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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

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

Housing. Recovery housing programs that are supported by the SUPTRS BG should be free from 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.

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[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

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 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

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

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

Application	Plan Due Date	Report Deadline[a]
Combined MHBG & SUPTRS BG	September 1, 2025	December 1, 2025[b]
MHBG	September 1, 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.

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;

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[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

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 – 16) 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 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.

[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.

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.

B. 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)
2. Individuals in need of behavioral health crisis services (BHCS) * (5 percent

MHBG set aside)(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

C. 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

[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

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.**

The Office of Substance Abuse and Mental Health (OSAMH) is Arkansas' State Mental Health Authority (SMHA) and Single State Authority (SSA) for all mental health and substance use disorder-related services. The SSA and SMHA include public mental health services and public alcohol and substance misuse prevention, treatment, and recovery services, utilizing block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). OSAMH is a division within the Department of Human Services (DHS). DHS serves as an umbrella agency that includes nine Divisions responsible for providing social, health, and human services to citizens of Arkansas, including individuals with mental illness and substance misuse needs, individuals with a developmental disability, the elderly, adjudicated youth, youth diverted from the justice system, and at-risk children and families. The SMHA and SSA provide oversight for the child and adult systems of care in Arkansas.

Through the administration of the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and the Mental Health Block Grant (MHBG) OSAMH allocates federal funds to a wide variety of programs and services that support our mission. Guided by the belief that the most effective treatment is community-based and locally supported, OSAMH collaborates with local stakeholders to deliver services tailored to each community's needs. To ensure equitable access across the state, OSAMH contracts with local providers to offer services in all 75 counties of Arkansas.

The provision of block grant funded substance use disorder treatment services is facilitated through state-wide contracts with eight (8) providers, blending SUPTRS and State Opioid Response funding, thirteen (13) prevention providers covering the state, eight (8) SUD treatment catchment areas, five (5) Specialized Woman's Service programs, and four (4) Recovery Community Organizations. OSAMH fulfills part of its responsibility for the provision of public mental health services through contracts with twelve (12) non-profit Community Mental Health Centers (CMHCs). These specific contracts cover a spectrum of services to individuals with SMI and SED needs with contracts with braided funding including block grant dollars, Social Service Block Grant dollars, and State General Revenue dollars. The SMHA also operates a 220-bed psychiatric facility, the Arkansas State Hospital (ASH), which is largely a forensic-service hospital. For those people without any insurance coverage, including adults and children, basic counseling level services are funded with State General Revenue dollars through twenty-two (22) Therapeutic Counseling Services contractors across the state to ensure easy and quick access. Additionally, the SMHA oversees three (3) Crisis Stabilization Units (CSU) in different areas of the state which provide an alternative to psychiatric hospitalization or emergency

room visits for persons in crisis or who encounter law enforcement due to their psychiatric or a co-occurring mental health and substance use condition.
OSAMH expects each contracted provider of services to assess and address the strengths and gaps within their own region and the populations they serve. Based on this self-assessment, providers are required to ensure that staff are trained to provide evidence-based services specific to the needs of everyone they serve, with a focus on the priority populations identified and services are structured to minimize barriers and gaps in their region of the state. As required by block grants, providers utilizing block grant funding of any type follow SAMHSA mandates for specific priority populations.
Medicaid is by far the largest payor of behavioral health services in Arkansas. Through different Medicaid programs coverage is present for outpatient mental health and substance abuse treatment assessment and services, crisis services, alcohol and drug detoxification, and Medications for Opioid Use Disorder treatment, along with medical and dental programs. Medicaid-funded services are provided by Federally Qualified Health Centers, Rural Health Centers, Independently Licensed Practitioners, and Department of Human Services certified or licensed mental health and substance use treatment agencies who are enrolled as Medicaid providers.
The PASSE (Provider led Arkansas Shared Savings Entities) model is a Medicaid-funded program that functions like a managed-care organization. For those individuals with higher levels of behavioral health service needs and all individuals with intellectual and/or developmental delays, an Independent Assessment is performed to confirm functional deficits. Those with deficits meeting a certain threshold are assigned to one of 4 PASSE organizations. Each PASSE is responsible for total care of their members, including medical needs, behavioral health services, physical/speech, occupational therapies, crisis services, and durable medical equipment, for example.
Arkansas is also a Medicaid expansion state with Qualified Health Plans being financially supported largely through Medicaid funding by using a demonstration project (waiver) approved under the authority of Section 1115 of the Social Security Act. ARHOME is Arkansas's Medicaid expansion program created by the federal Affordable Care Act (ACA). It serves adults ages 19 to 64 with income below 138% of the federal poverty level. Centers for Medicare & Medicaid Services (CMS) approved an amendment to the ARHOME waiver on November 1, 2022. The amendment created the Life360 HOME program, allowing DHS to contract with hospitals to provide additional support and intensive care coordination for ARHOME's most at-risk beneficiaries, numbering around 191,000 currently. Some of our Life360 HOME populations include maternal health, young adults at risk of poverty and poor health outcomes, and behavioral health needs in rural areas.

Child, youth, and young adult system

Prevention works within the primary and secondary schools as well as 23 different higher education programs through the Arkansas Collegiate Network and Save AR Students campaign.
Arkansas' Infant Mental Health services ensure specialized, dyadic-focused, mental health treatment for children 0-47 months of age. The child's caretaker is a vital part of this treatment process and is highly involved, with a primary goal of strengthening the relationship to ensure or restore a child's sense of safety, attachment, and appropriate affect.
Outpatient mental health services for children are largely covered by Medicaid-funded programs, including the PASSE with over 10,200 children and adolescent receiving services through PASSE in-network providers. For children and youth in need of mental health services, but ineligible for Medicaid or PASSE attribution, Therapeutic Counseling Service contracts are available in all 75 counties to ensure rapid access to mental health care.
Arkansas has a School-Based Mental Health program with services being provided in local schools

with Medicaid reimbursement. Additionally, schools can make referrals to certified and enrolled Medicaid providers with the school site being an allowable place of service.

Since 2019 Arkansas' juvenile justice program, the Division of Youth Services (DYS), has been completing comprehensive evaluations on every adjudicated child entering their custody. These evaluations include mental health, substance use disorder, medical, and educational needs, all of which are addressed directly by DYS staff or contractors.

A pilot project is in process with River Valley Medical Wellness utilizing their mobile medical unit, Arkansas Mobile Opioid Recovery (ARMOR) on a regular basis to the Arkansas Juvenile Assessment and Treatment Center (AJATC) at DYS, offering integrated care for youth including medications for opioid use disorder (MOUD). Peer recovery specialists are available, with one on site at AJATC, to facilitate referrals of youth in need of substance use treatment to visit ARMOR. ARMOR's team provides targeted technical assistance to on-site AJATC clinical staff, with the goal to improve access and utilization of evidence-based SUD services when youth leave incarceration to return to their environment. ARMOR staff are available for continued SUD care, peer support, identify referral sources, and assist with client reintegration.

Arkansas currently has limited specialty programs to address adolescent substance misuse issues, although the University of Arkansas for Medical Sciences (UAMS) does offer youth and adolescent outpatient substance use services through the Six Bridges clinic. The program is the first of its kind at UAMS, with a focus on youth between ages of 12 and 21 for substance dependency including opioids, alcohol, or marijuana.

The current crisis system for children and youth is limited in scope currently but is a heavy focus in the coming two years. Arkansas' current crisis intervention services cover both ends of the spectrum with services available on an outpatient basis and the more restrictive, out-of-home placement options in a sub-acute, acute, or Psychiatric Residential Treatment Facility (PRTF) setting. Since 2019 our child welfare and juvenile justice programs have been using evidence-based intensive in-home treatment services with encouraging results. To fill the continuum gap in crisis services for a broader array of children, OSAMH initiated a large-scale intensive in-home pilot program for all children and youth in a PASSE using the Family Centered Treatment model exclusively.

Three other child and youth-focused pilot programs have also been underway over the last year, and these are intended to become another aspect of our new crisis system for children.

- Prevention, Stabilization, and Support Project for Youth Children from birth through grade 6 who are at risk of losing home or education setting due to behaviors.
- Comprehensive Screening and Assessment for Children will target comprehensive screenings, such as for Fetal Alcohol Spectrum Disorder, for children displaying mental health needs and intellectual or developmental diagnosis, with screenings being performed by trained professionals who can also assist with educating families or other professionals.
- Families in Transition Team supports children and youth experiencing a major life transition, such as being at risk of entering or are entering foster care, being adopted, moving to live with other family members, or being discharged from a residential facility or juvenile detention facility. This pilot will also focus on preventing the need for extensive crisis services, such as emergency room or law enforcement involvement, and out-of-home placements.

OSAMH funds Specialized Women's Services (SWS) for substance use treatment services designed specifically for pregnant women and women with dependent children. Residential treatment is customized to address the unique needs of women within a structured, supportive, and non-judgmental

environment. In addition, the emotional, physical, medical, and mental health needs of each child (or unborn child) are addressed through the SWS program. A pilot program involving the evidence-based Family Centered Treatment-Recovery (FCT-R) model will be implemented in 2026 for pregnant women and women with dependent children who receive services through Arkansas' Specialized Women's Services Treatment programs.

In 2022 Arkansas implemented a new provider type, Community Support Service Provider, to more appropriately address children and youth with mental health and intellectual/developmental needs. An OSAMH provider has created and sustained a youth-specific program called Youth Empowerment Program (YEP), which is an after school and summer initiative that equips young people to face challenges, educates them about the risks of drug and alcohol use, and empowers them to make the best choices regarding their futures. Any adult can refer an individual ages thirteen (13) to eighteen (18), or young people can enroll themselves in the program.

2025 legislation lifted the moratorium on Psychiatric Residential Treatment Facility (PRTF) beds in Arkansas. As a direct result of the legislation, a central Arkansas provider of mental health services to deaf and hard-of-hearing children and youth can now accept Arkansas Medicaid clients. This will dramatically increase access to a critical level of care for this special and underserved population. Arkansas currently has one Community Reintegration program, a 12-bed unit for children/adolescents. This unit is used as a transition from high-cost settings like PRTFs and acute or sub-acute settings, or to divert from higher level of care program admission by serving as an intermediate level of care. The program provides twenty-four-hour care in a small group setting for those with emotional or behavioral problems.

Adult system

For outpatient substance use disorder services OSAMH supports a methadone program which offers Medication-Assisted Treatment (MAT) alongside counseling services to support recovery. To address the challenges of daily visits to opioid treatment programs (OTPs), OSAMH partnered with a major OTP provider to launch a hybrid care model aimed at improving patient outcomes and access to treatment. The program uses a virtual dosing system to expand safe access to take-home methadone, minimizing the need for frequent clinic visits. Clinically stable patients are eligible for the hybrid program, which not only helps reduce negative perceptions around methadone treatment but also encourages more individuals with opioid use disorder to seek care. Through alternative funding sources, Arkansans also have access to mobile health units which travel to rural areas within the state to deliver services such as opioid addiction assessments, onsite medical consultations, individualized treatment planning, counseling and peer recovery services and follow-up care.

According to the Arkansas Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs, the full continuum of treatment services includes individuals equal to and over the age of eighteen (18), utilizing the previously mentioned catchment and service delivery areas. All treatment providers contracted by OSAMH are required, as a condition of their contracts, to maintain both national accreditation and appropriate state licensure in accordance with Arkansas standards. In addition, all contracted providers are required to provide or arrange the full continuum of care, including intake, withdrawal management, residential treatment, and individualized outpatient services such as group and individual counseling. The OSAMH also contracts with a provider to deliver statewide medical detoxification services to those lacking adequate insurance.

OSAMH also manages the Drug and Alcohol Safety Education Program (DASEP), established to fulfill statutory requirements related to pre-screening, assessments, and alcohol/safety education for individuals charged with Driving While Intoxicated (DWI). There are eight (8) DASEP providers

across Arkansas who conduct assessments, teach DASEP classes, and provide treatment referrals to all 75 counties.

The mission of the Arkansas Peer Recovery Program (APRP) is to improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence and promoting better health for individuals who face substance use and mental health disorders. The recovery team oversees an innovative, three-tiered credentialing model as well as management of programs who deliver direct peer services to Arkansas citizens. There is not currently a differential in the training or delivery of adult and youth peer services, though both are being funded using both SUPTRS and alternate federal dollars. OSAMH currently is in the pilot stage of implementing the Hub and Spoke Model of service delivery, with vendors such as Recovery Community Organizations (RCOs) serving as the "hubs" and their providers who deliver direct services being the "spokes." This model represents a path to service delivery to more rural areas of the State of Arkansas.

Specialized Women's Services specifically serve pregnant women and women with dependent children, offering the full continuum of SUD treatment, with mental health services offered as needed. The primary goal is to reduce the harmful effects of alcohol and other drugs on both the mother and the unborn fetus, promoting healthier, drug-free babies. Mothers are empowered to live drug- and alcohol-free lives to become successful parents.

Recovery Residences have been implemented and are being piloted over the last year by OSAMH to assist National Alliance of Recovery Residences (NARR)-accredited residences with indigent funding for individuals new in their recovery who require recovery support services. Arkansas now has its own credentialing entity, certified by NARR, that is used to ensure NARR standards for recovery residences are fulfilled before issuing accreditation or any assistance for indigent funds.

Mental health and substance use disorder treatment services are widely available in all areas of the state for people with Medicaid, a Qualified Health Plan, or other private insurance. Outpatient mental health treatment services for adults without healthcare coverage are provided by Therapeutic Counseling Service contracts. Outpatient substance abuse treatment services for adults are covered by one of the 8 state funded SUD treatment programs. For individuals needing more intensive services, including SMI adults, our twelve Community Mental Health Centers (CMHC) are required to provide the full array of services. The CMHCs do serve a large portion of the SMI adults in the state, but other behavioral health agencies serve smaller numbers.

FOR SMI adults needing the support of a longer-term structured and supervised treatment program in a more secure setting, Arkansas has two levels of Therapeutic Community services. Level 1 is a locked unit with intensive services, care, and supervision, while Level 2 is still intensive, and completely supervised, but not a locked unit.

Crisis services for adults also cover both ends of the spectrum with limited options for intermediate treatment services. Crisis intervention services are available from any behavioral health provider on an outpatient basis. The other end of the spectrum includes Crisis Stabilization Units and acute hospitals. In particular, the CHMC contracts require performance of crisis screenings upon demand, 24/7, for any individual without health insurance. If the screening indicates the need for hospitalization, the CMHC has funds to purchase acute bed days. If the screening does not indicate the need for immediate hospitalization, the CMHC works to ensure an expedited mental health appointment with a licensed practitioner.

The adult forensic system is entered by individuals when an attorney or judge suspects that someone charged with a crime may not be mentally fit. A Forensic Evaluation is then ordered by the judge. Based on the outcome of the evaluation, that person may be found fit to proceed in the justice system,

meaning they have no mental disease or defect; or they may be found unfit to proceed and enter the Forensic Outpatient Restoration Program (FORP). FORP attempts to provide treatment and education to the individual to restore them to fitness so they may proceed with the justice system process.
In Arkansas, individuals acquitted due to mental disease or defect may be committed for psychiatric treatment at the Arkansas State Hospital (ASH), almost exclusively a forensic-based program. Upon completion of inpatient treatment, individuals are discharged from the hospital on a conditional release order that allows the state to monitor their community functioning for up to five years. Licensed Certified Social Workers perform the monitoring, and they have regular face-to-face contact with those on conditional release to ensure compliance with the terms of release, typically court-ordered medical and psychiatric care determined to be appropriate for the client's mental disease or defect. Individuals on "911 status" are required to comply with medications, treatment and therapy, substance abuse treatment, and drug testing as prescribed.
Involuntary commitments can be filed through the Prosecuting Attorney's office in the county of residence for any individual demonstrating significant mental health symptoms that put them or others at risk. Arkansas judges typically order "up to seven days" evaluations for those involuntary committed to mental health treatment. Other specialized substance use treatment services include the statewide court-ordered program known as ACT 10, which provides treatment to individuals involuntarily mandated by the court through a citizen petition for evaluations and treatment services specific to substance use disorder issues.
Arkansas currently has 3 CMHCs who are providing grant funded services through the Projects for Assistance in Transition from Homelessness (PATH) program. Arkansas PATH providers focus on outreach and engagement, community mental health services, including diagnostic treatment, and referrals and assistance with obtaining housing.

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.**

The Arkansas SMHA and SSA mainly execute the role of grant management to providers of direct mental health and substance use services throughout the state. This includes strategic planning, contract management, guidance in providing services, conducting site evaluations, ensuring compliance, and ongoing communication with providers and other stakeholders. In addition to grant management, the SMHA and SSA provide trainings for direct service providers, program evaluations, information systems, and advisory councils directly related to mental health, prevention, treatment, and recovery support services, as well as a state-legislatively mandated councils, the Arkansas Alcohol and Drug Abuse Coordinating Council and the Deaf and Hard of Hearing Mental Health Advisory Committee, and federally mandated council, the Arkansas Behavioral Health Planning and Advisory Council.
OSAMH is uniquely positioned to work in collaboration with our eight (8) sister divisions, as well as other Arkansas State Departments, to provide a broad variety of social service programs. Prevention, treatment, and recovery services touch all other divisions in one or more ways. Our divisions oversee programs which include child welfare (prevention, foster care, and adoption services), services to adjudicated youth (including prevention and custody cases), services to adults and older adults meeting waiver criteria or in need of maltreatment prevention/intervention services, persons with a developmental/intellectual delay, Division of Medical Services, Division of County Operations, the Arkansas State Office of the Drug Director, the Arkansas Administrative Office of the Courts, and the Arkansas Problem Gambling Council. OSAMH works closely with each of the other eight (8)

divisions either through assisting with getting eligible persons enrolled in needed benefits like health insurance, collaboratively writing and managing policy and regulations to ensure timely and appropriate treatment services are available to all in need of them, regardless of where they live, and ensuring youth in state custody and their caregivers, older adults, justice-involved individuals, and individuals with gambling addictions have access to evidence-based mental health and substance misuse prevention, treatment, and recovery-based services.

Arkansas has also been awarded the fourth iteration of State Opioid Recovery (SOR) grant funding. Arkansas is using SOR-4 funding to generate, implement, and sustain projects relating to prevention, treatment, recovery, workforce development, evaluation, and data collection. OSAMH manages fifteen (15) areas of focus with seventeen (17) providers under this funding source. These providers deliver services such as opioid reversal medication saturation, prevention infrastructure for underserved populations, collegiate initiatives, provider development and education, maternal health, youth treatment and recovery services, RCO development, recovery stability and continuum of care, recovery residences, and justice-involved services. This funding source is also used to gather evaluation and Government Performance and Results Act (GPRA) data. OSAMH has contracted with a provider to contact individuals involved with treatment programs by phone, email, or social media to collect intake, discharge, and six (6)-month follow up data.

The Arkansas State Drug Director's Office is responsible for coordinating the state's illicit drug response strategy, including prevention, treatment, and recovery programs in the field of substance use disorder. The Drug Director serves as the chairperson and Governor's appointee of the Office. This individual is a liaison with the Arkansas Drug Task Force, collaborating closely with the Arkansas Department of Finance and Administration and Division of Public Safety. Additionally, the Drug Director chairs the Arkansas Alcohol and Drug Abuse Coordinating Council, which oversees planning and budgeting of education, prevention, treatment programs, and law enforcement services as they relate to the enforcement of Arkansas laws to combat the abuse of drugs and alcohol in the state.

OSAMH has a collaborative relation with the Arkansas Department of Health who manages our 988-call center program. OSAMH staff provide training and assistance to call center staff to identify the array of available mental health and substance use disorder programs across the state.

The University of Arkansas for Medical Sciences (UAMS), the largest teaching hospital in the state, and OSAMH partner on several projects. Many of the psychiatrists working at the Arkansas State Hospital (ASH) are UAMS staff and residents do psychiatric rotation work at ASH frequently. UAMS houses one of our funded Opioid Treatment Programs and oversees our two Coordinated Specialty Care (CSC) Programs for the Early Serious Mental Illness population. OSAMH is partnering with UAMS on the Integrating Behavioral Health 5-year grant from the Substance Abuse and Mental Health Administration (SAMHSA). This grant is working to integrate behavioral health and primary care to have early intervention and convenient access for people with common behavioral health conditions (depression, anxiety, alcohol and other substance use disorders) using the Collaborative Care Model (CoCM).

The Arkansas Department of Education (ADE) is also a partner of OSAMH. Collaboration has taken place to provide support and education to ADE staff regarding our Medicaid programs which impact their student population. 2025 legislation was passed requiring the Department of Human Services to work collaboratively with ADE on a new pilot project in northwest Arkansas to provide stabilization and services to children and youth in school who are demonstrating severe behavior problems to the point of safety concerns.

The OSAMH has provided funds to support the Office of Public Safety to support Crisis Intervention

Trainings (CIT) for officers. OSAMH also provides partial funding for a position who works in the Commission on Law Enforcement Standards and Training (CLEST). This relationship has led to all new officers in central Arkansas being trained in the full 40-hour course of CIT, greatly increasing the number of CIT-trained officers. Act 423 of 2017 mandated that any law enforcement agency in Arkansas employing 10 or more staff must have at least one CIT-trained officer. CIT training typically involves a visit to the closed Crisis Stabilization Unit for a tour and description of how the unit can assist officers who encounter someone experiencing a behavioral health crisis.
The OSAMH is also partnering with the Administrative Offices of the Court to continue a pilot program started with American Rescue Plan funding in 2023 which works to incorporate Peer Support Services into Specialty Courts.

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."**

There are links imbedded under the first question in this section. There are state maps for many types of services and programs offered in Arkansas which support the SAMHSA priority populations. They also include agency names and contact information. Although our regions and catchment areas don't match across programs, the maps are posted on our website (https://humanservices.arkansas.gov/) and are easily located using most common search engines. Entities identified on these maps specifically receive funding from OSAMH (either block grant funding, state general revenue, or a combination of both) to ensure mental health and substance use treatment services are available to those who need them, regardless of health insurance coverage.

Serious Emotional Disturbance

All youth who are covered by Medicaid and demonstrate a need for higher level mental health services undergo an Independent Assessment. If the Independent Assessment confirms significant functional deficits, thus establishing SED status, the child or youth is placed in a PASSE. The PASSE is mandated to provide Care Coordination services to help ensure all behavioral health and medical needs are met.

SMI including older adults

All people over 18 with Medicaid and demonstrating a need for higher level mental health services undergo an Independent Assessment. If the Independent Assessment confirms significant functional deficits, thus establishing SMI status, the adult is placed in a PASSE. The PASSE is mandated to provide Care Coordination services to help ensure all behavioral health and medical needs are met.

SED and SMI in rural areas and among those experiencing homelessness

All individuals, including SED and SMI, who live in rural areas have access to services in their county of residence. OSAMH requires contracted mental health providers to either have a clinical location in every single county of Arkansas, or ensure services are available within that county, such as at a school location. Most mental health providers, including rural health clinics and Federally Qualified Health Centers, also offer telehealth services.
While the homeless population is more challenging to engage, our PATH (Projects for Assistance in Transition from Homelessness) providers are required to conduct fairly extensive outreach activities to

connect with the homeless population who may be in need of assistance and support in locating more permanent housing. Additionally, PATH housing and treatment funds are exclusively dedicated to SMI adults.

Early Serious Mental Illness or First Episode of Psychosis

Since 2015, our Community Mental Health Center contractors have been our primary means of identifying and ensuring treatment options are available for this small, but unique population. Conservative estimates indicate that around 750 Arkansans may experience a first episode annually. Although more details will be illustrated in the Environmental Factors section later in the application, Arkansas was very proud to announce the implementation of our first Coordinated Specialty Care (CSC) programs in 2024-2025. Thanks to supplemental federal funding, two CSC clinics have been opened in our two most populated counties of the state, Pulaski and Washington counties.

Individuals in Need of Behavioral Health Crisis Services

Arkansas' current crisis system lacks a coordinated hub and spoke model. Although the system has pieces of an evidence-based system, our system lacks critical infrastructure and elements like mobile crisis teams. There are multiple entities with "crisis" lines, a few with "warm" lines, and now the 988 system. Many Arkansans still seek emergent behavioral health services through 911, emergency rooms, or acute hospitals, while others forego or refuse crisis intervention and end up with law enforcement involvement, ultimately landing in jail, or involuntarily committed to a treatment program. Though Community Mental Health Center contractors serve a great deal of individuals in crisis every year, most of those are their own clients, clients without health insurance, or those in jails. OSAMH partners with three county judges (elected county administrators – not criminal justice system judges) to implement contracts for three Crisis Stabilization Units (CSU). Referrals to the units are slow in coming which leaves empty beds, CSU are available to people 18 and older, and units exclusively accept only voluntary and non-aggressive admissions.

Arkansas's Governor supplied $10,000,000.00 of supplemental, but short-term, federal funding to allow OSAMH to develop and implement a large-scale crisis pilot project which will encompass seven different areas of the state, with direct oversight and management by a centralized "hub" agency. This crisis hub project is underway now, but in the early stages. More details will be shared in Environmental Factors Section 9.

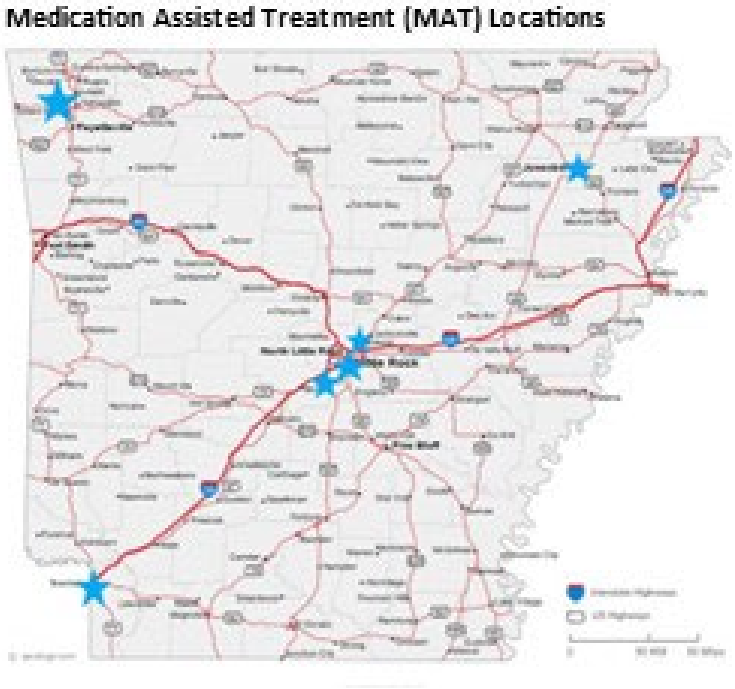
Pregnant women and women with dependent children

Specialized Women's Services (SWS) uses evidenced-based models of treatment aimed at addressing the specific needs of pregnant and women with dependent children seeking support and growth through their substance use disorder challenges. Services focus on challenges faced by parents and offer job skills training, therapy, daycare, parenting classes, care coordination, and aftercare planning to promote holistic well-being. Funding for SWS treatment is based on county of residence (see map). SWS caters to mothers who are residents of Arkansas with up to two children under the age of 7, providing up to 20 beds for a residential SUD treatment duration of up to 120 days.

