six prevention strategies: 1) Information dissemination; 2) Education; 3) Alternatives that decrease alcohol, tobacco, and other drug use; 4) Problem identification and referral; 5) Community based programming and; 6) Environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco, and other drugs used in the general population. SUPTRS BG primary prevention set-aside funds can only be expended to fund universal, selective, and/or indicated substance use prevention strategies.

Primary 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](#) 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](#)).

These primary prevention efforts should focus on the range of risk and protective factors at the individual, relationship, community, and societal levels associated with substance use and substance use disorders and 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, well-being, and other positive individual and interpersonal skills; implement evidence-based and cost-effective models to prevent substance use and use disorders among 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 strategies to change the community's norms around, and parental acceptance of, substance use as well as policies that address underlying risk factors for substance use and the availability and accessibility of substances in communities; and offer the latest science and research on prevention, treatment and recovery; and addressing underserved communities that experience a cluster of risk factors and cultural 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:
  - a. Children with SED\*
  - b. Adults with SMI\* including Older Adults
  - c. Individuals with SMI or SED in rural areas and among those experiencing homelessness, as applicable\*
  - d. Individuals who have an Early Serious Mental Illness (ESMI) \* (10 percent MHBG set aside)
  - e. Individuals in need of behavioral health crisis services (BHCS) \* (5 percent MHBG set aside)
2. (SUPTRS BG) Treatment and Recovery Support Services for persons with substance use disorder:
  - a. Pregnant women and women with dependent children;\*
  - b. Persons who inject drugs;\*
  - c. Persons in need of recovery support services for substance use disorder;\*
  - d. Individuals with a co-occurring mental health and substance use disorder;\*
  - e. Persons experiencing homelessness.\*
3. (SUPTRS BG) Services for persons with SUD who have or are at risk of:
  - a. HIV/AIDS, designated states per CDC only;\*

<sup>33</sup> Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 USC § 300x24). Retrieved online: <https://www.govinfo.gov/content/pkg/USCODE-2022-title42/pdf/USCODE-2022-title42-chap6A-subchapXVII-partB-subpartii-sec300x-24.pdf>

- b. Tuberculosis.\*
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 (*Note: for MHBG, all populations served must have SMI or SED.*):
    - a. Racial and ethnic minorities, such as American Indians/Alaska Natives;
    - b. Youth;
    - c. Older adults;
    - d. Persons with disabilities;
    - e. LGBTQI+ populations;
    - f. Military personnel (active, guard, reserve, and veteran) and their families
    - g. Individuals with mental health and substance use disorders involved in the adult or juvenile justice systems;
    - h. Individuals with mental health and substance use disorders who live in rural and frontier areas;
    - i. Members from other under-represented and underserved populations;
    - j. Community populations for environmental prevention activities, including policy and behavior change activities to change community, school, family, and business norms through laws, policy and guidelines and enforcement (SUPTRS BG only);
    - k. Community settings for universal, selective, and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies (SUPTRS BG only);
    - l. Individuals new in their recovery who require additional recovery support services, as appropriate, to maintain their recovery.

In addition, states should consider linking their *Olmstead* planning work in the block grant application (which can be found in Section C, question 18), 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 in developing the state plan portion of their block grant application:

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

Provide an overview of the state’s prevention system (description of the current prevention system’s attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public behavioral health system is

currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services.

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 do and do not 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. Partnerships and collaborations with community-based behavioral health organizations and other community-trusted entities serving these populations should be built into the service system. The lack of such collaborations and strengths might be considered needs of the system, which should be discussed under Step 2. Without these partnerships, outreach and engagement of these underserved populations will be difficult. 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, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s).**

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

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

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees

should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as SAMHSA's [National Survey on Drug Use and Health \(NSDUH\)](#), [Treatment Episode Data Set \(TEDS\)](#), [National Substance Use and Mental Health Services Survey \(N-SUMHSS\)](#), the Behavioral Health Barometer, [Behavioral Risk Factor Surveillance System \(BRFSS\)](#), [Youth Risk Behavior Surveillance System \(YRBSS\)](#), the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans. Grantees should also discuss 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*<sup>34</sup> in developing this narrative.

### **C. Planning Tables**

In addition to the descriptive narratives outlined in the planning steps above, states are required to present both their programmatic and fiscal plans for the planning period. States will demonstrate the planned activities through a series of tables presented below.

First, states should establish measurable goals and objectives to address the unmet needs highlighted in the state's narratives through Plan Table. In this table, states should describe specific performance indicators that they will use 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 have been used to develop the baseline for FFY 2026 and how the state proposes to measure the change in FFY 2027. States must use the template (Plan Table 1: Priority Areas and Annual Performance Indicators) below. As a reminder, these population performance indicators should reflect the unmet needs and critical gaps identified and discussed in the *Planning Step 2* narrative above.

SAMHSA highlights several considerations for states as they work to complete Plan Table 1, including:

#### *Prioritizing state planning activities*

Prioritize state planning activities that will include MHBG and SUPTRS BG. The priorities

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<sup>34</sup> 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.

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 priority populations (those required in statute and regulation for each block grant) and other priority populations described in the narrative. States should list priorities in Plan Table 1 and indicate the priority type: substance use primary prevention (SUP), substance use disorder treatment (SUT), substance use disorder recovery (SUR), mental health services (MHS), early serious mental illness (ESMI), and behavioral health crisis services (BHCS).

#### *Developing goals, performance indicators, and strategies*

In developing Plan Table 1, states must first specify a priority area that aligns with an unmet need or critical gap. Once a priority area is specified, grantees should select only one of the three (3) priority types for either MHBG (MHS, ESMI, or BHCS) or SUPTRS BG (SUP, SUT, or SUR) under which the priority area aligns. Grantees should not select more than one priority type for any priority area. To accompany priority types, grantees must indicate the population(s) served or whose needs are met by the priority being established. With a priority area, type and population(s) identified, grantees must develop relevant measurable goals and associated strategies to attain them. To ensure goals are measurable, grantees must define and describe at least one performance indicator for each goal for the next two years. If more than one population is specified under any given priority, at least one performance indicator for each population must be established.

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.

The identified 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, recovery support services, and system improvements that will address the objective.

Strategies to consider and address include:

1. Strategies that support successful integration and attention to SAMHSA's five priorities in the 2023-2026 Strategic Plan (i.e., preventing substance use and overdose; enhancing access to suicide prevention and mental health services; 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).
2. Strategies that will focus on 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.

3. Strategies that result in developing recovery support services (e.g., peer support services, recovery housing, peer run respite programs, 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.
4. 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.
5. Strategies to address system improvement activities, as identified in the needs assessment, which should:
  - a. Allow states to position their providers to increase access, retention, adoption, or adaptation of EHRs or to develop strategies to increase workforce numbers, including the prevention workforce. 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 behavioral health workforce. System improvements that seek to expand the workforce should build upon existing efforts to increase mental health and substance use-related skill development in a wide range of professions as well as increase the role of people in recovery from mental and substance use disorders, including people from underserved communities, in the planning, delivery, and evaluation of services.
  - b. 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.
  - c. Encourage the use of peer specialists, family support providers, and/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.
  - d. Increase links between primary, specialty, emergency and recovery care and specialty behavioral health providers working with specialty behavioral health provider organizations for expertise, collaboration, and referral arrangements, including the

- support of practitioner efforts to screen and provide care for patients with mental health and substance use disorders. Activities should also focus on developing model contract templates for reciprocal physical and behavioral health integration and identifying state policies that present barriers to reimbursement. This would include efforts to implement dual eligible products, ACOs, and medical homes, among other emerging health care and health system financing strategies.
- e. Develop support systems to provide communities, including underserved communities, with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other resources to foster the development of culturally and linguistically informed and comprehensive community plans to improve behavioral health outcomes.
  - f. 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.
  - g. 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.

**Plan Table 1. Priority Area and Annual Performance Indicators – Required for MHBG & SUPTRS BG**

States should follow the guidelines presented above in *Framework for Planning and Planning Step 2* 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 enter the following information into WebBGAS:

1. *Priority area* (based on an unmet service need or critical gap): After this 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 **SUP** – substance use primary prevention, **SUT** – substance use disorder treatment, **SUR** – substance use disorder recovery support services, **MHS** – mental health service, **ESMI** – early serious mental illness, or **BHCS** – behavioral health crisis services.
3. *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 performance indicator for each required population. For example, at least one priority area must be denoted SUP (*substance use primary prevention*, priority type) and PP (*persons in need of substance use primary prevention*, required population). From the drop-down menu select:
  - a. **SMI**: Adults with SMI,
  - b. **SED**: Children with an SED,
  - c. **ESMI**: Individuals with ESMI including psychotic disorders,
  - 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,
  - 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. **PRSUD:** Persons in need of recovery support services from substance use disorder,
  - k. **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. There should be at least one goal related to the primary prevention priority area.
  5. *Strategies to attain the goal.* Indicate program strategies or means to achieve the stated goal. A strategy should be a concrete, precise, and measurable statement.
  6. *Annual Performance Indicators to measure goal success.* Each performance indicator must reflect progress on a measure that is impacted by the Block Grant. At least one performance indicator should be created for each population specified under the priority area. A performance indicator must have the following components:
    - a. Baseline measurement from where the state assesses progress
    - b. First-year target/outcome measurement (Progress to the end of SFY 2026)
    - c. Second-year target/outcome measurement (Final to the end of SFY 2027)
    - 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 (SUP, SUT, SUR, MHS, ESMI, BHCS):   |
| 3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):       |
| 1. Goal of the priority area:  |
| 2. Strategies to attain the goal:  |
| 7. Annual Performance Indicators to measure achievement of the objective:<br>Indicator #1: |
| <b>Plan Table 1: Priority Area and Annual Performance Indicators, continued</b>            |
| a) Baseline measurement (Initial data collected prior to and during SFY 2026):             |
| b) First-year target/outcome measurement (Progress to the end of SFY 2026):                |
| c) Second-year target/outcome measurement (Final to the end of SFY 2027):                  |
| 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, strategies 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 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.

