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FFY 2026-2027 Combined Block Grant Application Guide

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

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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 Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG), 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).[1]

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.

In addition to addressing the annual MHBG and SUPTRS BG appropriations, this application includes sections on planned expenditures for the 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, recommendations are 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.

Opportunities for individuals to work while in substance use disorder treatment and recovery need to 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 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 best practice guidance regarding work in recovery housing. This guidance is outlined in a publication titled Best Practices for Recovery Housing. Recovery housing programs that are supported by the SUPTRS BG should be free from

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

any form of resident abuse or neglect, and free from any form of forced or coerced labor.

A. *Background*

Two major Block Grants exist that specifically support mental health and substance use related activities and services: 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[2] 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.).[3] 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 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 technical assistance to support state efforts.

The MHBG and SUPTRS BGs 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, the Block Grants may be used:

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

B. *Impact of Block Grants on State Authorities and Systems*

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

[2] 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.

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

funding be used only for authorized activities.[4] Guidance on the use of Block Grant funding for co-pays, deductibles (including high deductible health plans), and premiums can be found on the SAMHSA Block Grant Resources page. States that choose to take advantage of this provision will need to develop specific policies and procedures for ensuring compliance with this guidance.

Make America Healthy Again by Prioritizing Whole-Person, Integrated Care

To truly make America healthy again, we must confront a troubling reality: far too many Americans are living shorter, less healthy lives due to preventable and treatable substance use disorder and mental health conditions. According to the 2023 National Survey on Drug Use and Health (NSDUH), over 54 million people aged 12 and older needed treatment for substance use disorders (SUDs) in the past year—but only 23.6% received it. Nearly 59 million adults reported having any mental illness, and of those, 27.1 million, approximately 45%, went untreated. One in four of these individuals recognized an unmet need for care.

In addition, research shows that use of tobacco, alcohol, and drugs along with other health risk behaviors that emerge during childhood and adolescence are intimately linked to risk for chronic disease, substance use disorders, and mental health conditions later in life and they account for much of the costs associated with chronic disease. Fortunately, decades of prevention science demonstrates that substance use, chronic disease, and mental health all share modifiable risk and protective factors at the individual, family, school, and community levels. Thus, prioritizing the prevention of substance use and related risk behaviors, promoting mental health, and creating opportunities for healthy lifestyles is a smart, cost-effective, and high-impact strategy to actualize a healthy, safe, and thriving society. The consequences of inaction are staggering—not just for individuals, but for families, communities, and our healthcare system as a whole. For example, people with SMI or SUDs face significantly shorter life expectancies than their peers. And in recent years, deaths due to overdose and suicide have contributed to declining life expectancy in our nation. Early mortality among these populations is not only the result of behavioral health conditions themselves but is often compounded by co-occurring physical illnesses, many of which are preventable or manageable with timely, integrated care.

That's why the federal government strongly urges states to prioritize integrated, community-based approaches to health—approaches that meet people where they are, address the full spectrum of their needs from prevention to recovery, and connect behavioral health with primary care services and settings, such as Federally Qualified Health Centers (FQHCs), and consider integrating physical health care services into specialty behavioral health settings for people with significantly complex sets of conditions, that are often driven by severe behavioral health illnesses.

A Whole-Person Vision for Health

To effectively address the complex needs of individuals with co-occurring behavioral health and physical health conditions, it is imperative to establish a seamless integration between the behavioral health and primary care systems. This integration ensures that individuals receive comprehensive, whole-person care that addresses both their mental health, substance use, and

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

physical health needs concurrently.

Elements of a roadmap to strengthen this vision can occur through:

- Bi-directional integration of behavioral and physical health systems
- Training primary care providers to screen, prevent, and intervene early
- Supporting health workers and care navigators who guide individuals through complex systems
- Addressing barriers in justice-involved, homeless, and high-risk populations

These actions not only improve individual health outcomes—they begin to shift the system from reactive to preventive, from fragmented to cohesive.

The Need for Bold, Coordinated State Action

To make America healthy again, states must move beyond fragmented systems and treat behavioral and physical health as two sides of the same coin. States can utilize the MHBG and SUBG to promote integrated care initiatives. By partnering with qualified community programs, health centers, rural health clinics, or FQHCs, states can develop and implement integration project plans that improve health outcomes for individuals with behavioral health conditions. These partnerships are essential for creating a coordinated system of care that bridges the gap between behavioral health and primary care services.

Adopting evidence-based models, such as the Collaborative Care Model (CoCM), is one model for effective integration. The CoCM involves a primary care team, including a case manager, consulting psychiatrist, and other mental health professionals, working together to address mental and substance use conditions within primary care settings. States are encouraged to collaborate with primary care practices to develop the necessary staffing and systems to implement the CoCM, thereby enhancing the identification and treatment of mental health and substance use conditions for individuals who access care through primary care practices.