People who inject drugs

OSAMH supports a methadone program which offers Medication-Assisted Treatment (MAT) alongside counseling services to support recovery. To address the challenges of daily visits to opioid treatment programs (OTPs), OSAMH partnered with a major OTP provider to launch a hybrid care model aimed at improving patient outcomes and access to treatment. This approach reduces stigma by making care more discreet, personalized, and manageable. The program uses a virtual dosing system to expand safe access to take-home methadone, minimizing the need for frequent clinic visits. Through a web-based application, patients scan a tamper-evident QR code on their methadone bottle

and submit a video of their dosing, which is reviewed by their care team. Clinically stable patients are eligible for the hybrid program, while those requiring closer supervision will continue with traditional in-clinic care. This model not only helps reduce negative perceptions around methadone treatment but also encourages more individuals with opioid use disorder to seek care. Here are six (6) OSAMH-funded Opioid Treatment Program providers, that utilize block grant funding, and HUB & Spoke funds (See Map below).



UAMS MAT Services assist agencies throughout the state in providing comprehensive Medication-Assisted Treatment (MAT) services using the three FDA approved medications (naltrexone, buprenorphine, and methadone) for the treatment of opioid use disorder (OUD). Through the MAT program, UAMS connected with medical professionals and treatment providers who lack access to resources and services. Distribution of MAT occurred at a variety of locations where minimal MAT providers currently exist in each of the eight regional catchment areas as defined by the Division of Aging, Adult & Behavioral Health Services (OSAMH).

Persons in need of recovery support services for substance use disorder

OSAMH provides oversight for approximately 100 substance use disorder treatment providers across the state. Of these, eight (8) receive SUPTRS funding to provide substance use disorder treatment to uninsured or underinsured individuals. All providers contracted by OSAMH are required, as a condition of their contracts, to maintain both national accreditation and appropriate state licensure in accordance with Arkansas standards. In addition, all contracted providers are required to provide or arrange the full continuum of care, including intake, withdrawal management, residential treatment, and individualized outpatient services such as group and individual counseling. OSAMH also contracts with a provider to deliver statewide medical detoxification services to those lacking adequate insurance.

OSAMH manages the Drug and Alcohol Safety Education Program (DASEP), established to fulfill statutory requirements related to pre-screening, assessments, and alcohol/safety education for individuals charged with Driving While Intoxicated (DWI). Through funding and supervision, DHS-OSAMH manages the DASEP providers who assist the court system by offering recommendations for

education or treatment for DWI/Driving Under the Influence (DUI) offenders. There are eight (8) DASEP providers across Arkansas who conduct assessments, teach DASEP classes, and provide treatment referrals to all 75 counties.

Arkansas provides peer recovery services to individuals with substance use disorder, mental health challenges, or those who are cooccurring through a variety of programs. Providers of these direct services include carceral settings, Recovery Community Organizations (RCO), recovery residences, specialty court settings, treatment settings, community mental health centers, rehab day services settings, primary care settings, and mobile health units. These settings are funded in several ways, including state, federal, and private funding. SUPTRS-specific recovery support services related funding will be awarded to provide direct services to those in carceral settings as well as RCO settings. Services provided will include not only individual and group sessions, but also innovative solutions such as guidance toward resources, education and training, and community outreach events. Programs are provided in carceral settings and operate under three phases corresponding with three different levels of supervision, freedom, and opportunity. Apart from providers who currently have peer workers within their organization, Arkansas has had a goal of integrating behavioral health services between SUD and mental health services for quite some time. Roadblocks experienced toward this goal mainly revolve around sustainability, outdated state policy and systems, and the complications regarding holistic services versus clinical or medical services.

Co-occurring MH and SUD

Per Arkansas State Licensure Standards, all treatment providers are required to provide consulting services regarding individuals with cooccurring mental health and substance use disorders.

Any current Medicaid provider with Arkansas credentialed or Arkansas licensed mental health staff with documented training of substance use disorder treatment can provide co-occurring treatment services. The Division of Medical Services also recently added Licensed Alcohol and Drug Abuse Counselors (LADAC) as approved rendering providers for billing Medicaid-reimbursable treatment services if the individual has a primary diagnosis of a substance use disorder.

People experiencing homelessness

Using alternative federal funding, OSAMH provides funding to support recovery residences according to the National Alliance of Recovery Residences (NARR) standards through Arkansas Alliance of Recovery Residences (AARR). AARR provides indigent funding to residences which are NARR-certified to provide housing to individuals who would otherwise be experiencing homelessness. As stated above, OSAMH also has oversight of the PATH (Projects for Assistance in Transition from Homelessness). Arkansas' PATH providers cover 26 of our 75 counties (35%) to ensure that people who are homeless or chronically unhoused and have a mental health diagnosis can obtain access to housing in a timely manner.

Tuberculosis

Although Arkansas is not an HIV or Tuberculosis-mandated state, as defined by the CDC, Per Arkansas State Licensure Standards, SUD treatment providers within the state are required to adopt policies and procedures which provide mandatory education and voluntary testing for tuberculosis, sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV) to individuals receiving services.

Individuals in need of substance use primary prevention

The Arkansas Prevention System currently consists of thirteen (13) Regional Prevention Providers (RPP). These providers target substance misuse populations through the following methods:

- Information dissemination: Public Awareness campaigns through media, brochures, and presentations to educate about substance abuse risks and consequences.
- Education Programs: School-based curriculum on refusal skills, decision making, stress management, and healthy coping mechanisms.
- Social Norms Marketing: Marketing that promotes positive social norms regarding substance use through community campaigns.
- Prosocial alternative activities: Promotion of alternative pro-social activities that include community service, recreational/social activities (community, school, faith-based, and cultural events) and adult/youth leadership activities.

The system serves as a statewide infrastructure for providing resource support necessary to promote capacity development at the local level. The RPP represents OSAMH, Office of Substance Abuse and Mental Health in forming a statewide infrastructure to develop knowledge, skills, and abilities within communities to address substance abuse prevention needs. The RPP representatives must make progress towards the accomplishment of the state prevention plan and support the requirements of the federal funding source.

The primary focus for the RPP will be to build substance abuse prevention capacity within their respective region and specific communities to address local issues as they relate to SAMHSA's National Outcome Measure (NOMs). The secondary focus will be to assist with the statewide prevention infrastructure for promoting and increasing behavioral health prevention across the lifespan through implementation of the Strategic Prevention Framework (SPF) strategy.

The SPF's Guiding Principles of Sustainability and Cultural Competence are at the center of the five (5) guiding prevention efforts that include 1. Assessment; 2. Capacity; 3. Planning; 4. Implementation; and 5. Evaluation.

Expansion of services to incorporate persons with disabilities

Arkansas has been working hard to collaborate with our sister Division, the Division of Developmental Disabilities (DDS), to create and implement a new provider type to better coordinate services for people with behavioral health and co-occurring developmental or intellectual deficits. The provider type, Community Support Systems Provider (CSSP), has an array of home and community-based services. Agencies with CSSP certifications can select the intensity level of services they wish to provide, from basic, paraprofessional driven services (Basic) to medium level services, paraprofessional and professional driven services or team-based services like Family Centered Treatment (Intensive), or facility-based services with daily rates for clinic-based services.

Legislation was passed in 2019 for OSAMH to develop a program to better support those in need of mental health and substance use disorder (MH/SUD) issues who are deaf or hard of hearing. The program has a three-pronged approach. First to improve access to culturally and linguistically appropriate MH/SUD services by hiring an individual with appropriate background and experience to implement and oversee the program; second by providing education and training to providers of these services who may encounter this population; and third, to develop an Advisory Committee to make recommendations and provide advice on implementing this program.

Mental Health and Substance Use Disorder involved with juvenile and/or adult justice system

In Arkansas attorneys or judges who suspect that someone, an adult or a youth, charged with a crime may not be mentally fit to stand trial may request a mental evaluation by a trained forensic psychologist or psychiatrist to advise whether fitness to proceed in the justice system exists. A significant number of Forensic Evaluations are ordered annually (almost 3,000 in 2023). If the

outcome of the evaluation is that the individual is fit, they proceed through the justice system. If the outcome is not fit due to "mental disease or defect," the individual may be ordered to participate in the Forensic Outpatient Restoration Program (FORP). Any individual in the FORP program may also receive a mental health evaluation and mental health services, including medication management. The FORP program covers a specific curriculum taught by 12 contracted Community Mental Health Center staff either in a community setting or a jail setting. If the individual can pass a competency-based test, they are considered "restored" and can continue in the justice system. For people unable to be restored in a community or jail setting, they may be referred to the Arkansas State Hospital (ASH) for more intensive restoration services and psychiatric care. If restoration takes place or a conditional release is ordered per Act 911 (of 1989), the individual can be released from ASH with intensive monitoring by a licensed social worker for up to five (5) years. The social worker ensures the individual is compliant with the terms of the conditional release, which may include outpatient psychiatric care.

Other specialized substance use treatment services include the statewide court-ordered program known as ACT 10, which provides treatment to individuals involuntarily mandated by the court through a citizen petition. The professional development of its grant-funded providers is prioritized by OASMH by offering training on the latest evidence-based counseling techniques and treatment interventions.

Mental Health and Substance Use Disorder in rural or frontier areas

The OSAMH currently is in the early stage of implementing a pilot Hub and Spoke Model of service delivery for substance use disorder treatment services as well as recovery support services, with vendors serving as the "hubs" and their providers who deliver direct services being the "spokes." This model represents a path to service delivery for the more rural areas of the State of Arkansas. With a limited number of treatment and recovery support services locations available within the state, this model aims to distribute services more evenly. However, some discomfort associated with change has been experienced both from DHS vendors and providers of direct services due to the system alteration in progress. This discomfort has led to the underperformance of Hub and Spoke implementation, therefore constituting the inability to address underserved communities such as those who inject drugs and individuals experiencing homelessness.

Rural services are covered by mental health programs and services using our Community Mental Health Center (CMHC) and Therapeutic Counseling Services contracts. Through these contracts, OSAMH ensures coverage is available across all 75 counties for people who may not have current health insurance coverage for treatment services. Arkansas currently has over 200 different agencies providing Medicaid-funded mental health services.

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.**

How Needs Assessments are Conducted

The Arkansas Department of Human Services makes use of public resources available to our state through federal and state research agencies. Several needs assessments have been conducted as well as evaluations for programs relating to mental health and substance use disorders. These assessments and evaluations were done by reputable third-party agencies and are posted on our website for public viewing. Our contracted evaluators gather quantitative and qualitative data from DHS, our direct services sub recipients, and publicly available data sources.

Quantitative data includes unduplicated individuals receiving mental health, prevention, treatment, and recovery services based on demographics, geographic information, services delivered, and background relating to services delivered, among other pieces. Qualitative data evaluations include interviews with program participants, program staff, and program managers to gain a full view of the effectiveness and efficiency of certain direct services programs.

Adequacy Determination

The US Census Bureau reports that as of July 1, 2024, the population of Arkansas is estimated to be 3,088,354. Of the 75 counties in Arkansas, 55 are considered rural. Children in Arkansas, those 18 years of age and younger, comprise 23% of the state's population while those 65 and older comprise 18% of the population. The male to female ratio is fairly even in Arkansas with females having a slightly higher ratio at 50.7%. The most predominant race and ethnic origins in the state are individuals who are white and Non-Hispanic or Latino (70.2%). The largest minority group are individuals who are African American (15.6%). Arkansans aged 25 and older who were high school graduate or higher represented 88.6% of the population and 25.1% had received a bachelor's degree or higher. The median household income was $58,773 from 2019-2023. The percentage of Arkansans living below the poverty level was 15.7%.[1]

America's Health Ranking 2024 Annual Report ranks Arkansas 48th in the United States in overall health. Some reported strengths include a low prevalence of excessive drinking (14.5% compared to 16.7% nationwide. Drug deaths (deaths per 100,000) are lower in Arkansas (20.3%) compared with the US overall (32.4%). Challenges Arkansans can work on include high prevalence of cigarette smoking. Arkansas ranks 47th in e-cigarette usage among adults 18 and older (10.6% compared to 7.7% nationwide). While smoking tobacco among adults 18 and older ranks 39th in the nation (15% compared to 12.2% nationwide). Arkansas ranks 34th in the nation for nonmedical drug use in adults 18 and older (18.2% compared to 17.6%).[2]

The 2024 Arkansas State Epidemiological Outcomes Workgroup's Annual Profile of Substance Use[3] provides a report on substance abuse in Arkansas prepared by the University of Arkansas for Medical Sciences (UAMS) for the Arkansas Department of Human Services (DHS), Office of Substance Abuse and Mental Health (OSAMH) to provide a demographic breakdown of population, education, economy and health to highlight the past successes and areas of focus for the future. Findings from this report, summarized as follows, are used to target areas of improvement:

Mental Health

- Overall, the percentage of Arkansas respondents who experienced at least one adverse childhood experience was higher than the national average.
- More than one in three (34.7%) students reported having felt nervous most or all the time during the past 30 days in 2021-2023
- Almost two in five (39.4%) students reported feeling restless most or all the time during the past 30 days in 2021-2023.
- About one in five (19.5%) students reported feeling depressed in the past 30 days in 2021-2023.
- Almost one in four (23.3%) students reported feeling hopeless in the past 30 days in 2021-2023.
- Arkansas adults were consistently more likely than U.S. adults to report poor mental health in the prior 14 days across time. The prevalence of a major depressive disorder was consistently higher among Arkansas adults relative to their U.S. counterparts.

Tobacco and E-Cigarette Usage

- Overall, the rates of current cigarette and smokeless tobacco use among Arkansas youth sharply declined from 2018 to 2023. Compared to the U.S., cigarette use was higher for

Arkansas students in grade 12, lower for grade 10, and similar for grade 8. Smokeless tobacco prevalence was higher for Arkansas students in grade12, similar for grade 10, but lower in grade 8 relative to the U.S. students.

- The age at which Arkansas youth start using E-cigarette products continues to decrease.
- Lifetime and current use of any electronic vaping product increased as grade increased among Arkansas students in 2023, with more than 1 in 4 Arkansas seniors reporting lifetime use, although use was lower among Arkansas students relative to their U.S. counterparts.
- In 2022, a higher percentage of Arkansas adults currently smoked cigarettes relative to U.S. adults; however, current cigarette use continued to decline over time among Arkansas adults.
- In 2023, the prevalence of lifetime and current vaping of flavoring only among Arkansas students was lower than that among their US counterparts.
- In 2023, a smaller proportion of Arkansans in grades 8, 10, and 12 report lifetime or current use of nicotine-containing electronic vaping products relative to their U.S. counterparts.

Alcohol Use

- The prevalence of lifetime and current alcohol use decreased slightly from 2022 to 2023 among Arkansas students and was lower relative to their U.S. counterparts.
- The overall rate of current alcohol, alcopop use, or binge drinking among Arkansas youth has generally been declining since 2016; however, current alcohol use, alcopop use, or binge drinking has remained essentially the same or increased among Arkansas 6th grade students.
- Since 2016, current alcohol use among Arkansas adults has remained stable and lower than national rates.
- Among Arkansas college students, past 30-day alcohol use generally increased from 2021 to 2023 while past 30-day frequent use increased among Arkansas college students aged 25-29 years.
- The prevalence of binge drinking generally decreased slightly until 2021 then rose again in 2022. Arkansas rates were only slightly lower relative to U.S. adults in 2022. In contrast, heavy drinking prevalence increased very slightly since 2016 among both Arkansas and U.S. adults and was very slightly higher among Arkansas relative to U.S. adults in 2022.

Marijuana Use

- Lifetime and current marijuana vaping among Arkansas youth was lower than among their U.S counterparts in 2023.
- Rates of lifetime and current marijuana use has generally declined since 2016 among Arkansas youth and prevalence is lower than among their U.S. counterparts.
- In 2021-2022, the prevalence of past-year and past-month marijuana use remained lower among Arkansas adults relative to their U.S. counterparts.
- Past 30-day marijuana use generally increased from 2021 to 2023 among Arkansas college students.

Prescription Drug & Heroin Use

- Rates of lifetime prescription drug and heroin use among Arkansas students have generally declined in the state since 2016; however, among 6th grade students, lifetime use of prescription drugs or heroin increased. Lifetime prevalence of heroin use was lower among Arkansas 8th and 10th grade students relative to their U.S. counterparts.
- In 2023, Arkansas seniors reported lower prevalence of lifetime prescription drug misuse but a similar prevalence of lifetime heroin use, relative to their U.S. counterparts.

Other Drug Use

- In 2023, female students again reported higher usage rates across substances than male students for alcohol, marijuana, nicotine e-cigarette, CBD product and nonmedical prescription

drug use.

- Inhalants, the most used substance, remained stable from 2015 to 2019, then decreased in 2020 and remained stable from 2020 to 2023.
- Over-the-counter drug use decreased from 2015 to 2023.
- Cocaine, methamphetamine, or hallucinogens, already low, decreased from 2015 to 2020, before stabilizing or decreasing slightly from 2020 to 2023.
- Other chemical products like bath salts generally increased from 2015 to 2022, but no data are available for 2023.
- Current inhalant or hallucinogen use remained relatively stable over time, while use of other chemical products like bath salts increased such that use was slightly higher than inhalant use in 2021 and 2022. Current over-the-counter drug, cocaine, and methamphetamine use showed decreasing trends from 2015 to 2023.
- The 2021-2022 prevalence of past-year prescription opioid misuse was higher among Arkansas adults relative to their U.S. counterparts, with the higher rate driven by higher prevalence of use among adults 26+ years.
- In 2021-2022, Arkansas and U.S. adults had a similar prevalence of past-year heroin use.
- In 2021-2022, past-year opioid (prescription opioid OR heroin) use among Arkansas adults was higher than that among the U.S. population, with Arkansas again ranking 7th in the nation for opioid misuse.
- Although prescription opioid dispensing rates have generally decreased from 2013 to 2022, Arkansas continued to rank 2nd in the county, with a dispensing rate was almost double that of the U.S. in 2022.
- Prescription opioid misuse and opiate use were generally very low in 2021-2023 among Arkansas college students.
- Past-year cocaine use was less prevalent among Arkansas than U.S. adults in 2021-2022. Cocaine use was higher among Arkansas and U.S. adults aged 18-25 than 26+ years
- Past-year methamphetamine use prevalence was almost double that nationally among Arkansas adults in 2021-2022. Arkansas ranked 3rd in the U.S. in prevalence of methamphetamine use.
- Past 30-day prevalence of cocaine or methamphetamine use was generally very low from 2021 to 2023 among Arkansas college students.
- Past 30-day use of sedatives generally increased from 2021 to 2023 among Arkansas college students aged 26-29, but not 18-25, years.
- Past 30-day use of steroids, inhalants, hallucinogens, or designer drugs was generally very low among Arkansas college students in 2021-2023.
- Past 30-day use of illegal drugs was generally very low among Arkansas college students in 2021-2023, although use increased slightly from 2021 to 2023.
- Past-month use of any illicit drug (including marijuana) among Arkansas adults was less prevalent than among U.S. adults in 2021-2022; however, past-month use of any illicit drug other than marijuana was similar among Arkansas and U.S. adults in 2021-2022.

Arkansas currently has an inability to effectively collect consistent data relating to mental health services delivery in a centralized location, although data collected by SAMHA and other groups is often accessed. For instance, SAMHSA Behavioral Health Barometer, Region 6, Volume 7 [4] from 2021-2022 data indicates:

- For youth aged 12 – 17 years:

a. 19% of Arkansas youth reported a Major Depressive Episode in the past year. The national average is 20.2%.
b. 14% of Arkansas youth reported suicidal thoughts and behaviors in the past year. The national average is 13.2%.
c. 6.8% of Arkansas youth reported making a suicide plan in the last year. The national average is 6.3%.
d. 4.1% of Arkansas youth reported a suicide attempt in the last year. The national average is 3.7%.

- For adults 18 and older
  a. 23.9% of Arkansas adults reported a mental illness in the last year. The national average is 23.1%.
  b. 6.3% of Arkansas adults reporting a Serious Mental Illness in the last year. The national average is 5.9%.
  c. 8.2% of Arkansas adults reported a Major Depressive Episode in the past year. The national average is 8.6%.
  d. 5.2% of Arkansas adults reported serous suicidal thoughts in the past year. The national average is 5%.
  e. 1.5% of Arkansas adults reported making a suicide plan in the last year. The national average is 1.4%.
  f. 0.8% of Arkansas adults reported a suicide attempt last year. The national average is 0.7%

1 U.S. Census Bureau. Quick Facts: Arkansas. https://www.census.gov/quickfacts/AR. Accessed June 25, 2025.
2 American's Health Rankings. 2022 Annual Report, State Summary: Arkansas. americashealthrankings.org Accessed June 25, 2025.
3 Bollinger M, Thostenson J, Porter A, Oliveto AH (2022) Arkansas State Epidemiological Outcomes Workgroup: 2020 Arkansas State Epidemiological Profile of Substance Use. Little Rock: Psychiatric Research Institute, University of Arkansas for Medical Sciences. SEOW-2024-Annual-Profiles-Report-Part-1.pdf , Accessed June 26, 2025.
4 Behavioral Health Barometer: Region 6, Volume 7, Accessed July 12, 2025.

Challenges in Delivery

OSAMH has identified the following unmet service needs and/or gaps in the behavioral health system:

- **Centralized Data Hub:** Data is siloed throughout multiple agencies, and data privacy concerns restrict access, limiting the creation of data linkages and predictive data models. A needs assessment conducted by Arkansas Foundation for Medical Care recommended the creation of a centralized data hub that can work to develop MOUs with the differing agencies to bring data together so that these important data linkages and predictive data models can be created.

- **Housing and Transportation:** Transportation issues were discussed in all aspects of programming. Interviews with stakeholders, those with lived experience with substance use disorder and mental health challenges, and individuals receiving services expressed frustration in the lack of reliable transportation to training events, programming, medical appointments, and daily errands in their areas. An evaluation completed by the University of Wyoming Survey and Analysis Center recommended

promotion of state policies with the intention to invest in both transportation solutions, such as ride-sharing partnerships, or mobile units by promoting the rurality of areas in need of service, and housing initiatives for individuals involved in the justice system.

Consumers, mental health providers, and substance use disorder treatment providers report a lack of consistent and stable housing options, especially for those in transition periods. For instance, youth transitioning out of the foster care system, adults in need of Supported Housing secondary to mental health or substance use disorders, and adults leaving intensive hospital-based services but returning to a community setting are some of Arkansas' most critical needs, and they are priority populations.

- **Provider and Stakeholder Engagement:** Regular conversations are ongoing with providers and stakeholders to discuss their perception of identified gaps and potential solutions to assist with assurances of service availability during the meantime. Gaps in services are now being addressed through pilot programs, contracts, or are under development for future projects. Unmet service needs specific to provider and stakeholder engagement include communication barriers with populations that need behavioral health services.

- **Policy Creation/Update:** Policy updates, service definition revisions, and rate reviews need to be made to the current mental health system of care. Policy updates are complicated due to having four independent managed care organizations (MCO), all with unique policy, procedures, and leadership. Aligning across the MCOs while incorporating federal and state Medicaid requirements is difficult to coordinate. Organizational issues, such as data management and patient tracking, add to these challenges, underscoring the need for more robust infrastructure, and policy changes to support these programs effectively. Additionally, contract language and scopes of work need to be modernized to more robustly outline data requirements and demonstrate quality outcomes.

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.**

Areas of need identified through needs assessments and evaluation of Arkansas' behavioral health services systems are broken into several main categories of need below.

- **Continuum of Care:** Many of our shortcomings related to delivering direct services involve lack of awareness of the programs or the variety of services being offered by OSAMH-funded initiatives. We have found that this is due to lack of education, participation, connection between providers, and connection from provider to individual. Populations of individuals affected by this gap include individuals in need of substance use primary prevention, youth, children with SED, adults with SMI, including older adults, individuals with ESMI, individuals in need behavioral health crisis services, persons with disabilities, pregnant women and women with dependent children, individuals with mental health and substance use disorders involved in the adult or juvenile justice systems, and persons in need of recovery support services for

substance use disorder. Several identified needs within our state include the need for residential SUD treatment for youth, an ineffective, outdated, and underutilized crisis system, coordinated specialty care clinics for the ESMI population, a stressed forensic system experiencing inordinate delays, legislative decisions having resulted in unfunded mandates, the lack of access to transitional services, and excessive out of home placements. Arkansas' continuum also lacks culturally and linguistically appropriate mental health and substance abuse disorder services for the deaf and hard of hearing.

- **Early Detection and Intervention:** In addressing pregnant women and women with dependent children, individuals in need of substance use primary prevention, youth populations, children with SED, persons with ESMI, and individuals in need of behavioral health crisis services, Arkansas has been made aware that the reduction in the incidence of health problems is a major need. Enhancing the overall wellbeing of citizens by preventing the progressions of illnesses and crises will also address individuals in need of substance use primary prevention as well as individuals with mental health and substance use disorders who live in rural areas.
- **Immediate Care and Crisis Intervention:** Our state needs a proven recovery path that encompasses mental health, prevention, treatment, and recovery support services, to function at the highest possible level. This includes the provision of immediate care, crisis intervention, and support for individuals during challenging periods of illness or trauma. Working toward this goal will impact both individuals new in their recovery who require additional recovery support services and pregnant women and women with dependent children, children with SED, adults with SMI, including older adults, individuals with ESMI, individuals in need behavioral health crisis services, and persons with disabilities who have co-occurring mental health needs.
- **Stability and Recovery:** There is a need for stability for individuals with disabling conditions or long-term challenges, as well as those exiting an institution, prison, or jail. This will be beneficial to individuals in need of recovery support services, individuals new in their recovery who require additional recovery support services, individuals with mental health and substance use disorders who live in rural areas, and individuals with mental health and substance use disorders involved in the adult or juvenile justice systems, individuals with ESMI, and adults with SMI. Stability, in this case, refers to not only increased independence and the facilitation of long-term recovery, but also internal and external policy expansion, data improvement, and service model revisions. Some areas of our workforce are underpopulated, such as those focusing on primary prevention and mental health services, while some have an adequate number of individuals who require further training to refine their delivery of services. Supplementary training, following an evaluation in some cases, will focus on molding members of the workforce to deliver services according to best practices as well as learning new skills. OSAMH's collaboration with outside entities like area-specific certification bodies will also be necessary. Another update being made to address workforce shortages is developing a more team-based service approach, with teams of paraprofessionals being led by licensed mental health professionals. Some providers have been reluctant to adopt this sort of model.

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.

