State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State DUNS Number

Number	878890425
Expiration Date	

I. State Agency to be the Grantee for the Block Grant

Agency Name	Tennessee Department of Mental Health and Substance Abuse Services
Organizational Unit	Division of Planning, Research and Forensics
Mailing Address	5th Floor Andrew Jackson Building 500 Deaderick Avenue
City	Nashville
Zip Code	37243

II. Contact Person for the Grantee of the Block Grant

First Name	E. Douglas
Last Name	Varney
Agency Name	Tennessee Department of Mental Health and Substance Abuse Services
Mailing Address	6th Floor Andrew Jackson Building 500 Deaderick Street
City	Nashville
Zip Code	37243
Telephone	8633277543
Fax	
Email Address	doug.varney@tn.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Suzanne
Last Name	Weed
Telephone	615-253-6396
Fax	
Email Address	suzanne.weed@tn.gov

Footnotes:

BILL HASLAM

GOVERNOR

STATE OF TENNESSEE

July 13, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

This letter is to designate Mr. E. Douglas Varney, Commissioner of the Tennessee Department of Mental Health and Substance Abuse Services, as the authorized designated official to sign all agreements, assurances and certifications for the FY 2016-2017 SAMHSA Mental Health Block Grant and Substance Abuse Block Grant.

Contact information for Commissioner Varney is as follows:

E. Douglas Varney
Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
Andrew Jackson Building
500 Deaderick Street, 6th Floor
Nashville, TN 37243
615-532-6500 (Office)
615-532-6514 (Fax)

Thank you for your assistance.

Sincerely,

Bill Haslam
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPMâ€™s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to childrenâ€™s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to childrenâ€™s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

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Name of Chief Executive Officer (CEO) or Designee: E. DOUGLAS VARNEY

Signature of CEO or Designee[1]: _____

Title: COMMISSIONER

Date Signed: 7/8/15
mm/dd/yyyy

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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: E. DOUGLAS VARNEY

Signature of CEO or Designee[1]: _____

Title: COMMISSIONER

Date Signed: 7/8/15
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

[B]
a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

[A]
a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

[A]
a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____

date of last report

4. Name and Address of Reporting Entity:

[X] Prime [ ] Subawardee

Tier _____, if known: _____

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
500 DEADERICK ST. 6TH FLOOR
ANDREW JACKSON BUILDING
NASHVILLE, TN 37243

Congressional District, *if known:* 5

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

HEALTH + HUMAN SERVICES / SAMHSA

7. Federal Program Name/Description:

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:

$

10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*

NONE

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

NONE

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: [signature]

Print Name: E. DOUGLAS VARNEY

Title: COMMISSIONER

Telephone No.: 615-532-6514 **Date:** 7/15/2015

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DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: NONE

Page **of**

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Standard Form – LLL-A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Planning Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Section 2: Planning Steps

Step 1: Strengths and Needs of the Service Delivery System

Table of Contents

Brief History of the TDMHSAS…page 3

Planning and Policy Council System, Research, and Data…page 3

Organization of TDMHSAS…page 4

Organization at the State Level…page 5

Organization at the Local Level…page 6

Main Priority Areas and Programs for TDMHSAS Block Grant Planning…page 7

Conclusion…page 9

Strengths and Needs of the Service Delivery System in Tennessee

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as the state's mental health and substance use disorders and opioid authority. TDMHSAS is responsible for system planning, setting policy and quality standards, system monitoring and evaluation, disseminating public information and advocacy for persons of all ages who live with mental illness, serious emotional disturbance, and/or substance use disorders.

Brief History of TDMHSAS

- 1953--the Tennessee General Assembly (TGA) created the Department of Mental Health to provide for better treatment and improved welfare of persons with mental illness.
- 1973--under the Comprehensive Alcohol and Drug Treatment Act, TGA gave the Department responsibility for developing programs for treating and preventing alcohol and drug abuse.
- 1975--the department was renamed the Tennessee Department of Mental Health and Mental Retardation to reflect services to individuals with intellectual disabilities (then called mental retardation).
- 1991--the Division of Alcohol and Drug Abuse Services was transferred to the Department of Health.
- 2000--TGA changed the Department's name to the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) and revised the mental health and developmental disability law, Title 33 of the Tennessee Code Annotated (TCA).
- 2007--the Bureau of Alcohol and Drug Abuse Services (BADAS) was transferred to TDMHDD from the Department of Health by executive order and codified in 2009. This transfer added substance use disorder (SUD) treatment and prevention authority to the Department.
- 2010--legislation was passed that created a Department of Intellectual and Developmental Disabilities (DIDD). Responsibility for services related to developmental disabilities and/or intellectual disabilities was transferred to the new Department. DIDD now serves as the state's developmental disability authority. 2010--TGA changed the name of TDMHDD to the Tennessee Department of Mental Health (TDMH) effective January 15, 2011.
- 2012--TGA changed the name of the Department of Mental Health to the Department of Mental Health and Substance Abuse Services (TDMHSAS) to more accurately reflect the mission of the agency.

Planning and Policy Council System, Research, and Data

TDMHSAS administers seven Regional Planning and Policy Councils (Council[s]) from which regional mental health and substance abuse needs and information are funneled to the Statewide Council and to TDMHSAS. Needs assessment priorities and recommendations from the Statewide Planning and Policy Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department's Three-Year Plan. Title 33, Chapter 2, Part 2 of the Tennessee Code Annotated requires the TDMHSAS to develop a Three-Year Plan (Plan) based on input from the TDMHSAS Planning and Policy Council. The plan must be revised at least annually based on an assessment of the public need for mental health and substance use disorders services.

In 2011 and 2012, TDMHSAS Commissioner restructured the Department to create the Division of Planning, Research and Forensics. While Planning is an Office that existed prior to the restructuring, Research is a new and innovative staffing arrangement designed to ensure that data informs the direction and growth of the Department and the service delivery system. In the years since, the Office of Research has become an integral part of decision-making for programming, grant writing, and all aspects of Departmental operations.

Data is provided to the Regional Councils to assist members with identifying and prioritizing needs. Following the sharing of data, a needs assessment is conducted annually by the TDMHSAS Regional Councils to assist TDMHSAS with planning for resource allocation. Prioritized needs are shared with TDMHSAS staff to inform the development of strategies for the Three-Year Plan and report progress annually.

The needs assessment process creates a data-informed method for Regional Councils to influence the design of the mental health and substance use service delivery system by identifying each region's needs and targeting limited state resources to more effectively and efficiently meet identified needs. This information is used to communicate and integrate results into a strategic planning and action process that ensures assessment information is used in meaningful ways.