States are encouraged to:

- Work closely with primary care providers and settings such as FQHCs as the front line of whole-person care especially for people with lower severity of behavioral health conditions
- Expand behavioral health prevention, screenings, and early interventions across all age groups
- Address the co-occurring nature of mental illness, SUDs, and other chronic diseases
- Target efforts toward high risk populations, including those with justice involvement, housing insecurity, or infectious comorbidities

States are also encouraged to consider and develop models in which physical health care is integrated into specialty behavioral health settings. For example, Certified Community Behavioral Health Centers (CCBHCs) and the Integrated Behavioral Health (IBH) model being tested by the Center for Medicare and Medicaid Innovation (CMMI) recognize that, for some

patients, the severity of their SUDs and/or mental illness drives a significantly complex set of other health and social needs. For this group, whole person care in a specialty behavioral health setting that can offer more specialized and intensive services may offer the best opportunity for optimal outcomes.

Commitment to Data and Evidence

States are encouraged to draw from federal 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 collective activities. It is vital that data and evaluation inform policies and determine the impact of services on mental health and substance use disorders.

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. Efforts are underway to streamline and modernize data collection activities, while also coordinating evaluation 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. States can leverage Block Grant resources in support of enhancing data collection, analysis, evaluation, and dissemination.

On March 29, 2024, the Office of Management and Budget (OMB), 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:

- **American Indian or Alaska Native**: 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
- **Asian**: 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.

- **Black or African American**: Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.
- **Hispanic or Latino**: Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.
- **Middle Eastern or North African**: 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.
- **Native Hawaiian or Pacific Islander**: 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.
- **White**: Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish.

As a result, all states will be required to begin reporting race and ethnicity to align with these revised SPD 15 requirements. 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, states should anticipate working with federal 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/.

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 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, 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 https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-B 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. Visit https://www.healthit.gov/topic/certification-ehrs/certification-health-it 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/.

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, and Innovation in Behavioral Health (IBH) Model) that support efforts to provide behavioral health services. States may also find the Medicare-Medicaid-Coordination Office a helpful resource in serving people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals. States should also consult any 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 on the Medicaid.gov page for Federal Policy Guidance.

States should also consult other potential HHS resources as well as TRICARE and the Department of Veterans Affairs (VA) for enhanced behavioral health services opportunities that may benefit individuals, families, and communities within their state.

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 2, 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[a]
Combined MHBG & SUPTRS BG	September 2, 2025	December 1, 2025[b]
MHBG	September 2, 2025	December 1, 2025
SUPTRS BG	October 1, 2025	December 1, 2025
Annual Synar Report	N/A	December 31, 2025

[a] 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.
[b] 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 budgets (Planning Tables), and supporting forms for service delivery planning and emphasis (Environmental Factors & Plan).

B. Application Requirements

For the Secretary of HHS to make an award under the Block Grant programs, states must submit an application(s) sufficient to meet the requirements described in the respective Block Grant authorizing statute and implementing regulations, as relevant. Information provided in the application(s) must be sufficiently detailed and clear to allow for monitoring of the states' compliance efforts regarding the obligation and expenditure of MHBG and SUPTRS BG funds. Awarded funds will be available for obligation and expenditure[5] 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[6] 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 is required of states to reflect in their applications.

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

MHBG Expenditure Requirements and Restrictions

The MHBG portion of the statute requires states to provide services to those with SMI and SED as described in the state's plan only through appropriate, qualified community programs (which may include community mental health centers, certified community behavioral health clinics, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health peer and family-operated programs) which meet the criteria as described in 42 U.S.C. §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 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 elucidate the whole of the applicant state's efforts and identifies how the federal government can assist the applicant state in meeting its goals. In addition, this information helps 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. Budget (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 of/receiving 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 the federal government.

There is tremendous value and importance in 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 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,[7] 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.