- **Continuum of Care:** Based on identified needs within conducted needs assessments, we plan to develop or revise policies and agreements that align with state priorities, that are effective, and that also can reach all priority populations across their lifespan when applicable. Populations addressed under the development or revision of policies and improvements to the continuum of care, for the purposes of implementation, include persons in need of recovery support services for substance use disorder, youth, children with SED, Adults with SMI, including older adults, ESMI, individuals in need behavioral health crisis services, persons with disabilities, and individuals with mental health and substance use disorders involved in the adult or juvenile justice systems. OSAMH will also enhance training practices to address challenges arising within certain priority populations by offering additional training to the new and existing OSAMH-contracted providers to enhance the quality of services being provided. Regional prevention providers' mission to engage youth in meaningful activities, offering ways to benefit others and their communities as an alternative to participation in harmful behaviors. Across the behavioral health continuum, the result of these efforts will lead to increased awareness, increased early identification/intervention, and improved referral processes within several youth-related areas, treatment and recovery areas, and mental health areas. Currently, an evaluation is being completed of OSAMH's crisis system, following an agreement solicitation. The evaluation is working to outline how implementation of this program will look, beginning with seven (7) crisis hubs across the State of Arkansas. Implementation of evidence-based services such as Family Centered Treatment is currently in its pilot phase to address lack of transitional services or diversion from out of home placements. Developing new training for all evaluators, revision of contracts to be awarded to a single entity to oversee and manage all contractors, entity will also develop a single database to store information related to forensic evaluations, increase the number of people incompetent to stand trial, cut down on the number that are being inappropriately referred. In addressing Arkansas' stressed forensic system, a single hub entity will create a central database for forensic evaluations and oversee completion of those evaluations, ensuring quality is present. OSAMH's forensic team will partner with the Community Mental Health Centers to move toward reducing the number of months necessary to graduate from the forensic program as well as reducing the number of individuals that are being inappropriately referred to the program. In conjunction with these efforts, OSAMH has goals of developing a training for all forensic evaluators, decrease the wait time for a quality forensic evaluation to be completed, and reduce the number of initial competency evaluation with findings of "no mental disease or defect." OSAMH now employs a staff member with significant and long-term knowledge about the deaf and hard of hearing community who will begin work on identifying solutions to meet the gaps in mental health and substance use disorder treatment services.

- **Early Detection and Intervention:** The promotion of health behaviors, early detection, and intervention includes addressing the restricted access to prevention services available to the pregnant women and women with dependent children, individuals in need of substance use primary prevention, youth, ESMI, SED, SMI, and individuals with mental health and substance use disorders who live in rural areas populations. To confront this area of need, we will target regional populations with different levels of substance misuse risk, provide opioid-reversal medications to reach underserved and rural communities, and distribution data for saturation by county to focus efforts on underserved areas. Additionally, some of our continuum focus areas – like crisis services for children- will also target earlier detection, accurate diagnostic exams, family education, and crisis intervention to prevent out of home placements.
- **Immediate Care and Crisis Intervention:** Our state will continue to provide treatment to individuals who require additional recovery support services and pregnant women and women with dependent children, especially focusing on those who are uninsured or under insured and the expansion of programs through workforce development. We will also provide a statewide system for medical detoxification and plan to provide a secure facility for involuntary commitment through court-ordered SUD treatment.
- **Stability and Recovery:** Arkansas will provide an Outpatient Methadone Program, which will address individuals in need of recovery support services, SED and SMI populations, and individuals new in their recovery who require additional recovery support services. Further implementation of the Hub and Spoke Model of direct service delivery will support individuals with mental health and substance use disorders who live in rural areas, and individuals with mental health and substance use disorders involved in the adult or juvenile justice systems. Finally, we plan to evaluate and modify the Arkansas License Standards as well as the Arkansas Peer Recovery Program to further transform to meet the changing federal landscape and identified needs within our state. In the mental health side, new services are being implemented for SMI adults and SED youth transitioning from higher levels of care to promote more home and community-based services.

D. 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 Areas and Performance Indicators:

Priority Area #1	**Lack of Continuum of Care Across Programs**
Priority Type(s)	**SUT, SUR, MHS, ESMI, BHCS**
Required Population(s)	**SMI, SED, ESMI, BHCS, PWIS, PRSUD, other - Developmentally/Intellectually disabled**
Goal of Priority Area	**To ensure current and new programs are filling identified service gaps for all priority populations.**
Objective	**To ensure long-term sustainable funding for all new programs; to use needs assessment data to identify existing service gaps, and to ensure evidenced-based services are available to Arkansans.**
Strategies to attain the objective	**1. Increase the number of medical withdrawal management services, and numbers accessing services.** **2.** **3. Move from pilot phase of Family Centered Treatment to a permanent part of service array available to children and youth enrolled in a PASSE.** **4.** **5. Increase the number of certified Infant Mental Health providers and increase the number of young children served.** **6.**

	7. **Move from pilot phase of Prevention, Stabilization, and Support Project for Young Children, Comprehensive Screening and Assessment for Children, and Families in Transition to a permanent part of service array.** 8. 9. **Develop and begin implementation phase of new crisis hub pilot program.** 10. 11. **Open new residential program tailored for youth with substance use disorders.** 12. 13. **Increase the number of providers of Community Support Services, geared toward providing integrated care for those with behavioral health and developmental/intellectual delays.** 14. 15. **Increase options for transitional care across settings and populations.**
-	
Indicator 1	**Increase the number of state-funded providers of medical withdrawal management treatment services.**
Baseline Measurement	Develop a baseline measurement of how many persons access state-funded medical withdrawal management services in the previous year. Our current provider is based in far western Arkansas and not centrally located.
First Year Target/Outcome Measurement	Identify and implement contract with at least one new medical withdrawal management treatment provider in a different area of the state and increase medical withdrawal management admissions by 5%.
Second Year Target/Outcome	Evaluate any increases in medical withdrawal management to determine if needs are being met by additional provider in new area of the state. If state needs are still not being met, identify and implement contract with at least one additional new medical detoxification treatment provider in another location in the state and increase admissions by another 5%.
Data Source	Bi-Annual statistical reports, monthly ADMIS data, Division of Provider Services and Quality Assurance (DPSQA) and Office of Substance Abuse and Mental Health (OSAMH) reports, Procurement solicitations, contract documents
Description of Data	Quantitative data includes number of medical withdrawal management referrals and admissions by program. DPSQA report of new or existing providers licensed to provide medical withdrawal management services. OSAMH implemented contracts.

Data Issues/Caveats	Consideration is being given to expanding roles of current Crisis Stabilization Units as they can perform medical withdrawal management services with their current staff array; and they offer short-term observation stays with Medicaid reimbursement for eligible persons.
Indicator 2	**Develop and increase access to community-based, in-home services for children, youth and their caregivers who need the support of intensive interventions to address serious and chronic emotional and behavioral issues using the Family Centered Treatment model.**
Baseline Measurement	As of July 1, 2025 a. Number of counties covered: 69 b. Number of certified staff: 1. 9 Level 1 Certified 2. 4 Supervisors Certified 3. 3 Level 2 staff Certified c. Number of staff undergoing certification: 1. 83 staff enrolled in Level 1 Certification 2. 14 staff enrolled in Supervisor Certification 3. 6 staff enrolled in Level 2 Certification d. Number of agencies enrolled in the Licensing process: 7 e. Number of families referred: 524 f. Number of families enrolled: 247 g. Percentage of families who received 20+ sessions who agree that FCT improved family life 80% h. Number of families with successful reunification: 45 i. Develop a baseline for the number of families completing all 4 Phases of FCT j. Develop a baseline for the number of children not having out-of-home placements for 6 months post-FCT discharge
First Year Target/Outcome Measurement	a. Increase number of counties covered: 75 b. Increase number of certified staff to: 1. 20 Level 1 Certified 2. 6 Supervisors Certified 3. 4 Level 2 staff Certified c. Increase number of staff undergoing certification to: 1. 100 staff enrolled in Level 1 Certification 2. 20 staff enrolled in Supervisor Certification 3. 8 staff enrolled in Level 2 Certification d. Maintain number of agencies enrolled in Licensing process at 7 e. Increase number of families referred annually to: 600 f. Increase number of families enrolled annually to: 350

	g. Increase the percentage of families who received 20+ sessions who agree that FCT improved family life to: 82% h. Increase the number of families with successful reunification to: 120 i. Increase the number of families completing all 4 Phases of FCT by 10%. j. Increase the number of children not having out-of-home placements for 6 months post-FCT discharge by 15%.
Second Year Target/Outcome	a. Number of counties covered is maintained at 75 b. Increase number of certified staff to: 1. 30 Level 1 Certified 2. 8 Supervisors Certified 3. 6 Level 2 staff Certified c. Increase number of staff undergoing certification to: 1. 100 staff enrolled in Level 1 Certification 2. 22 staff enrolled in Supervisor Certification 3. 9 staff enrolled in Level 2 Certification d. Increase the number of agencies enrolled in Licensing process to: 8 e. Increase number of families referred annually to: 600 f. Increase number of families enrolled annually to: 375 g. Increase percentage of families who received 20+ sessions who agree that FCT improved family life to:85% h. Increase the number of families with successful reunification to: 150 i. Increase the number of families completing all 4 Phases of FCT by an additional 10%. j. Increase the number of children not having out-of-home placements for 6 months post-FCT discharge by another 15%.
Data Source	FCT Implementation and Benchmark data, FCT Key Performance Indicators, FCT Satisfaction Surveys
Description of Data	Family Centered Treatment Foundation tracks agencies undergoing licensing, number of staff in training, number of staff certified, number of families referred, number of families enrolled, number completing all 4 phases of treatment. PASSE data will demonstrate the number of members who receive FCT services and the number of members who required out-of-home placement 6 months and 12 months post-FCT services.
Data Issues/Caveats	There will be a delay in obtaining post-discharge data from FCT Foundation, and there are 4 different PASSEs with which to coordinate data sharing.
Indicator 3	**Increase the access and availability of evidence-based screenings and services for young children and their caregivers to promote healthy child development and**

	parenting skills.
Baseline Measurement	As of April 30, 2025 a. Develop baseline measure of the number of clinicians certified by DHS to provide Infant Mental Health Services. b. Develop baseline measures of the number of children who have received Infant Mental Health services from a Medicaid-enrolled behavioral health provider in the last 12 months. c. Develop baseline measures of the number of children who have received Infant Mental Health services specifically from a Specialized Women's Service provider in the last 12 months. d. Develop a baseline measure of the number of children who have received Infant Mental Health services from a Primary Care Physician/Pediatrician's office in the last 12 months. e. Develop a baseline measure of the number of children/families served in the Prevention, Stabilization, and Support Project for Young Children (PSSP-YC) pilot in the last 12 months. f. Develop a baseline measure of the number of children/families served in the Comprehensive Screening and Assessment for Children (CSAC) pilot in the last 12 months. g. Develop a baseline measure of the number of children/families served in the Families in Transition (FiTT) pilot in the last 12 months.
First Year Target/Outcome Measurement	a. Increase the number of clinicians certified by DHS to provide Infant Mental Health Services by 5%. b. Increase the number of children receiving Infant Mental Health services from a Medicaid-enrolled behavioral health provider by 10%. c. Increase the number of children receiving Infant Mental Health services from a Specialized Women's Service provider by 5% d. Increase the number of children receiving Infant Mental Health services from a Primary Care Physician/ Pediatrician's office by 5%. e. Increase the number of children/families served in the Prevention, Stabilization, and Support Project for Young Children (PSSP-YC) program in the last 12 months by 5%. f. Increase the number of children/families served in the Comprehensive Screening and Assessment for Children (CSAC) program in the last 12 months by another 5%. g. Increase the number of children/families served in the Families in Transition (FiTT) program in the last 12 months by 5%.
Second Year Target/Outcome	a. Increase the number of clinicians certified by DHS to provide Infant Mental Health Services by another 5%.

	b. Increase the number of children receiving Infant Mental Health services from a Medicaid-enrolled behavioral health provider by another 5%. c. Increase the number of children receiving Infant Mental Health services from a Specialized Women's Service provider by another 5%. d. Increase the number of children receiving Infant Mental Health services from a Primary Care Physician/ Pediatrician's office by another 5%. e. Increase the number of children/families served in the Prevention, Stabilization, and Support Project for Young Children (PSSP-YC) program in the last 12 months by another 5%. f. Increase the number of children/families served in the Comprehensive Screening and Assessment for Children (CSAC) program in the last 12 months by another 5%. g. Develop baseline measure of the number of children/families served in the Families in Transition (FiTT) program in the last 12 months by another 5%.
Data Source	Specialized Women's Services program reports, ADMIS reports, Medicaid claims data by provider type, Healthy Steps data, Infant Mental Health Certification data, Partners for Inclusive Communities reports.
Description of Data	• Claims data indicating the unique number of young children who receive Infant Mental Health Services and from what provider type. • The number of currently certified Infant Mental Health professionals. • The number of children/families being served in the PSSP-YC program. • The number of children/families being served in the CSAC program. • The number of children/families being served in the FiTT program.
Data Issues/Caveats	Delays in claims data being finalized may be a challenge.
Indicator 4	**Crisis Hub development and implementation for a pilot project in 7 areas of the state.**
Baseline Measurement	Arkansas does not have a coordinated and comprehensive crisis system. Project management services have been contracted to perform development and implementation tasks.
First Year Target/Outcome Measurement	a. Define the model for a centralized system to connect all children, youth, and adults to behavioral health interventions

	and treatment in a timely manner regardless of where they live in the state b. Develop clear guidance as to the role of the central hub in the crisis system including governance and accountability, policies and procedures, data tracking and reporting, and Memoranda of Understandings (MOU) with partner community "spokes" in responding to any adult or youth experiencing a behavioral health crisis anywhere in the five geographic regions of Arkansas c. Build capacity to assess, triage, and stabilize all children, youth, and adults experiencing symptoms of a mental health crisis d. Engage vendors to identify a partner for the central hub provider to meet the state's needs. As part of that engagement, see demonstration of technology capacity to create an integrated crisis hub model for coordinated system of care e. Develop data sharing agreements across behavioral health system entities f. Identify and engage with all collaborating partners and access points into, and service options upon entry into, the crisis system g. Provide technical assistance in the development of business requirements to build technology solutions enabling individual status and overall system capacity updates including bed tracking, on a close to real-time basis, using existing technology where possible h. Develop closed-loop notifications to communicate outcomes of referrals, hand-offs, and track service referrals and follow-ups i. For crisis capacity infrastructure, research best practices and develop process flows, triage and screening tools, staffing roles, and education/training requirements based on where they fit into the crisis hub j. Develop communication policies and call flow guidelines on how the hub will communicate with community "spoke" partners. Include protocols on when mobile crisis teams are to be dispatched and include response time standards k. Engage with 988, 911, and all local phone numbers to transition to one central number l. Determine if hub will include chat, messaging, and email capabilities with people experiencing crisis in addition to phone

Second Year Target/Outcome	a. Targets and Outcomes not met in Year 1 will continue if not completed. In addition, the following will take place in Year 2: b. Develop mobile crisis teams to meet the needs of community providers in responding in real time to behavioral health crises. Included in the model will be training requirements including engagement with different populations experiencing a behavioral health crisis (e.g. IDD, OA with cognitive impairment, other disabilities) c. Develop process to engage acuity-based follow-up behavioral health care after stabilization and assist people in continuing their recovery journey d. Implement change management activities through partnership with the Community Mental Health Centers (CMHCs) throughout the implementation process, acknowledging and addressing concerns, highlighting short term wins, to foster collaboration.
Data Source	OSAMH reports, Project Management implementation and development reports, meetings and identified tasks with assigned persons
Description of Data	Historical data, literature regarding crisis system development reflecting best-practice models and activities, MOUs, and stakeholder meeting minutes, project plans
Data Issues/Caveats	Sustainable funding, stakeholder participation is not guaranteed for a new program, some aspects of comprehensive crisis programs may be a challenge to implement due to continued workforce issues.
Indicator 5	**Implement a Residential Adolescent Substance Use Disorder Program**
Baseline Measurement	Arkansas does not currently have a residential substance use disorder program for adolescents. Using supplemental, short-term sources, building funds were supplied by the Department of Human Services and the unit is expected to open in the Spring of 2026. Policy revisions will be necessary and have begun.
First Year Target/Outcome Measurement	The new program will serve at least 15 youth in the first 6 months of opening.
Second Year Target/Outcome	The program will serve at least 30 youth by July of 2027.
Data Source	Medicaid and PASSE claims data
Description of Data	Quantitative claims data
Data Issues/Caveats	This program requires extensive preparation by the direct service provider, such as getting the unit licensed and prepared for billing third party payors prior to opening. OSAMH will be working to update service definitions in the applicable Medicaid manuals.

Indicator 6	**Increase the number of Community Support Service Provider (CSSP), a provider type created to serve both mental health and developmental/intellectually disabled persons.**
Baseline Measurement	As of July 1, 2025, Arkansas has 72 unique CSSPs with Base, Intensive, or Enhanced levels of certification. Of those 72 unique providers, there are 57 unique Enhanced level certifications with unique addresses.
First Year Target/Outcome Measurement-	CSSPs will increase by 3 new providers.
Second Year Target/Outcome	CSSPs will increase by another 2 new providers.
Data Source	DPSQA reporting
Description of Data	Quantitative data reflecting a count of CSSPs
Data Issues/Caveats	Although providers have been willing to update to a new provider type, many are still exclusively serving either mental health or developmental/intellectually disabled persons.
Indicator 7	**Increase transitional options across settings and populations, especially priority populations.**
Baseline Measurement	Arkansas has very limited transition programs to either divert from higher levels of care, or allow for a step-down option from a higher level of care across most of our identified populations. A baseline will be established identifying the current number of transitional programs, which may include transitional housing, step-down programs, and diversion programs from higher levels of care.
First Year Target/Outcome Measurement	Arkansas will develop and implement at least 2 new transitional programs for priority populations.
Second Year Target/Outcome	Arkansas will develop and implement 2 additional new transitional programs for priority populations.
Data Source	Division of Provider and Quality Assurance reports on provider types, number of programs employed as a Medicaid provider, PASSE claims data, Medicaid service array.
Description of Data	Quantitative data will include an increase in transitional programs and the population(s) impacted.
Data Issues/Caveats	Sustainability of new programs is a challenge due to funding restraints of a neutral budget being required.
Indicator 8	**Implementation of new substance use disorder services to broaden the continuum of treatment services by adding a new level of service, Intensive Outpatient Programs.**
Baseline Measurement	Arkansas currently has no substance use disorder providers (funded by the Block Grant) who offer Intensive Outpatient Program (IOP) services.
First Year Target/Outcome Measurement	Arkansas does have a service definition for Intensive Outpatient, but no providers of the service, the baseline would start with a gap analysis. A review of the current service definition, licensure

	manual requirements, and funding sources would also be completed. A survey of agencies would be needed to ensure interest in providing IOP services.
Second Year Target/Outcome	If the outcome of year 1 exploration indicates that IOP implementation would be favorable, then a workgroup would be put together to develop an implementation framework,
Data Source	OSAMH will work to collect needed information.
Description of Data	Gap analysis, licensure manual reviews and updates, identification of funding streams, survey of agencies to determine interest.
Data Issues/Caveats	Provider interest may remain poor; funding streams may not be available.
Priority Area #2	**Ineffective Early Detection and Intervention**
Priority Type(s)	**SUP, SUT, SUR, MHS, BHCS, ESMI**
Required Population(s)	**PWWDC, PP, PRSUD, SMI, SED, ESMI, BHCS**
Goal of Priority Area	**To reimagine and enhance access to services for populations who could benefit from early detection and intervention services for mental health and substance use disorder programs.**
Objective	**Policy creation as well as increased number of provider training sessions, providers trained, and usage of available services, expansion of existing services.**
Strategies to attain the objective	**Implementation of the Arkansas Prevention Policy Manual, including training of all prevention staff.** **Evaluate impact of outreach and awareness event(s) from year 1 for increased utilization of SWS programs.** **Increase community partners trained in SBIRT.** **Increase in Naloxone distribution, use, and community referrals to grow in the number served, with a targeted focus on underserved and rural areas.** **Increase the number of implemented strategies provided to youth in each regional prevention provider area.** **Expand primary prevention outreach activities.** **Increase the number of certified prevention specialists.** **Recruit new and maintain current Primary Care Clinics using the CoCM.**
Indicator 1	**Establish Primary Prevention service policies that demonstrate alignment with state priorities, are effective, and have ability to reach priority populations across their lifespan**

Baseline Measurement	No primary prevention policy currently exists.
First Year Target/Outcome Measurement	Create a workgroup of individuals, including stakeholders, to review policies from other states and develop a draft of an Arkansas specific Prevention Policy manual that aligns with Arkansas' priority goals and federal priority populations.
Second Year Target/Outcome	Implementation of the Arkansas Prevention Policy Manual, including training of all prevention staff.
Data Source	Meeting minutes from all workgroup sessions reflecting which state policies were reviewed, priorities identified, and stakeholders involved; draft and final versions of policy manual; competency-based training pre- and post-tests for all prevention staff.
Description of Data	A review of states' current prevention policies compared to public health data relating to prevention outcomes.
Data Issues/Caveats	Possible lack of available information
Indicator 2	**Low access of Specialized Women's Services for pregnant women and women with dependent children.**
Baseline Measurement	SFY 2024 (calendar) data indicates 400 number of women utilized Specialized Women's Services (SWS).
First Year Target/Outcome Measurement	Facilitate at least one statewide outreach and awareness event through Regional Prevention Providers that highlights the unique needs of pregnant women and women with dependent children who are at-risk for having SUD and in need of SWS services, as well as informs attendees about SWS programs and locations providing those services.
Second Year Target/Outcome	Evaluate impact of outreach and awareness event(s) from year 1 for increased utilization of SWS programs. If utilization remains at less than 70% of capacity, a workgroup will be created to discuss additional avenues to improve utilization.
Data Source	REDcap, SEOW, and bi-annual reporting, ADMIS
Description of Data	Qualitative reports on progress made with increasing referrals to and utilization of SWS services.
Data Issues/Caveats	Current prevention events and outreach does not include messaging targeting the pregnant and women with dependent children population. Curriculum may need to be revised to address these needs.
Indicator 3	**Increase Naloxone distribution as evidenced by data demonstrating saturation by county to improve efforts on underserved and rural areas.**
Baseline Measurement	Data is currently being tracked by a subrecipient contract and the state's counties are at 81% opioid-reversal medication saturation, but 73% of Arkansas' counties are considered rural.
First Year Target/Outcome Measurement	Increase naloxone distribution by 2.5% within the State of Arkansas, with a focus on underserved and rural areas.
Second Year Target/Outcome	Increase naloxone distribution by another 2.5% within the State of

	Arkansas, with a focus on underserved and rural areas.
Data Source	Nationally recognized nonprofit organization for overdose training and Naloxone distribution data.
Description of Data	The distribution survey will include county and zip code of the requester and amount of Naloxone requested and distributed.
Data Issues/Caveats	Access to online services for requests in rural areas may be limited.
Indicator 4	**Improve community referrals and the referral process within several youth-related areas by providing training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Naloxone distribution and use.**
Baseline Measurement	Develop a baseline gathering SFY2025 data regarding persons served through prevention programs and training interests and needs, including the current number with SBIRT and Naloxone training.
First Year Target/Outcome Measurement	Develop a training plan with existing prevention partners and community providers (including schools, DCFS, etc.) to facilitate trainings or train-the-trainer in SBIRT and Naloxone training by 10% from the baseline. Additionally, work with prevention partners to increase outreach events addressing SUD challenges, and recovery opportunities to increase community referrals by 5% as evidenced by increase in number served.
Second Year Target/Outcome	Increase community partners trained in SBIRT and Naloxone distribution and use by another 5%, as well as increase community referrals by another 5% as evidenced by growth in the number served.
Data Source	REDcap, SEOW, and bi-annual reports.
Description of Data	quantitative data gathered from regional providers from bi-annual reporting and qualitative data on the amount of youth and families referred to services, training interests and needs, numbers trained in SBIRT and Naloxone use and distribution, and the number of new partners undergoing training or train-the-trainer training.
Data Issues/Caveats	Outcomes will depend on funding opportunities for providers to work in conjunction with other systems of care along the continuum which may present a new set of challenges.
Indicator 5	**Increase regional prevention providers' engagement with youth in meaningful activities, offering ways to benefit others and their communities as an alternative to participation in harmful behaviors.**
Baseline Measurement	Six (6) current curriculum models relating to youth are in use and being trained with.
First Year Target/Outcome Measurement	Increase the number of implemented strategies provided to youth by 1-2 new curriculum in each region by the region prevention providers.

Second Year Target/Outcome	Increase the number of implemented strategies provided to youth by an additional 1-2 new curriculum in each regional prevention providers.
Data Source	REDcap database
Description of Data	Tracking the number of strategies and activities for youth reported by the providers.
Data Issues/Caveats	Access to the youth population within education establishments.
Indicator 6	**Target regional prevention populations with different levels of substance misuse risk across Arkansas**
Baseline Measurement	Primary, secondary, and tertiary prevention activities currently exist within Arkansas. Previous years' measure an average of 57,000 individuals served annually.
First Year Target/Outcome Measurement	An expansion of primary prevention outreach activities by 5%.
Second Year Target/Outcome	An expansion of primary prevention outreach activities by an additional 5%.
Data Source	REDcap database
Description of Data	Universal, Selective, and Indicated individuals served through Center for Substance Abuse Prevention (CSAP) strategies
Data Issues/Caveats	Access to transportation for trainings and events, along with access to funding for individuals being trained.
Indicator 7	**Increase the number of new certified prevention specialists trained each year**
Baseline Measurement	Currently Arkansas has 36 certified prevention specialists.
First Year Target/Outcome Measurement	Increase the number of certified prevention specialists by 2 individuals.
Second Year Target/Outcome	Increase the number of certified prevention specialists by an additional 2 individuals.
Data Source	Prevention Professionals of Arkansas Certification Board
Description of Data	Number of Certified prevention specialists
Data Issues/Caveats	Access to funding for certification costs for individuals being trained.
Indicator 8	**To increase the number of unique clinics using the Collaborative Care Model (CoCM).**
Baseline Measurement	As of May 2025, Arkansas has 5 unique clinics using CoCM.
First Year Target/Outcome Measurement	Increase the number of unique clinics using the CoCM by two new clinics.
Second Year Target/Outcome	Increase the number of unique clinics using the CoCM by one additional new clinic.
Data Source	UAMS reporting
Description of Data	Number of clinics who have implemented CoCM, barriers to recruiting new providers identified and being addressed, number

	of clients being served, outcome data as provided by the clinics and entered into the registry.
Data Issues/Caveats	Interest in implementing the CoCM has not been as eager as planned, even after recruiting and training; the model can be implemented in many different types of primary care clinics; time and funding invested in providers who may elect not to implement the model; workforce issues with mental health staff and psychiatric staff are still limited in the state.
Priority Area #3	**Need for Programs to Increase Accessibility for Stability and Recovery Services for at-risk populations**
Priority Type(s)	**SUP, SUT, SUR, MHS, BHCS**
Required Population(s)	**PWWDC, PP, PWID, EIS, PRSUD, SMI, SED, ESMI, other - Developmentally/Intellectually disabled**
Goal of Priority Area	**Increase access to existing services and the creation and implementation of new, sustainable services which provide stability to individuals in need of recovery as well as support the behavioral health workforce shortages in Arkansas.**
Objective	**Through evidence-based training, policy updates, program evaluation, and new program implementation, Arkansas will offer more recovery-based treatment services accessible to identified vulnerable populations and increase participation in treatment services.**
Strategies to attain the objective	**Complete a program review and evaluation for all aspects of the Arkansas Peer Recovery Program and use evaluation results to make program improvements.** **Creation of framework for competency-based peer trainings identified and implement additional training courses for Arkansas peer workers.** **Reduce post-discharge overdose incidents and relapse rates among program participants through the implementation of evidence-based treatment, recovery support services, and regular follow-up data monitoring.** **Implement Family Centered Treatment – Recovery services to reach new clients. Demonstrate improved family functioning, especially pregnant women and women with dependent children while partnering with child-welfare staff and other stakeholders for referrals.** **Recruit 3-4 new participants, either hubs, spokes, or a combination of both, following the engagement, support, and evaluation recovery services activities.** **Modernize current licensure standards and increase those**

	served by state-funded Outpatient Methadone Treatment Provider(s). **Implement new programs/models which use a team-based approach to more effectively utilize current behavioral health workforce.** **Complete rate reviews on all home and community-based services to ensure providers have reasonable reimbursement rates such that new providers of services can be recruited, and existing providers have the support to continue to provide the needed services.**
Indicator 1	**Complete an evaluation of the Arkansas Peer Recovery Program.**
Baseline Measurement	No prior evaluation of the peer program has been conducted within the State of Arkansas.
First Year Target/Outcome Measurement	Completion of an evaluation of Arkansas Peer Recovery Program, including current ethics, curriculum, and supervision, among other things, to create a strategic plan for moving forward. The evaluation process will include an objective agency leading the evaluation, but incorporate a variety of stakeholders from the recovery and peer fields.
Second Year Target/Outcome	Creation of implementation framework using evaluation recommendations, incorporating areas of current strengths, areas for improvement, and any recommended new elements which Arkansas elects to adopt.
Data Source	The final evaluation report
Description of Data	Public health data, qualitative interviews, and quantitative data gathered by Arkansas state agencies from past and current unduplicated data collection platforms, evaluation report and general feedback.
Data Issues/Caveats	Data is not currently housed in a centralized location and must be compiled to gain a full perspective of the program.
Indicator 2	**Provide an expanded array of competency-based trainings to be offered to existing and future peer workforce.**
Baseline Measurement	Current trainings subsequent to the baseline certification trainings include Ethics, Professional Development, and a Justice-Involved specialty training for peer workers.
First Year Target/Outcome Measurement	Based on feedback obtained during the evaluation process completed in year 1, and incorporating stakeholder feedback, training modules which would enhance competency levels of peer workforce will be identified.
Second Year Target/Outcome	Creation of implementation framework for trainings identified in year 1 and work toward incorporating at least 2 additional trainings for Arkansas peer workers in year 2.