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**Plan Table 2. Planned State Agency Budget for Two State Fiscal Years (SFY) – Required for MHBG & SUPTRS BG**

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

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

*\*Please note that MHBG and SUPTRS BG have two separate Table 2 submissions: Table 2a (MHBG) and Table 2b (SUPTRS BG).*

**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:  |                                 |  |  |                   |  |             |                                     |   |
| Activity   | A.<br>Mental Health Block Grant | B.<br>Medicaid (Federal, State, and Local) | C.<br>Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.) | D.<br>State Funds | E.<br>Local Funds (excluding local Medicaid) | F.<br>Other | G.<br>ARP Funds (MHBG) <sup>a</sup> | H.<br>Bipartisan Safer Communities Act Funds <sup>b</sup> |
| 1. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award) <sup>d</sup> | \$                              | \$   | \$   | \$                | \$   | \$          | \$                                  | \$  |
| 2. State Hospital  |                                 | \$   | \$   | \$                | \$   | \$          |                                     |   |

| Table2a (Cont.)                                       | A.<br>Mental<br>Health<br>Block<br>Grant | B.<br>Medicaid<br>(Federal,<br>State, and<br>Local) | C.<br>Other<br>Federal<br>Funds (e.g.,<br>ACF, TANF,<br>CDC, CMS<br>(Medicare),<br>SAMHSA,<br>etc.) | D.<br>State<br>Funds | E.<br>Local Funds<br>(excluding<br>local<br>Medicaid) | F.<br>Other | G.<br>ARP Funds<br>(MHBG) <sup>a</sup> | H.<br>Bipartisan<br>Safer<br>Communities<br>Act Funds <sup>b</sup> |
|---|--|---|---|----------------------|---|-------------|--|--|
| 3. Other Psychiatric Inpatient Care                   |  | \$  | \$  | \$                   | \$  | \$          |  |  |
| 4. Other 24-Hour Care (Residential Care)              | \$                                       | \$  | \$  | \$                   | \$  | \$          | \$                                     | \$   |
| 5. Ambulatory/Community Non-24 Hour Care              | \$                                       | \$  | \$  | \$                   | \$  | \$          | \$                                     | \$   |
| 6. Crisis Services (5 percent Set-Aside) <sup>e</sup> | \$                                       | \$  | \$  | \$                   | \$  | \$          | \$                                     | \$   |
| 7. Administration <sup>f</sup>                        | \$                                       | \$  | \$  | \$                   | \$  | \$          | \$                                     | \$   |
| 8. Total  | \$                                       | \$  | \$  | \$                   | \$  | \$          | \$                                     | \$   |

<sup>a</sup>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. Column G should reflect the state planned expenditures period of State Fiscal Years 2026 and 2027, for most states this planning period (FY2026 and FY2027) is July 1, 2025, through June 30, 2027. *Note: ARP funds expire September 30, 2025.*

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

<sup>d</sup> Row 2 in Columns A, G, and H: per statute, states are required to set-aside 10 percent of the total MHBG, ARP, and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

<sup>e</sup> Row 7 in Columns A and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

<sup>f</sup> Per statute, administrative expenditures for the MHBG, ARP, and BSCA funds cannot exceed 5 percent of the fiscal year award.

**SUPTRS BG Plan Table 2b. Planned State Agency Budget for Two State Fiscal Years (SFY)**

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

| <b>Planning Period</b>   |                         | <b>From: 7/1/2025</b>  |  |                           | <b>To: 6/30/2027</b>   |                     |                               |
|--|-------------------------|--|--|---------------------------|--|---------------------|-------------------------------|
| <b>ACTIVITY</b>  | <b>A.<br/>SUPTRS BG</b> | <b>B.<br/>Medicaid<br/>(Federal,<br/>State, and<br/>local)</b> | <b>C.<br/>Other<br/>Federal<br/>Funds (e.g.,<br/>ACF<br/>(TANF),<br/>CDC, CMS<br/>(Medicare)<br/>SAMHSA,<br/>etc.)</b> | <b>D.<br/>State funds</b> | <b>E.<br/>Local funds<br/>(Excluding<br/>local<br/>Medicaid)</b> | <b>F.<br/>Other</b> | <b>G.<br/>ARP<sup>a</sup></b> |
| 1. Substance Use Disorder Prevention <sup>b</sup> and Treatment          | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| a. Pregnant Women and Women with Dependent Children (PWWDC) <sup>c</sup> | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| b. All Other   | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| 2. Recovery Support Services <sup>d</sup>                                | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| 3. Primary Prevention <sup>e</sup>                                       | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| 4. Early Intervention Services for HIV <sup>f</sup>                      | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| 5. Tuberculosis  | \$                      | \$   | \$   | \$                        | \$   | \$                  | \$                            |
| 6. Other Capacity Building/Systems Development <sup>g</sup>              |                         |  |  |                           |  |                     |                               |

|                                |    |    |    |    |    |    |    |
|--------------------------------|----|----|----|----|----|----|----|
| 7. Administration <sup>h</sup> | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 8. <b>Total</b>                | \$ | \$ | \$ | \$ | \$ | \$ | \$ |

<sup>a</sup> Per the instructions, the planning period for SUPTRS BG expenditures is July 1, 2025 – June 30, 2027. Please enter SUPTRS BG ARP planned expenditures for the same two-year period from July 1, 2025 – June 30, 2027. Planned ARP expenditure totals should reflect the remaining balance of ARP funds available to the grantee at time application submission. *Note: ARP supplemental funds are set to expire September 30, 2025.*

<sup>b</sup> Prevention other than primary prevention.

<sup>c</sup> Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women’s Maintenance of Effort (MOE) over the two-year planning period.

<sup>d</sup> This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under SAMHSA’s 2023 guidance, “Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG.” Only report RSS for those in need of RSS from substance use disorder.

<sup>e</sup> Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

<sup>f</sup> 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.

<sup>g</sup> Other Capacity Building/Systems development include those activities relating to substance use per [§96.122 \(f\)\(1\)\(v\)](#).

<sup>h</sup> Per 45 § 96.135 Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.



**Plan Table 3. Persons in Need/Receipt of SUD Treatment – Required for SUPTRS BG Only**

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

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of 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 B), 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).

States should contact SAMHSA’s Center for Behavioral Health Statistics and Quality (CBHSQ) for assistance in drawing these estimates from national and state survey data, [CBHSQrequest@samhsa.hhs.gov](mailto:CBHSQrequest@samhsa.hhs.gov).

| <b>SUPTRS BG Plan Table 3. Persons in Need/Receipt of SUD treatment</b>                        |   |   |
|--|---|---|
| <i>Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.</i> |   |   |
|  | <b>A.<br/>Aggregate Number Estimated in<br/>Need of SUD Treatment</b> | <b>B.<br/>Aggregate Number in SUD<br/>Treatment</b> |
| 1. Pregnant Women  |   |   |
| 2. Women with Dependent Children   |   |   |
| 3. Individuals with a co-occurring M/SUD   |   |   |
| 4. Persons who inject drugs  |   |   |
| 5. Persons experiencing homelessness   |   |   |



Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

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## **Plan Table 4. Planned Block Grant Award Budget by Planning Period – Required for MHBG & SUPTRS BG**

States are asked to use Table 4 to present their planned budget for the Block Grant award for which they are applying. States should specify the planned expenditures by each service category identified in each table. When planning how they will allocate their BG award, states should keep in mind all statutory and regulatory requirements and restrictions on amounts expended in each category.

### **MHBG Plan Table 4a - State Agency Planned Budget for MHBG**

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

Please use the following categories to describe planned budget your state supports with MHBG funds.

#### **1. Services for Adults:**

**1a. EBPs for Adults:** In this row, provide the amount of MHBG funds budgeted for the provision of evidence-based practices (EBPs) for adults (individuals aged 18 and over). To be considered an EBP, a service must adhere to a specific model of treatment that has been tested and validated through peer-reviewed research. Commonly used EBPs for adults include Assertive Community Treatment (ACT), Integrated Treatment for Co-occurring Disorders, Supported Employment, Supported Housing, Family Psychoeducation, Illness Self-management and Recovery, Medication Management, etc. The SAMHSA Evidence-Based Practices Resource Center provides a comprehensive list of EBPs. (*Note: Please do not include EBPs for Early Serious Mental Illness (ESMI) services including Coordinated Specialty Care (CSC) for First Episode Psychosis in this row; see 1c.*)

**1b. Crisis Services for Adults:** In this row, provide the amount of MHBG funds budgeted for the provision of crisis services for adults (individuals aged 18 and over). This row should include the core crisis services—crisis contact centers (988 or non-988), 24/7 mobile crisis services, crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by the State, with referrals to inpatient or outpatient care—states should include any portion of MHBG funds budgeted for this purpose (i.e., not limited to the required 5 percent set-aside. However, the total for this row plus row 3b in the Services for Children section of the table must equal at least 5 percent of the total MHBG award).

**1c. ESMI Programs for Adults:** In this row, provide the amount of MHBG funds budgeted for the provision of EBPs to address Early Serious Mental Illness (ESMI) including psychotic disorders for individuals aged 18 years and older. States should include any portion of MHBG funds budgeted for this purpose (i.e., not limited to the required 10 percent set-aside). However, the total of this row plus row 3c in the Service for Children section of the table must equal at least 10 percent of the total MHBG award).

**1d. Other Outpatient/Ambulatory Services for Adults:** In this row, provide the amount of MHBG funds budgeted for the provision of other outpatient/ambulatory services for adults (individuals aged 18 and older). Services included in this total may include standard outpatient therapy (individual, group, and/or family therapy), case management, intensive outpatient program, and partial hospitalization programs. Outpatient psychiatric medication maintenance should also be included in this row. Do not include EBPs or ESMI/CSC services accounted for in rows 1a and 1c.

**1e. \*Other Direct Services for Adults:** In this row, provide the amount of MHBG funds budgeted for the provision of any other services for adults (individuals aged 18 and older) that have not already been accounted for in rows 1a – 1d. Examples of services received may include peer support services, recovery support services, care coordination services, transportation, pre-trial and post-trial diversion services, and services for individuals who are uninsured or underinsured. Suicide and/or relapse prevention services for individuals with SMI, if not covered in row 8, may be included in this row.

**2. Subtotal of Services for Adults:**

This row should reflect the sum of rows 1a – 1e.

**3. Services for Children:**

**3a. EBPs for Children:** In this row, provide the amount of MHBG funds budgeted for the provision of evidence-based practices (EBPs) for children (individuals aged 17 and under). To be considered an EBP, a service must adhere to a specific model of treatment that has been tested and validated through peer reviewed research. Commonly used EBPs for children include Multisystemic Therapy, Therapeutic Foster Care, Functional Family Therapy, etc. The SAMHSA Evidence-Based Practices Resource Center provides a comprehensive list of evidence-based practices. (*Note: please do not include EBPs for ESMI services including CSC in this row; see 3c.*)

**3b. Crisis Services for Children:** In this row, provide the amount of MHBG funds budgeted for the provision of crisis services for children (individuals aged 17 and under). This should include the core crisis services—crisis contact centers (988 or non-988), 24/7 mobile crisis services, crisis stabilization programs offering acute care or subacute care in a hospital or

appropriately licensed facility, as determined by the State, with referrals to inpatient or outpatient care—states should include any portion of MHBG funds budgeted for this purpose (i.e., not limited to the required 5 percent set-aside. However, the total for this row plus row 1b in the Services for Adult section of the table must equal at least 5 percent of the total MHBG award).