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

[7] Title XIX, Subpart III, section 1941 of the PHS Act (42 USC § 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 the federal government.

and reporting, the definitions of SED and SMI have been clarified. 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 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 U.S.C. §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 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 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, the plan will be reviewed with the state to assure that the approach proposed meets the understanding

of an evidence-based approach for individuals experiencing ESMI. In consultation with other federal agencies 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 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)). 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 applicable federal and state laws and in accordance with best practices.
- *Criterion 5*: *Tuberculosis Services* (42 U.S.C. §300x-24(a) and 45 CFR §96.127). In accordance with 45 CFR §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 45 CFR §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 45 CFR §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 CFR. §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 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 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 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, other federal guidance, 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, school, 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 vulnerable communities that experience a cluster of risk factors that make them especially susceptible 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:[8]
    a. HIV/AIDS, designated states per CDC only*
    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. Youth
    b. Older adults
    c. Persons with disabilities
    d. Military personnel (active, guard, reserve, and veteran) and their families
    e. Individuals with mental health and substance use disorders involved in the adult or juvenile justice systems
    f. Individuals with mental health and substance use disorders who live in rural and frontier areas
    g. 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)
    h. Community settings for universal, selective, and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies (SUPTRS BG only)
    i. Individuals new in their recovery who require additional recovery support services, as appropriate, to maintain their recovery

[8] 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. *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. 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."

1. Please describe how the public mental health and substance use services system is currently organized at the **state** level, differentiating between child and adult systems.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description 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 states 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.

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 the 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.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the **required** populations specified

under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

3. Please 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 plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

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 the 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.

There are 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 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 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.
2. 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.
3. 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.
4. 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 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 with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other resources to foster the development of 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). 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. It is required for there to be at least one goal related to the primary prevention priority area that addresses one or more of the six prevention strategies and proposed populations to be served.
5. *Objective*. Objective should be a concrete, precise, and measurable statement.
6. *Strategies to attain the objective*. Indicate program strategies or means to achieve the stated objective.
7. *Annual Performance Indicators to measure achievement of the objective*. 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 2026)
c. Second-year target/outcome measurement (Final to the end of 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):
4. Goal of the priority area:
5. Objective:
6. Strategies to attain the objective:
7. Annual Performance Indicators to measure achievement of the objective: Indicator #1:
Plan Table 1: Priority Area and Annual Performance Indicators, continued
a) Baseline measurement (Initial data collected prior to and during 2026):
b) First-year target/outcome measurement (Progress to the end of 2026):
c) Second-year target/outcome measurement (Final to the end of 2027):
d) Data source:
e) Description of data:
f) Data issues/caveats that affect outcome measures:

The federal government 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. This will include 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) as approved by the federal government, the state will be asked to provide a description of corrective actions to be taken. If further steps are not taken, the state may be asked for a revised plan to achieve its goals and objectives.

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 planned budget of 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. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other	H. Bipartisan Safer Communities Act Funds [b]
1. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award) [b]	$	$	$	$	$	$	$
2. State Hospital		$	$	$	$	$	
3. Other Psychiatric Inpatient Care		$	$	$	$	$	

Table2a (Cont.)	A. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other	G. Bipartisan Safer Communities Act Funds [a]
4. Other 24-Hour Care (Residential Care)	$	$	$	$	$	$	$
5. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$	$
6. Crisis Services (5 percent Set-Aside)[b][c]	$	$	$	$	$	$	$
7. Administration [d]	$	$	$	$	$	$	$
8. Total	**$**	**$**	**$**	**$**	**$**	**$**	**$**

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

[b] Row 1 in Columns A and G: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c] Row 6 in Columns A and G: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d] Per statute, administrative expenditures for the MHBG 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 budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.						
Planning Period		**From: 7/1/2025**			**To: 6/30/2027**	
ACTIVITY	A. SUPTRS BG	B. Medicaid (Federal, State, and local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	D. State funds	E. Local funds (Excluding local Medicaid)	F. Other
1. Substance Use Disorder Prevention[a] and Treatment	$	$	$	$	$	$
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$	$	$	$	$	$
b. All Other	$	$	$	$	$	$
2. Recovery Support Services[c]	$	$	$	$	$	$
3. Primary Prevention[d]	$	$	$	$	$	$
4. Early Intervention Services for HIV[e]	$	$	$	$	$	$
5. Tuberculosis	$	$	$	$	$	$
6. Other Capacity Building/Systems Developement[f]	$	$	$	$	$	$
7. Administration[g]	$	$	$	$	$	$
8. **Total**	**$**	**$**	**$**	**$**	**$**	**$**

[a] Prevention other than primary prevention.

[b] Grantees must plan budget for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of

RSS from substance use disorder.

[d] 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.

[e] 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.

[f] Other Capacity Building/Systems development include those activities relating to substance use per 45 CFR §96.122 (f)(1)(v).

[g] Per 45 CFR § 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 of/Receiving 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 the 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 the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

SUPTRS BG Plan Table 3. Persons in Need of/Receiving SUD treatment		
Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.		
	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
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.

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 budget 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 the 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. (*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 1a, 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. (*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.