Data Source	Public health data, qualitative interviews, and quantitative data gathered by Arkansas state agencies from past and current unduplicated data collection platforms.
Description of Data	Results of the evaluation done of the Arkansas Peer Recovery Program.
Data Issues/Caveats	Data is not currently housed in a centralized location and must be compiled to gain a full perspective of the program. Funding for additional trainings is not yet identified.
Indicator 3	**Substance Use Disorder treatment for involuntary commitment through court-ordered SUD treatment (ACT 10 cases).**
Baseline Measurement	OSAMH currently contracts with one (1) vendor tasked with providing SUD treatment for individuals court-ordered to services. Services rendered are tracked through an internal database (ADMIS). A baseline will be established using historical data.
First Year Target/Outcome Measurement	Monitor and verify that at least one funded provider in the state meets and maintains all required standards for delivering court-ordered substance use disorder treatment services to individuals under involuntary commitment, ensuring ongoing compliance through reviews two times a year.
Second Year Target/Outcome	Monitor and verify that funded provider continues to meet minimum standards for delivering court-ordered substance use disorder treatment services to individual under involuntary commitment, demonstrating a decrease in the number of citations from compliance reviews by 5% from the previous year.
Data Source	Alcohol and Drug Management Information System (ADMIS) data, and site evaluations.
Description of Data	Quantitative data including treatment intake and discharge information, adjudication results. Qualitative data includes site evaluation results.
Data Issues/Caveats	Due to the limited availability of locked SUD treatment, the current provider will need continued monitoring and collaboration to meet the needs and requirements of involuntary commitments.
Indicator 4	**Compliance with full continuum of care for Substance Use Disorder (SUD) treatment across the state with new requirement of post-discharge follow-up reporting.**
Baseline Measurement	Currently, the SUD treatment continuum is implemented through eight (8) subaward grantee providers covering the state. Services rendered through treatment services are being tracked through an internal Alcohol and Drug Monitoring Information System (ADMIS). There is no baseline data on follow-up reports post discharge as this is a new initiative.
First Year Target/Outcome Measurement	Monitor and verify that eight funded providers in the state meet and maintain all required standards for delivering the full continuum of care for substance use disorder treatment services to

	individuals while ensuring ongoing compliance through bi-annual reviews.
Second Year Target/Outcome	Within 24 months, providers funded through this initiative will reduce post-discharge overdose incidents and relapse rates among program participants by 20% through the implementation of evidence-based treatment, recovery support services, and regular follow-up data monitoring. This outcome reflects the long-term effectiveness of structured, evidence-based treatment combined with after treatment recovery support services.
Data Source	ADMIS data and cross-sectional data collection
Description of Data	Quantitative data includes overdose incidents and relapse rates. Qualitative data includes coordination with public health and emergency services data.
Data Issues/Caveats	There is not currently a practice of gathering follow-up reports on clients and how often they have reentered treatment or where they end up post treatment. There are frequently delays in obtaining up-to-date data. Obtaining data from other agencies can be a challenge.
Indicator 5	**Enroll and train providers in the Family Centered Treatment - Recovery (FCT-R) model while also collaborating with the Division of Children and Family Services (DCFS) in identifying and providing in-home services to pregnant women and/or women with dependent children.**
Baseline Measurement	Current services to pregnant women and/or women with dependent children across the state include three providers. The Family Centered Treatment-Recovery (FCT-R) model is a new initiative for Arkansas which will begin in 2026.
First Year Target/Outcome Measurement	Successfully engage and initiate the FCT-R training process for a minimum of three (3) providers in four (4) locations. Establish formal collaboration protocols with DCFS, including referral and communication processes. Begin service delivery, with at least 25 pregnant women and/or women with dependent children receiving in-home, FCT-R-informed services through the trained providers
Second Year Target/Outcome	Monitor the implementation of the FCT-R model by 3 trained providers with ongoing fidelity monitoring. Expand service delivery to reach 50 new clients. Demonstrate improved family functioning, with at least 50% of enrolled participants showing increased treatment engagement, reduced risk of child removal, and improved maternal health outcomes, as measured by client progress data and DCFS coordination reports.
Data Source	Collect baseline data on family engagement, treatment retention, and child welfare involvement, ADMIS, and TEDs.
Description of Data	Qualitative data includes baseline and cross-sectional data on family engagement and child welfare involvement. Quantitative data includes treatment retention data, ADMIS treatment data, and

	TEDs data. There are several family-based assessments, completed in conjunction with the family and their FCT-R practitioner which are required by the Family Centered Treatment Foundation. The Foundation also monitors fidelity measures.
Data Issues/Caveats	Sustainability and workforce development is a primary focus and concern within current ongoing programming. Current cross-section data platforms are not currently being used for DCFS clients and OSAMH.
Indicator 6	**SUD treatment of pregnant women and women with dependent children who are under-insured or uninsured.**
Baseline Measurement	Approximately 400 pregnant women and women with dependent children were served through five subaward grant contracts focused on providing Specialized Women Services (SWS) covering the catchment areas across the state through the 2024 calendar year. OSAMH is not currently gathering data on those that complete the SWS treatment program, only those that are admitted to the program.
First Year Target/Outcome Measurement	Improve data gathering for services rendered through ADMIS to review and analyze women who have completed the full continuum of SWS services to establish a baseline measure. Additionally, to establish 10% of SWS referrals for women and women with dependent children to participate in the FCT-R model of care.
Second Year Target/Outcome	Increase referral rates to 35% of SWS eligible women and women with dependent children to FCTR model of care and demonstrate a 10% increase of treatment completion for pregnant women and women with dependent children from year 1.
Data Source	ADMIS data, and TEDs data
Description of Data	Qualitative review from annual reporting to DHS and quantitative reports pulled from ADMIS of services rendered.
Data Issues/Caveats	Data review through ADMIS is currently not being analyzed to capture a baseline measurement for women who have completed the full continuum of services provided through SWS.
Indicator 7	**Implementation of a Hub and Spoke Model of funding allows OSAMH to more effectively and efficiently manage contracts.**
Baseline Measurement	Arkansas currently supports 3 hubs through the Hub & Spoke Model through alternative federal funding. These 3 current hubs support 43 agencies (or spokes).
First Year Target/Outcome Measurement	Arkansas will maintain participation of current hubs and spokes through year 1. Engagement, support, and evaluation activities will be organized through year 1 to encourage continued participation and utilization of the model.
Second Year Target/Outcome	Arkansas will recruit 3-4 new participants, either hubs, spokes, or a combination of both, following the engagement, support, and evaluation activities from the previous year.

Data Source	A nationally recognized non-profit recovery advocacy organization will conduct capacity building of RCOs through community listening sessions, evaluation, and training and technical assistance.
Description of Data	Capacity building with Recovery Community Organizations and Group Homes for Persons in Recovery from Substance Use Disorders, as well as community listening sessions conducted through Arkansas Department of Human Services.
Data Issues/Caveats	Current implementation of this model has been an adjustment for both hubs and spokes.
Indicator 8	**Increase use of state-funded services for Outpatient Methadone Treatment Providers**
Baseline Measurement	A baseline will be established using historical data. Arkansas needs to update SUD Treatment licensure standards to match federal regulations for Opioid Treatment Providers.
First Year Target/Outcome Measurement	During Year 1, Arkansas will modernize current licensure standards to match current federal regulations. Upon request, training will be provided to state-funded treatment providers regarding new regulations. Using baseline measurement from prior years, those served by state-funded Outpatient Methadone Treatment Provider(s) will increase by 5%.
Second Year Target/Outcome	During Year 2, those served will increase by another 5%.
Data Source	ADMIS, updated licensure standards, training documents if any training is requested
Description of Data	Quantitative date from ADMIS, updated licensure standards, sign-in sheets and training documents if any training is requested.
Data Issues/Caveats	Updates to licensure standards is an extensive and lengthy process.
Indicator 9	**To address continued work-force limitations, Arkansas will implement team-based treatment models to effectively and efficiently use licensed staff to oversee multi-disciplinary teams, thus increasing access.**
Baseline Measurement	Arkansas implemented one team-based model, Family Centered Treatment services.
First Year Target/Outcome Measurement	Arkansas will implement one additional team-based model in SFY 26.
Second Year Target/Outcome	Arkansas will implement one additional team-based model in SFY 27.
Data Source	OSAMH, PASSEs, Medicaid
Description of Data	Medicaid policy updates to service definitions; Number of team-based approaches implemented; numbers of individuals served from DHS or PASSE data.
Data Issues/Caveats	None identified at this time.
Indicator 10	**Per legislative mandate, payment rate reviews will be**

	completed on all home and community-based services (HCBS) to evaluate and establish fair and competitive rates to ensure adequacy of the number of providers of services for priority and other populations.
Baseline Measurement	Current HSBS rates are established by managed-care organizations but cannot be lower than rates established by Medicaid.
First Year Target/Outcome Measurement	Rate reviews will be completed by December 31, 2025 and those will be published.
Second Year Target/Outcome	Legislation allows for a phased in approach over 2 years if new rates are increased more than 10% from 2025 rates. Additionally, updated rates will only be implemented if DHS receives appropriation and funding.
Data Source	Cost and wage surveys developed in conjunction with a broad variety of HCBS providers; cost and wage surveys completed by a broad variety of HCBS providers and aggregate data as presented by DHS-approved consulting group; large and more targeted provider workgroup meetings throughout the review process to elicit open discussion and transparency from DHS with workgroups being conducted jointly by DHS and DHS-approved consultant group.
Description of Data	Completed rate study documents and outcomes; presentation agenda, slide-decks, and provider feedback.
Data Issues/Caveats	DHS does not currently have legislative assurance that appropriation and additional funding will be available.
Priority Area #4	**Rebalancing of the Forensic System**
Priority Type(s)	**MHS, ESMI**
Required Population(s)	**SMI, ESMI, other – Intellectually/Developmentally Disabled, a small number of SED may also be impacted**
Goal of Priority Area	**The current forensic system will be modernized to ensure timely completion of quality evaluations and restoration processes.**
Objective	**By the end of the grant cycle the Forensic Evaluation process will demonstrate an increase in the number of timely evaluations completed, reduce the number of low-quality evaluations submitted for review, and decrease the number of unnecessary Forensic Evaluation orders being made.**
Strategies to attain the objective	• **A single vendor will oversee managing the entire Forensic Evaluation process.** • • **New vendor will develop and comprehensive database to support tracking, data, and reporting, contract with forensic evaluators, and ensure timeliness of reports per statutory requirements.** •

	• **A new training curriculum is under development to ensure consistent training and increase quality in forensic evaluation reports.** • • **A subject matter expert has been engaged to help guide OSAMH and the vendor in the new processes.**
Indicator 1	**Increase the number of Incompetent to Stand Trial (IST) persons restored to competency in 6 months or less.**
Baseline Measurements	Establish an initial baseline of the number of persons found to be Incompetent to Stand Trial who were restored to competency within 6 months by reviewing data for the previous 12 months.
First Year Target/Outcome Measurement	At least 60% of the total number of IST defendants will be restored within 6 months.
Second Year Target/Outcome	At least 75% of the total number of IST defendants will be restored within 6 months.
Data Source	Forensic database
Description of Data	Data from court orders filed to date of competency re-evaluation with a finding of "competent."
Data Issues/Caveats	Receipt of forensic order may be delayed due to court delays; individuals with intellectual disability or mental defect may impact numbers due to lack of restorability in many with one or both of these conditions; the database is under development as of the writing of this application. As with most new data systems, there are expected problems with implementation.
Indicator 2	**Reduce the number of initial competency evaluations with findings of "no mental disease or defect."**
Baseline Measurement	Establish a baseline of the number of persons with initial competency evaluations with findings of "no mental disease or defect" by reviewing data for the previous 12 months.
First Year Target/Outcome Measurement	Reduce the number of initial competency evaluations with findings of "no mental disease or defect" by 20%.
Second Year Target/Outcome	Reduce the number of initial competency evaluations with findings of "no mental disease or defect" by an additional 15%.
Data Source	Administrative Office of the Court records, forensic database
Description of Data	The number of evaluations indicating "no mental disease or defect"
Data Issues/Caveats	Significant culture shift is needed in our judicial/legal system to recognize the undue burden and significant delays unnecessary orders for forensic evaluations cause to the forensic system process and timeline.
Indicator 3	**Increase the use of civil commitment procedures and admissions to mental health diversion courts.**

Baseline Measurement	Establish a baseline of the number of diversions to civil commitment and mental health courts.
First Year Target/Outcome Measurement	In lieu of forensic evaluations, increase diversion to civil commitment by 10% and increase diversion to mental health courts by 20%.
Second Year Target/Outcome	In lieu of forensic evaluations, increase diversion to civil commitment by another 10% and increase diversion to mental health courts by another 15%.
Data Source	Administrative Office of the Court records, forensic database
Description of Data	Records indicating diversion to civil commitments and mental health courts
Data Issues/Caveats	Data limitations of outside resources and obtaining records consistently from all sources.
Indicator 4	**Decrease the wait time for a quality forensic evaluation to be completed.**
Baseline Measurement	Establish a baseline of the number of quality evaluations completed in the statutory time frame of 60 days by reviewing data for the previous 12 months.
First Year Target/Outcome Measurement	Increase the number of quality evaluations completed in the statutory time frame of 60 days by 20%.
Second Year Target/Outcome	Increase the number of quality evaluations completed in the statutory time frame of 60 days by another 10%.
Data Source	Administrative Office of the Court records, forensic database
Description of Data	Timelines regarding completion of evaluations as compared to date of the original order.
Data Issues/Caveats	The database is under development as of the writing of this application. As with most new data systems, there are expected problems with implementation. A new vendor will also begin oversight of Forensic Evaluation process by January 1, 2026, and challenges are expected with any new program.

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 Table 2a

Planning Period	From: 7/1/2025 To: 6/30/2027					
State Identifier:	Arkansas					
Activity	A. MHBG	B. Medicaid (Federal, State & Local)	C. Other Federal Funds (TANF, CDC, CMS, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	G. Bipartisan Safer Community Act Funds
1. EB Practices for ESMI (10%)	$1,840,980	0	0	0	0	N/A
2. State Hospital	0	$6,100,000	$2,200,000	$90,000,000	$1,050,000	N/A
3. Other Psychiatric Inpatient Care	0	0	0	0	0	N/A
4. Other 24-hour care (residential)	0	0	0	0	0	N/A
5. Ambulatory/Community non-24 hour care	$14,427,435	$51,000,000	$5,807,000	$42,318,000	0	N/A
6. Crisis Set aside (5%)	$920,465	0	$10,000,000	$5,000,000	0	N/A
7. Administration*	$11,220,464	0	0	0	0	N/A
8. Total	**$28,409,294**	**$ 57,100,000.00**	**$ 18,007,000.00**	**$137,318,000.00**	**$ 1,050,000.00**	**N/A**

* Administration combines 5% for DHS, plus funds for NAMI and Planning Council
Based on new award $9,204,647
2 years = $18,409,294

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	$ 15,210,398.96	$10,236,169	$2,500,000	$5,578,755	$0	$4,800,000
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$ 2,338,784.00	$ 0	$0	$0	$0	$0
b. All Other	$ 12,871,614.96	$10,236,169	$2,500,000	$5,578,755	$0	$4,800,000
2. Recovery Support Services[c]	$ 2,700,000.00	$0	$0	$0	$0	$0
3. Primary Prevention[d]	$ 8,600,000.00	$0	$0	$0	$0	$0
4. Early Intervention Services for HIV[e]	$ 0	$0	$0	$0	$0	$0
5. Tuberculosis	$ 0	$0	$0	$0	$0	$0
6. Other Capacity Building/ Systems Development[f]	$ 0	$0	$0	$0	$0	$0
7. Administration[g]	$ 1,443,053.90	$0	$0	$0	$0	$0
8. **Total**	$ 27,953,452.86	$10,236,169	$2,500,000	$5,578,755	$0	$4,800,000

[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.

Click or tap here to enter text.

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	N/A	143
2. Women with Dependent Children	N/A	427**
3. Individuals with a co-occurring M/SUD	487,800*	217,900 *
4. Persons who inject drugs	N/A	276
5. Persons experiencing homelessness	N/A	1,373

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.

- For sections without data entered: Currently, the Office of Substance Abuse and Mental Health does not have a way to account for individuals within these specific populations needing SUD treatment services.
- *Sources include the following: Number 3: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023*. Numbers 1, 4, & 5: For persons who received treatment services, an inhouse database system (ADMIS) used by grant funded providers, collect client level data upon intake are referred to as "treatment episodes." The numbers were aggregated out of 15,000 client treatment episodes for services in 2024.

**Estimating the population numerical amount from publication percentages of populations aged 18 or older in Arkansas - Total Arkansas population (2023 estimate): 3,050,000 Estimated % aged 18 or older: 77% (based on U.S. Census data)*

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: 7/1/2025	To: 6/30/2027	
State Identifier:	Arkansas		
MHBG Funded Services		MHBG Funds Budget for this Item for 2 years	
1. Services for Adults			
1a. EBP for Adults		$	-
1b. Crisis Services for Adults		$	460,232.00
1c. CSC/ESMI programs for Adults		$	1,564,790.00
1d. Other outpatient/ambulatory services for adults		$	12,263,321.00
1e. * Other Direct Services for Adults		$	-
2. Subtotal of Services for Adults		**$**	**14,288,343.00**
3. Services for Children			
3a. EBP for Children		$	-
3b. Crisis Services for Children		$	460,232.00
3c. CSC/ESMI program for Children		$	276,140.00
3d. Other outpatient/ambulatory services for Children			$2,164,116
3e. *Other Direct Services for Children		$	-
4. Subtotal of Services for Children		**$**	**2,900,488.00**
5. Other Capacity Building/System Development		**$**	**300,000.00**
6. Adminstrative Costs		**$**	**920,463.00**
7. *Any Other Costs		**$**	**-**
8. Total MHBG Allocation		**$**	**18,409,294.00**

2026 award is $9,204,647
$7,213,718 left to divide after pull outs

[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.

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	$ 7,605,199.48	$ 7,605,199.48
2. Recovery Support Services[b]	$ 1,350,000.00	$ 1,350,000.00
3. Substance Use Primary Prevention[c]	$ 4,300,000.00	$ 4,300,000.00
4. Early Intervention Services for HIV[d]	$	$
5. Tuberculosis Services	$	$
6. Other Capacity Building/Systems Development[e]	$	$
7. Administration[f]	$ 721,526.95	$ 721,526.95
8. **Total**	$ 13,976,726.43	$ 13,976,726.43

[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. [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	$243,214	$243,214
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$243,214**	**$243,214**
2. Education	Universal	$2,375,262	$2,375,262
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$2,375,262**	**$2,375,262**
3. Alternatives	Universal	$207,667.32	$207,667.32
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$207,667.32**	**$207,667.32**
4. Problem Identification and Referral	Universal	$37,417	$37,417
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$37,417**	**$37,417**
5. Community-Based Processes	Universal	$628,613	$628,613
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$628,613**	**$628,613**
6. Environmental	Universal	$200,183	$200,183
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$
	Total	**$200,183**	**$200,183**
7. Section 1926 (Synar) - Tobacco	Universal	$49,391	$49,391
	Selective	$	$
	Indicated	$	$
	Unspecified	$	$

	Total	**$49,391**	**$49,391**
Universal Indirect	$3,741,749.32	$3,741,749.32	
Selective	$	$	
Indicated	$	$	
Unspecified	$	$	
Total	**$3,741,749.32**	**$3,741,749.32**	
9. Total Prevention Budget		**$4,041,388.00**	**$**
Total Award[a]		**$**	**$**
Planned Primary Prevention Percentage		**100%**	**%**

[a] Total SUPTRS BG Award is populated from Plan Table 4b – Planned SUPTRS BG Award Budget by Federal Fiscal Year

[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	$3,741,749.32	$3,741,749.32
3. Selective	$	$
4. Indicated	$	$
5. Column Total	$	$
6. **Total SUPTRS Award**	**$3,741,749.32**	**$3,741,749.32**
7. **Planned Primary Prevention Percentage**	**100%**	**100%**

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	X	
Tobacco/Nicotine-Containing Products	X	
Cannabis/Cannabinoids	X	
Prescription Medications	X	
Cocaine	X	
Heroin	X	
Inhalants	X	
Methamphetamine	X	
Fentanyl or Other Synthetic Opioids	X	
Other	X	
Priority Populations	**A. SUPTRS BG**	
Students in College	X	
Military Families	X	
American Indian/Alaska Native	X	
African American	X	
Hispanic	X	
Persons Experiencing Homelessness	X	
Native Hawaiian/Pacific Islander	X	
Asian	X	
Rural	X	

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

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[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 Table 6a		
Planning Period	From: 7/1/2025	To: 6/30/2027
State Identifier:	Arkansas	
Activity	A. MHBG	B. BSCA
1. Information Systems	0	0
2. Infrastructure Support	0	0
3. Partnerships, Community Outreach, and Needs Assessments	$210,000	0
4. Planning Council Actitivities	$90,000	0
5. Quality Assurance and Improvement	0	0
6. Research and Evaluation	0	0
7. Training and Education	0	0
8. Total	**$ 300,000.00**	**0**

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.

[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			289,500.00			289,500.00
2.Infrastructure Support						
a.Single State Agency (SSA)						
b.All other subrecipient contracts	300,000.00			300,000.00		
3.Partnerships, community outreach, and needs assessment						
a.Single State Agency (SSA)						
b.All other subrecipient contracts	7,231,076.48	400,000.00	3,613,469.71	7,231,076.48	400,000.00	3,613,469.71
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		140,000.00	191,166.00		140,000.00	191,166.00
6.Research and Evaluation						
a.Single State Agency (SSA)						
b.All other subrecipient contracts		15,000.00	99,500.00		15,000.00	99,500.00
7.Training and Education						
a.Single State Agency (SSA)						
b.All other subrecipient contracts	74,123.00	795,000.00	106,364.29	74,123.00	795,000.00	106,364.29
8. Total	**$7,605,199.48**	**$1,350,000.00**	**$4,300,000.00**	**$7,605,199.48**	**$1,350,000.00**	**$4,300,000.00**

$13,255,199.48 for direct services only (1 year)
+ $1,443,053.90 for admin/tech 10%
$14,698,253.38 total (DOES NOT INCLUDE SALARIES)
- $14,430,539.00 award amount
= $267,714.38 over award amount

E. 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 need**. States

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[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

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

In 2014 Arkansas became a Medicaid Expansion state. As a result, more individuals in the state became eligible for state assistance with obtaining health insurance coverage via Qualified Health Plans (QHP). Our expansion program, ARHOME's (Arkansas Health and Opportunities for Me) January 2023 enrollment was 342,267. Arkansas completed the "unwinding" of the pandemic-era continuous coverage by the fall of 2023 and enrollment in ARHOME dropped to 239,990 by October of 2024. As of May 2025, enrollment sits at 191,821. This amounts to about 16% of the state's total Medicaid population (1,172,934), according to the SFY 2024 Medicaid Program Overview. This overview also indicates that about 30% of Arkansans are covered by some form of Medicaid. (https://humanservices.arkansas.gov/wp-content/uploads/Medicaid_Program_Overview_SFY2024.pdf). On 5/24/25, www.Healthinsurance.org reports that during the height of the pandemic, Arkansas total Medicaid roles surpassed one million people, including those on Affordable Care Act expansion policies. As of October of 2024, 821,017 Arkansans were covered by Medicaid/CHIP, an increase of over 47% since 2013.

Another crucial part of our transformation includes the development of managed-care like organizations, called PASSEs (Provider-led Arkansas Shared Savings Entities). PASSEs serve Medicaid clients with complex behavioral health (BH) (i.e. SED/SMI) and/or intellectual and/or developmental disabilities (I/DD). Individuals are attributed to a PASSE by way of assessing functional deficit areas. These individuals typically are not responding well to simple outpatient services and need intensive home and community-based services, or services in residential/institutional settings. Those indicating the highest degree of deficits are assigned to one of four PASSEs. PASSEs are responsible for ensuring care coordination services, in addition to all services in the current state plan, the 1915(i)-state plan amendments, and the 1915(c) CES waiver. These include behavioral health services, and/or I/DD waiver services related to intellectual/developmental disabilities, along with primary care needs. The goal of our managed care system is for the full array of services to be made available to all PASSE

members to allow them to remain in the community, and outside of an institutional setting.

In 2022 Arkansas created a new provider type which was intended to boost community-based services for our BH, I/DD, and dually diagnosed populations. Our Community Support System Provider (CSSP) type focuses on home and community-based services. CSSP providers can choose different levels of service provision including Base, Intensive, and Enhanced. All services at the Base and Intensive Levels are home and community-based services, with a heavy infusion of primarily paraprofessional-delivered services. Providers at the Enhanced level also provide facility-based services, but they are also able to provide all services at the Intensive and Base levels as well. Intensive and Enhanced-level CSSPs may also provide mental health professional services found in the Counseling and Crisis Service Manual.