In addition to the needs assessment, the Councils also review and provide input on the Block Grant plans and funding, the annual budget for TDMHSAS, legislative proposals for review of the Commissioner and possible consideration by the Governor, and other departmental reports and initiatives.

The Council system is large, robust, active, and fully-integrated with individuals from both the substance abuse and mental health communities with a consistently successful method of integration. It acts as an independent body and great care is taken by the Planning Program Manager (administrator for the Council system) to avoid influencing the deliberations of, and recommendations made by, the Councils. The Regional Council system serves a secondary purpose that, although not part of the legal requirement, is beneficial to the service delivery system in Tennessee: the Councils allow all participants to become acquainted with each other and with services, events, and other aspects of the service delivery system.

Organization of TDMHSAS

- **Division of Administrative Services** (DAS) oversees monitoring, information technology, general services, and the budget. DAS coordinates major maintenance and capital outlay projects and provides consultation and administrative oversight for the Regional Mental Health Institutes.
- **Office of Fiscal Services** oversees general accounting functions including accounts receivable and payable and interactions with state and federal funding sources.
- **Division of Substance Abuse Services** (DSAS) is responsible for planning, developing, administering, and evaluating a statewide system of prevention, treatment, and recovery support services for the general public, persons at risk for substance abuse, and persons abusing substances.
- **Division of Clinical Leadership** (DCL) seeks to assure high quality services through the following activities: consultations; clinical oversight; education; the development and revision of clinical policies and best practice guidelines; and the advancement of research reviews.

- **Division of Planning, Research & Forensics** (DPRF) includes the Offices of Planning, Research, and Forensics and Juvenile Court Services. All Departmental planning, decision support and evaluation, and forensic administration is housed in the DPRF.
- **Division of Mental Health Services** (DMHS) administers and supports a diverse array of services and supports for individuals of all ages living with mental illness, co-occurring disorders, and/or serious emotional disturbances. DMHS creates, expands, and oversees community-based programs and community support services including children's services, housing, crisis services, suicide prevention and peer-to-peer recovery services.
- **Division of Hospital Services** (DHS) provides oversight of operation for the four Regional Mental Health Institutes for administrative, quality management, program services, and nursing services.
- **Division of General Counsel** (DGC) provides the mandated services of advising the Commissioner on legal matters, overseeing the licensure review panel and representing TDMHSAS in involuntary commitment and civil service proceedings.
- **Office of Licensure** (OLIC) The Office of Licensure is charged with licensing all Tennessee agencies providing mental health, substance abuse, and personal support services. OLIC also investigates complaints of abuse, neglect or fraud against licensed organizations.
- **Office of Human Resources** (OHR) works to ensure the Department of Mental Health and Substance Abuse Services obtains and maintains a workforce that is capable of fulfilling the Department's mission and objectives.

Organization of the Service Delivery System at the State Level

Goals central to TDMHSAS's operations are used to develop strategic programming in both the mental health and substance abuse delivery systems. The Department's planning goals include the following:

1. Tennesseans understand that behavioral health is essential to overall health.
2. Services are service-recipient and family driven and youth-guided.
3. Disparities in services are eliminated.
4. Early screening, assessment, and referral to services are common practice.
5. Excellent services are delivered.
6. Technology is used to access services and information.

Each Division of TDMHSAS (listed on page 3) develops strategies for programming and/or direct services based on each of the above-referenced goals and also reports annually on the outcomes of the programs (new and existing) or the plans in progress based on these main goals. The Division of Mental Health Services (DMHS) is responsible for implementing programming that utilizes Mental Health Block Grant dollars. The Division of Substance Abuse Services (DSAS) is responsible for the programming that utilizes the Substance Abuse Block Grant dollars. State funding serves as the main resource for services under the purview of TDMHSAS either via Medicaid (with federal match) or TDMHSAS funding.

TennCare, the state's Medicaid agency, operates under the purview of the Tennessee Department of Finance and Administration. TDMHSAS acts in collaboration with, and consultation for, TennCare and provides services and programs that fill the gaps for those services not covered by TennCare. For example, TennCare and TDMHSAS act in concert to provide statewide Crisis Services for both TennCare beneficiaries and citizens who are not eligible for TennCare or covered by insurance. Crisis Services could not function at the necessary level of care and competence without the

collaborative effort of both organizations. The preponderance of direct behavioral health care is funded through Medicaid (TennCare) benefits for the population served by TennCare and TDMHSAS. TDMHSAS provides funding for ancillary services not covered by TennCare, Medicare or another insurance plan.

One direct service program is operated through TDMHSAS DMHS: the First Episode Psychosis Initiative. Even so, the funding for the treatment piece of the program is a collaborative effort between TennCare and TDMHSAS. Planning, development, training, outreach, public information and implementation are funded through Block Grant dollars. Some direct service is also funded by the Mental Health Block Grant in the event that a patient fits the parameters of the program but is unable to pay for services or there are co-pays that the patient is unable to pay. Otherwise, the provider bills the patient's insurance company for services rendered. See the Narrative Plan section, item 5.

Different ages and populations are served by different benefit plans via TennCare, the Behavioral Health Safety Net of Tennessee (BHSNTN) and different ancillary service programming. Funding includes grants and federal and state funding funneled from and through TDMHSAS. TennCare provides a range of services to eligible children and adults covered by Medicaid benefit plans. TennCare's plan array utilizes an eligibility algorithm that pairs individuals with benefit plans ranging from shared cost plans (with and without Medicare and other benefit sources) to total coverage through TennCare at no cost to the patient.

Other State Departments also provide behavioral health treatment components embedded in services already provided. Examples include the Department of Corrections which provides behavioral health services to inmates when needed and the Department of Children's Services which provides behavioral health services through TennCare to children involved in the child welfare system.