MHBG Table 4a.		
Planning Period:	**From:**	**To:**
State Identifier:		
MHBG-Funded Services		**MHBG Funds Budgeted for This Item**
1. Services for Adults		
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		$
2.Subtotal of Services for Adults		**$**
3. Services for Children		
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		$
4. Subtotal of Services for Children		**$**
5. Other Capacity Building/Systems Development[a]		$
6. Administrative Costs[b]		$
7. *Any Other Costs		$
8. Total MHBG Allocation[c]		**$**

1.

[a]This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6a.
[b]Administrative Costs should not exceed 5 percent of total MHBG allocation.
[c]The total budget should be equal to your MHBG allocation for the next two years.

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

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

In addition to projecting planned budget 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 FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year. **Note:** The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

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

[a] Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b] This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c] This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be

presented in Row 6 of this table.
[d] 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.
[e] Other Capacity Building/System Development include those activities relating to substance use per 45 CFR §96.122 (f)(1)(v). The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.
[f] Per 45 CFR §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.

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. 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, states are encouraged to 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 Budget by Strategy and Institutes of Medicine (IOM) Categories

States are encouraged to be flexible 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 this table, the state 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 amounts 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 amounts 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 budget information is only available by strategy type, then the state should include planned costs 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. Accordingly, guidance was revised to clarify that the prevention set-aside may be used to fund revisions to States' Synar program to comply with PL 116-94. States should report any funds being used for this purpose in the appropriate columns.

SUPTRS BG Plan Table 5a. Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories			
Planning Period		**FFY 2026 10/1/2025 - 9/30/2026**	**FFY 2027 10/1/2026 - 9/30/2027**
Strategy	**IOM Classification**	**A. SUPTRS BG**	**A. 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	**$**	**$**
7. Section 1926 (Synar) - Tobacco	Universal	$	$
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$**	**$**
8. Other	Universal	$	$

	Direct		
	Universal Indirect	$	$
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$**	**$**
9. Total Prevention Budget		**$**	**$**
Total Award[a]		**$**	**$**
Planned Primary Prevention Percentage		**%**	**%**

[a] 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 budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

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

SUPTRS BG Plan Table 5c. Planned Primary Prevention Priorities

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

SUPTRS BG Plan Table 5c. Planned Primary Prevention Priorities		
Planning Period	**From: 10/1/2025**	**To: 9/30/2027**
Priority Substances	**A. SUPTRS BG**	
Alcohol	☐	
Tobacco/Nicotine-Containing Products	☐	
Cannabis/Cannabinoids	☐	
Prescription Medications	☐	
Cocaine	☐	
Heroin	☐	
Inhalants	☐	
Methamphetamine	☐	
Fentanyl or Other Synthetic Opioids	☐	
Other	☐	
Priority Populations	**A. SUPTRS BG**	
Students in College	☐	
Military Families	☐	
American Indian/Alaska Native	☐	
African American	☐	
Hispanic	☐	
Persons Experiencing Homelessness	☐	
Native Hawaiian/Pacific Islander	☐	
Asian	☐	
Rural	☐	

Plan Table 6.[9] Categories for Planned 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 budget for other capacity building/systems development with MHBG, SUPTRS BG, and/or BSCA (MHBG only) funds.

Expenditures for these activities may be those SMHA/SSA expenditures and those expenditures through funding mechanisms with subrecipients[10] 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, capacity building/systems development expenditures provide support to the more direct service and primary prevention 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 acceptable professional standards, adaptation and review of implementation of evidence-based

[9] This table was previously named "Plan Table 6. Categories for Expenditures for Non-Direct Service/System Development Activities"
[10] Subrecipient rows are not separated out in Table 6a for MHBG.

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 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 budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Table 6a.		
State Identifier:		
MHBG Planning Period:	**From:**	**To:**
Activity	A. MHBG[1]	B. BSCA Funds[2]
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		
8. Total	**$**	**$**

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

[2] 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 September 30, 2025 – September 29, 2027 (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [July 1, 2025, through June 30, 2027 for most states].

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.

SUPTRS BG Plan Table 6b. Other Capacity Building/Systems Development Activities						
Planning Period	**FFY 2026 10/1/2025 to 9/30/2026**			**FFY 2027 10/1/2026 to 9/30/2027**		
Activity	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
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						
6. Research and Evaluation						
a. Single State Agency (SSA)						

b. All other subrecipient contracts						
7. Training and Education						
a. Single State Agency (SSA)						
b. All other subrecipient contracts						
8. Total	**$**	**$**	**$**	**$**	**$**	**$**

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: The Essential Aspects of Parity: A Training Tool for Policymakers; Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States.