Arkansas uses State General Revenue funding to ensure rapid access to light-touch counseling services for anyone without health insurance coverage under the Therapeutic Counseling Services contract. This contract, with 22 different providers covering all 75 counties, requires contractors to assist people seeking services with getting enrolled for health insurance coverage if they are eligible and requires services be offered within seven calendar days of request.

a. Adults with serious mental illness

SMI adults can access services in a variety of ways. Approximately 191,800 adults are currently served through Qualified Health Plans which provide a full continuum of behavioral health services, including Substance Use/Misuse Disorder services. Approximately 27,735 adults are receiving behavioral health services in the PASSE system at this time.

Adults in Arkansas are deemed Seriously Mentally Ill (SMI) via an Independent Assessment (IA), which evaluates functional deficits, and are typically assigned to a managed-care-like organization, our Provider-led Arkansas Shared Savings Entities (PASSE). The PASSEs are responsible for coverage of all behavioral health and medical services which are medically necessary. The PASSE's main goal is to provide all necessary home and community-based services to increase the likelihood of success of the person being able to remain outside of an institutional setting.

Approximately 80% of our Mental Health Block Grant (MHBG) provides support for SMI adults. MHBG funds are braided with State General Revenue (SGR) and Social Service Block Grant funds to support Community Mental Health Center (CMHC) contracts to ensure those without insurance coverage for necessary services have access to those services. Arkansas contracts with 12 Community Mental Health Services to ensure state-wide coverage and access in all 75 counties. Additionally, there are approximately 100 other agencies which accept a combination of Medicaid, Medicare and private insurance reimbursement for mental health services.

Arkansas is in the process of planning as we develop pilot projects in 7 areas of the state for a robust crisis system using a hub and spoke model. Consultants are currently evaluating our available crisis services to better evaluate our needs. Our crisis system will serve all populations, including our SMI adults.

b. Adults with SMI and a co-occurring I/DD

Adults deemed dually diagnosed with an SMI and I/DD diagnosis via an Independent Assessment (IA), which evaluates for functional deficits, are typically assigned to our PASSEs. The PASSEs are responsible for coverage of all behavioral health and medical services which are medically necessary. Arkansas' new provider type, Client and Community Support Providers, was specifically designed to ensure appropriate care for individuals who may have a serious mental illness and/or an I/DD diagnosis.

DHS recently required the PASSEs to implement "complex care" teams. Individuals referred to the complex care teams are typically co-occurring with BH and I/DD needs. A more sophisticated IA was developed to better evaluate a person with those deficits and needs. A PASSE member may be considered for a complex care referral if they have previously be tiered at a 2 (in need of home and community-based services [HCBS]) or 3 (in need of HCBS and/or residential-type services), and meeting the following; i) member has an intellectual/ developmental disability and a behavioral health need; or, ii) member requires a higher level of care coordination and services due to court involvement; or, iii) a member's behavioral needs are complex.

c. Pregnant women with substance use disorders

Arkansas has 5 catchment areas with 4 funded providers for specialized women's services. These programs can take a pregnant or parenting woman for up to 120 days with 2 dependent children. Exceptions can be made by the substance abuse treatment director for more children or for more time.

d. Women with substance use disorders who have dependent children

Women with substance use disorders with dependent children can be evaluated and placed into specialized women's services with their children.

e. Persons who inject drugs

Persons who inject drugs are priority for admissions into treatment.

f. Persons with substance use disorders who have, or are at risk for, HIV or TB

Arkansas treatment programs refer those providers who are offering medications for opioid use disorder (MOUD) guidance and reimbursement for testing for HIV and TB on intake and as necessary.

g. Persons with substance use disorders in the justice system

Arkansas prisons will continue medications prescribed prior to entrance to the criminal justice system. Arkansas Community Corrections partners offer vivitrol inside the system and works with justice involved persons to continue care after release through Medicaid and partners with grant funding filling gaps if Medicaid is not available.

h. Persons using substances who are at risk for overdose or suicide

Arkansas has a standing order for naloxone; all Opioid Treatment Program clients are offered a prescription for naloxone. Intake assessments for suicide require referrals to clinicians with that expertise.

i. Other adults with substance use disorders

All three forms of MOUD are approved by Arkansas Medicaid.

j. Children and youth with serious emotional disturbances (SED) or substance use disorders

The Community Mental Health Center, Substance Use Treatment, and Therapeutic Counseling Service contracts cover uninsured children/youth with SED or SUD issues. DHS' Monthly Enrollment and Expenditure Report for 2025 indicates that 415,672 children are enrolled in traditional Medicaid (as of April 1, 2025) and approximately 10,200 of them are assigned to a PASSE.

Children and youth with substance use disorders can access buprenorphine and traditional outpatient services for substance use disorder if deemed necessary.

k. Children and youth with SED and a co-occurring I/DD

Children with SED and a co-occurring I/DD diagnosis with high needs and who have undergone an Independent Assessment (IA) and met tier requirements are typically assigned to a PASSE. The PASSEs are responsible for coverage of all behavioral health and medical services which are medically necessary, including needs specific to individuals with I/DD. Arkansas' new provider type, Client and Community Support Providers, was specifically designed to ensure appropriate care for individuals who may have a serious mental illness and I/DD diagnosis.

Children and youth demonstrating more significant needs for services and supports can be referred to a "complex care" team for oversight. Individuals referred to the complex care teams are typically co-occurring with BH and I/DD needs. A more sophisticated IA was developed to better evaluate a person with those deficits and needs. A PASSE member may be considered for a complex care referral if they have previously be tiered at a 2 (in need of home and community-based services [HCBS]) or 3 (in need of HCBS and/or residential-type services), and meeting the following; i) member has an intellectual/developmental disability and a behavioral health need; or, ii) member requires a higher level of care coordination and services due to court involvement; or, iii) a member's behavioral needs are complex.

l. Individuals with co-occurring mental and substance use disorders

As stated above regarding SMI adults, many of our providers also employ clinical level staff with credentials which allow for co-occurring MH/SUD treatment services in one location. If specialty SUD treatment services are needed and there is not a skilled staff person available, a referral may be made to a licensed SUD provider in Arkansas.

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.

The state's Medicaid agency (the Division of Medical Services) is another division of the Arkansas Department of Humans Services, as is the Office of Substance Abuse and Mental Health (OSAMH). OSAMH staff work closely with the Division of Medical Services (DMS) (aka Medicaid) to assure the provision of behavioral health services for Arkansas Medicaid beneficiaries. Medicaid reimburses providers for outpatient mental health and/or substance use disorder treatment services, either directly or through our managed-care providers. While Arkansas Medicaid does not currently cover inpatient substance abuse treatment services, our SUPTRS Block Grant dollars are being used to cover that gap for uninsured persons. Arkansas has applied to Centers for Medicaid/Medicare for an IMD waiver for mental health and substance use services.
Medicaid and OSAMH staff members are currently working on the development of a collaborative care model within primary care clinics to improve access and recently updated Arkansas Medicaid Physician's Manual, which now allows physicians to hire licensed behavioral health professionals to provide services in clinics.

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.

   Youth and adults have access to screening, assessment, and treatment services for co-occurring mental health and substance use disorder treatment.

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

      Not at this time.

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

      N/A

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

      N/A

   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

A) In September 2023, the Office of Substance Abuse and Mental Health (OSAMH) was awarded a five-year SAMHSA grant for Integrating Behavioral Health services. OSAMH partnered with the University of Arkansas for Medical Science (UAMS) to assist with the development and implementation of the Behavioral Health Collaborative Care Model (CoCM) in primary care clinics across Arkansas. UAMS is Arkansas' only academic medical center with 15 primary care clinics across Arkansas, and their Psychiatric Research Institute includes psychiatry residency and fellowship programs. UAMS' CoCM is a specific type of care that integrates behavioral health and primary care to provide treatment for common mental health conditions among patients seeking treatment in primary care clinics. Behavioral health conditions such as depression, anxiety, post-traumatic stress disorder, alcohol and other substance use disorders are among the most common.

B) This grant has also facilitated a close partnership with the Arkansas Behavioral Health Integration Network (ABHIN). ABHIN is a non-profit organization dedicated to increasing integrated healthcare access in Arkansas. They provide site-specific consultations as well as hosting a website with extensive resources for education about and implementation of CoCM. ABHIN has been instrumental in breaking down one of our most difficult barriers, recruiting Psychiatric Consultants trained in the Collaborative Care Model.

C) UAMS Health AR ConnectNow Virtual Clinic is a comprehensive behavioral health treatment program created to provide care to all Arkansans dealing with a variety of mental health issues including anxiety, depression, bipolar disorder and schizophrenia, as well as substance use disorder. The AR ConnectNow call center has an RN triage response available 24/7. They have a virtual clinic with support from clinicians which is operated Monday through Friday from 8 am to 5pm. Their staff can refer to community providers after short-term counseling is complete or if services are not covered by insurance.

Primary care providers have outreach from our partner, the Arkansas Foundation for Medical Care (AFMC) and have provider representatives that provide on-site support and a quarterly information packet. This packet has included information about medications for opioid use disorder, AR Connect Now services, and referral sources.
Several of the state's Community Mental Health Center providers have integrated primary care into behavioral health through CCBHC grant support.

D) Arkansas continues to work on enhancing co-occurring care across various populations and age groups through our Medicaid system by allowing new licensure types to provide services, developing new provider types, recruiting new providers, and providing training in evidence-based models.

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

In Arkansas, adults and children are determined to be SMI or SED through an assessment of functional deficits. Those with the highest degree of deficits are attributed to one of four PASSEs (Provider-led Arkansas Shared Savings Entity), our managed care providers. All people in a PASSE automatically have conflict-free Care

Coordination services to ensure behavioral health needs, substance use disorder or misuse needs, developmental/intellectual disability needs, and/or their primary care needs are met. Each PASSE is funded through Medicaid dollars structured into a per-member-per-month capitated rate. The capitated rate for each person is driven directly by the outcome of the Independent Assessment (IA). The capitated rates are re-evaluated periodically to ensure they are fair and keep pace with costs versus needs.

An individual's needs and service arrays are documented on a Person-Centered Service Plan (PCSP) which is developed in conjunction with the individual, and his/her guardian or caretaker(s) when appropriate. The PCSP also includes goals and objectives identified by the individual. All PCSPs are individualized based upon identified issues and preferences.

Examples of an individualized PCSP may include:

- An adult with co-occurring behavioral health and substance-use disorder treatment needs will be inclusive of services for behavioral health and substance use disorder needs, and
- A child with behavioral health and developmental disabilities may have a plan which reflects behavioral health treatment services, physical therapy, speech therapy, and personal care services.

For people without current health care coverage, our Community Mental Health Center, Therapeutic Counseling, and Substance Use Disorder Treatment contracts require vendors to assist uninsured persons to obtain health insurance coverage if they are eligible. Over the past year, data has indicated that some of our vendors need additional training and guidance on how to assist with obtaining health insurance coverage and we are working to get this gap addressed.

a) Adults with SMI

Arkansas' most complex adults with Medicaid and attributable to our managed care organizations receive care coordination services. Adults with less complex needs are also able to receive care coordination under Therapeutic Counseling Service (funded with state general revenue) contracts and Community Mental Health Center contracts (funded by block grant dollars and state general revenue). For an individual without health insurance coverage, the care coordination/case management must include assistance with obtaining health insurance coverage for which they are eligible.

Arkansas has a small population of individuals in the 1915(i) "spend down" category. Care coordination is performed through a contractor and includes the development of a person-centered service plan to ensure continuity of care across all necessary services.

b) Adults with SUD

Care coordination is provided to adults with substance use disorders by our funded providers that provide the full array of services through their internal structures and memorandums of understanding or subcontracts with providers who offer services not offered by the funded provider. The assessment and coordination of the best level of care for the patient is offered by the funded providers, regardless of insurance status, and is driven by use of American Society of Addiction Medicine (ASAM) for continuum of care criteria.

c) Adults with SMI and I/DD

Just as with highest need SMI adults in item a) above, individuals with Intellectual/Developmental Disabilities (I/DD) are also placed in a PASSE after receiving a functional assessment, called an Independent Assessment (IA). The I/DD functional assessment does differ from the behavioral health version and has a different scoring mechanism. For adults with both SMI and I/DD deficits, a new IA has been developed to confirm the scope of needs and assistance the SMI/I/DD individual would need to remain in a community setting. Just as with the

populations exclusive to a behavioral health or intellectual/ developmental disabilities diagnosis, those with qualifying diagnosis for both would receive care coordination by a person knowledgeable and experienced with dually diagnosed needs.

For SMI and I/DD co-occurring adults with the most significant functional impairments and highest needs, the PASSEs have "complex care" teams who oversee and coordinate services for those with the most challenging combinations of difficult behaviors and intensive needs for assistance and support to maintain community-based care services.

d) Children and youth with SED or SUD

As with the SMI population, our most complex children with Medicaid and attributable to PASSEs receive care coordination services. As with our most complex adults, children can also be referred for "complex care" team oversight.

Children with less complex mental health needs are also able to receive care coordination under Therapeutic Counseling Service (funded with state general revenue) contracts and Community Mental Health Center contracts (funded by block grant dollars and state general revenue).

Children and youth with substance use disorders can access buprenorphine for substance use disorder if deemed necessary.

e) Children and youth with SED and I/DD

Children and youth are determined to be SED and I/DD by way of assessment of functional deficits. Those with the highest degree of deficits are attributed to one of four PASSEs. PASSE members automatically receive care coordination services to ensure behavioral health, substance use disorder, developmental/intellectual disabilities, and/or their primary care needs are met. Individual needs and service arrays are documented on a Person-Centered Service Plan (PCSP) which is developed in conjunction with the individual, and his/her guardian or caretaker(s) when appropriate. The PCSP also includes goals and objectives identified by the individual. All PCSPs are individualized based upon identified issues and preferences. A child with behavioral health needs and developmental disabilities may have a plan which reflects behavioral health treatment services, physical therapy, speech therapy, and personal care services. Additionally, the are eligible for referral to a "complex care" team, which each PASSE is required to implement.

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.

Since 2019, Medicaid has covered an array of mental health and substance abuse treatment services which are provided on an outpatient basis for youth and adults. Arkansas service providers are encouraged to utilize existing evidence-based and age-appropriate assessment tools for all people who seek services. For instance, some providers utilize the American Society of Addiction Medicine (ASAM) criteria, Screening, Brief Intervention, and Referral to Treatment (SBIRT), the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), the Columbia, and the Patient Heath Questionnaire (PHQ-9). The screening and assessment tools drive placement at the appropriate level of care and determine if there is a need for additional referrals. Overall processes are the same for youth and adults, though the assessment tool may vary depending on age.

7. 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.

Service integration and support for co-occurring mental health and intellectually/ developmental disorders begin with an Independent Assessment. Independent Assessments incorporate evidence-based tools, such as a PHQ 9, or Batelle Developmental Inventory and can vary by the age of the individual. Other testing, such as IQ testing, Vineland Adaptive Behavioral Scales, or GAD-7, can help to isolate specific treatment needs. All adult and youth PASSE members regularly receive risk assessments, as well as an evaluation of strengths and assets each time their Person-Centered Service Plan is updated.

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

We are not in need of technical assistance at this time

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
Cognitive Behavioral Therapy for Psychosis Individual Resiliency Therapy Illness Management and Recovery Coordinated Specialty Care (CSC)	12 contracted community Mental Health Centers have at least one staff person trained in one of these models, with state-wide coverage. 1 contracted provider is currently providing CSC services in 2 areas of Arkansas.

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

FY2026	FY 2027
$843,489.00 + $224,000* = $1,067.489 *Unused MHBG from a prior year (approved by FPO for MHBG)	$843,489.00

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.

Medicaid currently covers all individual services which might be provided to a person within the ESMI/FEP population for people enrolled in one of our Provider-led Arkansas Shared Savings Entity (PASSE), managed care organizations. These services would include outpatient individual therapy, pharmacological management, psychoeducation, and supported employment/education; however, only a few Arkansas agencies have elected to provide supported employment/education.

Arkansas' Qualified Health Plans (QHP) cover counseling-level services, including medication management, and residential treatment for substance use/misuse or acute psychiatric hospitalization. All services are currently being billed on a fee-for-service basis.

After many years of work, Arkansas elected to partner with the University of Arkansas for Medical Sciences, Psychiatric Research Institute, to fund a Coordinated Specialty Care (CSC) program in our 2 most populated areas of the state, central and northwest Arkansas.

The Office of Substance Abuse and Mental Health (OSAMH) is discussing the option of team-based billing, or per diem billing for CSC services going forward, as long a fidelity measures are followed.

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

Currently, 10% of the regular Mental Health Block Grant funding (not COVID/ARPA funding) is divided among the 12 Community Mental Health Center (CMHC) contracts. The CMHCs are expected to use this funding for: outreach and education in the community, to support all the services needed if there is no payor source, and to ensure training opportunities for staff providing direct services. In previous years, OSAMH directly sponsored and funded training but has not done so recently. This has created a limited workforce trained to serve the ESMI population, as many of Arkansas' previously trained workforce are now in supervisory positions and only a limited number of trained individuals are still providing direct care services.

To encourage additional CMHC training for this population, OSAMH shares information about training opportunities for FEP/ESMI when possible.

Using American Rescue Plan funding and COVID 19 funding, our CSC clinics provided two free training opportunities between 2024 and 2025 to interested professionals, and developed short videos regarding FEP/ESMI services, with helpful tips for persons who may be experiencing their first episode of psychosis. (https://odysseyclinic.org/video-series/ .) Additional videos have been created to provide information for families or other natural supports.

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.

Arkansas plans to distribute MHBG funding to CSC-based services starting 7/1/2026. Funding will include outreach, treatment services for individuals without health insurance coverage, consultation, and education for professionals.

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

Arkansas' current list for Community Mental Health Centers:

Schizophrenia, Schizophreniform, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder with Psychotic Features, Major Depression with Psychotic Features, and Unspecified Schizophrenia Spectrum Disorder.

Arkansas' CSC clinics include:

Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Bipolar Type, Schizoaffective Disorder, Depressive Type, Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Delusional Disorder, and Brief Psychotic Disorder.

The CSC clinic will take more time to differentiate clients with affective psychosis and direct individuals to appropriate types of treatment services.

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

Moderate estimates show that nearly 750 people per year in Arkansas may experience their first episode of psychosis (incidence rate of 25 per 100,000).

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Through 6/30/2026, Arkansas' Community Mental Health Centers are contractually obligated to perform outreach and FEP/ESMI community education; this includes where to get connected for mental health treatment services for the underserved, uninsured, and all other populations.

Simultaneously, our Coordinated Specialty Care clinics are spearheading additional outreach initiatives that focus on:

- Mental health clinics and medical care clinics where a practitioner may encounter a person or family member of someone meeting FEP/ESMI criteria
- Consultation and continuing education opportunities for medical and mental health professionals.
- Continuing education is not limited to professionals though, particularly with their Annual FEP Conference.

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

We are not in need of technical assistance at this time.

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.

Arkansas Behavioral Health Agencies and Community Support System Providers (also Medicaid providers) are required to be nationally accredited through either: the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), The Council on Quality and Leadership (CQL), or Council on Accreditation (COA). Accredited agencies/providers are required to have a plan of care

Those with Provider-led Shared Saving Entity (PASSE) membership must have a Person-Centered Service Plan (PCSP) created collaboratively by the PASSE Care Coordinator and the beneficiary and their identified support. The PASSE Care Coordinator is required to engage all service providers, the PASSE member, and any caregivers or natural support in the development of the PCSP. Any child/youth 17 or under is required to have caregiver participation in the development of a plan of care.

State contracts specifically related to ensuring behavioral health services for SMI (and SED) people without insurance, or without a payor source for a medically necessary behavioral health services, require the collaborative development of a care plan. Individuals receiving fee-for-service Medicaid funded Counseling Level services require a Primary Care Physician referral for behavioral health services going beyond 12 initial visits and this referral services as the plan of care.

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

All person-centered plans must be developed in collaboration with the person receiving services and their caretakers when appropriate. Plans are written in plain language which can be understood by the person receiving services and are signed

by the individual receiving service and their caretakers. Most agencies include direct quotes from their clients within the document when it comes to identifying specific treatment goals and objectives. Individuals receiving services receive copies of their plans upon request.

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)?

Contracts through Community Mental Health Centers emphasize special attention to individuals who are repeatedly involved in re-occurring crises; CMHCs are to provide individualized supportive services, including the development of a Psychiatric Advance Directive (PAD), once the crisis situation is stabilized or resolved. Guidance on PADs is located on the DHS website.

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

We are not in need of technical assistance at this time.

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? X 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? X Yes ☐ No
3. Does the state have any activities related to this section that you would like to highlight?

Procurement for new contracts typically goes through a competitive bid process following State Procurement Laws. Confidentiality of all client records is a requirement and Business Associate Agreements are implemented when data sharing is planned.

Pursuant to Arkansas Code Annotated 19-11-1010 and 19-11-267, the selected contractor must comply with performance-based standards. The contractor must comply with all statutes, regulations, codes, ordinances, licensure, or certification requirements applicable to the contractor or to the contractor's agents and employees, and to the subject matter of the contract. Failure to comply must be deemed unacceptable performance. The Division of Aging, Adult, and Behavioral Health Service's (DAABHS)/Office of Substance Abuse and Mental Health (OSAMH) continues to update contract performance expectations, deliverables and damages to be imposed for non-compliance to include corrective action plans, financial penalties and up to contract termination. OSAMH is constantly working to develop more robust monitoring and auditing practices related to access and quality of services, as well as to ensure that MHBG and SUPTRS funds are the payor of last resort.

OSAMH uses block grant dollars and/or state general revenue toward contracts providing mental health services to individuals without health insurance coverage for medically necessary services. These contracts provide case management services to ensure enrollment with an insurance carrier where appropriate for people who are eligible for health insurance.

SUPTRS has not implemented billing for this type of case management assistance. However, the process to implement billing for case management may be added to the contract language during the next renewal period.

Current health insurance coverage and concrete knowledge regarding vastly different Medicaid eligibility categories is very complicated. OSAMH is working on educational information and technical guides regarding different types of health insurance coverage and eligibility criteria, which will be distributed to all mental health and substance use providers.

OSAMH will utilize block grant funds in conjunction with Maintenance of Effort toward contracts that provide substance use services to individuals who are underinsured or uninsured and whose medical needs necessitate such services. The determination of eligibility will be made based on the ASAM level of care, ensuring that appropriate modalities are utilized. The funded provider contract will retain language to ensure that health insurance will be applied for during the person-centered planning process. To further assist in program integrity, all block grant providers will be licensed by DHS.

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

Not at this time as our SUPTRS recently underwent a federal audit along with Maintenance of Effort review. If technical assistance needs are identified, we will work through those with federal program staff.

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. X Youth (ages 12-17)
c. X Young adults/college age (ages 18-26)
d. X Adults (ages 27-54)
e. X Older adults (age 55 and above)
f. X 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. X Behavioral Risk Factor Surveillance System (BRFSS)
   d. X Youth Risk Behavior Surveillance System (YRBS)
   e. X Monitoring the Future
   f. ☐ Communities that Care
   g. X State-developed survey instrument
   h. X Other (please list

   Arkansas Prevention Needs Assessment; Arkansas Collegiate Substance Use Assessment

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds?
   a. X No
      i. If yes, (please explain in the box below)
      ii. If no, please explain how SUPTRS BG funds are allocated:

      Allocations are determined using publicly available population and census data

Capacity Building

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

      Arkansas Prevention Certification Board
   b. ☐ No
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?
   a. X Yes (if yes, please describe mechanism used)

   Department of Health Prevention Technology Transfer Center
   b. ☐ No
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

a. X Yes (if yes, please describe mechanism used)
   Strategic Prevention Framework (SPF) Application for Prevention Success Training (SAPST)

b. ☐ No

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years?
   a. X 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. X Yes ☐ No
   b. ☐ Not applicable (no prevention strategic plan)
3. Does your state's prevention strategic plan include the following components? (check all that apply):
   a. X Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
   b. X Timelines
   c. X Roles and responsibilities
   d. X Process indicators
   e. X 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. X Yes ☐ No
   b. Does the composition of the Advisory Council represent the demographics of the State?
      X 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. X Yes ☐ No
   b. If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The Strategic Prevention Framework (SPF) is a planning model promoted by Substance Abuse and Mental Health Services Administration (SAMHSA) to support coordinated, comprehensive, data-driven planning and accountability. Designed to be long-term and evolutionary in nature, the resulting plan should build on knowledge and experience over time, and lead to measurable outcomes and system improvements. There are five (5) steps of the SPF developed to organize prevention strategies and objectives for change: Five Steps: Assessment: What is the problem? Capacity: What do you have to work with? What are your human resources? Planning: What works, and how do you build upon success? Implementation: Put a plan into action - deliver evidence-based interventions as needed. Evaluation: Examine the process and outcomes of interventions. Is it succeeding?

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:
   a. X SSA staff directly implements primary prevention programs and strategies.
   b. X The SSA has statewide contracts (e.g., statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c. X The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d. X The SSA funds regional entities that provide training and technical assistance.
   e. X The SSA funds regional entities to provide prevention services.
   f. ☐ The SSA funds county, city, or tribal governments to provide prevention services.
   g. X The SSA funds community coalitions to provide prevention services.
   h. X The SSA funds individual programs that are not part of a larger community effort.
   i. X 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:

   Clearinghouse; material and media

   b. Education:

   Education for youth and families

   c. Alternatives:
   Youth Leadership Activities
   d. Problem Identification and Referral:
   N/A
   e. Community-Based Processes:
   Coalition building
   f. Environmental:
   Synar; local enforcement of policies and law
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. X 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. X 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. X 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. X Numbers served
   b. X Implementation fidelity
   c. X Participant satisfaction
   d. X Number of evidence-based programs/practices/policies implemented
   e. X Attendance
   f. X 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. X 30-day use of alcohol, tobacco, prescription drugs, etc.
   b. X Heavy alcohol use
      X Binge alcohol use
      X Perception of harm
   c. X Disapproval of use
   d. X 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.

The Office of Substance Abuse and Mental Health (OSAMH) ensures mental health and behavioral health care is available to children, youth, and adults throughout the state, specifically using a combination of Mental Health Block Grant (or Substance Use Prevention, Treatment, and Recovery Services), State General Revenue, and Social Services Block Grant funding. Arkansas' higher needs Medicaid population with mental health needs are attributed to our PASSE (Provider-led Arkansas Shared Savings Entity) program, a managed-care like organization. Arkansas is also a Medicaid Expansion State, with Medicaid paying premiums for those eligible for expansion policies (also known as Qualified Health Plans [QHP]). Arkansas' consistent goal is care in the least restrictive setting, preferably the individual's home community.