Organization of the Service Delivery System at the Local Level

In Tennessee, there are a full range of facilities licensed by the TDMHSAS for mental health services delivery purposes and substance abuse delivery purposes. At the time of this application there are licensed agencies as follows (not the total list of licenses--see https://mhddapps.state.tn.us/Licensure/Inquiry.aspx?RPT=TDMHSAS%20License%20Inquiry to view the total list and categories at the local level):

Crisis Stabilization Units (CSUs)	10 Licensees with 9 sites
Mental Health Supportive Living	148 Licensees with 249 sites
Outpatient Facilities	125 Licensees with 394 sites
Mental Health (only) Hospitals	13 Licensees with 13 sites (include state hospitals)
Residential Rehabilitation Treatment SA	37 Licensees with 54 sites
Residential Treatment SA Children and Youth	14 Licensees with 20 sites
Residential Detox Center SA	27 Licensees with 39 sites

For the above categories and licenses, and other services offered locally through the service delivery system, TDMHSAS establishes contracts for services according to funding and program with each organization. TennCare contracts with three statewide Managed Care Organizations (MCOs) which then subcontract for services within the three grand regions of the state (East,

Middle, West). Some medical hospitals which are licensed through the Department of Health also offer psychiatric care as part of the service milieu. Medical hospitals offering psychiatric beds have such beds included in the need calculations for the State (for psychiatric beds) as new or altered facilities are reviewed and approved, but are not licensed by TDMHSAS. Overall, the review, monitoring, and licensing of behavioral health providers are shared tasks (among Tennessee Departments) depending on the service offered and the context in which it is offered.

Licensed and contracted agencies are required to comply with state and federal law related to serving persons who may need an interpreter (for deaf and hard of hearing and for individuals for whom English may not be the native language). While there are no specific laws or regulations guarding the rights of gender minorities or sexual orientation concerns in the state, each contracted provider receiving federal Block Grant dollars must provide culturally sensitive services that meet the needs of all specific populations required by federal law.

Services and corresponding funding are distributed to the seven Planning and Policy Council Regions based on a number of factors including the following:

- Annual needs assessment conducted by the Regional Planning and Policy Councils.
- Anecdotal information available to the public in general (i.e. need for Veteran's services in areas around a military base, need for homelessness services in urban areas where it is known that many homeless persons exist, etc.).
- Data gathered that illustrates that certain needs for services exist in certain regions (i.e. increased levels of opiate addiction or overdose shown in certain areas of the state, increased levels of suicide shown to exist in certain areas of the state, increased need for children's services shown to exist in urban areas, etc.).
- The discretion of the Commissioner to place services.
- The discretion of the Governor to place services.
- The appropriations approved by the State Legislature.
- Recommendations from the Statewide Planning and Policy Council.

Main Priority Areas and Programs for TDMHSAS Block Grant Planning

TDMHSAS has made a concerted effort to align different plans to ensure that strategic planning is consistent regardless of funding source. The Governor has provided broad areas of focus to each State Department known as Customer-Focused Government goals (CFG). The CFG goals are applicable to all Departments, however there are two goals that are specifically impactful to the considerations for growth and operational needs for TDMHSAS: Fiscal Strength and Efficient Government; and Health and Welfare. The TDMHSAS Commissioner has developed goals and objectives for the Department that not only address the Governor's focus, but also address the needs of the citizens and take into consideration the guidelines and requirements inherent in diverse funding resources including the federal Block Grant program.

The Commissioner's goals for TDMHSAS as they pertain to the Governor's plans for Tennessee are as follows:

1. Effective and efficient management of Regional Mental Health Institute (RMHI) facilities;
2. Strengthen and improve community mental health and substance abuse services;
3. Provide effective substance abuse prevention and treatment services; and

4. Lead in partnership with State agencies and community partners to prevent and treat the prescription drug abuse epidemic in Tennessee.

In aligning all goals, common threads appear along the following priority areas for the Mental Health Block Grant:

1. Elimination of service disparities.
2. Early screening, assessment and referral to services for citizens diagnosed with, or at risk of developing, SMI, SED.
3. The delivery of excellent services through the implementation of research-supported evidence-based practices and program evaluation.
4. Crisis services and suicide prevention.

Program staff has been encouraged to develop programming that fits into one of the goals noted on page 5, this document. The milieu of services contracted through TDMHSAS is such that some programming could be considered outside of one of the priority areas or outside of the goal areas associated with the Department's Three-year Plan. In the main, however, all programming is designed to meet a need, however specific, for the citizens of Tennessee.

In summary, the whole of programming for the Division of Mental Health Services fits into the four priority areas either funded in part or in whole by the Block Grant, or funded by State or other dollars. Programs are categorized as follows:

1. Elimination of service disparities.
    - Emotional Fitness Centers (EFC) for African American faith community
    - Older Adults Program (Geriatric Care)
    - Behavioral Health Safety Net for adults not eligible for TennCare
    - Healthy Transitions for Transitional Aged Youth

2. Early screening, assessment and referral to services for citizens diagnosed with, or at risk of developing, SMI, SED.
    - Violence & Bullying Prevention
    - Child & Family Mental Health Education
    - Healthy Transitions for at-risk young adults
    - Education & Training Mental Health/Substance Abuse (Erase the Stigma)
    - Mental Health 101
    - Family Support & Advocacy
    - Renewal House
    - Project B.A.S.I.C.
    - Planned Respite Services
    - YouthScreen (formerly TeenScreen)
    - Child Care Consultation
    - Respite Voucher Program
    - School-based Mental Health & A&D Liaisons
    - Preadmission Screening & Resident Review (PASRR)
    - SOAR Liaison

3. The delivery of excellent services through the implementation of research-supported evidence-based practices and program evaluation.

- First Episode Psychosis Initiative
- TIES Program (Therapeutic Intervention Education and Skills)
- PATH (Projects in Assistance for Transitions from Homelessness)
- System of Care Initial and Expansion Project
- Regional Intervention Program (RIP)
- My Health, My Choice, My Life
- Creating Jobs Initiative (CJI)
- Peer to Peer Support and Education [BRIDGES]
- Peer Run Call Center
- Peer Support Centers
- Peer Wellness [Coaches]
- Consumer Housing Specialists (CHS)
- Supported Employment Initiative (SEI)
- Supported Living
- Community Supported Housing
- Children & Youth Homeless Outreach
- Community Targeted Transitional Support
- Emerging Adults
- Targeted Transitional Support (Forensic Programming)

4. Crisis services and suicide prevention.
    - Project Tennessee (The Jason Foundation)
    - Tennessee Lives Count (TLC) grant
    - Tennessee Suicide Prevention Network (TSPN)
    - Tennessee Suicide Prevention Network (TSPN-Youth)
    - Crisis Stabilization Unit/Walk-In Triage
    - Mobile Crisis
    - Crisis Respite
    - 1-800-Number Crisis Services

Conclusion

Tennessee's Department of Mental Health and Substance Abuse Services is charged with:

- operating the State's Regional Mental Health Institutes (state hospitals);
- developing a service array for Substance Abuse and Mental Health services that seeks to comply with state and federal law;
- meeting the needs of the citizenry; and
- serving as the opiate authority for the state.