**3c. ESMI Programs for Children:** In this row, provide the amount of MHBG funds budgeted for the provision of EBPs to address ESMI including psychotic disorders for children (individuals aged 17 and under). States should include any portion of MHBG funds budgeted for this purpose (i.e., not limited to the required 10 percent set-aside. However, the total of this row plus row 1c in the Service for Adults section of the table must equal at least 10 percent of the total MHBG award).

**3d. Other Outpatient/Ambulatory Services for Children:** In this row, provide the amount of MHBG funds budgeted for the provision of other outpatient/ambulatory services for children (individuals aged 17 and under). Services included in this total may include standard outpatient therapy (individua, group, and/or family therapy), case management, intensive outpatient program, and partial hospitalization programs. Outpatient psychiatric medication maintenance should also be included here. Do not include EBPs or ESMI services accounted for in rows 3a and 3c.

**3e. \*Other Direct Services for Children:** In this row, provide the amount of MHBG funds budgeted for the provision of any other services for children (individuals aged 17 and under) that have not already been accounted for in rows 3a – 3d. Examples of services may include peer support services, recovery support services, care coordination, transportation, pre-trial and post-trial diversion services, and services for children who are uninsured or underinsured, transportation, case management, services for children in the juvenile justice system, etc. Suicide and/or relapse prevention services for children with SED, if not covered in row 3a, may be included in this row.

**4. Subtotal of Services for Children**

This row should reflect the sum of rows 3a – 3e.

**5. Other Capacity Building/Systems Development**

In this row, provide the amount of MHBG funds budgeted for the provision of other capacity building/systems development (see MHBG Planning Table 6 for service categories and definitions).

**6. Administrative Costs**

In this row, provide the amount of MHBG funds budgeted for grant administrative expenses. Planned expenditures for administrative expenses cannot exceed 5 percent of the total MHBG allocation.

**7. Any Other Costs**

In this row, provide the amount of MHBG funds budgeted for any other allowable activity that is not covered in any other row. Please include a brief explanation of costs included in this row in the text box at the bottom of the table.

**8. Total MHBG Allocation**

This row should reflect the sum of rows 2, 4, 5, 6, and 7 and must be equal to the state’s total MHBG allocation.

| <b>MHBG Table 4a.</b>                               |   |  |  |  |
|---|---|--|--|--|
| <b>Planning Period:</b>                             | <b>From:</b>  |  | <b>To:</b>                               |  |
| <b>State Identifier</b>                             |   |  |  |  |
| <b>MHBG-Funded Services</b>                         |   |  | <b>MHBG Funds Budgeted for This Item</b> |  |
| <b>1. Services for Adults</b>                       |   |  |  |  |
| 1a. EBPs for Adults                                 |   |  |  |  |
| 1b. Crisis Services for Adults                      |   |  |  |  |
| 1c. CSC/ESMI program for Adults                     |   |  |  |  |
| 1d. Other outpatient/ambulatory services for Adults |   |  |  |  |
| 1e. *Other Direct Services for Adults               |   |  |  |  |
| <b>2. Subtotal of Services for Adults</b>           |   |  |  |  |
| <b>1.</b>   | <b>3. Services for Children</b>                                   |  |  |  |
|   | 3a. EBPs for Children   |  |  |  |
|   | 3b. Crisis Services for Children                                  |  |  |  |
|   | 3c. CSC/ESMI program for Children                                 |  |  |  |
|   | 3d. Other outpatient/ambulatory services for Children             |  |  |  |
|   | 3e. *Other Direct Services for Children                           |  |  |  |
|   | <b>4. Subtotal of Services for Children</b>                       |  |  |  |
|   | <b>5. Other Capacity Building/Systems Development<sup>a</sup></b> |  |  |  |
|   | <b>6. Administrative Costs<sup>b</sup></b>                        |  |  |  |
|   | <b>7. *Any Other Costs</b>  |  |  |  |

|   |  |
|---|--|
| <b>8. Total MHBG Allocation<sup>c</sup></b> |  |
|---|--|

<sup>a</sup>This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6a.

<sup>b</sup>Administrative Costs should not exceed 5 percent of total MHBG allocation.

<sup>c</sup>The total budget present should be equal to your MHBG allocation for the next two years.

Please provide brief explanation for services with an asterisk\* below.

|  |
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**SUPTRS BG Plan Table 4b. Planned SUPTRS BG Award Budget by Federal Fiscal Year**

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

| <b>SUPTRS BG Plan Table 4b. Planned SUPTRS BG Award Budget by Federal Fiscal Year</b> |                               |                               |
|---|-------------------------------|-------------------------------|
| <b>Planning Period</b>  | <b>FFY 2026</b>               | <b>FFY 2027</b>               |
|   | <b>10/1/2025 to 9/30/2026</b> | <b>10/1/2026 to 9/30/2027</b> |
| <b>Expenditure Category</b>   | <b>A.<br/>SUPTRS BG</b>       | <b>A.<br/>SUPTRS BG</b>       |
| 1. Substance Use Disorder Prevention <sup>a</sup> and Treatment                       | \$                            | \$                            |
| 2. Recovery Support Services <sup>b</sup>   | \$                            | \$                            |
| 3. Substance Use Primary Prevention <sup>c</sup>                                      | \$                            | \$                            |
| 4. Early Intervention Services for HIV <sup>d</sup>                                   | \$                            | \$                            |
| 5. Tuberculosis Services  | \$                            | \$                            |
| 6. Other Capacity Building/Systems Development <sup>e</sup>                           | \$                            | \$                            |
| 7. Administration <sup>f</sup>  | \$                            | \$                            |
| <b>8. Total</b>   | \$                            | \$                            |

<sup>a</sup> Prevention other than primary prevention.

<sup>b</sup> This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of expenditures allowable under SAMHSA’s 2023 guidance, “Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG.” Only report RSS for those in need of RSS from substance use disorder.

<sup>c</sup> Row 3 should account for the 20 percent minimum set-aside of SUPTRS BG funds used for universal, selective, and indicated substance use prevention activities.



<sup>d</sup>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.

<sup>e</sup>Other Capacity Building/System Development include those activities relating to substance use per [§96.122 \(f\)\(1\)\(v\)](#). The amount presented here should reflect the total found in Planning Table 6b.

<sup>f</sup>Per 45 § 96.135 Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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## **Plan Tables 5 a-c. Primary Prevention Planned Budget & Priorities – Required for SUPTRS BG Only**

### **SUPTRS BG Plan Tables 5a and 5b. Primary Prevention Planned Budget**

States must spend no less than 20 percent of their SUPTRS BG award on substance use primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not in need of treatment. Primary prevention programs may (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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. T. In presenting their primary prevention planned budgets, states must complete either Plan Table 5a or Plan Table 5b, or may choose to complete both. *If Table 5b is completed, the state must also complete Section 1926 –Tobacco on Table 5a.* If both Tables 5a and 5b are completed, then the table totals should be identical.

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.

### **SUPTRS BG Plan Table 5a and 5b. Primary Prevention Planned Expenditures by Strategy and Institutes of Medicine (IOM) Categories**

SAMHSA promotes and encourages flexibilities by states in the implementation of the six prevention strategies in line with their data and specific needs. The state’s primary prevention program must include at least one of the six primary prevention strategies defined below. When completing, the states should list their FFY 2026 and FFY 2027 SUPTRS BG planned budget within the six primary prevention strategies, depending on capacity, need, and other factors identified in the planning process. Budgeted 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 materials, 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 Row 8 “Other” in Table 5a.

In most cases, the total SUPTRS BG amount for primary prevention presented in Plan Table 5a and/or Plan Table 5b should equal the amount reported on Plan Table 4b, Row 3, “Substance Use Primary Prevention.” The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Other Capacity Building/System Development activities. In this

instance, the sum of Plan Table 5a/Table 5b and Plan Table 6b (Primary Prevention) should equal the value in Plan Table 4b, Row 3.

### **Primary Prevention Planned Budget by Strategy**

In developing their planned budget, states should present how much is to be expended under each of the six strategies described below.

**Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, misuse, and substance use disorders, 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 engaged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have engaged in initial use of illicit drugs in order to assess if their behavior can be addressed through education or other interventions to prevent further substance use. 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 2026 and FFY 2027 SUPTRS BG planned expenditures in each of these categories.

### **Institute of Medicine (IOM) Classification: Universal, Selective, and Indicated**

States may further classify planned prevention strategies 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:** 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:** 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 Federal 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.

**SUPTRS BG Plan Table 5a. Primary Prevention Planned Expenditures by Strategy and Institutes of Medicine (IOM) Categories**

| Planning Period                        |                    | FFY 2026              | FFY 2027              |
|--|--------------------|-----------------------|-----------------------|
|  |                    | 10/1/2025 - 9/30/2026 | 10/1/2026 - 9/30/2027 |
| Strategy                               | IOM Classification | A.<br>SUPTRS BG       | A.<br>SUPTRS BG       |
| 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              |                       |                       |

|                                       |                    |    |    |
|---------------------------------------|--------------------|----|----|
|                                       | Total              |    |    |
| 7. Section 1926 (Synar) - Tobacco     | Universal          | \$ | \$ |
|                                       | Selective          | \$ | \$ |
|                                       | Indicated          | \$ | \$ |
|                                       | Unspecified        | \$ | \$ |
|                                       | Total              |    |    |
| 8. Other                              | Universal Direct   | \$ | \$ |
|                                       | Universal Indirect | \$ | \$ |
|                                       | Selective          | \$ | \$ |
|                                       | Indicated          | \$ | \$ |
|                                       | Unspecified        | \$ | \$ |
|                                       | Total              |    |    |
| 9. Total Prevention Expenditures      |                    | \$ | \$ |
|                                       |                    |    |    |
| Total Award <sup>a</sup>              |                    | \$ | \$ |
| Planned Primary Prevention Percentage |                    | %  | %  |

<sup>a</sup>Total SUPTRS BG Award is populated from Plan Table 4b – Planned SUPTRS BG Award Budget by Federal Fiscal Year

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

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

Planning Period Start Date:10/1/2025

Planning Period End Date: 9/30/2027

| <b>SUPTRS BG Plan Table 5b. Primary Prevention Planned Budget by Institutes of Medicine (IOM) Categories</b> |                              |                              |
|--|------------------------------|------------------------------|
| <b>Planning Period</b>   | <b>FFY 2026</b>              | <b>FFY 2027</b>              |
|  | <b>10/1/2025 - 9/30/2026</b> | <b>10/1/2026 - 9/30/2027</b> |
| <b>Strategy</b>  | <b>A.<br/>SUPTRS BG</b>      | <b>A.<br/>SUPTRS BG</b>      |
| 1. Universal Direct  | \$                           | \$                           |
| 2. Universal Indirect  | \$                           | \$                           |
| 3. Selective   | \$                           | \$                           |
| 4. Indicated   | \$                           | \$                           |
| 5. Column Total  | \$                           | \$                           |
| 6. <b>Total SUPTRS Award</b>   | \$                           | \$                           |
| 7. <b>Planned Primary Prevention Percentage</b>  | %                            | %                            |

**SUPTRS BG Plan Table 5c. Planned Primary Prevention Priorities**

States should identify the categories of substances the state BG plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG awards.