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.[11] 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 and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual**

[11] Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Medical care*, 599-604.Avaiable at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

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 details on efforts to increase access to services for:
    a. Adults with serious mental illness (SMI)
    b. Adults with SMI and a co-occurring intellectual and developmental disabilities (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 serious emotional disturbances (SED) or substance use disorders
    l. Children and youth with SED and a co-occurring I/DD
    m. 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 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.

    a. Please describe how this system differs for youth and adults.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

c. How many IT-COD teams do you have? Please explain.

d. Do you monitor fidelity for IT-COD? Please explain.

e. Do you have a statewide COD coordinator? ☐ Yes ☐ No

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

5. 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

6. 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. 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 [*Note: 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*]. 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.

The 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 the 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 federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

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?

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

3. 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 (PCP) 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. PCP resources may be accessed from https://acl.gov/news-and-events/announcements/person-centered-practices-resources.

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 people with SMI 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 A Practical Guide to Psychiatric Advance Directives)?

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

4. Program Integrity – Required for MHBG & SUPTRS BG

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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, states are reminded of restrictions on the use of Block Grant funds outlined in 42 U.S.C. §300x–5 and 42 U.S.C. §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), there are periodic 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. 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, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based 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.

5. 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. ☐ Rural communities
   g. ☐ 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:

Capacity Building

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

c.

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. ☐ 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 demographics 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?

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

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?
   a. ☐ Yes (If yes, please attach the plan in WebBGAS)
   b. ☐ No
2. Does your state's prevention evaluation plan include the following components? (check all that apply)
   a. ☐ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
   b. ☐ Includes evaluation information from sub-recipients
   c. ☐ Includes National Outcome Measurement (NOMs) requirements
   d. ☐ Establishes a process for providing timely evaluation information to stakeholders
   e. ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f. ☐ Other (please describe)

   g. ☐ Not applicable/no prevention evaluation plan
3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:
   a. ☐ Numbers served
   b. ☐ Implementation fidelity
   c. ☐ Participant satisfaction
   d. ☐ Number of evidence-based programs/practices/policies implemented
   e. ☐ Attendance
   f. ☐ Demographic information
   g. ☐ Other (please describe)

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:
   a. ☐ 30-day use of alcohol, tobacco, prescription drugs, etc.
   b. ☐ Heavy 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)

6. 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 federal prevalence estimate from the National Survey on Drug Use and Health 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 care [12]

   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 the federal Rural Behavioral Health page for program resources.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal Homeless Programs and Resources for program resources[13]

c. Describe your state's tailored services to the older adult population with SMI. See the federal Resources for Older Adults webpage for resources[14]

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

[13] https://www.samhsa.gov/homelessness-programs-resources

[14] https://www.samhsa.gov/resources-serving-older-adults

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

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

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 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 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 federal resource guideTelehealth 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 needs related to this section.

7. 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 (with medications for addiction treatment included in v-x):
      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), and Hypodermic Needle Prohibition

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. Monitoring requirements as outlined in the authorizing statute and implementing regulation? ☐ Yes ☐ No
2. Has your state identified a need for any of the following:
   a. Electronic system with alert when 90 percent capacity is reached? ☐ Yes ☐ No
   b. Automatic reminder system associated with 14–120-day performance requirement? ☐ Yes ☐ No
   c. Use of peer recovery supports to maintain contact and support? ☐ Yes ☐ No
   d. Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? ☐ Yes ☐ No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make 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

Hypodermic Needle Prohibition

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

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, persons experiencing homelessness)? ☐ 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

Service Coordination

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

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[15] (TTCs)?
   a. Prevention TTC? ☐ Yes ☐ No
   b. SMI Adviser ☐ Yes ☐ No
   c. Addiction TTC? ☐ Yes ☐ No
   d. State Opioid Response Network? ☐ 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.

[15] https://www.samhsa.gov/technology-transfer-centers-ttc-program

8. 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 the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data 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)), mandates the Secretary of the Department of Health and Human Services 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. Data collected annually from the 59 MHBG grantees is done 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. 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 the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The 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. 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.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of*

states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process

This effort reflects the federal 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 the federal government.

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

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

There is a mandatory 5 percent set-aside within 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 fund 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 has 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. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, 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 services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include Crisis Services: Meeting Needs, Saving Lives, which consists of the National Guidelines for Behavioral Health Coordinated System of Crisis Care as well as an Advisory: Peer Support Services in Crisis Care. There is also the 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 the 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 a 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 medications for opioid use disorder (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 is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-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 describe 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.

   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.

   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 published guidance. This includes coordination, training and community outreach and education activities.

   Initial Implementation stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.

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

   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

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

Briefly explain your stages of implementation selections here.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, explain how the state will develop the crisis system.

5. 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): ____

6. 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.