TDMHSAS also serves in a consultative capacity to the state's Medicaid agency (TennCare) and assists other Departments with implementing effective policies and programming regarding related services. TDMHSAS licenses and monitors the service delivery system, and participates in the process of the delivery system's development and enhancement. The program milieu either offered by or administered by TDMHSAS is robust and consistent with best- and promising-practices and supported by the latest research.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

Footnotes:

Step 2: Identify Unmet Needs and Service Gaps

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS or the Department) priorities align closely with Tennessee Governor Bill Haslam's top five priorities: health and welfare, public safety, fiscal strength and efficient government, education and workforce development, and jobs and economic development. Soon after taking office, Governor Haslam asked each member of the governor's cabinet to conduct a top-to-bottom review of each state agency's mission and develop goals for action. TDMHSAS Commissioner Doug Varney identified the following goals:

1. Elimination of service disparities.
2. Early screening, assessment and referral to services for citizens diagnosed with, or at risk of developing, SMI, SED.
3. Excellent services delivered through the implementation of evidence-based practices and program evaluation.
4. Crisis services and suicide prevention.

The Block Grants provide critical resources for the state to be able to achieve these goals. Mental Health Block Grant (MHBG) funds provide essential dollars needed for strengthening community mental health services, expanding and improving mental health services to children, decreasing health disparities and encouraging consumer recovery, resiliency and personal achievement.

To determine the unmet service needs and critical gaps within the current service system, TDMHSAS conducts a data-driven needs assessment based on the compilation of behavioral health data from multiple data sources into data books comparing Tennessee to the United States and compiling county level behavioral health data.

Needs Assessment Process

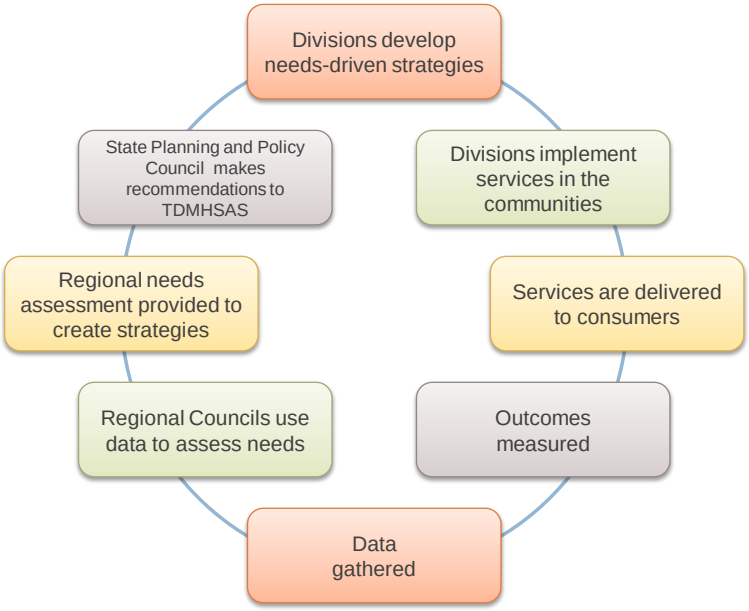
Service needs are identified through an annual needs assessment process with input from TDMHSAS Statewide Planning and Policy Council (Council), the Regional Council system, and TDMHSAS staff. Regional needs are identified, reviewed, and prioritized by the Planning and Budget Committee of the Council as recommendations for inclusion into the TDMHSAS Three-year Plan. This process allows for a broad grassroots forum to advise the Department on the desirable array of prevention, early intervention, treatment, and rehabilitative services and supports for consumers and their families. Additionally, this process allows for citizen participation in the development of the TDMHSAS annual budget improvement request.

The TDMHSAS needs assessment process involves state level collaboration involving the TDMHSAS research team, the TDMHSAS Statewide Planning and Policy Council, and other TDMHSAS staff. TDMHSAS also administers seven Regional Planning and Policy Councils across the seven geographically defined state treatment planning areas shown in Exhibit 1.1. The seven Regional Councils are comprised of consumers and their families, advocates, adults and older adults, providers, and other stakeholders and organizations. The Councils advise the TDMHSAS Statewide Planning and Policy Council on the development of the state Three-year Plan and provide guidance to the Department on policy, budgeting, and evaluation from the regional perspective. This engagement process embodies TDMHSAS' mission and commitment to establishing a quality, comprehensive prevention, early intervention, treatment, and rehabilitation system based on the needs and preferences of individual consumers and their families.

Beginning in October 2013 TDMHSAS instituted a new needs assessment model to integrate feedback from the Regional Councils on the design of the mental health and substance use system. The goals of the needs assessment model are to identify regional resources and unmet needs, and to allocate limited resources more efficiently. The model is also designed to help Regional Councils prioritize local needs, direct state level planning and resource allocation efforts, and assure compliance with federal block grant funding requirements. The needs assessment model outlines eight steps as part of a cyclical process that begins with implementing needs-driven services in communities, proceeds to collecting and analyzing indicators of

prevalence, service use, quality, and outcomes, and results in formulating recommendations for service strategies that reflect emergent regional needs and preferences. These recommendations are further shaped by outside considerations, such as federal and state policy initiatives and priorities, legal requirements, and funding constraints. The TDMHSAS needs assessment model is described in detail in Exhibit 1.2.

Exhibit 1.2
TDMHSAS Needs Assessment Model



- **Divisions implement services in the communities.** TDMHSAS funds needs-driven community mental health services.
- **Services are delivered to consumers.** Providers deliver a comprehensive array of prevention, intervention, treatment, and recovery support services.
- **Outcomes measured.** Providers measure consumer outcomes resulting from the service experiences.
- **Data gathered.** TDMHSAS uses extant data sources and provider, consumer, and stakeholder surveys to compile indicators of mental health prevalence, system capacity, service utilization, service quality, and unmet need. Information is used to identify trends, patterns and other useful information that can inform future service delivery planning and resource allocation.
- **Regional councils use data to assess needs.** Regional councils identify local strengths and weaknesses and prioritize needs using previously collected data.
- **Regional needs assessment provided to create strategies.** Integrating results into the strategic planning process to ensure that findings from the assessment process are used in meaningful ways and that changes to service systems are driven by local input.