Planning Period Start Date: 10/1/2025

Planning Period End Date: 9/30/2027

| <b>SUPTRS BG Plan Table 5c. Planned Primary Prevention Priorities</b> |                          |                      |
|---|--------------------------|----------------------|
| <b>Planning Period</b>  | <b>From: 10/1/2025</b>   | <b>To: 9/30/2027</b> |
| <b>Priority Substances</b>  | <b>A.<br/>SUPTRS BG</b>  |                      |
| <b>Alcohol</b>  | <input type="checkbox"/> |                      |
| <b>Tobacco/Nicotine-Containing Products</b>                           | <input type="checkbox"/> |                      |
| <b>Cannabis/Cannabinoids</b>  | <input type="checkbox"/> |                      |
| <b>Prescription Medications</b>                                       | <input type="checkbox"/> |                      |
| <b>Cocaine</b>  | <input type="checkbox"/> |                      |
| <b>Heroin</b>   | <input type="checkbox"/> |                      |
| <b>Inhalants</b>  | <input type="checkbox"/> |                      |
| <b>Methamphetamine</b>  | <input type="checkbox"/> |                      |
| <b>Fentanyl or Other Synthetic Opioids</b>                            | <input type="checkbox"/> |                      |
| <b>Other</b>  | <input type="checkbox"/> |                      |
| <b>Priority Populations</b>   | <b>A.<br/>SUPTRS BG</b>  |                      |
| <b>Students in College</b>  | <input type="checkbox"/> |                      |
| <b>Military Families</b>  | <input type="checkbox"/> |                      |
| <b>LGBTQI+</b>  | <input type="checkbox"/> |                      |
| <b>American Indian/Alaska Native</b>                                  | <input type="checkbox"/> |                      |
| <b>African American</b>   | <input type="checkbox"/> |                      |
| <b>Hispanic</b>   | <input type="checkbox"/> |                      |
| <b>Persons Experiencing Homelessness</b>                              | <input type="checkbox"/> |                      |
| <b>Native Hawaiian/Pacific Islander</b>                               | <input type="checkbox"/> |                      |
| <b>Asian</b>  | <input type="checkbox"/> |                      |
| <b>Rural</b>  | <input type="checkbox"/> |                      |
| <b>Other Underserved Racial and</b>                                   | <input type="checkbox"/> |                      |



|                          |  |
|--------------------------|--|
| <b>Ethnic Minorities</b> |  |
|--------------------------|--|

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## **Plan Table 6.<sup>35</sup> Categories for Expenditures for Other Capacity Building/ Systems Development Activities – Required for MHBG & SUPTRS BG**

Please note there are separate tables for MHBG (Table 6a) and SUPTRS BG (Table 6b). Only complete this table if the state plans to fund expenditures for other capacity building/systems development with MHBG, SUPTRS BG, BSCA (MHBG only), and/or ARP dollars.

Expenditures for these activities may be those SMHA/SSA expenditures and those expenditures through funding mechanisms with subrecipients<sup>36</sup> and should not include administration activities of the agency which is capped at 5% for both the MHBG and SUPTRS BG. Other Capacity Building/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.

Although the states may use a different classification system, please use these categories to describe the types of activities provided by the SMHA/SSA and by subrecipients of SUPTRS BG funds, when the preponderance of the activity fits within a category.

**Information systems** – This includes the collecting and analyzing treatment data as well as prevention data under the SUPTRS BG in order to monitor performance and outcomes. Costs for electronic health records (EHRs), telehealth platforms, digital therapeutics, and other health information technology also fall under this category.

**Infrastructure Support** – This includes the 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), bed registries, drop-in centers, and respite services.

**Partnerships, community outreach, and needs assessment** – This includes the SMHA/SSA or subrecipient 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 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 SMHA/SSA or subrecipient 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 the SMHA/SSA or subrecipient activities to improve the overall quality of services, including those activities to assure conformity to

<sup>35</sup> This table was previously named “Plan Table 6. Categories for Expenditures for Non-Direct Service/System Development Activities”

<sup>36</sup> Subrecipient rows are not separated out in Table 6a for MHBG.

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 of the SMHA/SSA or contracted out to subrecipients, 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 the SMHA/SSA or contracting with subrecipients to provide 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 trainer(s) and support staff salaries and expense reimbursements, and certification expenditures.

**MHBG Plan Table 6a. MHBG Other Capacity Building /Systems Development Activities**

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

| <b>MHBG Table 6a.</b>                                     |                                |                                     |                                      |
|---|--------------------------------|-------------------------------------|--------------------------------------|
| <b>State Identifier</b>                                   |                                |                                     |                                      |
| <b>MHBG Planning Period</b>                               | <b>From:</b>                   |                                     | <b>To:</b>                           |
| <b>Activity</b>   | <b>A.<br/>MHBG<sup>1</sup></b> | <b>B.<br/>ARP Funds<sup>2</sup></b> | <b>C.<br/>BSCA Funds<sup>3</sup></b> |
| 1. Information Systems                                    |                                |                                     |                                      |
| 2. Infrastructure Support                                 |                                |                                     |                                      |
| 3. Partnerships, Community Outreach, and Needs Assessment |                                |                                     |                                      |
| 4. Planning Council Activities                            |                                |                                     |                                      |
| 5. Quality Assurance and Improvement                      |                                |                                     |                                      |
| 6. Research and Evaluation                                |                                |                                     |                                      |
| 7. Training and Education                                 |                                |                                     |                                      |
| <b>8. Total</b>   |                                |                                     |                                      |

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

<sup>2</sup> The expenditure period for the American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – September 30, 2025. Column B should reflect the state planned expenditures for the SFY 2026 planning period.

<sup>3</sup> The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is September 30, 2024 – September 29, 2026 (3rd increment) and the September 30, 2025 – September 29, 2027 (4th increment). Column H should reflect the state planned expenditures for SFYs 2026 and 2027 this planning period (FY2026 and FY2027) [July 1, 2025, through June 30, 2027 for most states].

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**SUPTRS BG Plan Table 6b. Other Capacity Building/Systems Development Activities**

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

| <b>SUPTRS BG Plan Table 6b. Other Capacity Building/Systems Development Activities</b> |                                    |  |   |                                    |  |   |
|--|------------------------------------|--|---|------------------------------------|--|---|
| <b>Planning Period</b>   | <b>FFY 2026</b>                    |  |   | <b>FFY 2027</b>                    |  |   |
|  | <b>10/1/2025 to 9/30/2026</b>      |  |   | <b>10/1/2026 to 9/30/2027</b>      |  |   |
| <b>Activity</b>  | <b>A.<br/>SUPTRS<br/>Treatment</b> | <b>B.<br/>SUPTRS<br/>Recovery<br/>Support<br/>Services</b> | <b>C.<br/>SUPTRS<br/>Primary<br/>Prevention</b> | <b>A.<br/>SUPTRS<br/>Treatment</b> | <b>B.<br/>SUPTRS<br/>Recovery<br/>Support<br/>Services</b> | <b>C.<br/>SUPTRS<br/>Primary<br/>Prevention</b> |
| 1. Information Systems   |                                    |  |   |                                    |  |   |
| a. Single State Agency (SSA)   |                                    |  |   |                                    |  |   |
| b. All other subrecipient contracts  |                                    |  |   |                                    |  |   |
| 2. Infrastructure Support  |                                    |  |   |                                    |  |   |
| a. Single State Agency (SSA)   |                                    |  |   |                                    |  |   |
| b. All other subrecipient contracts  |                                    |  |   |                                    |  |   |
| 3. Partnerships, community outreach, and needs assessment                              |                                    |  |   |                                    |  |   |
| a. Single State Agency (SSA)   |                                    |  |   |                                    |  |   |
| b. All other subrecipient contracts  |                                    |  |   |                                    |  |   |
| 4. Planning Council Activities   |                                    |  |   |                                    |  |   |
| a. Single State Agency (SSA)   |                                    |  |   |                                    |  |   |
| b. All other subrecipient contracts  |                                    |  |   |                                    |  |   |
| 5. Quality assurance and improvement   |                                    |  |   |                                    |  |   |
| a. Single State Agency (SSA)   |                                    |  |   |                                    |  |   |

|                                     |    |    |    |    |    |    |
|-------------------------------------|----|----|----|----|----|----|
| b. All other subrecipient contracts |    |    |    |    |    |    |
| <b>6. Research and Evaluation</b>   |    |    |    |    |    |    |
| a. Single State Agency (SSA)        |    |    |    |    |    |    |
| b. All other subrecipient contracts |    |    |    |    |    |    |
| <b>7. Training and Education</b>    |    |    |    |    |    |    |
| a. Single State Agency (SSA)        |    |    |    |    |    |    |
| b. All other subrecipient contracts |    |    |    |    |    |    |
| <b>8. Total</b>                     | \$ | \$ | \$ | \$ | \$ | \$ |

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## ***D. Environmental Factors and Plan***

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

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

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections.** SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: <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.<sup>37</sup> 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**

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<sup>37</sup> 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](https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx)



**intensity of care coordination support based on the 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 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 (SMI)
- b. Adults with SMI and a co-occurring I/DD
- c. Pregnant women with substance use disorders
- d. Women with substance use disorders who have dependent children
- e. Persons who inject drugs
- f. Persons with substance use disorders who have, or are at risk for, HIV or TB
- g. Persons with substance use disorders in the justice system
- h. Persons using substances who are at risk for overdose or suicide
- i. Other adults with substance use disorders
- j. Children and youth with serious emotional disturbances (SED) or substance use disorders
- k. Children and youth with SED and a co-occurring I/DD
- l. Individuals with co-occurring mental and substance use disorders

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, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

- a. Access to behavioral health care facilitated through primary care providers
- b. Efforts to improve behavioral health care provided by primary care providers
- c. Efforts to integrate primary care into behavioral health settings
- d. How this will be a strategy to better engage underserved populations and reduce disparities

- e. How the state provides integrated treatment for individuals with co-occurring disorders

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 (SMI)
- b. Adults with substance use disorders
- c. Adults with SMI and I/DD
- d. Children and youth with serious emotional disturbances (SED) or substance use disorders
- e. Children and youth with SED and I/DD

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

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

## 2. Health Disparities – Required for MHBG & SUPTRS BG

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](#),<sup>38</sup> [Healthy People 2030](#)<sup>39</sup>, [National Stakeholder Strategy for Achieving Health Equity](#),<sup>40</sup> and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health 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).<sup>41</sup> In addition, SAMHSA has issued “[Guidance to States and Communities on Using Federal Funding to Support Mental Health Services for LGBTQI+ Youth](#).” This guidance includes examples of how MHBG funds can be used to support LGBTQI+ youth with SMI/SED.