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

10. 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 the promotion of 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 physical 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 needs of the individual, their family, and communities. Because mental and substance use disorders can be 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.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 Working Definition of Recovery.

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the Recovery Support Services Table.

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.

11. 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.[16] 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.[17] 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.[18]

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.[19]

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, states are encouraged 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, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants 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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[16] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).

[17] 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.

[18] 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.

[19] 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.[20]

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.

The expectation is 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

[20] 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 needs related to this section.

12. 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, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 – 2025 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.

13. 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 M/SUD, 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 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.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. 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.

14. 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, states should consult the State Behavioral Health Planning Councils: An Introductory Manual.

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, 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, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

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., 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.[21]

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

[21] 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)		
5. Total individuals in recovery, family members, and parents of children with SED	*Sum of rows 1 - 4*	*Sum of rows 1 – 4 divided by row 16*
6. State employees		
7. Providers		
8. Vacancies (state employees and providers)		
9. Total state employees and providers	*Sum of rows 6 – 8*	*Sum of rows 6 – 8 divided by row 16*
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		
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)		
15. Total non-required but encouraged members	*Sum of rows 10 – 14*	*Sum of rows 10 – 14 divided by row 16*
16. Total membership (<u>all</u> members of the council)	*Subtotal of rows 5, 9, and 15*	

15. 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 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 the federal government.

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.

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the HIV.gov website.

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 – Request a Determination of Need from the CDC
Step 2 – Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 – Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Service Program (SSP) Agency Name	**Main Address of SSP**	**Planned Budget of SUPTRS BG for SSP**	**SUD Treatment Provider (Yes | No)**	**Number of Locations (include any mobile locations)**	**Naloxone or other opioid overdose reversal medication Provider (Yes | No)**
		$			
		$			
		$			
Total		$		0	

Acronyms

ACF	Administration for Children and Families
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
AI	American Indian
AIDS	Acquired Immune Deficiency Syndrome
AN	Alaskan Native
AOT	Assisted Outpatient Treatment
BHSIS	Behavioral Health Services Information System
BHCS	Behavioral Health Crisis Services
CAP	Consumer Assistance Programs
CCBHC	Certified Community Behavioral Health Center
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
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)
ICD-10	*The International Statistical Classification of Diseases and Related Health Problems*, 10th Revision
ICT	Interactive Communication Technology
IDU	Intravenous Drug User
IMD	Institutions for Mental Diseases
KIT	Knowledge Information Transformation (associated with EBP implementation)
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
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
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
SSP	Syringe Service Program
SUD	Substance Use Disorder
TIP	Treatment Improvement Protocol
TLOA	Tribal Law and Order Act
U.S.C.	United States Code
VA	U.S. Department of Veterans Affairs

Resources

RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE		
TOPIC	**LINK**	**DESCRIPTION**
Children Mental Health	https://eric.ed.gov/?id=ED540209	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)
Co-Occurring Resources and Models	https://www.samhsa.gov/substance-use/treatment/co-occurring-disorders	Webpage dedicated to co-occurring models and practice. Includes: resources, webinars, public resource links and more.
Health Financing	https://www.samhsa.gov/cfri	Behavioral health financing mechanism, options, and innovations
Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT	https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366	Provides practice principles about integrated treatment for co-occurring disorders, an approach that helps people recover by offering M/SUD services at the same time and in one setting. Offers suggestions from successful programs.
Medicaid Policy Guidance	https://www.medicaid.gov/federal-policy-guidance/index.htmlhttp://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html	Searchable database of Medicaid Policy Guidance; including peer support services, affordable care act, health homes, prescription drugs, etc.
Medications for Substance Use Disorders	https://www.samhsa.gov/substance-use/treatment/options	Resources and guides

RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE		
TOPIC	**LINK**	**DESCRIPTION**
Mental Health and Substance Use Disorder Block Grant Laws and Regulations	http://www.samhsa.gov/grants/block-grants/laws-regulations	Links to the laws and regulations that govern the Mental Health and Substance use disorder Block Grants
Mental Health Crisis	https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care	Resources for implementing behavioral health crisis care
National Center of Excellence for Integrated Health Solutions	https://www.samhsa.gov/national-coe-integrated-health-solutions	National Center of Excellence for Integrated Health Solutions offers resources, trainings, and webinars on primary and behavioral health care integration
MHBG and SUPTRS Block Grants	http://samhsa.gov/grants/block-grants	Description of Block Grant, its purpose, deadlines, laws and regulations and resources
Evidence-Based Practices Resource Center	https://www.samhsa.gov/resource-search/ebp	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.
Library	https://library.samhsa.gov/	Search a library to download or order publications and resources

RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE		
TOPIC	**LINK**	**DESCRIPTION**
National Strategy for Suicide Prevention and Federal Action Plan	National Strategy for Suicide Prevention national-strategy-suicide-prevention.pdf (hhs.gov) National Strategy for Suicide Prevention Federal Action Plan nnsp-federal-action-plan.pdf (hhs.gov)	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. The National Strategy seeks to prevent suicide risk in the first place; identify and support people with increased risk through treatment and crisis intervention; prevent reattempts; promote long-term recovery; and support survivors of suicide loss. 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. 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.