Data Sources

To inform the needs assessment process, TDMHSAS developed a number of data books comparing state-specific and national data, as well as providing Regional Planning and Policy Councils with regional and county-level data. Data books are posted on the TDMHSAS website. Information about the TDMHSAS needs assessment process and the data used to determine regional and state needs is posted on the department's website at http://tn.gov/behavioral-health. TDMHSAS utilized various data sources to inform the regional and county data books including, but not limited to:

- Behavioral Health Safety Net of Tennessee (BHSNTN)
- Behavioral Risk Factor Surveillance System (BRFSS) and the Youth BRFSS with the Centers for Disease Control and Prevention
- Kids Count website (http://datacenter.kidscount.org)
- National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)
- SAMHSA: National Survey on Drug Use and Health (NSDUH)
- SAMHSA Uniform Reporting System tables
- SAMHSA: Treatment Episode Data Set
- Tennessee Department of Health
- Tennessee Health Care Financing Administration: TennCare (state Medicaid program)
- Tennessee Outcome Measurement System (TOMS)

- Youth Risk Behavior Survey
- U.S. Census

In addition to the data books which are provided to the Statewide and Regional Councils, the Office of Research provided a Needs Assessment Data Report to provide program specific data to councils about needs identified in the statewide needs assessment.

Prevalence of mental illness in Tennessee

Adults with serious mental illness

Estimates of the annual prevalence of severe mental illness (SMI) in Tennessee are taken from the 2012-2013 National Survey on Drug Use and Health (NSDUH) by SAMSHA. An estimated 20.52% of Tennessee adults (or 995,241 adults[1]) over the age of 18 had a mental illness in the past year and 4.59% of adults (or 222,620 adults) over the age of 18 live with a serious mental illness (SMI) such as schizophrenia, major depression, or bipolar disorder.[2] An estimated 7.04% of Tennessee adults (or 341,447 adults) over the age of 18 "had at least one major depressive episode in the past year", compared to 6.77% nationwide. An estimated 9.39% of Tennessee children, ages 12 to 17, had at least major depressive episode in the past year. In 2013, an estimated 9% of children grades 9 to 12 attempted suicide, compared to 8% nationally.[3]

Anxiety disorders are the most common group of mental health diagnoses, affecting approximately 18 percent of the adult population in a given year. These disorders include generalized anxiety disorder (GAD), obsessive-compulsive disorders (OCD), panic disorders, social phobias, and post-traumatic stress disorder (PTSD). Based on national prevalence estimates, each year more than 860,000 Tennessee residents over the age of 18 may experience problems with anxiety. Anxiety disorders usually first appear in early adolescence, with the average age of onset around age 11, although this varies considerably across specific diagnosis types. Almost a quarter of all cases (23 percent) are considered severe, resulting in significantly impaired functioning.[4]

Mood disorders are a category of disorders that affect an individual's emotional state. This group of disorders includes bipolar disorder, dysthymic disorder, and depression. Mood disorders affect about 9.5 percent of the adult population in a given year or an estimated 460,000 Tennessee residents over the age of 18. Bipolar disorder and dysthymic disorders are less common than depression, affecting about 2.6 and 1.5 percent of the population respectively; however, more than 80 percent of cases of bipolar disorder and about half of dysthymic disorders are considered severe. Major depressive disorder is more common, affecting about 7 percent of the population, although a lower percentage of these cases (30.4 percent) result in serious impairment. The average age of onset for mood disorders is around age 30, although bipolar disorder may appear earlier in life (25 years).[4]

Personality disorders, including antisocial personality disorder, avoidant personality disorder, and borderline personality disorder, affect about 9.1 percent of the adult population in a given year. Avoidant personality disorder is the most common form of illness in this category. Based on national prevalence estimates, nearly 440,000 Tennessee residents over the age of 18 will be potentially affected by these types of illness.[4]

Eating disorders, including binge eating disorder and bulimia nervosa, are less common in the adult population that other forms of mental illness. Binge eating disorder affects 1.2 percent of the adult population, and bulimia nervosa affects 0.3 percent. Eating disorders typically appear during young adulthood, with an average age 25 for the onset for binge eating disorder and an average age of onset of 20 for bulimia nervosa.[4]

Hyperactivity and attention deficit disorder is a very common childhood disorder that can continue into adulthood, affecting about 4.1 percent of the adult population in a given year. This means that almost 200,000 Tennessee residents will be impacted by adult ADHD each year, of which about 40 percent of cases will be considered severe. The average age of onset for ADHD is seven years.[4]

Schizophrenia affects about 1.1 percent of the adult population. Based on national prevalence estimates, over 53,000 Tennesseans over the age of 18 may be impacted by the disease. [4]

Children with serious emotional disturbance

Children, much like adults, will often struggle with mental illness. Statistics indicate that almost half of all children and adolescents 13–17 years of age, or more than 230,000 Tennessee youth, will experience some form of mental health disorder in their lifetimes. Anxiety disorders are also the most common group of mental health issues among children, as well as adults, with 25 percent of children experiencing anxiety in their lifetimes. These disorders include generalized anxiety disorder (GAD), panic disorders, social phobias, and post-traumatic stress disorder (PTSD). Based on national prevalence estimates, nearly 127,000 Tennessee children will be affected by anxiety in their lifetime and about 6 percent of cases will be considered severe. The most common category of anxiety disorders involves specific phobias, which affect more than 15 percent of the child and adolescent population. [4]

Mood disorders impact 14 percent of children at some point in their lifetimes, with about 11 percent of children experiencing a major depressive disorder or dysthymia. On average, 4.7 percent of mood disorders are considered severe. These estimates suggest that as many as 70,000 children in Tennessee will be affected by mood disorders in their lifetimes. [4]

ADHD is the third most common mental health issue among children. Nearly one in ten children is diagnosed with ADHD during their lifetime, although only 1.8 percent of diagnosed cases in children are considered severe. Based on national prevalence estimates over 45,000 Tennessee children will experience challenges associated with ADHD. [4]

Eating disorders are the least common mental health issue among children. Less than three percent of children under 18 (2.7 percent) will experience an eating disorder during their lifetime and about 2.7 percent of cases will be considered severe. These estimates indicate that more than 14,000 children in Tennessee will experience problems associated with eating disorders. [4]

Service-related priorities

Priority 1: Elimination of service disparities.

To determine the unmet health disparities within the current service system, TDMHSAS (1) analyzes multiple state and federal data sources in respect of various disparity indicators (currently, disparity data about race, ethnicity, age and gender are available) and (2) plans to establish methods to assess health disparities among other groups (sexual orientation, place of residence, socio-economic status, physical abilities, etc.) over the next years. TDMHSAS has incorporated information about age, gender, race, and ethnicity into all Department surveys. Information on sexual orientation will be reported through the Common Data Platform for SAMHSA discretionary grants.