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity, including adoption of revised measures to more completely capture diverse populations. For example, on March 29, 2024 the Office of Management and Budget (OMB), under the Executive Office of the President, issued revisions to the Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15). The revised SPD 15 replaces and supersedes OMB’s 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The revisions made under SPD 15 are intended to result in more accurate and useful race and ethnicity data across the Federal government. The major changes include combined race and ethnicity questions into a single question; adding Middle Eastern or North African (MENA) as a new category; presenting seven minimum categories, each with a set of more granular level options; and ‘requiring’ not only ‘encouraging’ the collection of detailed data on race and ethnicity. As such, SAMHSA is actively working with states and their partners to aid in the adoption of these standards for Federal data reporting on race and ethnicity, with the expectation that all states will begin reporting the new race categories no later than State Fiscal Year 2027.

In addition, the U.S. Department of Health and Human Services required all of its agencies to develop a language access plan by May 2024. SAMHSA’s Language Access Plan (LAP) was issued in May 2024,<sup>42</sup> SAMHSA 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/Non-English language preferences. SAMHSA’s LAP addresses 10 Elements put forward by the U.S. Department of Health and Human Services. Provision of reasonable

<sup>38</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>39</sup> <https://health.gov/healthypeople>

<sup>40</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

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

<sup>42</sup> : <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>

language assistance in all federally funded programs and activities is in statute under the U.S. Civil Rights Act of 1964, codified in Title VI and is reiterated in the LAP. Key elements of the LAP include provision of interpreter services, written language translation, rights of persons with limited English proficiency/ Non-English language preference; legally mandated responsibilities of federally funded programs to provide language assistance; grant assurance and compliance; staff training; and accountability and reporting requirements.

These 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 behavioral health 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 practices, adaptations of evidence-based practices 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 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, it will be essential to 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/language access?  Yes  No
4. Does the state have a workforce-training plan to build the capacity of specialty behavioral health 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 align with some of the Culturally and Linguistically Appropriate Services (CLAS) Standards?  Yes  No
6. Please describe your state's plans and readiness to report the revised race and ethnicity categories based on OMB's [Updated Statistical Policy Directive No. 15 \(SPD 15\)](#).

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

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

### 3. Innovation in Purchasing Decisions – Requested for MHBG & SUPTRS BG

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<sup>43</sup>. 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](https://www.thenationalcouncil.org/program/center-of-excellence/)<sup>44</sup> 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 specialty behavioral health services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health 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.

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,<sup>45</sup> The New Freedom Commission on Mental Health,<sup>46</sup> the IOM,<sup>47</sup> NQF, and the

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<sup>43</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161317/>

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

<sup>45</sup> 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

## Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).<sup>47</sup>

One activity of the EBPRC<sup>48</sup> 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.”<sup>49</sup> 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 behavioral health 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. In recent years, there has been a growing body of research examining a spectrum of evidence ranging from evidence-based practices to practice-based evidence or evidence generated by community-developed practices which have shown sustained effectiveness in communities and by community endorsement.

SAMHSA’s Treatment Improvement Protocol Series ([TIPS](#))<sup>50</sup> 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](#))<sup>51</sup> 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 behavioral health services. Please respond to the following items:

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<sup>47</sup> National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

<sup>48</sup> <https://www.samhsa.gov/ebp-resource-center/about>

<sup>49</sup> <http://psychiatryonline.org/>

<sup>50</sup> <http://store.samhsa.gov>

<sup>51</sup> <https://store.samhsa.gov/?f%5B0%5D=series%3A5558>

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
2. Which value-based purchasing strategies do you use in your state? (check all that apply):
  - a.  Leadership support, including investment of human and financial resources.
  - b.  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c.  Use of financial and non-financial incentives for providers or consumers.
  - d.  Provider involvement in planning value-based purchasing.
  - e.  Use of accurate and reliable measures of quality in payment arrangements.
  - f.  Quality measures focus on consumer outcomes rather than care processes.
  - g.  Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
  - h.  The state has an evaluation plan to assess the impact of its purchasing decisions.
3. Does the state have any activities related to this section that you would like to highlight?

4. Please indicate areas of technical assistance needs 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

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-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset.”

States may implement models that have demonstrated efficacy, including the range of services and principles identified by 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 experiencing 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 experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

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

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

| Model(s)/EBP(s) for ESMI | Number of programs |
|--------------------------|--------------------|
|                          |                    |

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

| FY2026 | FY 2027 |
|--------|---------|
|        |         |

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

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

5. Does the state monitor fidelity of the chosen EBP(s)?  Yes  No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI?  Yes  No

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

8. Please describe the planned activities in FY2026 and FY2027 for your state’s ESMI programs.

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

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

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system? Please include a description of the state's plan to outreach and engage those experiencing ESMI in underserved populations (e.g., racial/ethnic minorities, LGBTQ+, individuals who are unhoused, etc.).

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

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

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. 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](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 needs related to this section.

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## **6. Program Integrity – Required for MHBG & SUPTRS BG**

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 behavioral health 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. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention, 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 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 informed 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 behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

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 needs related to this section.

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## 7. Tribes – Requested for MHBG & SUPTRS BG

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 statute, regulations, executive orders, and Presidential memoranda support and define the nation-to-nation 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](#)<sup>52</sup> 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. The 2020 Executive Order 13175 Consultation and Coordination with Indian Tribal Governments ushered in the new Order to support efforts to deepen our nation-to-nation relationship, strengthen Tribal consultation, and deepen the federal government's respect for Tribal sovereignty. It also affirms that Tribal governments must be treated as permanent, equal, and vital parts of America's overlapping system of government. The 2023 Executive Order 14112 Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination reiterates that tribal sovereignty should be respected by ensuring that tribes are able to make their own decisions about where and how to meet the needs of their community.

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

States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or for

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



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.

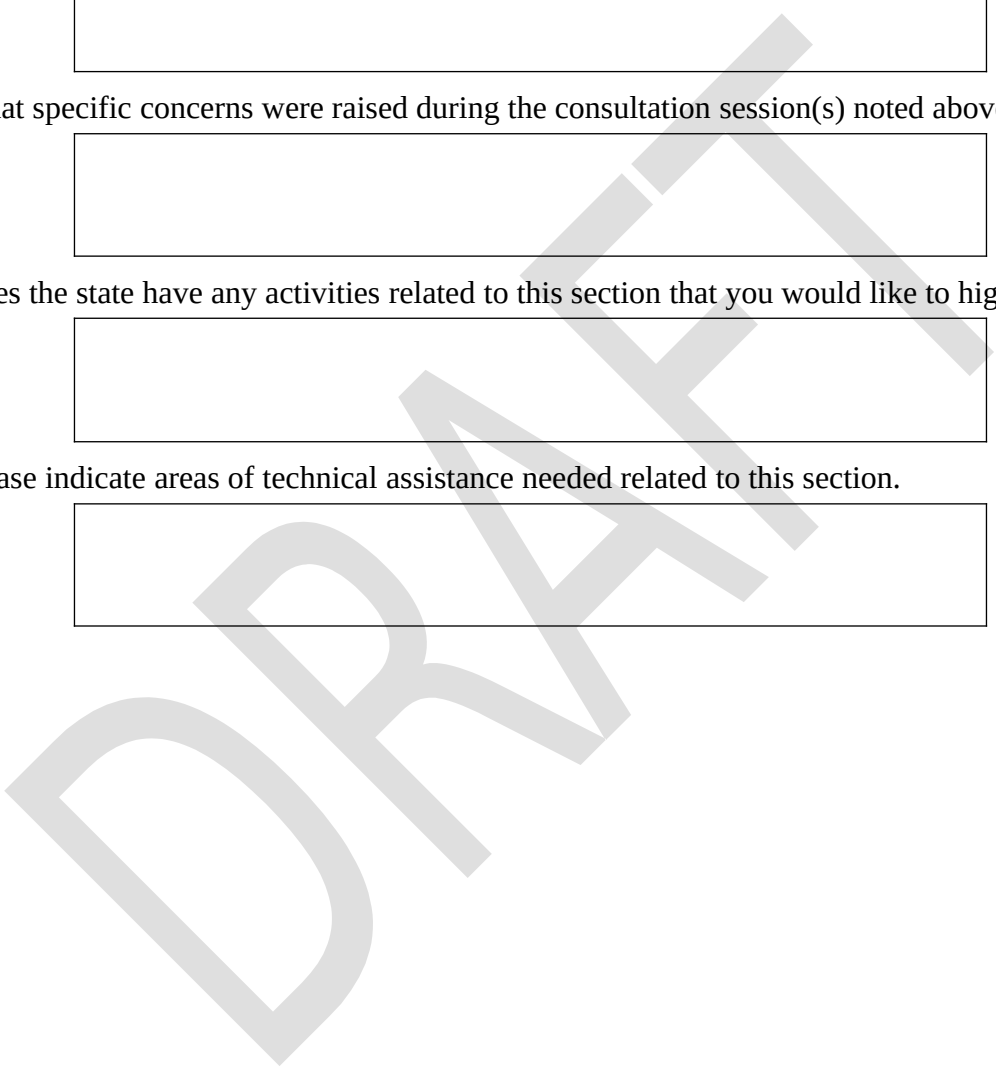
Please respond to the following items:

1. How many consultation sessions have the state conducted with federally recognized tribes since the FY2024-25 Plan was submitted?

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 for SUPTRS BG

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

1. **Information dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral**, that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions 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 use of alcohol, tobacco, and other drugs used in the general population.

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

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 Standards<sup>53</sup> 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

<sup>53</sup> <https://thinkculturalhealth.hhs.gov/clas>

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

a.  Yes (if yes, please describe)

b.  No

2. Does your state have a formal mechanism to provide training and technical assistance to the 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, Social determinant of health)
  - 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
  - b. Does the composition of the Advisory Council represent the racial/ethnic distribution of the State?  
 Yes  No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?
  - 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. Problem Identification and Referral:

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.





- a.  30-day use of alcohol, tobacco, prescription drugs, etc.
- b.  Heavy alcohol use
  - Binge alcohol 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 use prevention and SUD treatment services  Yes  No
  - h. Medical and dental services  Yes  No
  - i. Recovery Support services  Yes  No
  - j. Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  Yes  No
  - k. Services for persons with co-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

| Priority 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 needs 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.