RESOURCES	**LINK**	**DESCRIPTION**
Resources for Older Adults	https://www.samhsa.gov/communities/older-adults	Products for serving older adults with mental and substance use disorders that can be useful to clinicians, other service providers, older adults,

RESOURCES	LINK	DESCRIPTION
		and caregivers.
The Essential Aspects of Parity: A Training Tool for Policymakers	https://library.samhsa.gov/sites/default/files/pep21-05-00-001.pdf	This document provides an overview of essential information necessary for understanding mental health and substance use disorder parity and how to implement and comply with federal parity laws. This guide applies to parity laws in employer-sponsored health plans and group and individual insurance.
Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States	https://library.samhsa.gov/sites/default/files/sma16-4983.pdf	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	http://www.ncbi.nlm.nih.gov/books/NBK44360/	The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking seeks to engage all levels of government as well as individuals and private sector institutions and organizations in a coordinated, multifaceted effort to prevent and reduce underage drinking and its adverse consequences.
Recovery	https://www.samhsa.gov/brss-tacs	Resources, guides, and technical assistance on recovery
Data Resources	http://www.samhsa.gov/data/	Links to data sets including: NSDUH, NSUMHSS, TEDS, Uniform Reporting System (URS), National and State Barometers, etc.
Substance Use Disorder for	https://store.samhsa.gov/sites/default/files/d7/priv/sma13-	Guidance on components of quality SUD treatment services for women, states can refer to

RESOURCES	LINK	DESCRIPTION
Women	4789.pdf	the documents found at this link
Suicide Prevention	https://www.samhsa.gov/mental-health/suicidal-behavior/prevention	Links to resources and guides around suicide prevention and other mental and substance use prevention topics.
Synar Program	http://samhsa.gov/synar	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	https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf	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

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 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 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 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, 4, 6	42 U.S.C. §300x–1 State plan for comprehensive community mental health services for certain individuals and management services	Table 1 provides information on priority areas and performance indicators. Table 2 requests state agency planned budget. Table 4 requests state agency planned MHBG budget. Table 6 requests Other Capacity Building/system development activities planned expenditures.	42 U.S.C. §300x-32 Application for grant; approval of State Plan (b) State plan; (1) In general	Table 1 provides information on priority areas and performance indicators. Table 2 requests state agency planned budget. Table 4 requests state agency planned SUPTRS BG budget. Table 6 requests Other Capacity Building/system development activities planned expenditures.
Plan- Tables 3, 5a, 5b	N/A	N/A	42 U.S.C. §300x-32 Application for grant; approval of State Plan (b) State plan; (1) In general	Table 3 requests a summary of need, and a summary of persons served in SUD treatment. Tables 5a and 5b request a description of planned primary prevention expenditures.
Set-aside for Children	42 U.S.C. §300x–2(a) Allocation for systems of integrated services for children	The state must demonstrate the amount expended is greater or equal to dollars spent to provide services for children with SED in FY 1994.	N/A	Rather than a specific set-aside for children, the SUPTRS BG requires a 20% Primary Prevention Set-Aside which focuses primarily on children and adolescents but does not require that all activities be directed to this population.
Maintenance of Effort (MOE)	42 U.S.C. §300x–4(b) Maintenance of effort regarding State expenditures for mental health	The state must demonstrate the state funds expended for the state community mental health system is at least the average of the two years prior.	42 U.S.C. §300x-30 Maintenance of effort regarding State expenditures (a) In general; (b) Exclusion of certain funds	The methodology for the calculation for the SUPTRS BG MOE expenditure requirement is based on an average of the state expenditures for the past two state fiscal years, but normally includes only those funds which flow directly through the SSA, so this MOE total may or may not include state Medicaid funds for SUD treatment. States have the option of co-designation of state Medicaid funds managed by

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
				another state agency when certain criteria are met.
MOE-Women	N/A	N/A	42 U.S.C. §300x-22 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) 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 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) 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 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 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