Further information on available services and resources:

- Outpatient mental health and substance use disorder services are available through DHS-certified community providers and as such, must comply with State and federal requirements, including least restrictive setting parameters.
- PASSE members, as well as those without insurance or a payor source for needed services, can access a broader scope of rehabilitative services, which include Peer Support, Behavioral Assistant, Child and Youth Support Services, and Adult Life Skills Development.
- Arkansas has developed a new home and community-based provider type called Community Support System Provider. This provider type has allowed providers to serve those with mental health needs and/or developmental/intellectual delays.
- Aftercare Recovery Services provides a transitional service to assist individuals stepping down from a higher level of care and helps to promote and maintain community integration and decrease future hospitalizations.
- Many Counseling Level services are available by telehealth, including crisis services.
- All DHS contractors are grouped by region or county and contractually mandated to have coverage over the entire region to improve accessibility.
- Two Coordinated Specialty Care clinics have been opened to ensure evidence-based services for the ESMI/FEP population.
- Counseling Level services can be obtained from DHS certified Behavioral Health Agencies or Community Support System Providers at the Intensive/Enhanced level as well as Independently Licensed Clinicians who are enrolled as Medicaid providers. Twelve outpatient counseling services are available without any prior authorization requirements, though an extension of benefits can be requested.
- Traditionally licensed mental health professionals (e.g. LCSW, LPC, LAC, LMSW) are able to provide SUD counseling/co-occurring counseling services for people with co-occurring diagnoses if they have documented training in SUD treatment services.
- Masters-level Licensed Alcohol and Drug Abuse Counselors (LADAC) and Provisionally Licensed Master of Social Work clinicians are now able to provide Medicaid-reimbursable Counseling Level services.
- Individuals on QHPs have access to intensive outpatient SUD services, and SUPTRS Block Grant funding covers those without health insurance coverage.
- For several years there has been a gap in SUD treatment for adolescents, but Arkansas is excited to resume this service, which includes an evidence-based model, Six Bridges, being implemented by the University of Arkansas for Medical Sciences.
- In 2023 Arkansas was awarded a five-year SAMHSA grant for Integrating Behavioral Health Services. Grant funds are being used to implement a Collaborative Care Model, integrating behavioral health care managers with 5 primary care clinics currently.
- Arkansas is working to implement a Deaf Mental Health program to oversee service accessibility to people who are deaf/hard of hearing who are in need of mental health and/or substance misuse counseling services. This program will aim to identify strengths and needs regarding Arkansas service provider's understanding of the

unique needs of this population.

- Arkansas is focusing on crisis services for children and their families. We are in the final stages of 4 pilot projects with the goal of all becoming a Medicaid-reimbursable service by 1/1/2026.
- Arkansas is collaborating with a local university to develop and implement a pilot of a hub and spoke crisis model in 5 areas of the state. This plan will work to incorporate our existing Crisis Stabilization Units.
- Arkansas is working to ensure mental health services are available to those undergoing forensic restoration services.
- Arkansas is working to develop and implement a secured restoration unit to decrease wait times in jails.
- DHS is further developing our Independent Assessment tools to streamline the process of entering or maintaining PASSE attribution.
- DHS is working with the SMI Advisory group to develop new services and update existing service definitions in order to enhance the continuum for adult mental health services. One of these new services include provider-owned housing which will serve SMI adults, and transition-aged youth who are SED/SMI.
- Arkansas is undergoing a large rate review process for all home and community-based services. With updated and more competitive rates, we expect providers to be better equipped to provide these services.

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

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

All employment services and most housing services are for our I/DD population, so this is considered a gap for our mental health population. While these have been Medicaid-reimbursable services for several years in Arkansas, there has been limited interest by providers to include this service in their array.

Educational services and Individuals with Disabilities Education Act (IDEA)-related services are a collaborative act with the Department of Education. These services are primarily associated with schools, which is an allowable place of service for Medicaid funded Counseling and Crisis Services and some Home and Community-based services.

DHS has recently been working to implement more team-based services to more efficiently use our Licensed Mental Health Professionals to oversee bachelor's level paraprofessionals as well as working on updating rates to better capture the cost of

providing services with a team approach.

DHS is consistently working to implement evidence-based services, obtain a variety of stake-holder input, and relies on guidance from consultation firms with extensive experience in behavioral health systems. Additionally, DHS is looking ahead to insure stainable funding for existing and new programs.

3. Describe your state's case management services.

Through Care Coordination, PASSEs assist both adults and children in obtaining the best array of services to meet their needs.

Additionally, case management is now a reimbursable service for people accessing Counseling Level services under our state contracts. Case management focuses on ensuring the individual gets access to available and appropriate healthcare insurance, and access to other resources which positively impact the social determinants of health.

As a part of the "Rural Life360 HOME" in the Arkansas Medicaid expansion program, a care coordinator will be assigned to all persons who have a social determinant of health need and a behavioral health need.

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

Community Mental Health Center (CMHC) contractors provide on-demand crisis screenings as the Single-Point of Access (SPOA) for all adults, youth, and children who are uninsured and not a member of a PASSE. The goal of all crisis screenings is to determine the least restrictive and most appropriate setting to meet the mental health needs of the individual, including hospital diversion when it can be done safely.

CMHCs complete crisis screenings for all individuals in custody of the Division of Children and Family Services (DCFS). For the DCFS population specifically, CMHC staff must provide crisis intervention services, in most cases within 2 hours, in a community setting which focuses on stabilization and prevents hospitalization when appropriate. Furthermore, CMHCs must include a safety plan and face-to-face follow-up within 24-48 hours of the initial crisis.

For all those receiving a crisis screening, if the outcome of the crisis screening is not acute hospitalization, other available services may include a Crisis Stabilization Unit admission (currently only for 18 and above), crisis intervention and stabilization services, referral to detoxification program or other appropriate substance use disorder treatment services, and/or immediate or urgent outpatient treatment appointments.

For individuals with re-occurring crises, the CMHC must re-evaluate previous crisis and safety plan(s) and revise or update plans using a collaborative approach to ensure safety and that behavioral health services are at an appropriate level of intensity, with the intent of averting future hospitalizations.

For those individuals screened by CMHCs who are hospitalized, the vast majority are hospitalized in a community hospital and not the Arkansas State Hospital, now almost exclusively a forensic hospital. The CMHCs are financially incentivized to provide utilization management and expeditious aftercare services such that people can be moved to community care as soon as safe and appropriate. The first outpatient appointment after a hospitalization is required to be within seven calendar days of hospital discharge.

Outside of the CMHC contracts, any Medicaid enrolled behavioral health provider is required to ensure crisis services are made available to their clients on a rapid basis. Each PASSE is required to develop, implement, and maintain a 24/7 crisis response for their members. The contact information for each PASSE's crisis response

number is disseminated to all members upon enrollment and then each Care Coordinator includes a crisis plan in the Person-Centered Service Plan.

Arkansas has three Crisis Stabilization Units that are financially supported by a combination of State General Revenue and insurance reimbursement, including Medicaid, since the inception in 2018. Originally, only CMHCs and Crisis Intervention-Trained officers were allowed to refer to the units. As of 2022, referrals are accepted by any entity, including self-and/or family referrals. In the first half of SFY 25, the CSUs admitted 3,918 persons, in total, almost doubling figures from SFY 2022. A new addition to our CSUs is the ability to bill for a less than 24- hour stay. This short-term observation stay was piloted in SFY 2024 and implemented as a Medicaid-reimbursable service July 1, 2025.

Arkansas used COVID Supplemental funding for two Mobile Crisis pilot teams. Some lessons learned and wins are being compiled to share information with our university partner assisting with the development and implementation of our crisis hub pilot project. Even though the teams were not able to be staffed to provide services 24/7, we do believe their efforts were helpful in enhancing collaboration with law enforcement, other community partners, and resulted in diversion from hospitalizations over the course of the pilot project.

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

We are not in need of technical assistance at this time.

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	127,352*	27,735**
2. Children with SED	40,415+	10,208++

*Based on SAMHSA estimates, 2023 https://www.samhsa.gov/data/sites/default/files/reports/rpt53158/adults-with-smi-and-children-with-sed-prevalence-in-2023.pdf

**Based on PASSE data

+ Based on SAMHSA estimates, 2023 https://www.samhsa.gov/data/sites/default/files/reports/rpt53158/adults-with-smi-and-children-with-sed-prevalence-in-2023.pdf

++ Based on PASSE data

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.

Prior to 2017, the determination of whether an adult or child was Seriously Mentally Ill or Seriously Emotionally Disturbed was made by the behavioral health provider. In late 2017, Arkansas implemented a process whereas a 3rd party entity completes a functional assessment, called an Independent Assessment (IA), on Medicaid beneficiaries in need of, or already receiving a high level of behavioral health services. Based on the outcome of this IA, which is updated annually, Medicaid beneficiaries are attributed to a PASSE if they scored as a Tier 2 or Tier 3 category. An outcome of a Tier 2 or 3 indicates a person has complex behavioral healthcare needs, with Tier 2 being fairly moderate needs, and Tier 3 being designated as the highest-needs category. Individuals scoring a Tier 1 are not attributed to a PASSE but are still able to access counseling level behavioral health services funded by Medicaid on a fee-for-service basis. Due to this significant change, the way Arkansas determines a person insured by traditional Medicaid to be SMI or SED is now determined by the outcome of the IA being a Tier 2 or Tier 3.

Recently a Tier 4 category has been developed to capture high needs for those with behavioral health and intellectual/developmental disabilities.

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

We are not in need of technical assistance at this time.

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 X Yes ☐ No

   b. Educational services, including services provided under IDEA X Yes ☐ No

   c. Juvenile justice services X Yes ☐ No

   d. Substance use prevention and SUD treatment services X Yes ☐ No

   e. Health and mental health services X Yes ☐ No

   f. Establishes defined geographic area for the provision of the services of such systems
   XYes ☐ No

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

We are not in need of technical assistance at this time.

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.

Arkansas is primarily a rural state with a few pockets of urban areas focused in central, central west, north-west and north-east areas of the state. Fifty-four of our seventy-five counties are considered to meet the rural definition

identified by the Census Bureau. Several sources report that 41% of Arkansas' 3.011 million population live in rural locations, including about 1.2 million individuals.

In 2018 Arkansas increased the rates for Independently Licensed Mental Health Practitioners who enrolled Medicaid providers, which equalized reimbursement rates for agencies and the independent practitioners. This resulted in a massive increase in the number of providers for professional, Counseling Level services. The independent practitioners alone increased from about 50 on average, to almost 500. While many of these practitioners are in urban hubs, there was also an increase in the number serving rural areas.

During the pandemic, many services became allowable by telehealth, as did follow-up annual Independent Assessments (but not the initial one). Arkansas elected to continue liberal use of services by telemedicine, which is helping those in rural areas, but also assists with overall workforce shortages.

According to the Health Resources and Service Administration, as of January 2025, there are 161 services sites for Federally Qualified Health Clinics and 150 Rural Health Clinics in Arkansas, both of which an also behavioral health services, including telehealth services.

Arkansas is moving toward integrating behavioral health and primary care services. Primary care clinics are now able to employ behavioral health clinicians who can provide services in the same location as the PCP.

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]

Arkansas is a recipient of the Projects for Assistance in Transition from Homelessness (PATH) grant. Our PATH providers cover three different areas of the state, with one being exclusively urban, and in our capital city, and the other two providers cover a combination of urban and rural areas in the southwest and northeast areas of the state.
In addition to PATH, we also have a few agencies with staff trained in SOAR (SSI/SSD Outreach, Access, and Recovery), which increases access to SSI/SSD benefits for eligible citizens experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or co-occurring substance use disorder. While DHS no longer spearheads the SOAR program, we do believe it's an important program.
Our PATH grant manager regularly participates in webinars provided by the Homelessness and Housing Resource Center (HHRC). These training notices, and applicable information, are distributed to our 3 PATH providers.

Arkansas utilized 9817 funding to create some housing opportunities via the creation of a new service called Therapeutic Communities (TC) Level 3. Providers were able to apply for one-time funds to purchase, renovate, or build homes or apartment complexes for supportive living for transition-aged SED youth and SMI adults. This TC Level 3 service adds to our current TC 1 (locked unit/24-hour supervision) and TC 2 (secure/24-hour supervision, but some supervised community outings) service array. The new TC 3 will add another transition program, along with new housing options for the SMI population, with individuals living in provider-owned housing, having access to supported housing and supported employment as appropriate, and include less intensive mental health services by professionals and paraprofessionals. TC3 is a good option for youth aging out of the foster care system or juvenile justice system, but still in need of mental health services and housing options.

a. Describe your state's tailored services to the older adult population with SMI. See SAMHSA's Resources for Older Adults webpage for resources[1]

Older adults with behavioral health issues have access to the same services as the general adult population. Nursing homes have been added as an allowable place of service for Medicaid-funded mental health services. DHS also

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

works with Senior Centers and AAA Centers through agency nurses to assure information regarding accessing mental health and/or substance use services and emergency service numbers, including 988, are distributed to the older adult population.

Specifically for older adults with mental health issues, our Independent Assessment (IA) includes evaluations for functional impairment of Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL), Safety/Self Preservation, Geriatric Depression Scale, along with psychosocial deficits like aggression to self or others (physical and verbal), agitation, withdrawal, anxiety, psychosis, susceptibility to victimization, and difficulty regulating emotions.

The 2024 State Plan on Aging notes that more than 17.5% of Arkansas's total population are aged 65 or older, and of those seniors, 10% live in poverty. In Arkansas, citizens who are aging or have physical disabilities may receive Medicaid State Plan services such as Personal Care or PACE (Program of All-Inclusive Care for the Elderly) to support them to stay in their homes and communities.

Individuals who meet a higher level of care and certain financial eligibility requirements may qualify for the ARChoices in Homecare waiver, a 1915(c) Medicaid waiver program for individuals 65+ and those with physical disabilities ages 21-64 who meet nursing home intermediate level of care. The ARChoices waiver includes an assessment for needed services like Adult Day Health, Respite (In-home and/or facility), Adult Day Services, Attendant Care Services, Environmental Accessibility Adaptations, Home-Delivered Meals, and Personal Emergency Response System.

Arkansans who cannot maintain independently in their homes may also qualify for the AR Living Choices Assisted Living waiver, another 1915(c) Medicaid waiver program, which offers participants 65+ and those with physical disabilities ages 21-64 apartment-style living with supervision and assistance with their activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

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]

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To address the growing range of needs of older citizens and those with disabilities, DHS invests in promotion initiatives that strengthen the HCBS workforce support seniors and those with disabilities within the care continuum. DHS has also committed to rebalancing initiatives that support those who use home and community-based LTSS (Long-Term Supports and Services).

By streamlining pathways to more HCBS services and waiver eligibility for individuals at risk, DHS is targeting those individuals who, with the right services and supports, can successfully remain in their homes and communities.

The Office of Substance Abuse and Mental Health has recently been invited to participate in Multidisciplinary Team meetings set up by our Adult Protective Services staff. The Behavioral Health team members have been asked to be the primary speakers at the late summer meeting. This group includes Adult Protective Services supervisors, several representatives from medical or psychiatric hospitals, local emergency room staff, Medicaid Eligibility staff, local ambulance service staff, and the Office of Public Guardians.

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

We are not in need of technical assistance at this time.

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[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

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.

Arkansas uses a significant amount of State General Revenue and Medicaid dollars to pair with our Block Grant funding to ensure mental health services are available to all persons in need. Though Arkansas underwent a significant transformation in 2017-2018, we continue to evaluate our entire system for needs, with additional gaps, like workforce, being exacerbated by the pandemic.

The Office of Substance Abuse and Mental Health (OSAMH) is continuing to examine the breadth of staff needs with our Office's workforce. Simultaneously, we are developing new services, completing rate reviews on all home and community-based services, updating manuals, revising contracts, and working to fulfill some other legislative mandates.

Providers and other stakeholders have been involved in multiple workgroups through each of these changes. For instance, based on work completed with consultants in conjunction with our Community Mental Health Centers, changes in contract performance indicators and overall requirements have been made. A legislatively driven workgroup was well-attended by a large variety of stakeholders, multiple state agencies, and providers, including those with lived experience, to identify and discuss potential legislation to resolve some of the problems and gaps. Some of the legislative proposals have now progressed into established statue.

As issues and gaps have been identified and discussed, DHS has worked to help all stakeholders understand how different resources and DHS programs/systems work together, where to find information, and who to contact with questions or concerns. Our website has been redesigned to be more user-friendly. Consumer-friendly one-pagers (a simplified version, and a more detailed version) have been developed and placed on our DHS website. These one-pagers provide descriptions, eligibility criteria, and contact information on many DHS programs. Training tools and Power-point slide decks have been widely disseminated to all stake holder groups. The OSAMH Liaison to the Arkansas Behavioral Health Planning and Advisory Council attends every Council meeting, sharing information and updates about policy, programs, and contract deliverables, as well as encouraging questions and feedback. All questions are answered, and any feedback is taken back to OSAMH leadership.

Training for emergency health responders takes place in a few different ways. Since 2018 we have been working to provide some financial assistance and other types of support via our Crisis Stabilization Units, to expand the number of Crisis Intervention Trained (CIT) Law Enforcement Officers. All CIT trainings include guest speakers who are mental health professionals and/or people with lived experience. A variety of grant initiatives were developed using COVID funding to provide Mental Health First Aid to first responders, educators, medical professionals, and the broader public.

The Arkansas Health Department oversees 988 and they, too, have been working to provide a variety of trainings to stakeholder groups, including first responders.

OSAMH has a close working partnership with the University of Arkansas for Medical Sciences (UAMS). Their ARBEST (Arkansas Building Effective Services for Trauma) program is state funded (though not exclusively via DHS) and aims to improve outcomes for traumatized children and families through excellence in clinical care, training, advocacy, and evaluation. UAMS has also partnered with OSAMH to open Coordinated Specialty Care services.

Our future plans will continue to focus on stakeholder involvement and active and diverse workgroups as we revise manuals and policy, develop new services, and review all home and community-based service rates. OSAMH staff continue to work toward ensuring providers, at all levels of service, have the opportunity to obtain training to understand policy and processes, expectations, contract deliverables, and who to contact with questions.

One large project for the next two years will involve a more informed and collaborative process with our forensic program. Arkansas has one state hospital, largely filled with forensic patients who have been court ordered there for restoration. The number of orders for forensic evaluations total about 5,000 per year, which has led to a lengthy waiting list for state hospital admission. Admissions are prioritized based on needs of the individual, such as those who are not responding to psychiatric medication, those who are violent. Silos and unnecessary court orders for forensic evaluations are being eliminated by the development of new processes and information sharing, and cohesive efforts to ensure necessary treatment services are made available to those awaiting completion of restoration services for those in jail. New, more efficient processes and quality assurance efforts are being incorporated into diversion for those who don't need to remain in jail and don't need admission to the State Hospital during the restoration process. Collaborative relations are being developed with judges, attorneys, Sheriffs, and Jail Administrators all over the state to discuss barriers and identify solutions.

> 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 guide Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

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

Arkansas defines telemedicine as below:

Arkansas Medicaid provides payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through tele-medicine if the service provided through telemedicine is comparable to the same service provided in person. Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is

authorized to bill Arkansas Medicaid directly for healthcare services. There is no facility fee for the distant site. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider. Any other originating sites are not eligible to bill a facility fee.

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a client. Telemedicine includes store-and-forward technology and remote client monitoring.

Store-and-forward technology is the transmission of a client's medical information from a healthcare provider at an originating site to a healthcare provider at a distant site. An originating site includes the home of a client. Remote client monitoring means the use of electronic information and communication technology to collect personal health information and medical data from a client at an originating site that is transmitted to a healthcare provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring.

Arkansas Medicaid shall provide payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in person. Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is authorized to bill Arkansas Medicaid directly for healthcare services. There is no facility fee for the distant site. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider. Any other originating sites are not eligible to bill a facility fee.

Coverage and reimbursement for services provided through telemedicine will be on the same basis as for services provided in person. While a distant site facility fee is not authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in person.

Professional Relationship

The distant site healthcare provider will not utilize telemedicine services with a client unless a professional relationship exists between the provider and the client. A professional relationship exists when, at a minimum:

1. The healthcare provider has previously conducted an in-person examination of the client and is available to provide appropriate follow-up care;
2. The healthcare provider personally knows the client and the client's health status through an ongoing relationship and is available to provide follow-up care;
3. The treatment is provided by a healthcare provider in consultation with, or upon referral by, another healthcare provider who has an ongoing professional relationship with the client and who has agreed to supervise the client's treatment including follow-up care;
4. An on-call or cross-coverage arrangement exists with the client's regular treating healthcare provider or another healthcare provider who has established a professional relationship with the client;
5. A relationship exists in other circumstances as defined by the Arkansas State Medical Board (ASMB) or a licensing or certification board for other healthcare providers under the jurisdiction of the appropriate board if the rules are no less restrictive than the rules of the ASMB.
    a. A professional relationship is established if the provider performs a face-to-face examination using real-time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination. (See ASMB Regulation 2.8);

b. If the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations, telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional's licensing board (See ASMB Regulation 38 for these safeguards including the standards of care); or

6. The healthcare professional who is licensed in Arkansas has access to a client's personal health record maintained by a healthcare professional and uses any technology deemed appropriate by the healthcare professional, including the telephone, with a client located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the client.

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

We are not in need of technical assistance at this time.

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 X Yes ☐ No
      ii. Education X Yes ☐ No
      iii. Brief intervention X Yes ☐ No
      iv. Assessment X Yes ☐ No
      v. Withdrawal Management (inpatient/residential) Yes ☐ No
      vi. Outpatient X Yes ☐ No
      vii. Intensive outpatient X Yes ☐ No
      viii. Inpatient/residential X Yes ☐ No
      ix. Aftercare/Continuing Care X Yes ☐No
      x. Recovery support X Yes ☐ No
   b. Services for special populations:
      Prioritized services for veterans? ☐ Yes X No
      Adolescents? X Yes ☐ No
      Older adults? X 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? X 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?

   XYes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? X Yes ☐ No
5. Has your state identified a need for any of the following?
   a. Open assessment and intake scheduling? X Yes ☐ No
   b. Establishment of an electronic system to identify available treatment slots? X Yes ☐ No
   c. Expanded community network for supportive services and healthcare? X Yes ☐ No
   d. Inclusion of recovery support services? X Yes ☐ No
   e. Health navigators to assist clients with community linkages? X Yes ☐ No
   f. Expanded capability for family services, relationship restoration, and custody issues?

      X Yes ☐ No
   g. Providing employment assistance? X Yes ☐ No
   h. Providing transportation to and from services? X Yes ☐ No
   i. Educational assistance? X 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.
   - *Please see attached CAP submitted in 2025*
   - OSAMH will meet the MOE in FY 2026 and FY 2027. Our MOE has been an issue for the last 2 years, and staff did not fully understand the requirements. Prior years have submitted waiver request letters. At a minimum, services for pregnant women and women with children should include the following: Primary medical care, including referral to prenatal care, and day care while women receive services; Primary pediatric care, including child immunization; Gender specific SUD treatment; Therapeutic interventions for children with women in treatment; Case management and transportation.

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? X Yes ☐ No
   b. 14-120 day performance requirement with provision of interim services? X Yes ☐ No
   c. Outreach activities? X Yes ☐ No
   d. Monitoring requirements as outlined in the authorizing statute and implementing

regulation? X 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? X Yes ☐ No
   b. Automatic reminder system associated with 14–120-day performance requirement? X Yes ☐ No
   c. Use of peer recovery supports to maintain contact and support? X Yes ☐ No
   d. Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? ☐ Yes X 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.

Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs.
Alcohol and Drug Abuse Prevention- Rules of Practice and Procedures
Comprehensive Substance Abuse Treatment- Performance -Based Indicators

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. X Yes ☐ No
2. Has your state identified a need for any of the following:
   a. Business agreement/MOU with primary healthcare providers? X Yes ☐ No
   b. Cooperative agreement/MOU with public health entity for testing and treatment? X Yes ☐ No
   c. Established co-located SUD professionals within FQHCs? X 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.

   The Division of Aging, Adult and Behavioral Health Services, Substance Abuse Treatment does not monitor the Tuberculosis *TB).
   Our agency requests updates from the Arkansas Department of Health for this data.

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? X 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 X No
   b. Establishment or expansion of tele-health and social media support services?

X Yes ☐ No

c. Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? ☐ Yes X 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 X 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? X Yes ☐ No
2. Has your state identified a need for any of the following:
   a. Workforce development efforts to expand service access? X Yes ☐ No
   b. Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? X Yes ☐ No
   c. Establish a peer recovery support network to assist in filling the gaps? X Yes ☐ No
   d. Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? ☐ Yes X 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? X Yes ☐ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered care? X 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. X Yes ☐ No
   b. Establish a program to provide trauma-informed care. X 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. X 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 X No
2. Does your state provide any of the following:

a. Notice to Program Beneficiaries? ☐ Yes X No
b. An organized referral system to identify alternative providers? ☐ Yes X No
c. A system to maintain a list of referrals made by religious organizations? Yes X 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? X Yes ☐ No
2. Has your state identified a need for any of the following:
   a. Review and update of screening and assessment instruments? X Yes ☐ No
   b. Review of current levels of care to determine changes or additions? X Yes ☐ No
   c. Identify workforce needs to expand service capabilities? X Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? X Yes ☐ No
2. Has your state identified a need for any of the following:
   a. Training staff and community partners on confidentiality requirements? X Yes ☐ No
   b. Training on responding to requests asking for acknowledgement of the presence of clients? X Yes ☐ No
   c. Updating written procedures which regulate and control access to records? X 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? X 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. X 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

   50% or 8

3. Has your state identified a need for any of the following?
   a. Development of a quality improvement plan? X Yes ☐ No
   b. Establishment of policies and procedures related to independent peer review?

      X Yes ☐ No
   c. Development of long-term planning for service revision and expansion to meet the needs of specific populations? X 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. X Yes ☐ No

b. **If Yes,** please identify the accreditation organization(s)

i. X Commission on the Accreditation of Rehabilitation Facilities

ii. X 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 X 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 X 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 X 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? X Yes ☐ No
   b. Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? X Yes ☐ No
   c. Performance-based accountability? X Yes ☐ No
   d. Data collection and reporting requirements? X 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? X Yes ☐ No
   b. Addition of training sessions designed to increase employee understanding of recovery support services? X Yes ☐ No
   c. Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? X 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? X 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? X Yes ☐ No
   b. SMI Adviser X Yes ☐ No
   c. Addiction TTC? X Yes ☐ No
   d. State Opioid Response Network? X Yes ☐ No
   e. Strategic Prevention Technical Assistance Center (SPTAC) X 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 X No
2. Is your state considering requesting a waiver of any requirements related to:
   a. Intravenous substance use (300x-23) ☐ Yes X 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 X No
   b. Early Intervention Services Regarding HIV ☐ Yes X 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 X No
   b. Professional Development ☐ Yes X No
   c. Coordination of Various Activities and Services ☐ Yes X No

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

https://codeofarrules.arkansas.gov/Rules/Rule?levelType=chapter&titleID=20&chapterID=131&subChapterID=null&partID=null&subPartID=null&sectionID=null

[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).

Arkansas data collection and reporting system include the following:

Mental Health Client Level Data (MH-CLD)
Data is reported monthly from 12 Community Mental Health Centers (CMHC) electronic health records based on guidelines set within the SPQM data dictionary protocols. This report is submitted by the CMHCs through MOVEit secure data transfer software. Arkansas contracts the facilitation of data, data storage, data preparation, and report submission through Deloitte. Arkansas refers to this database as the Arkansas Behavioral Health Analytics (ARBHA) database.
Uniform Reporting System (URS) Report
Data for this report comes from multiple sources. Our Deloitte contractor maintains the ARBHA database of client-level CMHC data. Once a year, Deloitte compiles this data into report format for Arkansas to submit for Annual URS Reporting.