1. Does your state integrate the following services into a comprehensive system of <sup>54</sup>

<sup>54</sup> 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

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

2. Please indicate areas of technical assistance needs 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 tailored services to rural population with SMI/SED. 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 tailored services to people with SMI/SED experiencing homelessness. See SAMHSA’s [Homeless Programs and Resources](#) for program resources<sup>55</sup>

c. Describe your state’s tailored services to the older adult population with SMI. See SAMHSA’s [Resources for Older Adults](#) webpage for resources<sup>56</sup>

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

**Criterion 5: Management Systems**

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them to function better at home, in school, in the community, and throughout life.

[https://gucchd.georgetown.edu/products/Toolkit\\_SOC\\_Resource1.pdf](https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf)

<sup>55</sup> <https://www.samhsa.gov/homelessness-programs-resources>

<sup>56</sup> <https://www.samhsa.gov/resources-serving-older-adults>

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.

1. Describe your state’s management systems.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) 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](#).

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

3. 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. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
 Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Has your state identified a need for any of the following?
  - a. Open assessment and intake scheduling?  Yes  No
  - b. Establishment of an electronic system to identify available treatment slots?  Yes  No

- c. Expanded community network for supportive services and healthcare?  Yes  No
  - d. Inclusion of recovery support services?  Yes  No
  - e. Health navigators to assist clients with community linkages?  Yes  No
  - f. Expanded capability for family services, relationship restoration, and custody issues?  
 Yes  No
  - g. Providing employment assistance?  Yes  No
  - h. Providing transportation to and from services?  Yes  No
  - i. Educational assistance?  Yes  No
6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

**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<sup>57</sup>**

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

<sup>57</sup> <https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf>

**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 CFR 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?  Yes  No
2. Has your state identified a need for any of the following:
  - a. Training staff and community partners on confidentiality requirements?  Yes  No
  - b. Training on responding to requests asking for acknowledgement of the presence of clients?  Yes  No
  - c. Updating written procedures which regulate and control access to records?  Yes  No
  - d. Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?  Yes  No

**Independent Peer Review**

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
  - a.  Yes  No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act ([42 U.S.C. § 300x-52\(a\)](#)) and [45 § CFR 96.136](#) require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
  - a. Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved

3. Has your state identified a need for any of the following?

- a. Development of a quality improvement plan?  Yes  No
  - b. Establishment of policies and procedures related to independent peer review?  
 Yes  No
  - c. Development of long-term planning for service revision and expansion to meet the needs of specific populations?  Yes  No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
- a.  Yes  No
  - b. **If Yes**, please identify the accreditation organization(s)
    - i.  Commission on the Accreditation of Rehabilitation Facilities
    - ii.  The Joint Commission
    - iii.  Other (please specify) \_\_\_\_\_

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

**Group Homes**

- 1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  Yes  No
- 2. Has your state identified a need for any of the following:
  - a. Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service?  Yes  No
  - b. Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?  Yes  No

**Professional Development**

- 1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a. Recent trends in substance use disorders in the state?  Yes  No
  - b. Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?  Yes  No
  - c. Performance-based accountability?  Yes  No
  - d. Data collection and reporting requirements?  Yes  No

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

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

- a. A comprehensive review of the current training schedule and identification of additional training needs?  Yes  No
  - b. Addition of training sessions designed to increase employee understanding of recovery support services?  Yes  No
  - c. Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?  Yes  No
  - d. State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?  Yes  No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers<sup>58</sup> (TTCs)?
- a. Prevention TTC?  Yes  No
  - b. Mental Health TTC/SMI Adviser  Yes  No
  - c. Addiction TTC?  Yes  No
  - d. State Opioid Response?  Yes  No
  - e. Strategic Prevention Technical Assistance Center (SPTAC)  Yes  No

### Waivers

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

1. Is your state considering requesting a waiver of any requirements related to:
  - a. Allocations Regarding Women (300x-22(b))  Yes  No
2. Is your state considering requesting a waiver of any requirements related to:
  - a. Intravenous substance use (300x-23)  Yes  No
3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)
  - a. Tuberculosis  Yes  No
  - b. Early Intervention Services Regarding HIV  Yes  No
4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements ([42 U.S.C. § 300x-28](#))
  - a. Improvement of Process for Appropriate Referrals for Treatment  Yes  No
  - b. Professional Development  Yes  No
  - c. Coordination of Various Activities and Services  Yes  No

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

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



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

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

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

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Behavioral Health Statistics and Quality (CBHSQ). State mental health agencies (SMHAs) are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by SAMHSA. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. SAMHSA’s MHBG program funds a total of 59 SMHAs in all 50 states, the District of Columbia, and 8 territories. MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the

sole unit of analysis.

MH-TEDS enhances the ability to report data on people with co-occurring mental health and substance use disorders. MH-TEDS also offers optional data fields for individuals with mental illness that are not captured in MH-CLD, such as referral source, details on criminal justice referral, income sources, and health insurance.

The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

SAMHSA is currently assessing the possibility of requiring either MH-CLD or MH-TEDS for future reporting, aiming to standardize data collection practices across states and streamline SAMHSA's ability to report data uniformly. This initiative seeks to establish a standardized approach to data collection, enhancing the consistency and comparability of mental health data collected nationwide. By selecting a single dataset for reporting, SAMHSA can simplify data management processes and ensure greater alignment with reporting requirements and objectives. This effort reflects SAMHSA's commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

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

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

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

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



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

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

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

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

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## 12. Quality Improvement Plan – Requested for MHBG & SUPTRS BG

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 since the FY2024-25 Plan was submitted?

a.  Yes  No

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

### 13. Trauma – Requested for MHBG & SUPTRS BG

Trauma<sup>59</sup> 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, treatment, and recovery supports. 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 behavioral health 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 mental health and 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 (e.g., via such approaches such as restraint and seclusion), 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 Trauma Informed Approaches Practical Guide.<sup>60</sup>

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<sup>59</sup> 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.*

<sup>60</sup> <https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach>

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 behavioral health 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 behavioral health providers?  Yes  No
3. Does the state provide training on trauma-specific treatment and interventions for behavioral health providers?  Yes  No
4. Does the state have a plan to build the capacity of behavioral health 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
7. Does the state have any activities related to this section that it would like to highlight.

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

#### 14. Criminal and Juvenile Justice – Requested for MHBG & SUPTRS BG

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.<sup>61</sup> Almost two thirds of people in prison and jail meet criteria for a substance use disorder.<sup>62</sup> As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.<sup>63</sup> 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 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 law enforcement/emergency medical services 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 and partnering with organizations on interventions that facilitate evidence-based treatment, such as medications for opioid use disorder, particularly during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;

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

<sup>62</sup> 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*.

<sup>63</sup> 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.

- 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 MH and/or 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 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 law enforcement /emergency medical services 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 and partnering with organizations to implement interventions, such as medications for opioid use disorder, particularly 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 MH and /or 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 MH and 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 needs related to this section.

## **15. Medications in the Treatment of Substance Use Disorders, Including Medication for Alcohol Use Disorder (MAUD) and Medications for Opioid Use Disorder (MOUD) – Requested for SUPTRS BG**

In line with the goals of the Overdose Prevention Strategy and SAMHSA’s priority on Preventing Substance Use and Overdose, SAMHSA strongly requests 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 substance use disorder 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, referred to as Medications for Opioid Use Disorder (MOUD). The combination of treatments 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. Despite the well-documented benefits of medication treatment, many treatment programs in the U.S. continue to 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 MAUD 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. Facilities that exclude people from accessing MOUD have been found in violation of the Americans with Disabilities Act.

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 MOUD, 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, within special priority audiences, particularly pregnant women?
  - a. Medications for Alcohol Use Disorder (MAUD)  Yes  No



b. Medications for Opioid Use Disorder (MOUD)  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
  - i)  Oral
  - ii)  Intramuscular (IM)
- f.  Naloxone
- g.  Other

For 'Other' medications purchased with block grant funds, please specify below:

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, including harm reduction 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?

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

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

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

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

A crisis response system 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, including guidance developed by SAMHSA, 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: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

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

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

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

be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

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

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

**988 – 3-Digit behavioral health crisis number.** The National Suicide Hotline Designation Act ([P.L. 116-172](#)) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK still operational and directs calls to the Lifeline network. 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, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

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

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.

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

| 4.                 | Exploration Planning | Installation | Early implementation<br>Less than 25% of counties | Partial Implementation<br>About 50% of counties | Majority Implementation<br>At least 75% of counties | Program Sustainment |
|--------------------|----------------------|--------------|---|---|---|---------------------|
| Someone to contact |                      |              |   |   |   |                     |
| Someone to respond |                      |              |   |   |   |                     |
| Safe place to be   |                      |              |   |   |   |                     |

Briefly explain your stages of implementation selections here.

5. Based on SAMHSA’s National Guidelines for Behavioral Health Crisis Care and SAMHSA’s [National Guidelines for Child and Youth Behavioral Health Crisis Care](#), explain how the state will develop the crisis system.

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

**Someone to contact: Crisis Contact Capacity**

- a. Number of locally based crisis call Centers in state

- i. In the 988 Suicide and Crisis Lifeline network: \_\_\_\_\_
- ii. Not in the suicide lifeline network: \_\_\_\_\_
- b. Number of Crisis Call Centers with follow up protocols in place
  - i. In the 988 Suicide and Crisis Lifeline network: \_\_\_\_\_
  - ii. Not in the suicide lifeline network: \_\_\_\_\_
- c. Estimated percent of 911 calls that are coded out as BH related: \_\_\_\_\_

**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 public safety first responder structures (police, paramedic, fire): \_\_\_\_\_
- b. Integrated with public safety first responder structures (police, paramedic, fire): \_\_\_\_\_
- c. Number that utilizes peer recovery services as a core component of the model: \_\_\_\_\_

**Safe place 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): \_\_\_\_\_

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

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

## 17. Recovery – Required for MHBG & SUPTRS BG

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives 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 health and 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. 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. Block Grant guidance is also available on the SAMHSA website at the [Recovery Support](#)

[Services Table \(PDF | 464 KB\).](#)

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

1. Does the state support recovery through any of the following:
  - a. Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
  - b. Required peer accreditation or certification?  Yes  No
  - c. Use block grant funds for recovery support services?  Yes  No
  - d. Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system?  Yes  No
2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

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 needs related to this section.



## 18. Community Living and the Implementation of Olmstead – Requested for MHBG & SUPTRS BG

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. 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.

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.

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 the following services for people with SMI/SED:  
Housing services provided  Yes  No  Not Applicable  
Home and community-based services  Yes  No  Not Applicable  
Peer support services  Yes  No  Not Applicable  
Employment services  Yes  No  Not Applicable
2. Does the state have a plan to transition individuals from institutional 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 needs related to this section.