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
				Advisory Council Composition by Member Type.
Public Input to Plan	42 U.S.C. §300x–51 Opportunity for public comment on State plans	A funding agreement for a grant under section 300x or 300x–21 of this title is that the State involved will make the plan required in section 300x–1 of this title, and the plan required in section 300x–32 of this title, respectively, public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.	42 U.S.C. §300x-51 Opportunity for public comment on state plans	Required item in SUPTRS BG Application/Behavioral Health Assessment and Plan, Form 22. Public Comment on the State Plan.
10% Set-aside for Early SMI	42 U.S.C. §300x–9(c) Early serious mental illness	...a State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.	N/A	N/A
Primary Prevention	N/A	N/A	42 U.S.C. §300x-22 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.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
Annual Report	42 U.S.C. §300x-52(a) Requirement of reports and audits by States	The state is required to submit to the Secretary a report with a description of the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program.	42 U.S.C. §300x-52(a) Requirement of reports and audits by States	The state is required to submit to the Secretary a report with a description of the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program.
Independent Peer Review	42 U.S.C. §300x-53(a) 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) 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 Intravenous substance abuse (a) Capacity of treatment programs; (b) Outreach to persons who inject drugs	The state is required to ensure that each SUPTRS BG funding subrecipient maintain an active capacity management system, and to notify the state upon reaching 90% of its capacity to admit individuals to the program. Syringe Services is also a required item in annual SUPTRS BG Application/Behavioral Health Assessment and Plan, Environmental Factors, Form 23. Syringe Services (SSP), and Syringe Services (SSP) Program Information – Table A.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
5% set-aside for Early Identification Services (EIS) for HIV	N/A	N/A	42 U.S.C. §300x-24 Requirements regarding human immunodeficiency virus (b) Human immunodeficiency virus	Designated states are required to expend 5% of each allocation on HIV services for individuals in SUD treatment who have HIV, or who are at risk for HIV.
Recovery Residences-Revolving Loan Fund	N/A	N/A	42 U.S.C. §300x-25 Group homes for persons in recovery from substance use disorders (a) State revolving funds for establishment of homes	States may establish and maintain the ongoing operation of a revolving loan fund to support group homes for persons in recovery from substance use disorders.
Services for individuals with co-occurring disorders	42 U.S.C. §300x–66 Services for individuals with co-occurring disorders	States may use funds available for treatment under sections 300x and 300x–21 of this title to treat persons with co-occurring substance use and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.	42 U.S.C. §300x–66 States may use funds available for treatment under sections 300x and 300x–21 of this title to treat persons with co-occurring substance and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.	States are required under 42 U.S.C. 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
Professional Development	N/A	N/A	42 U.S.C. §300x-28 Additional agreements (b) 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	Requested	Requested or recommended item narrative in annual SUPTRS BG Application/Behavioral Health Assessment and Plan, Environmental Factors and Plan, Form 15. Crisis Services.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
		all of the core crisis care service 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.		
Recovery	42 U.S.C. §300x–1 (b)(1)(A)(vii)(IV) Comprehensive community-based health systems	The plan shall provide a description of recovery and recovery support services for adults with a serious mental illness and children with a serious emotional disturbance.	42 U.S.C. §300x-32 Application for grant; approval of State plan (b) State plan	The state is required to provide a description of the system that is available to provide services by modality, including the provision of recovery support services.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
Children's Services	42 U.S.C. §300x–1(b)(1)(C) Children's services	In the case of children with a serious emotional disturbance (as defined pursuant to subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act).	N/A	N/A
Services to rural and homeless populations	42 U.S.C. §300x–1(b)(1)(D) Targeted services to rural and homeless populations	The plan shall describe the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.	42 U.S.C. § 300x-32 Application for grant; approval of State Plan (a) In general; (b) State plan	States are required to provide information in the plan on the need for substance use disorder prevention and treatment services in the State, to include persons who are experiencing homelessness.
Suicide Prevention	42 U.S.C. §300x–1 (b)(1)(A)(vii)(II) Comprehensive community-based health systems	The plan shall provide a description of the activities intended to reduce incidents of suicide for people with SMI and SED using the Block Grant funds.	N/A	N/A

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
Support of State Partners	42 U.S.C. §300x–1(b)(1)(A)(iii) Comprehensive community-based health systems	The plan shall include a description of the manner in which the State and local entities will coordinate services to maximize the efficiency, effectiveness, quality, and cost-effectiveness of services and programs to produce the best possible outcomes (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other 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.].	42 U.S.C. §300x-28 Additional agreements (c) Coordination of various activities and services	The state is required to coordinate SUD prevention and treatment activities with the provision of other appropriate services (including health, social, correctional, and criminal justice, educational, vocational rehabilitation, and employment services).

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
Reporting Requirements	42 U.S.C. §300x–35(b)(3) 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) 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.

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