Additional data is collected from Resource Summary (RS) and Special Services Program (SSP) reports compiled and submitted by each of the 12 CMHCs on a yearly basis and is facilitated by the Department of Human Services (DHS) employees. Part of this data also contributes to Annual URS Reporting.

Several URS tables are completed by the OSAMH internal finance team.

The Office of Substance Abuse and Mental Health (OSAMH) compiles data from these sources and submits the Annual URS report.

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.).

Arkansas' main database for CMHC client-level information is the ARBHA and is isolated from other data systems within DHS.

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.)?

OSAMH's internal databases are largely built in isolation from one another, and do not link with other data outside of OSAMH at Arkansas DHS.

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.

While some of Arkansas' ESMI data is gathered on a client-level basis, it is currently done by excel spreadsheets from 13 different entities. This makes it challenging to look for trends of any kind.

Our current crisis data is also done by excel spreadsheets from 12 different entities. As with ESMI data, the challenge is the ability to analyze data and monitor for any trends.

We are in the process of building a new crisis system to be piloted in 5 areas of the state. Part of our expectation is the development of a system to collect data, store data, and share data in a way that makes it easy to review and analyze trends and patterns.

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

Many of Arkansas' current data systems are built in isolation from one another. Current data systems store data securely but are not built to easily process data reports by DHS employees, or to present real-time discrepancies/trends in data.

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

Many of Arkansas' current data systems are built in isolation from one another. Current data systems store data securely but are not built to easily process data reports by DHS employees, or to present real-time discrepancies/trends in data.

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.

Arkansas' main barrier currently is lack of staffing. Currently, there is one clinical director, one data coordinator, and a 0.5 FTE grant/data manager role designated to maintain and facilitate the Mental Health Block Grant and associated services in Arkansas. A secondary barrier would be that our multiple data systems are not integrated.

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

We are not in need of technical assistance at this time.

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.

For many years Arkansas' Community Mental Health Centers (CMHC) were the only behavioral health providers in Arkansas. They were the exclusive safety net for individuals with SMI/SED needs. In more recent years, our Medicaid

provider list expanded significantly and per policy, all Medicaid providers are mandated to ensure crisis services are available for their clients. With the latter expansion, CMHCs were responsible for their own clients, but also for indigent care for people without health insurance coverage for medically necessary services. In 2014, Arkansas became a Medicaid expansion state, and many Arkansans obtained health care coverage expansion policies, further narrowing the scope of care for our CMHCs. An additional layer was added with the implementation of our managed-care programs in 2018-2019, the Provider-led Arkansas Shared Savings Entities (PASSE). Our managed care system was specifically designed to provide care for our high needs behavioral health population and any person on the CES Waiver. Individuals who qualify for Medicaid and need home and community-based services to avoid more restrictive and expensive care are given an Independent Assessment (IA) to evaluate functional deficits. If the IA confirms significant functional deficits, those individuals are assigned to one of four PASSEs. The PASSEs provide care coordination for all members. One of the main functions of all for PASSEs is to ensure access to crisis services for all assigned members. Although PASSEs are not service providers, they all have in-network organizations who are responsible for ensuring all services which are necessary, including crisis services.

Currently, CMHC contracts still require crisis screenings for people without health insurance coverage. Although Medicaid expansion has helped to reduce the number of uninsured individuals over the last 8 years, increases in the need for crisis services were observed during the pandemic. SFY2024 reports indicate that CMHC contractors completed 12,529 crisis screenings on adults and 2,994 crisis screenings on children/youth. This reflects a combination of insured and uninsured individuals and figures that are not unduplicated as some receive more than one crisis screening over the course of a year. Crisis screenings are required on children/youth served regardless of health insurance coverage to decrease unnecessary hospitalizations. CMHCs are contracted to perform crisis screenings in all local jails since those individuals are essentially uninsured. Crisis screening outcomes decide about the need for acute hospitalization or if there are other services to which the individual can be safely diverted. If diversion is appropriate, a written safety plan is developed in conjunction with the individual and caretaker when applicable. In SFY 2024 35% of the total number of adult screenings were performed on persons currently in jail. Out of the 12,529 adult screenings, 7,566 were determined to need acute hospitalization, leaving 4,963 who could be diverted to services in a less restrictive setting.

Another aspect of crisis services in Arkansas is our Crisis Stabilization Units (CSU), which became statutorily required in 2017 (Act 423). Four CSU opened between March of 2018 and October of 2019, with all being in more urban hubs across the state. Unfortunately, the Washington County CSU has not remained open, shutting down permanently in April of 2024.

CSUs are staffed by trained behavioral health professionals, nurses, and paraprofessionals with access to prescribers, as needed. These short-term stay, 16 bed units were originally developed for jail diversion, but have expanded their referral networks to include law enforcement, behavioral health providers, medical hospitals, and self/family referrals. In SFY2024, there were 3,010 individuals diverted from emergency rooms, jails, or acute psychiatric hospitals. Through the first 3 quarters of SFY 25, CSU admissions total 2,294 across three units. In July of 2024, a new Medicaid reimbursable service was developed to provide a funding source for those individuals who did not stay past midnight, thus were ineligible for the per diem rate. This new short-term observation service has demonstrated some improvement in reimbursable services for the CSUs. Some private insurance companies have been reluctant to recognize the benefit of CSUs as a part of their continuum of care and are not reimbursing CSU providers.

The same legislation which led to the implementation of CSUs also required law enforcement agencies across the state to attend Crisis Intervention Training (CIT). Act 423 required all law enforcement agencies employing more than 10 officers to send at least one officer to CIT training. Classes have continued and include 16 hours for new officers, 8 hours for veteran officers, and a 40- hour class for interested officers who volunteer. These classes include training about our CSUs as well as de-escalation and education about mental health issues. The classes consistently tour a CSU in the area and the CSU Unit Directors often spend several hours providing additional training and expertise regarding interactions with individuals with behavioral health issues. While CIT classes are not funded by block grant dollars, the classes are a vital part of our crisis system and Arkansas elected to help support additional CIT classes with COVID funding in SFY 24 and 25. Within the past year the Arkansas Commission on Law Enforcement Standards and Training implemented policy to require all new officers to undergo the 40-hour CIT course.

The Arkansas Department of Health spearheads 988 efforts. Please see the Suicide Prevention section for more information.

Arkansas elected to use COVID Supplemental funding to start two Mobile Crisis pilot projects. These projects were situated in two more populated areas of the state, but not our largest areas. One provider exhausted funding in April of 2024 and additional funding was not available. The second pilot continued until March of 2025 when the federal funding ended. In 2025, the remaining pilot averaged 28 calls a month with an average of 12 dispatches per month. Of note, neither of the pilots was able to be fully staffed to function 24/7 during the entire pilot project. Both were essentially fully staffed during the day and most evenings during the business week, but overnights and weekends went unstaffed despite consistent advertising and attempts to do specialty recruiting. We understand and embrace the importance of true mobile crisis teams, and they will be a critical piece of our new crisis system. We look forward to the mobile units being fully staffed and functioning 24/7/365, with the ability to rapidly deploy people trained in crisis intervention services. Sustainability of this aspect of a robust crisis system is incredibly important to OSAMH as we see its value and possibilities for diversion from higher levels of care.

Arkansas has acute hospitals which accept all ages across the state. Most, but not all are Medicaid providers, and most are in-network with all four PASSEs, along with private insurance plans. One of the most challenging patterns noted during the pandemic was the denial of clients who were considered "too acute for acute care." Hospitals reported significant staffing shortages which hindered their ability to keep higher acuity patients safe. DHS believes there has been some rebound but recognizes that staffing remains a challenge for the acute hospitals, too.

One of our biggest known challenges with our current crisis system is that it is extremely disjointed. There are multiple hotlines, crisis lines, a few warm lines, and now 988 has been added. Resources are not consistent in all areas of the state. People tend to rely on emergency rooms for crisis care. We lack consistent, 24/7/365, mobile crisis teams who can be dispatched quickly and assess, intervene, and/or connect to the right resources rapidly. Our crisis receiving agencies have criteria that are sometimes too restrictive, such as turning down people with court orders for involuntary commitment. Other crisis receiving agencies are not taking the more difficult and/or aggressive individuals, including adults and children.

While there are some barriers, there is evidence of innovation and forward thinking in some areas. For instance, our largest ambulance service in central Arkansas recently hired a Licensed Certified Social Worker to help train and coordinate mental health care and services for their clients. A large hospital system has developed a new leadership role, Vice President of Behavioral Health Services, upon recognizing the high need for behavioral health care based on the number of persons coming to the emergency department who need mental health and/or substance use treatment services. Several law enforcement agencies have hired social workers to be co-responders for those who may be experiencing a behavioral health crisis.

Arkansas is extremely fortunate to have the strong support of our Governor who recognizes the need for a statewide crisis system and the implementation of necessary infrastructure to support long-term stability. With the financial support from the Governor, we are working with a well-known local university to complete additional needs assessments, research crisis response models that will fit best for our state, and engage stakeholders, including those with lived experience, as discussions take place to select and implement a hub and spoke model. Our desire is that our new crisis system will be uniquely tailored to provide crisis services to children and their caregivers, adults, people to various disabilities and co-morbidities, and to keep people in their communities whenever possible. Our system must interface effectively with 988, law enforcement, behavioral health and substance use treatment providers, ambulance services, emergency departments, and the legal system. Our communities must clearly understand that we have a crisis system and know how to access it for themselves or their loved ones. Our crisis system needs to be able to serve those who need immediate intervention and provide evidence-based, caring, and quality services.

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.

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					X	
Someone to respond			X			
Safe place to be				X		

3. Briefly explain your stages of implementation selections here.

Individuals in all areas/counties of the state have access to 988. Some CMHCs have implemented warm lines answered by a peer or paraprofessionals, but all CMHC have crisis lines available 24/7. During the pandemic, Arkansas allowed for crisis screenings/crisis interventions by licensed professionals to be provided by telemedicine. CMHCs have a response time of no more than 15 minutes to directly connect with the individual in crisis. For individuals needing to be evaluated in-person, there is a two-hour time limit to make direct, face-to-face contact. CMHCs cover all 75 counties across the state. All Behavioral Health Agencies and Community Support Service Providers (Medicaid providers) are mandated to have 24/7 emergency response plans.

Arkansas has four challenges with program sustainment for crisis services. There is a high percentage of rural counties. Though broadband access is better than it's ever been, there are still some remote areas without reliable connections. There are individuals without access to technology, and perhaps even a phone in some cases. Lastly, literacy issues, whether related to computer/technology or for written word, are problematic with some areas/some populations.

Arkansas is doing moderately well with responding to crisis needs, though we have plans to update and expand our crisis system, including broad expansion on the aspect of *someone to respond*. CMHC contracts require rapid responses to requests for crisis screenings for their own clients, as well as individuals without insurance, but this does not meet all the needs. True mobile crisis response is a critical need.

Arkansas has partial implementation of somewhere safe to go in time of crisis. Our three CSUs, along with current acute hospitals and emergency rooms have good coverage across our state, even in some of the more rural areas. While we believe emergency rooms are not idea places for behavioral health crises, many emergency departments have begun to employ social workers, and some are starting to employ peers to provide additional support to those in crisis. All emergency rooms have access to contact CMHCs for crisis screenings (for those without health insurance) or PASSE crisis response teams for PASSE members. While we are developing and implementing a more effective crisis system, we must rely on this resource in the meantime.

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.

Arkansas will be relying heavily on the *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* as we develop our state-wide crisis system. A large local university has been contracted with to assist with evaluating our current behavioral health system, and to provide some guidance to building and implementing our new crisis system in 5 pilot areas initially.

Multiple elements of our new crisis system are being pulled from our collection of projects sponsored by our Governor-appointed American Rescue Plan (ARP) Act funding, with efforts documented in the *Roadmap to a Healthier Arkansas*, DHS' 2023 report which summarizes nearly two dozen other ARP-funded initiatives to improve and ultimately complete the public healthcare continuum through 2028. Many of these projects directly touch the development of our new crisis system and many projects began in pilot phases in 2024.

The pilots and initiatives in the *Roadmap* are organized across phases of implementation that build out the care continuum to meet the needs of three core populations who face increased risks for poor health outcomes: 1) Individuals with mental health needs and/or substance use disorders (SUD); 2) individuals who are aging and/or those with physical disabilities, and 3) individuals with intellectual and/or developmental disabilities (IDD). Phase 1 projects in the *Roadmap* lay the foundation to address gaps in home and community-based infrastructure and services available for children and adults, including a lack of transitional housing and the absence of youth residential substance abuse treatment. Below are some of the projects most intimately impacting crisis-related work, which are to be carefully considered and thoughtfully integrated as the crisis continuum model is developed and deployed:

- The Prevention Pilot Programs for Children & Families includes three programs designed to strategically prevent crisis by educating, supporting, and stabilizing children in need. The goals of these programs are to prevent crisis, emphasize early, accurate diagnosis, provide the right care at the right time, prevent institutionalization or higher level of care, support children in their childcare sites, elementary schools, and homes, and educate communities to support children in need.
- The Arkansas State Hospital (ASH) Transition Pilot is working to improve the forensic system, decrease waiting times for evaluations and treatment, streamline the conditional release program, and improve the discharge process for forensic patients leaving the ASH. This initiative will be sustained through engagement with partners in law enforcement, judges, and community organizations that support forensic behavioral health and the implementation of the ARCH demonstration waiver.
- The Community Mental Health Center (CMHC) Review completed in Spring of 2024 assessed the CMHC provider network that provides behavioral health supports to the under- and uninsured across the state, resulting in findings that highlighted how OSAMH could best align the CMHC service delivery model in SFY25-26 with new service ventures supporting people experiencing behavioral health crises in their communities. This revision to the CMHC model will be tied to the launch of the 1115 demonstration waiver in support of people involved with Institutions of Mental Disease (IMD) and justice system accessing behavioral health services through Medicaid.
- The development of missing behavioral health infrastructure throughout the state, via grants to Medicaid HCBS providers charged with building/expanding settings for critical step-down services in the community, including: Community Reintegration for Children; Therapeutic Communities for Adults with Co-occurring IDD and Mental Illness; Youth Substance Abuse Residential Treatment; Adult Substance Abuse Residential Treatment; Youth Supported Housing, for young adults exiting state custody into foster care or from the juvenile justice system; and Adult Supported Housing, for adults with mental illness or substance use disorders.

  The major cornerstone of Phase 2 of the *Roadmap*, is designing and implementing a coordinated crisis continuum to address one of the most significant gaps remaining in Arkansas' healthcare continuum today: a lack of integrated crisis services, especially those offering stabilization/recovery services in the least restrictive setting. The design of the crisis continuum will be community-focused, aligned and integrated with existing Crisis Receiving Entities (CREs) like hospitals, CSUs, and other community partners. DHS and other community stakeholders are seeking to implement a model that incorporates an analysis of the local population and its resources, ensuring that the mobile crisis teams and Crisis Receiving Entities (CREs) located in each geographic area are tailored to the needs of the community. Additionally, the model will be centered on the development of strong partnerships across agencies in DHS, the Department of Education, the Department of Corrections, the Arkansas State Hospital, and other critical stakeholders touching crisis-related systems. The model will be designed so that all Arkansas' children, youth, and adults experiencing symptoms of a behavioral health crisis, regardless of insurance or payer source, have access to community-based crisis response services provided by a coordinated network of first responders, social services professionals, and clinical staff. DHS will utilize one-time funding for the purpose of the development and deployment of a centralized system to connect Arkansas youth and adults to behavioral health intervention and

treatment, build capacity of a behavioral health crisis system, and identify sustainable funding for ongoing crisis services.

The University of Arkansas School of Social Work will oversee the development and deployment of a centralized behavioral health crisis continuum for the State over a two- year period, starting January 1, 2025, through December 31, 2026. The University, in collaboration with DHS, will design a unified crisis hub model for the State which includes the three main elements described below. During the pilot, these services will be available to anyone at any time in the five main geographic areas of Arkansas identified previously. It is expected that the crisis continuum will allow room for unique specializations within each of the 5 identified geographic areas—reflecting a true Arkansas model that addresses the needs, partners, and resources in the community. The model will be flexible enough to capitalize on pre-existing networks and associations with the providers, like hospitals, who already make up the fabric of the area. Crisis services will be available 24 hours a day, 7 days per week, 365 days a year through a "firehouse" model, meaning they are always available in the event they are needed. The shared vision is that the intensity, severity, and duration of behavioral crises experienced by individuals will be reduced.

Crisis services to be developed and deployed include:

1. Centralized crisis line(s), mobile tech, or online chat accepting all calls and dispatching support based on the assessed need of the caller,
2. Mobile crisis teams dispatched to wherever the need is in the community, and
3. Financially sustainable crisis receiving entities (CREs) and stabilization facilities that serve anyone in crisis from any referral sources. It is expected that the model developed will first be piloted in 5 geographically different areas of the state: Jonesboro, Fort Smith, Little Rock, Fayetteville and El Dorado. It is expected that upon completion of the two-year pilot project, DHS will seek to move the model statewide through procurement.

It is expected that the University of Arkansas will:

- Provide project management development and implement of a coordinated crisis continuum and system consisting of a central hub and community spoke model with available community crisis response and stabilization services in coordination with OSAMH/DHS.
- Define the model for a centralized system to connect all children, youth, and adults to behavioral health interventions and treatment in a timely manner regardless of where they live in the state.
    - Develop clear guidance as to the role of the central hub in the crisis system including governance and accountability, policies and procedures, data tracking and reporting, and Memoranda of Understandings (MOU) with partner community "spokes" in responding to any adult or youth experiencing a behavioral health crisis anywhere in the five geographic regions of Arkansas.
    - Build capacity to assess, triage, and stabilize all children, youth, and adults experiencing symptoms of a mental health crisis.
    - Engage vendors to identify a partner for the central hub provider to meet the state's needs. As part of that engagement, see demonstration of technology capacity to create an integrated crisis hub model for coordinated system of care.
    - Develop data sharing agreements across behavioral health system entities.
    - Identify and engage with all collaborating partners and access points into, and service options upon entry into, the crisis system.
- Provide technical assistance in the development of business requirements to build technology solutions enabling individual status and overall system capacity updates including bed tracking, on a close to real-time basis, using existing technology where possible.
    - Develop closed-loop notifications to communicate outcomes of referrals, hand-offs, and track service referrals and follow-ups.
    - For crisis capacity infrastructure, research best practices and develop process flows, triage and screening tools, staffing roles, and education/training requirements based on where they fit into the crisis hub.
    - Develop communication policies and call flow guidelines on how the hub will communicate with community "spoke" partners. Include protocols on when mobile crisis teams are to be dispatched and include response time standards.

    - Engage with 988, 911, and all local #s to transition to one central #
    - Determine if hub will include chat, messaging, and email capabilities with people experiencing crisis in addition to phone
- Develop mobile crisis teams to meet the needs of community providers in responding in real time to behavioral health crises. Included in the model will be training requirements including engagement with different populations experiencing a behavioral health crisis (e.g. IDD, OA with cognitive impairment, other disabilities).
    - Launch behavioral health training to support staff capacity in responding to the behavioral health needs of the identified specialty populations
    - Explore expansion of current peer support program to build capacity to support behavioral health service delivery
- Develop process to engage acuity-based follow-up behavioral health care after stabilization and assist people in continuing their recovery journey
- Implement change management activities through partnership with the Community Mental Health Centers (CMHCs) throughout the implementation process, acknowledging and addressing concerns, highlighting short term wins, to foster collaboration.

Assumptions:

- University of Arkansas will have access to data and reports as part of the analysis for development of the crisis continuum pilot
- Communications between University of Arkansas and DHS will be timely in meeting set timetable
- Community partners will be willing to discuss, develop, and launch the crisis system in meaningful ways
- OSAMH plans to implement strategies to address crisis service needs driven by recovery-oriented, trauma-informed care

Other Project Expectations:

- The designed crisis continuum pilot will include three core elements that operate distinctly:
    - centralized crisis phone line;
    - crisis mobile teams; and
    - financially sustainable crisis receiving entities (including crisis stabilization units).
- All core elements of the crisis continuum will collect data and feed up to University of Arkansas. DHS and UARK will retain intellectual property produced from the work of the pilot. At the end of two years, the data will be analyzed to determine if/how much the model works to shift costs away from ERs, jails, etc.
- The pilot design will focus on SMI/SED, but the crisis continuum model will expand to apply to broader populations, such as children, individuals with IDD, and aging Arkansans that need complex behavioral health care.
- The centralized crisis phone lines/call center must manage intake, screening, triage of mobile team dispatch, and management of community partners.
- The crisis mobile teams must provide response to crises in the field as well as follow-up case management.
- Partners and stakeholders working in crisis in each community will engage with the community to build trust, raise awareness, and provide education on crisis services.
- The crisis stabilization units are facility-based centers that offer crisis stabilization and observation, including access to Medication Assisted Treatment.

Following SAMHSA's guidelines, major elements will be organized as follows:

A. Crisis Call Center

24/7/365 crisis telephone lines operated by trained crisis specialists, integrating national and local emergency lines.

- **24/7 Availability**: The crisis hub must operate 24 hours, 7 days per week, 365 days per year with live, telephone-based services designed to actively engage callers with an array of mental health, substance abuse, and suicidality issues, to establish rapport, to assess risk, to deescalate acute distress, and to effectively connect individuals to the appropriate level of service.
- **Initial Assessments**: Must conduct comprehensive assessments for individuals in crisis, including mental health evaluations, risk assessments, and service needs assessments.
- **Crisis Intervention**: Must provide immediate crisis intervention services, including de-escalation, counseling, and stabilization.
- **Coordination with Emergency Services**: Must work closely with local emergency services, including police, fire departments, and hospitals.
- **Referral Services**: Must establish a robust referral network for ongoing support, including mental health services, substance abuse treatment, housing, and other social and supportive services.
- **Follow-up Services**: Must implement follow-up procedures to ensure clients receive continued support and do not relapse into crisis.
- **Collection of data**: Must collect data for monthly call volume, call sources, proportion of anonymous callers, proportion of callers by age group/adults vs. youth, top 3 reasons for calls, call outcomes (resolved by phone, dispatch initiated, public safety involvement); and proportion of callers by coverage/payor source. Report on findings to DHS quarterly.

B. Mobile Crisis Services

Crisis Services are intensive and time-limited services (24/72 hours) intended to stabilize or prevent a potentially dangerous condition and / or situation. Crisis services should be available to all individuals (adults and children) in Arkansas, irrespective of Medicaid eligibility.

- **Rapid Response**: This service must operate 24 hours a day, 7 days per week, 365 days per year providing active in-person response when dispatched.
- **Team Composition**: Each mobile unit should include qualified mental health professionals, such as licensed counselors, social workers, behavioral health providers and peer support specialists.
- **On-site Interventions**: Deliver on-site crisis intervention services, including assessment, de-escalation, and stabilization.
- **Transportation Services**: Offer transportation for individuals needing immediate relocation to a safe environment or crisis receiving entity.
- **Integration with Crisis Hub**: Ensure seamless integration and communication with the crisis hub for coordinated care.
- **Data Collection and Reporting**: Implement systems for collecting data on service utilization, outcomes, and client satisfaction. Regularly findings to DHS quarterly.

C. Crisis Receiving Entities (CREs)- including Crisis Stabilization Units

Crisis Receiving Entities (CREs) are safe places where a person in crisis may choose to go or be transported to. Once there, an individual will see a clinician, be assessed and a determination will be made on the length of stay needed for the individual in crisis to be stabilized. It is expected that most of the individuals seen will be in a CRE from as little as one hour to as long as 72 hours. Care planning will be done in conjunction with a mental health professional; the crisis care team and on an individual basis.

- Operates under a no wrong door approach
- Offers at least 24 hours of services in a safe place
    - Assessment
    - Peer Support Services
    - Mental health Provider
    - RN or Psych APRN Services
    - MAT

- **Collection of data**: referral sources (law enforcement, mobile team drop-off, walk-ins, clinical teams), monthly volume of users, proportion of users by age group/adults vs. youth, top 3 reasons for admits, visit outcomes (discharged to community, discharge to ER; Discharge to inpatient, admitted to Crisis Unit for stabilization); proportion of those discharged that remain stabilized in community after 90 days; proportion of users by coverage/payor source. Report on findings to DHS quarterly.

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: 3
      ii. Not in the suicide lifeline network: 12
   b. Number of Crisis Call Centers with follow up protocols in place
      i. In the 988 Suicide and Crisis Lifeline network: 3
      ii. Not in the suicide lifeline network: 12
   c. Estimated percent of 911 calls that are coded out as BH related: not available

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

   Safe place to be
   a. Number of Emergency Departments: 84
   b. Number of Emergency Departments that operate a specialized behavioral health component: 8
   c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 3

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.

Funding is being used to partially support our need for crisis receiving entities. However, the 5% set aside utilization will be revised as we develop our new crisis system.

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

We are not in need of technical assistance at this time.

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? X 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?

X Yes ☐ No

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

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services for adults with SMI in our state are still relatively new. In 2021 Arkansas began initiatives to incorporate training for mental health, substance use disorders, and co-occurring disorders into our Arkansas Model Peer Curriculum. Adjustments have been made, and are evaluated on an on-going basis, to our Peer Program (applications, curriculum, training) to ensure inclusivity for mental health challenges. At the state level we are working to incorporate recovery-based language and requirements in our documents, contracts, websites, and procedures.

The Division of Youth Services is currently our only youth Peer Support program, and they focus on justice-involved youth. Peer services include groups and individual contacts while in the DYS program but also focuses on resources for aftercare needs.

One of our main Therapeutic Community providers with 11 locations across the state has embraced employment of peer workers in recovery from mental health issues. We have Peers employed in 5 medical hospitals with plans to expand. Several of our Community Mental Health Centers provide Rehabilitation Day Services and have worked to hire and incorporate peers, but they have reported difficulty finding qualified peer workers with enough mental health experience. OSAMH's Recovery staff have offered to assist any agency with locating peers if they are interested in hiring one (or more). The State provides a list of certified Peers through an online directory, which is available at all times.

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.

Arkansas currently recognizes four Recovery Community Organizations (RCOs) throughout the state. Through the creation of the Arkansas Alliance of Recovery Centered Organizations, we can provide alternate federal funding to these four RCOs.

Further implementation of the Hub and Spoke Model, which is listed as an indicator under the Integrating Behavioral and Physical Health Care priority area in Step 2, is a service delivery model needed within our state. This is due to the previous grant management of approximately sixty individual agreements, removing staff from their work environment more than once per week while conducting quarterly site visits.

Through a proposed evaluation of both the entirety of the Arkansas Peer Recovery Program and the Recovery Community Organization structure, we hope to increase provider's understanding and support of the Hub and Spoke Model. Following that understanding, Hubs are expected to increase across the State of Arkansas, creating an efficient funding and service delivery system which can address additional underserved communities, including people experiencing homelessness, racial and ethnic minorities, and other underserved populations.

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

We are proud of our three-tiered certification program which we feel encourages professional growth and the development of a career ladder for this workforce.

We have also recently worked as a state department to develop a manual and policies for the Arkansas Peer Recovery Program, which are due to be promulgated into Arkansas law soon. This will further develop our program and workforce by providing them with concrete guidelines to follow that are accessible to both peer workers and providers.

Arkansas has invested in on-demand peer services through mobile applications during the last year. This is currently a pilot project and is forecasted to assist many individuals in rural areas or without transportation in receiving direct peer services.