An estimated 1,135,205 individuals, about 18% of the population in Tennessee, are living below the state's poverty line.[2] Poverty creates a number of potential health disparities in Tennessee. About 20.7% (or about 813,800) of nonelderly adults, ages 18 to 64, are uninsured, while only 5.3% (or about 79,244) of children are uninsured.[3] An estimated 4,800 children, ages 9-17, have a diagnosis of serious emotional disturbance (SED) and are uninsured[4]. As a continuation from the focus of last year's block grant, Tennessee is still focusing on service disparities due to socio-economic status (lack of insurance). Conservatively, over 46,000 adults living with SMI have no health insurance and would potentially be eligible for Medicaid expansion or an assisted purchase of coverage via the Health Insurance Marketplace. In addition, it is likely that many individuals living with SMI are underinsured for mental health benefits since most private insurance plans and Medicare do not include the types of wrap-around and rehabilitative services routinely needed by those individuals.

To address service disparities resulting from socio-economic status, the most vulnerable of uninsured individuals with SMI (those at 100% FPL and below) are eligible for the state-funded Behavioral Health

Safety Net of Tennessee (BHSNTN). The BHSNTN is a program offering a package of core, vital mental health outpatient clinical services, labs, and case management to people who are not eligible for Medicaid through TennCare, the state's Medicaid program. Services such as psychosocial rehabilitation have been added to the milieu of services for the coming fiscal year. During FY 2014, the BHSNTN provided paid services to 34,668 adults with SMI. In the absence of the BHSNTN, enrollees would have access to only the more expensive inpatient services provided at the State-operated RMHIs.

The TennCare program includes a wide variety of rehabilitative mental health services, including case management, crisis services, psychosocial rehabilitation, and illness management and recovery to individuals in various income groups depending on age and pregnancy status.

State	Children - Medicaid			Separate CHIP	Pregnant Women	Parents
	Ages 0-1	Ages 1-5	Ages 6-18		Medicaid	
Tennessee	195%	142%	133%	250%	195%	105%

Source: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/tennessee.html

As of May 2015, Tennessee had Medicaid and CHIP preliminary enrollment of 1,480,430 individuals, an 18.96% increase (about 280,700 individuals) over the average enrollment from July to September 2013 prior to the enactment of the Affordable Care Act. This increase is about double the average increase for states not expanding Medicaid (9.45%) but still lower than the average increase for state's expanding Medicaid (29.15%). In State Fiscal Year (SFY) 2014, Medicaid paid for behavioral health services for about 94,000 adults with SMI 32,400 children with SED.

Priority 2: Early screening, assessment and referral to services for citizens diagnosed with, or at risk of developing SMI, SED.

Failure to recognize and treat mental illness and serious emotional disturbance leads directly to higher incidences of physical illness, injury, other direct medical care costs, low workplace productivity, increased criminal justice costs, homelessness, suicide, and lost contributions to society. With early identification and early intervention and prevention services, however, we can promote emotional/behavioral health in children and youth and reduce the likelihood of SMI.

TDMHSAS supports the primary, secondary, and tertiary prevention of mental illness using a variety of strategies such as early screening, assessments, and referral services. The focus of primary prevention is decreasing stigma and increasing public awareness about mental illness; increasing public understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention will help people recognize mental and substance use disorders and seek assistance with the same urgency as any other condition, and make recovery the expectation. In a 2009 survey[5] conducted by the Center for Disease Control (CDC), 75% of Tennesseans strongly agreed that treatment can help people with mental illness lead normal lives, and only 1.3 percent strongly disagreed. Over 50 percent of Tennesseans strongly or slightly agreed that people are generally caring and sympathetic to people with mental illness. However, a SAMHSA report found that one in five Americans feel that persons with mental illness are a danger to others.

Early intervention for children with behavioral and emotional problems

TDMHSAS secondary prevention activities focus on providing early intervention services to children with behavioral and emotional problems, preventing suicides and providing crisis services so that individuals with SMI experiencing a psychiatric crisis do not end up in jails or emergency rooms inappropriately.

Emotional well-being is a critical component of children's health. It has a complex interactive relationship with physical health and the ability to succeed in school and ultimately at work and in society. One in five

children nationally has diagnosable mental health problems and a high rate of physical health problems. For children with diagnosable mental health problems, there is a higher potential for drug and alcohol dependence, increased interactions with the juvenile justice system and increased challenges at school. In the TOMS survey of youth ages 13-17 receiving mental health services, 26% reported feeling sad often or always in the past 30 days. Seven percent reported feeling suicidal often or always in the past 30 days.

Unless addressed, many children's mental health issues persist into adulthood. Researchers (Kessler et al, 2005) supported by the National Institute of Mental Health (NIMH) have found that half of all lifetime cases of mental illness begin by age 14 and three fourths by age 24, and that despite effective treatments, there are long delays between first onset of symptoms and when people seek and receive treatment. As many as 70% of children diagnosed with depression will have a relapse by adulthood. According to a study that looked at the World Health Organization's 2004 Global Burden of Disease Report, neuropsychiatric disorders such as depression, substance abuse, and schizophrenia account for nearly half (45%) of disability in young people between ages 10 and 24.

Tennessee uses MHBG dollars to fund a number of early intervention programs to intervene with children, youth and young adults diagnosed with serious emotional problems or challenging behavior. The Regional Intervention Program and Child Care Consultation program provide early intervention services to very young children with emotional problems or challenging behaviors who are referred by schools and child care centers. Two school based programs, the B.A.S.I.C. Program and Teen Screen, provide services or make referrals to address the needs of school-age children with emotional problems and challenging behaviors.

Early intervention for adults with serious mental illness

Early intervention for young adults can help mitigate the impact of serious mental illness over the course of a lifetime. To focus on early intervention and treatment for young adults, the Tennessee MHBG funds a program called RAISE (Recovery After an Initial Schizophrenia Episode) focusing on first episode psychosis. The premise of RAISE is to combine state-of-the-art pharmacologic and psychosocial treatments delivered by a well-trained, multidisciplinary team in order to significantly improve the functional outcome and quality of life for first-episode psychosis patients.[12]

Priority 3: Excellent services are delivered through the implementation of evidence-based practices and program evaluation.