## **19. 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 disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>64</sup> Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>65</sup> 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.<sup>66</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.<sup>67</sup>

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 prevention services and interventions, 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 and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

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

<sup>65</sup> 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.

<sup>66</sup> 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](http://www.cdc.gov/injury/wisqars/index.html).

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

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

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

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

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:

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

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

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<sup>68</sup> 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>

- d.** The resilience of children and youth with SUD?  Yes  No
- 2.** Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs
  - a.** Child welfare?  Yes  No
  - b.** Health care?  Yes  No
  - c.** Juvenile justice?  Yes  No
  - d.** Education?  Yes  No
- 3.** Does the state monitor its progress and effectiveness, around:
  - a.** Service utilization?  Yes  No
  - b.** Costs?  Yes  No
  - c.** Outcomes for children and youth services?  Yes  No
- 4.** Does the state provide training in evidence-based:
  - a.** Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - b.** Mental health treatment and recovery services for children/adolescents and their families?  
 Yes  No
- 5.** Does the state have plans for transitioning children and youth receiving services:
  - a.** to the adult M/SUD system?  Yes  No
  - b.** for youth in foster care?  Yes  No
  - c.** Is the child serving system connected with the Early Serious Mental Illness (ESMI) services?  Yes  No
  - d.** Is the state providing trauma informed care?  Yes  No
- 6.** Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

- 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.

## 20. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern and focus on those action steps outlined for states in the [National Strategy for Suicide Prevention and Federal Action Plan](#). 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 since the FY2024-25 Plan was submitted?  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 patients with suicidal ideation being discharged from inpatient units or emergency departments?   
Yes  No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted?  Yes  No

If so, please describe the population of focus?

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

## **21. Support of State Partners – Required for MHBG & SUPTRS BG**

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

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of 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 and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state’s agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state’s intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.

- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- 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 needs related to this section.

DRAFT



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

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in [42 U.S.C. § 300x-3](#) for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, SAMHSA has created [State Behavioral Health Planning Councils: An Introductory Manual](#).

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. 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. States should also submit 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, letter from the Council Chair etc.)

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?
  - a. State Plan    Yes     No
  - b. State Report    Yes     No

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

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

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work?  
 Yes     No
5. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  
 Yes     No

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

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

Additionally, please complete the Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.<sup>69</sup>

### Advisory Council Members

| Name | Type of Membership* | Agency or Organization Represented*      | Address & Phone | 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

<sup>69</sup> 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.

| Type of Membership  | Number                               | Percentage of Total Membership               |
|---|--------------------------------------|--|
| 1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)                                  |                                      |  |
| 2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)      |                                      |  |
| 3. Parents of children with SED   |                                      |  |
| 4. Vacancies (individuals and family members)   |                                      |  |
| <b>5. Total individuals in recovery, family members, and parents of children with SED</b>   | <i>Sum of rows 1 - 4</i>             | <i>Sum of rows 1 – 4 divided by row 16</i>   |
| 6. State employees  |                                      |  |
| 7. Providers  |                                      |  |
| 8. Vacancies (state employees and providers)  |                                      |  |
| <b>9. Total state employees and providers</b>   | <i>Sum of rows 6 – 8</i>             | <i>Sum of rows 6 – 8 divided by row 16</i>   |
| 10. Persons in Recovery from or providing treatment for or advocating for SUD services  |                                      |  |
| 11. Representatives from Federally Recognized Tribes  |                                      |  |
| 12. Youth/adolescent representative (or member from an organization serving young people)   |                                      |  |
| 13. Advocates/representatives who are not state employees or providers (members who are from diverse racial, ethnic minority/LGBTQI+ populations) |                                      |  |
| 14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)   |                                      |  |
| <b>15. Total non-required but encouraged members</b>  | <i>Sum of rows 10 – 14</i>           | <i>Sum of rows 10 – 14 divided by row 16</i> |
| <b>16. Total membership (all members of the council)</b>  | <i>Subtotal of rows 5, 9, and 15</i> |  |

**23. Public Comment on the State Plan – Required for MHBG & SUPTRS BG**

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from 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 needs 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 Health 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   |
| PP        | Persons in need of substance use primary prevention                       |
| PPW       | Pregnant and Parenting Women  |
| PPWC      | Pregnant and Postpartum Women and Children                                |
| PRSUD     | Persons in need of recovery support services from substance use disorder  |
| 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  |
| SUP       | Substance Use Primary Prevention  |
| SUPTRS BG | Substance Use Prevention, Treatment, and Recovery Services Block Grant    |
| SUR       | Recovery from Substance Use Disorder                                      |
| SUT       | Substance Use Disorder Treatment  |
| 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     |

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## Resources

| TOPIC   | LINK  | DESCRIPTION  |
|---|---|--|
| <b>SAMHSA Block Grants</b>                            | <a href="http://samhsa.gov/grants/block-grants">http://samhsa.gov/grants/block-grants</a>   | Description of Block Grant, its purpose, deadlines, laws and regulations and resources   |
| <b>SAMHSA Topic Search</b>                            | <a href="http://www.samhsa.gov/topics">http://www.samhsa.gov/topics</a>   | Search SAMHSA's website for resources, information and updates by topic or program   |
| <b>SAMHSA Store</b>                                   | <a href="http://store.samhsa.gov/">http://store.samhsa.gov/</a>   | Search SAMHSA's store to download or order publications and resources  |
| <b>RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE</b> |   |  |
| TOPIC   | LINK  | DESCRIPTION  |
| <b>Children Mental Health</b>                         | <a href="https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM">https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM</a> | 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) |
| <b>Co-Occurring Resources and Models</b>              | <a href="http://www.samhsa.gov/co-occurring/">http://www.samhsa.gov/co-occurring/</a>   | SAMHSA's webpage dedicated to co-occurring models and practice. Includes: resources, webinars, public resource links and more.   |
| <b>Healthy People Initiative</b>                      | <a href="https://health.gov/healthypeople">https://health.gov/healthypeople</a>   | Government website that reviews the goals of Healthy People 2030 and provides resources to help meet the goals.  |
| <b>Health Financing</b>                               | <a href="https://www.samhsa.gov/cfri">https://www.samhsa.gov/cfri</a>   | Behavioral health financing mechanism, options, and innovations  |



| TOPIC   | LINK  | DESCRIPTION  |
|---|---|--|
| <b>Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT</b> | <a href="https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366">https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366</a> | 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. |
| <b>LGBTQI+ Populations</b>  | <a href="https://www.samhsa.gov/behavioral-health-equity/lgbtqi">https://www.samhsa.gov/behavioral-health-equity/lgbtqi</a>   | Resources on the LGBTQI+ population include national survey reports, agency and federal initiatives, and related behavioral health resources.  |
| <b>Medicaid Policy Guidance</b>   | <a href="http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html">http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html</a>   | Searchable database of Medicaid Policy Guidance; including peer support services, affordable care act, health homes, prescription drugs, etc.  |
| <b>Medications for Substance Use Disorders</b>  | <a href="http://www.samhsa.gov/medication-assisted-treatment">http://www.samhsa.gov/medication-assisted-treatment</a>   | SAMHSA's resources and guides  |
| <b>Mental Health and Substance use disorder Block Grant Laws and Regulations</b>          | <a href="http://www.samhsa.gov/grants/block-grants/laws-regulations">http://www.samhsa.gov/grants/block-grants/laws-regulations</a>   | Links to the laws and regulations that govern the Mental Health and Substance use disorder Block Grants  |
| <b>Mental Health Crisis</b>   | <a href="https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care">https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care</a>   | Resources for implementing behavioral health crisis care   |
| <b>National Center of Excellence for Integrated Health Solutions</b>                      | <a href="https://www.samhsa.gov/national-coe-integrated-health-solutions">https://www.samhsa.gov/national-coe-integrated-health-solutions</a>   | SAMHSA's National Center of Excellence for Integrated Health Solutions offers resources, trainings, and webinars on primary and behavioral health care integration   |

| TOPIC   | LINK  | DESCRIPTION  |
|---|---|--|
| <b>National CLAS Standards</b>  | <a href="https://ThinkCulturalHealth.hhs.gov">https://ThinkCulturalHealth.hhs.gov</a>   | 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.  |
| <b>National HIV/AIDS Strategy (NHAS) for the United States</b>          | <a href="https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025">https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025</a>               | 2022-2025 National HIV/AIDS Strategy for the United States   |
| <b>SAMHSA’s Evidence-Based Practices Resource Center</b>                | <a href="https://www.samhsa.gov/resource-search/ebp">https://www.samhsa.gov/resource-search/ebp</a>   | 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.   |
| <b>National Strategy for Suicide Prevention and Federal Action Plan</b> | <a href="#">National Strategy for Suicide Prevention national-strategy-suicide-prevention.pdf (hhs.gov)</a><br>National Strategy for Suicide Prevention Federal Action Plan<br><a href="#">nnsf-federal-action-plan.pdf (hhs.gov)</a> | <p>The 2024 National Strategy for Suicide Prevention is a 10-year, comprehensive, whole-of-society approach to suicide prevention that provides concrete recommendations for addressing gaps in the suicide prevention field. This coordinated and comprehensive approach to suicide prevention at the national, state, tribal, local, and territorial levels rely upon critical partnerships across the public and private sectors. People with lived experience are critical to the success of this work.</p> <p>The National Strategy seeks to prevent suicide risk in the first place; identify and support people with increased risk through</p> |

| TOPIC | LINK | DESCRIPTION   |
|-------|------|---|
|       |      | <p>treatment and crisis intervention; prevent reattempts; promote long-term recovery; and support survivors of suicide loss.</p> <p>Four strategic directions guide the National Strategy: 1) Community-Based Suicide Prevention; 2) Treatment and Crisis Services; 3) Surveillance, Quality Improvement and Research; and 4) Health Equity in Suicide Prevention.</p> <p>The Federal Action Plan identifies more than 200 actions across the federal government to be taken over the next three years in support of those goals.</p> |