We believe there is a need for improved provider education about peer services, especially regarding the effective integration of peer workers into care teams. We anticipate that our evaluation will highlight this need, which is why we are assessing our program and offering additional training to address it.

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

We are not in need of any technical assistance at this time.

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.

[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).

[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

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? X Yes ☐ No
   b. The resilience of children and youth with SED? X Yes ☐ No
   c. The recovery of children and youth with SUD? X Yes ☐ No
   d. The resilience of children and youth with SUD? X 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? X Yes ☐ No
   b. Health care? X Yes ☐ No
   c. Juvenile justice? X Yes ☐ No
   d. Education? X Yes ☐ No
3. Does the state monitor its progress and effectiveness, around:
   a. Service utilization? X Yes ☐ No
   b. Costs? X Yes ☐ No
   c. Outcomes for children and youth services? X 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? X Yes ☐ No
   b. Mental health treatment and recovery services for children/adolescents and their families? X Yes ☐ No
5. Does the state have plans for transitioning children and youth receiving services:
   a. to the adult M/SUD system? X Yes ☐ No
   b. for youth in foster care? X Yes ☐ No
   c. Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? X Yes ☐ No
   d. Is the state providing trauma informed care? X 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.)

The Office of Substance Abuse and Mental Health (OSAMH) ensures behavioral health services are available to children and youth throughout the state. Currently outpatient services receive Medicaid funds under the Counseling and Crisis Services and Home and Community-based Service Medicaid Manuals. For children/youth without a payor source, the OSAMH Therapeutic Counseling Service contracts require assistance with helping all eligible children obtain health insurance coverage but also cover the cost of services in the meantime.

Any child/youth in Arkansas identified as SED, and who may or may not have a co-occurring disorder, are eligible for behavioral health services. Most SED children/youth are in our PASSE system which currently serves over 10,200 children and adolescents. The PASSE system incorporates Care Coordination functions as a system of care managers who coordinates necessary services and encourages all support networks to be involved in monthly/quarterly meetings as well as annual Person-Centered Service Plan updates.

For those who may not be identified as SED yet, or may not meet the threshold of SED, but are still in need of behavioral health services, OSAMH has a contract to cover services for those without a current payor source through our Therapeutic Counseling Services contracts. This contract can fund essential counseling services for children/youth in schools, juvenile detention centers, or those deemed ineligible for Medicaid.

A new service currently being piloted in Arkansas includes Family Centered Treatment (FCT), an evidence-based model. This family-centered, home-based service is targeting SED children/youth who are transitioning out of Psychiatric Residential Treatment Facilities, or to divert from an out-of-home treatment placement. The Division of Youth Services and Division of Children and Family Services have been using evidence-based intensive in-home service models to assist children/youth and their families to prevent transferring custody to a state agency (i.e. prevention) as well as for those who may be returning to their families, including adoptive families. As of January 1, 2026, Arkansas plans for the Family Centered Treatment service to be a Medicaid-funded option.

Building on the FCT model implementation, in 2026, using State Opioid Response funding, Arkansas will be implementing the Family Centered Treatment Recovery model in Specialized Women's Services programs (more below).

Other Systems of Care are described below:

Division of Youth Services

The Division of Youth Services (DYS) provides effective prevention, intervention, and treatment programs for youth involved in the Arkansas juvenile justice system. DYS' goal is to give youth and their families the opportunities and services they need to be successful in a way that ensures public safety.

The purpose of Arkansas' juvenile justice system is getting youth treatment – not punishment – so that they can flourish when they return to their homes and communities. DYS uses different strategies to help youth become productive and responsible members of society:

- Prevention and diversion programs based in communities across Arkansas, including the Civilian Student Training Program
- Residential treatment and correctional programs, including education, for youth placed in State custody by a judge. There are four state residential facilities in Arkansas
- Re-entry programs for youth leaving other programs

DYS also works to lead reform efforts and collaborate with juvenile judges, schools, and others working to prevent most youth from ever needing legal intervention and services related to criminal activity. When youth are placed in DYS care for treatment it is important that their families have a voice in their treatment and are active in treatment. DYS believes that involving families is critical to youth success, during and after DYS involvement.

DYS is divided into several sections:

- Service Delivery, Compliance, and Quality Assurance – monitors contracts and ensure vendors, including the private company that handles the day-to-day management of our residential treatment centers.
- Treatment – assesses every youth committed to DYS to determine treatment needs, including medical, mental health, and substance abuse issues. The same unit monitors the youth's progress and adjusts the plans as necessary to allow the youth to successfully return to the community.
- Education – works with youth and guardians to determine the most appropriate educational programming for youth in DYS care, such as earning a high school diploma, a GED, or post-graduate educational services that will help students meet their academic, college, career, and vocational goals.

Upon admission to DYS, every young person is given thorough assessments to include medical needs, educational needs, evidence-based mental health and substance use disorder screenings, and planning starts for robust aftercare services. For youth in need of mental health and/or substance misuse counseling, evidence-based models are selected for treatment services, and the family is included whenever possible. Youth in DYS custody have access to Peer Support services. The DYS treating team includes licensed mental health staff, licensed/certified teaching staff, case managers, licensed nurses, and psychiatrists. After a thorough evaluation,

the youth and involved family meet with the treatment team to participate in a staffing to discuss outcomes and identify goals. The treatment team makes final decisions about the most appropriate DYS placement, such as a residential program, a group home, or a specialty care program.

Arkansas believes that most youth entering DYS custody meet the criteria for SED. Based on that supposition, DYS staff work to have every youth preparing to leave DYS custody, as well as those involved in prevention & diversion programs, to have an Independent Assessment to evaluate functional deficits related to mental health and substance misuse treatment needs. For youth who meet criteria to be placed in a PASSE, the process of attribution takes place prior to existing DYS programs. For those exiting residential programs specifically, Medicaid benefits can be turned on almost immediately, meaning all services and Care Coordination can be rapidly implemented.

OSAMH has used other grant funding sources to collaborate with the Division of Youth Services (DYS) to develop peer recovery support to young people within the carceral setting to establish SUD treatment education and relapse prevention tools. Peer specialists working within the DYS system with the youth are also assisting in the development of relapse prevention planning prior to discharge and building partnerships with existing community-based providers that work with the youth and their families in establishing rapport to reduce recidivism. Staff working within DYS subgrant contractors are also receiving prevention training including SBIRT and Naloxone training.

Recent grant efforts have also developed training and implementation, with outside entities, to incorporate Family Centered Treatment model home-based services to families with children identified with emotional disturbances.

Division of Children and Family Services

The Division of Children and Family Services (DCFS) works to ensure safety and permanency for children and youth of all ages and to strengthen families. The Division, which includes over a thousand employees across 10 service areas throughout the state, works with national and local partners to respectfully engage children and youth, families, and communities to prevent and protect them from child abuse and neglect, provide safety and stability through foster care, and promote permanency through reunification, adoption, and other services.

Prevention & Protection

DCFS believes the best way to protect children and youth from abuse is to prevent it from happening. DCFS offers comprehensive prevention programs and services which focus on the overall health and well-being of both children and families and are designed to promote resilience and parent capacity while also preventing child maltreatment. DCFS uses federal and state funding provided by the Children's Bureau Community-Based Child Abuse Prevention (CBCAP) grant and the Arkansas Children's Trust fund to fund programs and services throughout the state like the *Baby and Me* Program, enhancing schools that implement the *Community School Model* and supporting families in need.

While prevention is a goal of DCFS, families in the child welfare system often are already experiencing abuse, neglect, or other harmful circumstances by the time they are referred to DCFS. The Division works to provide protection for children and youth in these circumstances through timely and thorough investigations and providing services to strengthen the entire family in the home. When necessary, the division temporarily removes children from their homes and places them in foster care to offer them the safety and stability they need to thrive. Whenever possible, kinship placements are a key resource.

One of the key prevention and protection tools used since 2019 involve similar contracts as DYS with providers of Family Centered Treatment Model ©or the Intercept Model ©of intensive in-home treatment services.

Safety & Stability

Typically, children who enter foster care are placed in traditional home settings with families and sometimes even relatives who have volunteered to partner with the agency to provide the safety and stability the child needs while the agency works with their parents to strengthen the family unit and create an environment that is safe for the children to return to. The current average number of children in foster care is 4,300 with an average of just under 1,700 foster homes to support those children.

On occasion, some children require a different type of care, and DCFS works with community partners and placement providers to ensure that children are in the best place for their needs and that those placements are well-supported and stable.

Permanency

For families whose children are in foster care, DCFS strives to help these families achieve permanency. Permanency varies by case and can happen several ways. It can come in the form of reunification, when children who have been removed from their biological families and temporarily placed in foster care safely reunite with their families; adoption, and transitional youth services, where youth continue to receive DCFS support o to help them transition into young adulthood until they reach 18 and exit foster care, or, if they choose to participate in the Extended Foster Care Program, until the age of 21.

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

Click or tap here to enter text.

Specialized Women's Services (SWS) uses evidenced-based models of treatment aimed at addressing the specific needs of pregnant and women with dependent children seeking support and growth through their substance use disorder challenges. Services focus on challenges faced by parents and offer job skills training, therapy, daycare, parenting classes, care coordination, and aftercare planning to promote holistic well-being. Funding for SWS treatment is based on the country of residence. SWS caters to mothers with two children under the age of 7, providing up to 20 beds for a residential SUD treatment duration of up to 120 days. Eligibility for treatment for pregnant women with or without their children includes the following: Female over the age of 18. No insurance or insurance coverage is not applicable to substance use disorder treatment. Proof of residency in Arkansas.

Family Centered Treatment – Recovery is a specialized home-based approach designed to address the confluence of substance use and trauma. Keeps the family together over the course of treatment, preventing out-of-home placement (also used as a reunification service). Based on the evidence-based practice (EBP) Family Centered Treatment. Integrates established recovery supports (drug testing, community groups, peer support), as well as community resources such as employment assistance, housing etc. Family systems treatment based on SUD best practices that harnesses the power of family attachment bonds to facilitate sustained change.

The Family Centered Treatment Foundation (FCTF) will complete in its efforts to address the confluence of substance use, trauma, behavioral health and child welfare. FCTF provides intensive in-home training and implementation services to licensed FCT-R provider organizations. FCT-R provider organizations provide direct FCT-R services to clients and families. FCTF will adapt and implement the Family Centered Treatment-Recovery (FCT- R) model to meet the needs of Arkansas women participating in the Specialized Women Services (SWS) program administered by the Department of Human Services and to pregnant women and women with children at-risk of needing SWS programs. FCTF will train and license the participating family preservation agencies in the FCT-R model, which will then implement the model with Arkansas SWS providers over the length of the project.

Infant Mental Health services have been a Medicaid reimbursable in Arkansas since 2019. With the increased focus on maternal health and integrated care, Arkansas is working to build partnerships with pediatrician's office to increase the number of young children accessing this program from an integrated care approach.

As Arkansas is preparing to develop and build a more responsive and comprehensive crisis system, work is being done to incorporate services specifically geared toward children and youth in crisis. We expect to build on several crisis service pilot programs to ensure our new system can address the unique needs of every child/youth and their caregiver, be sensitive to those with dual or co-occurring needs, and incorporate a mobile crisis team aspect to meet the child/youth in crisis in any community setting.

2025 legislation was passed to disallow students to use personal electronic devices, including cell phones and

smart watches in primary and secondary educational settings throughout the school day. Act 900 of 2025 expanded Arkansas' Social Media Safety Act from 2023 (which required parental consent before minors could create a social media account) to clarify the definition of "social media" to expand protections to additional platforms, lowers the age of minor users to 16, prohibits social media algorithms from targeting minors, and adds a penalty for companies that do not comply.

Act 811 of 2023 was initiated by the Office of Drug Director and led to placement of Naloxone kits in all schools and colleges.

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

Program-level challenges will be addressed and requests for technical assistance will be made on a case-by-case basis as these arise. We are not aware of any needs at this time.

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.

Suicide Prevention efforts in Arkansas are managed by the Arkansas Department of Health (ADH) Substance Misuse & Injury Prevention section. They have implemented several evidence-based programs to address the need for suicide prevention and intervention in the state. A significant amount of information can be found on-line at: https://healthy.arkansas.gov/programs-services/prevention-healthy-living/substance-misuse-injury-prevention/injury-violence-prevention/suicide-prevention/ . Below are some of their current programs or links to other Arkansas programs supporting suicide prevention efforts:

- Arkansas Lifeline Call Center is a part of the national 988 Suicide & Crisis Lifeline. This line has a special feature for those who are veterans. Arkansas currently has four call centers who support incoming calls on 988. These are the ADH Call Center in Little Rock, Arkansas Crisis Center (ACC) in Rogers, Arkansas Foundation for Medical Care (AFMC) and Western Arkansas Counseling (WAC) in Ft. Smith.
- ADH has added a Peer Support position to their call center staff.

The ADH Hometown Health Initiative (HHI) promotes or implements the following training:

a) Talk. Saves. Lives
b) Mental Health First Aid for Teens (tMHFA)

The Commission on Law Enforcement Standards and Training (CLEST)

Between January 2024 and June 2025, five law enforcement officers—three men and two women—reportedly died by suicide, with four of the five using a firearm.

Law enforcement officers face significant occupational stress, which has contributed to a rising number of suicides. Studies indicate that officers are more likely to die by suicide than in the line of duty. According to multiple

sources, including the FBI and Blue H.E.L.P., suicide rates among officers have consistently exceeded line-of-duty deaths. FBI data shows that law enforcement suicides have consistently outnumbered line of duty deaths over the past five years.

The Arkansas Drug Director's Office and the Alcohol and Drug Abuse Coordinating Council identified the urgent need for law enforcement training about two areas, crisis intervention and officer wellness. Funding for two years was awarded earlier this year (2025) to The Commission on Law Enforcement Standards and Training (CLEST) which now provides 40-hour Crisis Intervention Training (CIT) to between 600 – 800 newly certified police officers annually and implements the Officer Resiliency and Wellness Program to currently certified police officers. These projects are crucial to fill significant gaps in the training of law enforcement officers, particularly those serving the rural communities across the entire state of Arkansas.

The extended 40-hour CIT training implemented by this deepens officers' understanding and proficiency in crisis intervention techniques, resources, and de-escalation.

The Officer Resiliency and Wellness Program, based on the Indianapolis Wellness Model, the 6th Pillar of 21st Century Policing, and other agency models, represents a pioneering initiative in Arkansas. Unlike traditional law enforcement training programs which often defer leadership training until officers reach higher ranks, this program integrates leadership training at the recruit stage. This innovative approach aims to significantly enhance officers' ability to manage stressful situations both within their departments and with their personal interactions with the public. In addition, the program's commitment to providing peer and professional mental health support from "Hire to Retire," marks a proactive step in combating officer burnout and diminished overall wellness. By offering continuous support throughout an officer's career, the program seeks to foster resilience and well-being among law enforcement personnel, thereby enhancing overall job satisfaction and reducing turnover rates.

The Officer Wellness and Resiliency Program, in conjunction with the 40-hour CIT curriculum integration, is projected to create a state-wide mental health awareness initiative for Arkansas law enforcement as well as a model to be used for other academies across the country.

Suicide Prevention Helpful Web Sites
https://www.healthy.arkansas.gov/images/uploads/pdf/Suicide_Prevention_Helpful_Sites.pdf

- SAMHSA https://www.samhsa.gov/find-help/national-helpline, which includes links to helpful resources
- Special program and resources for veterans experiencing suicidal thoughts and behaviors, including treatment options and self-help tools https://www.maketheconnection.net/conditions/suicide
- The Trevor Project https://www.thetrevorproject.org/
- After a Suicide Toolkit – Second Edition: https://www.samhsa.gov/resource/ebp/after-suicide-toolkit-schools-second-edition

National Alliance on Mental Illness (NAMI) sponsored activities and events:

a) During Suicide Prevention Awareness Month, a NAMI Walk event for fundraising takes place
b) Hosted in-person and virtual support groups
c) NAMI on Campus program which supports peer-run clubs in high schools and on college campuses
d) NAMI Basic is a multi-session virtual course available for parents, caregivers, or other families who provide care for people who are 22 years old or younger who are experiencing mental health symptoms
e) NAMI Homefront is a multi-session educational program for families, caregivers, and friends of military service members/veterans with a mental health condition
f) NAMI supports a peer-led Family Support Group
g) NAMI Connections Recovery Support Group is a peer-led group for adults experiencing mental health symptoms

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
   X 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? Y Yes ☐ No

   If so, please describe the population of focus?

- Deaf and Hard of Hearing Population:

The National 988 Suicide & Crisis Lifeline now has ASL interpreters and text capabilities available for the Deaf and Hard of Hearing population. The Department of Human Services (DHS) provides that information to deaf and hard of hearing who are seeking assistance.

- Teens

The ADH Hometown Health Initiative (HHI) has recently approved implementation of the Applied Suicide Intervention Skills Training (ASIST), and it is set to be implemented as a Teen Peer led program within schools where high school students are trained to facilitate training in middle school settings.

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

We are not in need of any technical assistance at this time.

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?

X Yes ☐ No

Arkansas has struggled to recruit for the required Housing Representative for the last 2 years. In October of 2024 DHS was able to recruit a representative from the newly developed Metropolitan Housing Association serving central Arkansas. However, their participation has been inconsistent since that time. Work is being done with the Executive Director of that agency to identify a new representative who will be appointed shortly.

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

X Yes ☐ No

If yes, with whom?

We are mentoring current members to move into leadership roles and to maintain continuity in roles within specific areas of expertise and lived-experience.

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.

The Office of Substance Abuse and Mental Health (OSAMH) continues to communicate and collaborate with our behavioral health providers, consumer groups, courts, law enforcement, legislators, and other advocates and stakeholders regarding current initiatives and funding sources. OSAMH's focus is on enhancing home and community-based services for adults and children, taking a more targeted approach to educating consumers and their support networks and stakeholders about recovery-oriented approaches and how peer services can improve outcomes, implementing new and on-going pilot programs to fill gaps, the implementation of a more robust crisis system, improvement in quality and efficiency to the forensic system, and efforts to divert from the Arkansas State Hospital. Initiatives for the coming two years involve reviewing and updating many service definitions for home and community-based services, performing rate reviews and making necessary adjustments in those rates, and developing service definitions for new programs/services to broaden our service array and close gaps. Additionally, preparations are being made to make four programs piloted over the last twelve months into sustainable services using Medicaid funding. These services will directly support our new crisis system for children and their families. Close working relationships and open lines of communication with our four Provider-led Arkansas Shared Savings Entity (PASSE) groups are critical to the success of our programs. Key staff with each PASSE are involved in many aspects of decision-making and evaluation of needs and gaps and overall implementation for all new programs.

The Office of Substance Abuse and Mental Health (OSAMH) is uniquely positioned to work in collaboration with our eight (8) sister divisions, as well as other Arkansas State Departments, providing a broad variety of social service programs. OSAMH maintains a close working relationship with our sister Divisions, including the Division of Medical Services (DMS) (Medicaid), the Division of Children and Family Services (DCFS), the Division of Youth Services (DYS), and the Division of Developmental Disability Services (DDS). Maintaining agreements with multiple DHS agencies and state departments creates the most frugal utilization of federal funding possible while delivering direct services within the State of Arkansas.

- In 2024 the Department of Human Services restructured leadership to implement a new position who oversees all specialty populations, including Aging/Adult Services, OSAMH, DDS, DYS, and DCFS. This update has better aligned decision-making across divisions and is now working to align policy and services.
- OSAMH Leadership has recently recruited a Deputy Director who is extremely knowledgeable about the variety of Medicaid eligibility categories and this addition has enhanced our division's ability to provide additional support to behavioral health providers and contractors about assisting clients eligible for Medicaid to enroll.
- OSAMH works collaboratively with DMS managing, reviewing, and implementing policy for all behavioral health-related services.
- Consistent communication takes place between OSAMH, DYS, and DCFS leadership as many behavioral health programs serve the DYS and DCFS populations and their families.
- Other divisions and state agencies partnered with OSAMH include Division of Developmental Disability Services, Division of County Operations, the Arkansas State Office of the Drug Director, the Arkansas Administrative Office of the Courts, and the Arkansas Problem Gambling Council.
- Advisory councils directly related to mental health, prevention, treatment, and recovery support services are consulted regularly, as well as a state-legislatively mandated councils, the Arkansas Alcohol and Drug Abuse Coordinating Council and the Deaf and Hard of Hearing Mental Health Advisory Committee, and federally mandated council, the Arkansas Behavioral Health Planning and Advisory Council.

Updates to the Medicaid expansion program will target improved outcomes for maternal and infant health, stabilizing and strengthening rural communities, and a third category, the Success Life 360 Home population. The latter group includes veterans aged 19-30, people formerly in foster care and now aged 19-27, those formerly in custody of DYS and now aged 19-24, and people aged 19-24 who were formerly incarcerated. Each of these groups will receive support and intensive services to help address health-related social needs, including finding their individual path to long-term economic independence through work and education. The improved Qualified Health Plans will facilitate closer relationships with DHS and rural and critical access hospitals but also assist with DHS being able to hold the insurance carriers more accountable for outcomes and financial controls.

Arkansas has a School-Based Mental Health program with services being provided in local schools with Medicaid reimbursement. Additionally, schools make referrals to certified and enrolled Medicaid providers with the school site being an allowable place of service. Therefore, most students receive services through the existing Medicaid program. The schools may enter into agreements through Memorandum of Understandings with provider agencies, which fulfill the services needed regardless of payor source that have been identified by schools under IDEA. A new program is under development between OSAMH and the Arkansas Department of Education to develop and implement a pilot program in northwest Arkansas for intensive services for children and youth who demonstrate behaviors likely to cause injury to the student, other students, or staff.

A university also encompassed within the Arkansas Department of Education partners with our recovery program to provide training and education services to the Arkansas Peer Recovery Program through certification training, continued education offered during the annual Arkansas Peer Recovery Conference, and supplemental training for peer workers such as ethics, professional development, and justice involved training. This partnership ensures that OSAMH spends federal SUPTRS funds prudently by maintaining State procurement procedures and financially savvy selections are executed throughout the training and education process. During this planning period, agreements made with this entity will also prove to be even more advantageous to the federal dollar by offering additional supplemental training to active peer workers within the State of Arkansas, rather than continuing to train new recruits to the workforce.

OSAMH has entered into a partnership with the Arkansas Specialty Courts who support Justice-Involved trained peer workers in 19 courtrooms across the state. We hope that this endeavor will allow for opportunities to provide education to the judicial system on the many benefits of having Peers participate in the Specialty courtrooms.

OSAMH actively participates in multiple interdisciplinary teams across other DHS divisions and with our four PASSEs to staff complex cases involving children, youth, and adults.

The University of Arkansas for Medical Sciences (UAMS), the largest teaching hospital in the state, and OSAMH partner on several projects. Many of the psychiatrists working at the Arkansas State Hospital (ASH) are UAMS staff and residents do psychiatric rotation work at ASH frequently. UAMS houses one of our funded Opioid Treatment Programs and oversees our two Coordinated Specialty Care (CSC) Programs for the Early Serious Mental Illness population.
The OSAMH has provided funds to support the Office of Public Safety to support Crisis Intervention Trainings (CIT) for officers. OSAMH also provides funding for a position who works in the Commission on Law Enforcement Standards and Training (CLEST). This relationship has led to all new officers in central Arkansas being trained in the full 40-hour course of CIT, greatly increasing the number of CIT-trained officers.

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

We are not in need of technical assistance at this time.

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.)

To be added post public comment review.

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 X
    b. State Report Yes X 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?

The state of Arkansas has the Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC), which has the legislative mandated responsibility of "overseeing all planning, budgeting, and implementation of expenditures of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement." The members of the AADACC are appointed by the Governor. The meetings are held monthly. The Coordinating Council has a Treatment and Prevention Subcommittee that makes recommendations to the full council regarding substance abuse treatment and prevention. A representative from DAABHS/OSAMH chairs the Treatment and Prevention Subcommittee.
Community Mental Health Center treatment services are planned in conjunction with feedback from contractors via workgroups or monthly meetings, updates to policy, results of satisfaction surveys, results from needs assessments or evaluations, legislative mandates or requests, and requests from the Governor's office, if any are made. Additionally, feedback on services and identified gaps are welcomed from the Planning Council at any time and not limited to application submissions.

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

   X Yes ☐ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) X 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.

To be added post public comment review.

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

To be added post public comment review.

Advisory Council Composition by Member Type

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)	9	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	6666	
3. Parents of children with SED	4	
4. Vacancies (individuals and family members)	0	
5. **Total individuals in recovery, family members, and parents of children with SED**	*19*	*54%*
6. State employees	7	
7. Providers	2	

8. Vacancies (state employees and providers)	1	
9. **Total state employees and providers**	*Sum of rows 9*	*26%*
10. Persons in Recovery from or providing treatment for or advocating for SUD services	1	
11. Representatives from Federally Recognized Tribes	N/A	
12. Youth/adolescent representative (or member from an organization serving young people)	2	
13. Advocates/representatives who are not state employees or providers	4	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. **Total non-required but encouraged members**	*7*	*20%*
16. Total membership (<u>all</u> members of the council)	*33*	

IV. 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

V. 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
Evidence-Based Practices Resource Center	https://www.samhsa.gov/resource-search/ebp	The Evidence-Based Practices Resource Center (EBPRC) provides communities, clinicians, policymakers, 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
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
Library	https://library.samhsa.gov/	Search a library to download or order publications and resources
Medicaid Policy Guidance	https://www.medicaid.gov/federal-policy-guidance	Searchable database of Medicaid Policy Guidance; including peer support services, affordable care act, health homes, prescription drugs, etc.

RESOURCES IN ALPHABETICAL ORDER BY TOPIC/TITLE		
TOPIC	**LINK**	**DESCRIPTION**
Medications for Substance Use Disorders	https://www.samhsa.gov/substance-use/treatment/options	Resources and guides
MHBG and SUPTRS Block Grants	http://samhsa.gov/grants/block-grants	Description of Block Grant, its purpose, deadlines, laws and regulations and resources
Mental Health Crisis	https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care	Resources for implementing behavioral health crisis care
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
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
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, 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 Women	https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf	Guidance on components of quality SUD treatment services for women, states can refer to the documents found at this link
Suicide Prevention	https://www.samhsa.gov/mental-health/suicidal-behavior/prevention	Links to resources and guides around suicide prevention and other mental and substance use prevention topics.

RESOURCES	LINK	DESCRIPTION
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

VI. 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.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
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 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.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
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 Advisory Council Composition by Member Type.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
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.
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.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
Crisis Services	42 U.S.C. §300x–9(d)	A State shall expend at least 5 percent of the amount the State receives pursuant to section 300x of this title for each fiscal year to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable. At the discretion of the single State agency responsible for the administration of the program of the State under a grant under section 300x of this title, funds expended pursuant to paragraph (1) may be used to fund some or all of the core crisis care service 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.	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
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.
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.

Item	MHBG	MHBG Notes	SUPTRS BG	SUPTRS BG Notes
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
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	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
		Disabilities Education Act [20 U.S.C. 1400 et seq.].		
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.

VII. Required Forms

A. Face Page—Community Mental Health Services Block Grant

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

C. Funding Agreements/Certifications—Community Mental Health Services Block Grant

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

E. Assurances