The use of evidence-based practices and program evaluation has been a major focus of the state's implementation of programs and way of evaluating effectiveness of mental health programs. Over the past two years, the TDMHSAS surveyed community providers to determine the use of key evidenced based practices. About 52,000 adults received medication management, 12,870 adults received integrated treatment for co-occurring disorders, 1,800 adults received family psychoeducation services, and 1,800 adults received illness self-management and recovery services. Other 1,000 adults received supported housing and supportive employment services. Among children, about 950 children received family functional therapy services and 360 children received therapeutic foster care services.

Currently, Tennessee relies on several surveys to collect information about the use of best practices by service providers and about national outcome measures for people receiving mental health services. The Tennessee Outcome Measurement System (TOMS) Survey and is used to collect National Outcomes Measures (NOMs) information. In 2014, approximately 42,521 individuals who received mental health services in community-based settings from agency members of the Tennessee Association of Mental Health Organizations (TAMHO) completed the TOMS survey. This survey provides the state with information about the demographics of people receiving mental health services in Tennessee as well as information about national outcome measures such as employment, living situation and criminal justice involvement. The Department uses this information to guide the development of public policy for the mental health system.

TDMHSAS collects data from the Mental Health Statistical Improvement Program Survey (MHSIP) to determine consumer satisfaction with services as well as functional improvements in well-being, daily

functioning, and social connectedness. About 8,000 adults take the MHSIP annually and about 1,800 family/guardians complete the survey. More than 85% of consumers are satisfied with the mental health care they receive. Adult consumers scored Outcomes, Participation in Treatment, Functioning, and Social Connectedness lower than other domains in the MHSIP Survey. Parents and Guardians of youth consumers scored Perceptions of Outcomes and Functioning lower than other domains. The relatively low Perception of Treatment Outcomes (61% for adults and 67% for family/guardians) could be improved for both groups. Adult respondents perceived their social connectedness (65%) to be much lower than family/guardian respondents (85%).

In the past two years, the Office of Research also worked with multiple program directors to collect data about consumer demographics, consumer satisfaction, and program outcomes for a number of programs serving adults. Program evaluation surveys were rewritten to collect demographic information about program consumers as well as program outcome information. Program evaluations were conducted for the crisis services, housing and homeless services, peer recovery services and peer wellness programs, the first episode psychosis program and system of care services for children with emotional disorders and challenging behaviors.

The Division of Mental Health Services is committed to MHBG funding for evidenced-based practices including peer wellness programs, certified peer recovery specialists, and first episode psychosis programs. The block grant funds the First episode psychosis program, community supportive housing, peer wellness, and peer support and education.

Priority 4: Crisis services and suicide prevention.

The 2014 U.S. Census data indicate that roughly 23% of the State's population (or 1,494,526 children) is under age 18. According to Kids Count, almost one in four children (26.5%) in Tennessee live in poverty in 2013. An estimated 280,000 (21%) Tennessee children have one or more emotional, behavioral, or developmental conditions. From 2011-2013 the state received 128,279 crisis calls and 11,388 of those were from children. The state did 61,379 face-to-face crisis assessments and 7,046 of those were with children.

The Tennessee Youth Risk Behavior Survey (YRBS) highlights the seriousness of the issue as a major public health concern for adolescents. There are a number of risk factors that place youth at elevated risk for suicide, including, but not limited to, a personal or family history of suicide, problems with alcohol or drug abuse, or a history of depression or mental illness. YRBS survey results from 2011 show that nearly quarter of all high school students surveyed reported feeling sad or hopeless in the past year for a period lasting two weeks or more that was severe enough to pull them away from their usual activities. About 15 percent of high school students indicated that they had seriously considered attempting suicide in the 12 months prior to the survey and 11 percent of students had established a suicide plan. Six percent reported at least one suicide attempt over the same 12 month period and 2 percent of students required medical intervention as the result of their suicide attempt. Hispanic/Latino youth reported higher rates of sadness or hopelessness (43.7 percent) relative to their White (26.4 percent) or Black counterparts (22 percent).

Mortality data compiled by the Tennessee Department of Health shows that more than 950 youth and adults in Tennessee completed suicide in 2012. This translates into a rate of 14.8 deaths per every 100,000 residents. Among youth ages 10–19 years of age, the suicide rates was five deaths for every 100,000 resulting in 42 lives lost. Although suicide was the 10th leading cause of death among Tennessee residents in all age groups, it was the second leading cause of death among those 15–24 and 24–34, and the third leading cause of death among youth and adolescents ages 10–14 years. Suicide rates tend to increase with age to peak in middle age (45–65 years of age) and then gradually decline.

Over the last three years, Tennessee has decreased its rank for young adults (18-25) with a major depressive disorder and thoughts of suicide. In the previous year (2011-2012), Tennessee ranked among the top ten states; in 2012-2013, it ranked in the middle 30 states. Further, Tennessee decreased its rank regarding adults (18+ and 26+) who had serious thoughts of suicide in the past year, moving from top ten during 2011-2012 to the middle 30 states for these indicators in 2012-2013.

Tennessee's crisis services and outreach programs, like the Tennessee Suicide Prevention Network (TSPN) and the Tennessee Target Zero Suicide Initiative, target both youth and adults in crisis. Tennessee has a well-developed suicide prevention public education effort. Each year more than 40,000 Tennesseans are provided suicide prevention education

TDMHSAS expanded crisis stabilization services by contracting with agencies across the state to provide seven Crisis Stabilization Units (CSUs) and crisis walk-in triage centers in 2008. The addition of a new CSU in east Tennessee, which began providing services on August 2014, brings the statewide total up to eight CSUs and crisis walk-in triage centers. Each CSU has a 15-bed unit, with the exception of one 10-bed unit in Cookeville, providing a total of 115 community-based beds across the state.

Crisis walk-in triage centers provide non-hospital, facility-based services that offer 24-hour, seven-day-a-week behavioral health treatment to people 18 and older by providing assessment and evaluation, early intervention, prevention, stabilization, referral, and follow-up services for individuals seeking assistance in obtaining appropriate behavioral health services or linkage of services to achieve and/or improve their prior level of functioning following a crisis situation. For individuals with no acute medical concerns, crisis walk-in triage centers offer quick access to a mental health professional for screening and service referral at a lower total cost than traditional emergency department access. These services are provided at no cost to individuals without a third-party payer source.

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[1]2010 Census, United States Census Bureau.

[2]SAMSHA, Center for Behavioral Statistics and Quality. (2013). National Survey on Drug Use and Health: 2012-2013.

[3]2008-2010 NSDUH, Center for Behavioral Health Statistics and Quality of the Federal Substance Abuse and Mental Health Services Administration.