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| RESOURCES  | LINK  | DESCRIPTION  |
|--|---|--|
| Olmstead   | <a href="https://www.samhsa.gov/about-us/who-we-are/laws-regulations/olmstead">https://www.samhsa.gov/about-us/who-we-are/laws-regulations/olmstead</a>   | Links to resources to assist states and other stakeholders in their efforts to plan and implement systems of care that support community inclusion as required by the Olmstead decision  |
| Resources for Older Adults   | <a href="https://www.samhsa.gov/resources-serving-older-adults-old">https://www.samhsa.gov/resources-serving-older-adults-old</a>   | SAMHSA has a number of products for serving older adults with mental and substance use disorders that can be useful to clinicians, other service providers, older adults, and caregivers.  |
| The Essential Aspects of Parity: A Training Tool for Policymakers  | <a href="https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001?referer=from_search_result">https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001?referer=from_search_result</a>   | 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 | <a href="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">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</a> | 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 Underage Drinking  | <a href="http://www.ncbi.nlm.nih.gov/books/NBK44360/">http://www.ncbi.nlm.nih.gov/books/NBK44360/</a>   | The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking seeks to engage all levels of government as well as individuals and private sector institutions and organizations in a coordinated, multifaceted effort to prevent and reduce underage drinking and its adverse consequences. |

| RESOURCES  | LINK  | DESCRIPTION   |
|--|---|---|
| Recovery   | <a href="https://www.samhsa.gov/brss-tacs">https://www.samhsa.gov/brss-tacs</a>   | SAMHSA's resources, guides, and technical assistance on recovery  |
| SAMHSA.gov Data Resources  | <a href="http://www.samhsa.gov/data/">http://www.samhsa.gov/data/</a>   | Links to SAMHSA data sets including: NSDUH, DAWN, NSSATS/NMHSS, TEDS, Uniform Reporting System (URS), National and State Barometers, etc.   |
| Substance Use Disorder for Women   | <a href="https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf">https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf</a> | Guidance on components of quality SUD treatment services for women, states can refer to the documents found at this link  |
| Suicide Prevention   | <a href="https://www.samhsa.gov/suicide-prevention">https://www.samhsa.gov/suicide-prevention</a>   | Links to resources and guides around suicide prevention and other mental and substance use prevention topics.   |
| Synar Program  | <a href="http://samhsa.gov/synar">http://samhsa.gov/synar</a>   | Description and overview of the Synar program, which is a requirement of the SUPTRS BG.   |
| Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders | <a href="https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf">https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf</a>       | Review of the literature on the effectiveness of telehealth modalities for the treatment of SMI and SUD, recommendations for practice and examples of telehealth implementation in treatment programs |

| RESOURCES                   | LINK   | DESCRIPTION  |
|-----------------------------|--|--|
| Trauma & Violence           | <a href="http://www.samhsa.gov/trauma-violence">http://www.samhsa.gov/trauma-violence</a><br><a href="https://www.nctsn.org/">https://www.nctsn.org/</a> | <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 a 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 the U.S.</p> |
| Criminal & Juvenile Justice | <a href="http://www.samhsa.gov/criminal-juvenile-justice">http://www.samhsa.gov/criminal-juvenile-justice</a>  | <p>Review of behavioral health services and resources in the criminal justice and juvenile justice systems.</p>  |
| Tribal Consultation         | <a href="#">Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships</a>   | <p>The White House memorandum regarding the requirements related to tribal consultation</p>  |

## 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 U.S.C §300x-1(b), §300x-6<br>Criteria for plan and Application for grant | 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 U.S.C §300x-32<br>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 U.S.C §300x-68<br>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 U.S.C §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. |

| Item                        | MHBG   | MHBG Notes   | SUPTRS BG   | SUPTRS BG Notes   |
|-----------------------------|--|--|---|---|
| Plan- Tables 1,2,6          | <p>42 U.S.C §300x-1</p> <p>State plan for comprehensive community mental health services for certain individuals and management services</p> | <p>Table 1 provides information on priority areas and performance indicators. Table 2 requests state agency planned budget. Table 6 requests Other Capacity Building/system development activities planned expenditures.</p> | <p>42 U.S.C §300x-32</p> <p>Application for grant; approval of State Plan (b) State plan; (1) In general</p>                      | <p>Table 1 provides information on priority areas and performance indicators. Table 2 requests state agency planned budget. Table 6 requests Other Capacity Building/system development activities planned expenditures.</p>  |
| Plan- Tables 3, 5a, 5b      | N/A  | N/A  | <p>42 U.S.C §300x-32</p> <p>Application for grant; approval of State Plan (b) State plan; (1) In general</p>                      | <p>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.</p>   |
| Set-aside for Children      | <p>42 U.S.C §300x-2(a)</p> <p>Allocation for systems of integrated services for children</p>   | <p>The state must demonstrate the amount expended is greater or equal to dollars spent to provide services for children with SED in FY 1994.</p>   | N/A   | <p>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.</p>  |
| Maintenance of Effort (MOE) | <p>42 U.S.C §300x-4(b)</p> <p>Maintenance of effort regarding State expenditures for mental health</p>                                       | <p>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.</p>  | <p>42 U.S.C §300x-30</p> <p>Maintenance of effort regarding State expenditures (a) In general; (b) Exclusion of certain funds</p> | <p>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.</p> |



| Item                                      | MHBG   | MHBG Notes   | SUPTRS BG  | SUPTRS BG Notes   |
|---|--|--|--|---|
| MOE-Women                                 | N/A  | N/A  | 42 U.S.C §300x-22<br><br>Certain allocations (b) Allocations regarding women (1) In general; (2) Waiver; (3) Childcare and prenatal care                                     | 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.  |
| Tuberculosis                              | N/A  | N/A  | 42 U.S.C Chapter 6A, SUBCHAPTER XVII, Part B, subpart ii 42 U.S.C §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 U.S.C §300x-5 (a)(1)<br><br>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 provide inpatient services.                                   | 42 U.S.C §300x-31<br><br>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 U.S.C §300x-5(a)(2)<br><br>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 U.S.C §300x-31<br><br>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 U.S.C §300x-3<br><br>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  |

| Item                        | MHBG   | MHBG Notes   | SUPTRS BG   | SUPTRS BG Notes   |
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|                             |  |  |   | Member Type.  |
| Public Input to Plan        | 42 U.S.C §300x-51<br>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 U.S.C §300x-51<br>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 U.S.C §300x-9(c)<br>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 U.S.C §300x-22<br>Certain allocations (a) Allocation regarding primary prevention programs | The state is required to expend a minimum of 20% of the SUPTRS BG allocation for persons who do not require treatment for a substance use disorder. |
| Annual Report               | 42 U.S.C §300x-52(a)   | The state is required to submit to   | 42 U.S.C §300x-52(a)  | The state is required to submit to  |

| Item  | MHBG  | MHBG Notes   | SUPTRS BG   | SUPTRS BG Notes  |
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|   | Requirement of reports and audits by States     | 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. | Requirement of reports and audits by States   | 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 U.S.C §300x-53(a)<br>Additional requirements | 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 U.S.C §300x-53(a)<br>Additional requirements   | 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 U.S.C §300x-23<br>Intravenous substance abuse (a)<br>Capacity of treatment programs;<br>(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 for Early Identification             | N/A   | N/A  | 42 U.S.C §300x-24   | Designated states are required to expend 5% of each allocation on HIV services for individuals in  |

| Item   | MHBG  | MHBG Notes  | SUPTRS BG  | SUPTRS BG Notes   |
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| Services (EIS) for HIV                               |   |   | Requirements regarding human immunodeficiency virus (b) Human immunodeficiency virus   | SUD treatment who have HIV, or who are at risk for HIV.   |
| Recovery Residences- Revolving Loan Fund             | N/A   | N/A   | 42 U.S.C §300x-25<br>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 U.S.C §300x-66<br>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 U.S.C §300x-66<br>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. |

| Item                     | MHBG                | MHBG Notes   | SUPTRS BG  | SUPTRS BG Notes   |
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| Professional Development | N/A                 | N/A  | 42 U.S.C §300x-28<br>Additional agreements (b)<br>Professional development | The state is required to ensure that prevention, treatment, and recovery personnel operating in the States' substance use disorder prevention, treatment and recovery systems have an opportunity to receive training, on an ongoing basis, on a number of designated topics that would serve to further improve the delivery of substance use disorder prevention and treatment services within the State. |
| Crisis Services          | 42 U.S.C §300x-9(d) | A State shall expend at least 5 percent of the amount the State receives pursuant to section 300x of this title for each fiscal year 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. At the discretion of the single State agency responsible for the administration of the program of the State under a grant under section 300x of this title, funds expended pursuant to paragraph (1) may be used to fund some or all of the core crisis care service | Requested  | Requested or recommended item narrative in annual SUPTRS BG Application/Behavioral Health Assessment and Plan, Environmental Factors and Plan, Form 15. Crisis Services.  |

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|          |  | <p>components, as applicable and appropriate, including the following: (A) Crisis call centers, (B) 24/7 mobile crisis services, and (C) 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.</p> |   |  |
| Recovery | <p>42 U.S.C §300x-1 (b)(1)(A)(vii) (IV)<br/>Comprehensive community-based health systems</p> | <p>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.</p>  | <p>42 U.S.C §300x-32<br/>Application for grant; approval of State plan (b) State plan</p> | <p>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.</p> |

| Item                                       | MHBG  | MHBG Notes   | SUPTRS BG   | SUPTRS BG Notes  |
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| Children's Services                        | <p>42 U.S.C §300x-1(b)(1)(C)</p> <p>Children's services</p>                                     | <p>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 needs (such system to include services provided under the Individuals with Disabilities Education Act).</p> | N/A   | N/A  |
| Services to rural and homeless populations | <p>42 U.S.C §300x-1(b)(1)(D)</p> <p>Targeted services to rural and homeless populations</p>     | <p>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.</p>   | <p>42 U.S.C § 300x-32</p> <p>Application for grant; approval of State Plan (a) In general; (b) State plan</p> | <p>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.</p> |
| Suicide Prevention                         | <p>42 U.S.C §300x-1 (b)(1)(A)(vii) (II)</p> <p>Comprehensive community-based health systems</p> | <p>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.</p>   | N/A   | N/A  |

| Item                      | MHBG  | MHBG Notes  | SUPTRS BG   | SUPTRS BG Notes  |
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| Support of State Partners | <p data-bbox="289 667 667 703">42 U.S.C §300x-1(b)(1)(A)(iii)</p> <p data-bbox="289 727 695 792">Comprehensive community-based health systems</p> | <p data-bbox="726 232 1142 1235">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 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> | <p data-bbox="1167 618 1398 651">42 U.S.C §300x-28</p> <p data-bbox="1167 678 1562 776">Additional agreements (c) Coordination of various activities and services</p> | <p data-bbox="1604 581 2011 878">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).</p> |



| Item                   | MHBG                                     | MHBG Notes  | SUPTRS BG                                | SUPTRS BG Notes   |
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| Reporting Requirements | 42 U.S.C §300x-35(b)(3)<br>Core data set | 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. | 42 U.S.C §300x-35(b)(3)<br>Core data set | 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. |

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***Required Forms***

**Face Page—Community Mental Health Services Block Grant**

**Face Page—Substance Use Prevention, Treatment, and Recovery Services Block Grant**

**Funding Agreements/Certifications—Community Mental Health Services Block Grant**

**Funding Agreements/Certifications—Substance Use Prevention, Treatment, and Recovery Services Block Grant**

**Assurances**

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