[4]2013-2014 NSDUH, Center for Behavioral Health Statistics and Quality of the Federal Substance Abuse and Mental Health Services Administration.

[5]American Community Survey and U.S. Census Bureau's Small Area Income and Poverty Estimates (SAIPE). 2012.

[6]Luna, L., and Thacker, A. (2014). The Impact of TennCare: A Survey of Recipients. Center of Business & Economic Research. Knoxville, TN.

[7]Centers for Disease Control. Office of Surveillance, Epidemiology, and Laboratory Services Behavioral Risk Factor Surveillance System (BRFSS). 2009.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse 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. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Step 2: Quality and Data Collection Readiness

Because of different funding sources, Tennessee has separate data systems and data collection strategies for substance abuse and mental health services. Each data system is capable of collection client-level data. Tennessee continues to make progress toward a "finished" system that is interoperable and meets both state and federal reporting needs.

Like many other states, Tennessee collects substance abuse services data in the WITS data system (Vendor: FEI). This system is used to generate quarterly reports for the Treatment Episode Data Set (TEDS) through Synectics. Providers enter their data directly into WITS. Tennessee mental health client-level data is reported to NRI.

Mental health client-level data is collected in a number of different systems depending on the service type and the environment in which the service is provided. Data is collected, then, in each programmatic administration environments as follows:

- Psychiatric hospital services client data are maintained in an AVATAR database (Vendor: NETSMART).
- Behavioral Safety Net program is collected in a state-developed eligibility data base that syncs once a week with the state's Medicaid eligibility database.
- Crisis services collects and holds client data in a separate database.
- Contracted private psychiatric hospital services submit monthly client-level data in Excel spreadsheets.
- Tennessee Association of Mental Health Organizations (TAMHO) collects National Outcome Measures (NOMS) and MHSIP data through client surveys administered by community mental health agencies. NOMS survey data is combined with service data from TAMHO providers reported to the TAMHO data warehouse.

To create the mental health client-level data file for SAMHSA reporting, Tennessee combines client-level data from all of these sources. Tennessee's data collection is specific to mental health or substance abuse services.

Tennessee is able to collect and report on draft measures at the individual client level; however, the process of collecting, cleaning, and combining data from five data sources is labor intensive and time consuming. The Department is able to able to complete client-level data reporting on an annual basis. Combining data from these data sources makes quarterly reporting of data to the MH-TEDS system challenging using current resources.

Tennessee will have a number of challenges collecting the proposed block grant measures:

- First, about two-thirds of the measures are not currently collected by TDMHSAS, including measures of perception of care and measures requiring screening and intervention (depression remission at 12 months, smoking screening and cession intervention, controlling blood pressure for people with SMI, and diabetes care for people with SMI).
- Second, the state does not have a data warehouse where data from multiple services can be merged. Third, a survey methodology is used to collect some of the current mental health national outcome measures (employment, education, stable housing, and homelessness), although some of this information is collected by the crisis database.

- Third, although the proposed perception of care measures are already collected by managed care organizations for Medicaid enrollees, but client-level CAHPS-HEDIS data is not reported to TDMHSAS and is not collected for individuals receiving block grant services who are not Medicaid enrollees.

The biggest challenge in client-level data reporting is the absence of a department administrative data system for collecting, maintaining and reporting client-level data for people receiving community-based mental health services. While the state has several electronic data systems, linking of the systems is not yet complete and the state has no electronic data warehouse to store information from different electronic systems.

Finally, collecting client-level outcome data (NOMs) using the TOMS survey methodology, which collects NOMs on a sample of clients rather than all clients, is a challenge for Tennessee. TDMHSAS has explored a number of options for collecting NOMs including requiring all providers contracting with the TDMHSAS to collect NOMS. One of these options is to add language to current contracts with providers to require the collection of NOMs and the reporting of NOMs to TDMHSAS. A second option is for providers to add NOMs to their administrative databases and report this information to the TAMHO data warehouse. At the current time this option is cost-prohibitive. The third option is to maintain the status quo and continue to collect NOMs through the TOMS.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Elimination of service disparities.

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To eliminate disparities in services for uninsured adults in Tennessee, and in geographic and population areas (i.e. rural and ethnic populations).

Objective:

Ensure that the uninsured in Tennessee who are in need of treatment, medication, case management and/or psychosocial rehabilitation have access to those services. Also to ensure that populations located in rural areas have access to care and that ethnic populations have access to care that is culturally sensitive.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of uninsured persons served by the Behavioral Health Safety Net of Tennessee (BHSNTN) in a given year.

Baseline Measurement: Number served by the BHSNTN in FY2015

First-year target/outcome measurement: Serve as many uninsured individuals as are eligible and apply to the BHSNTN in FY 2016.

Second-year target/outcome measurement: Serve as many uninsured individuals as are eligible and apply to the BHSNTN in FY 2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Behavioral Health Safety Net of Tennessee database.

Description of Data:

Number of uninsured individuals served.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #: 2

Indicator: In Sullivan, Shelby, Davidson, Bledsoe, Clay, Cumberland, Dekalb, Fentress, Grundy, Jackson, Macon, Marion, McMinn, Meigs, Overton, Polk, Pickett, Putnam, Rhea, Sequatchie, Smith, VanBuren, Warren, and White Counties, Tennessee, the Older Adult Program will provide Care Management Services including outreach, screening, assessment, linkage, in-home therapy and other supportive services.

Baseline Measurement: Number of adults with mental health issues aged 50 and older receiving services in FY2015.

First-year target/outcome measurement: At least 140 older adults with mental health issues will receive services in FY2016.

Second-year target/outcome measurement: Maintain or increase the number of older adults receiving services in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Older Adult Services.

Description of Data:

Data compiled by report of contracted providers and the TDMHSAS Office of Older Adult Services.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	3
Indicator:	Number of screenings performed, events and training opportunities made available in programs noted this indicator in the data source field.
Baseline Measurement:	Number of screenings performed, events and training opportunities made available.in FY2015.
First-year target/outcome measurement:	Maintain number of screenings performed, events and training opportunities made available in FY2016.
Second-year target/outcome measurement:	Maintain Number of screenings performed, events and training opportunities made available in FY2017.

Data Source:

Information tracked and disseminated for the Emotional Fitness Centers of Tennessee, the System of Care Expansion, and the Early Connections Network by the TDMHSAS Office of Children and Youth Mental Health.

Description of Data:

Number of screenings performed, events and training opportunities made available each fiscal year.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	4
Indicator:	Number of transition-aged youth served in program noted in data source field.
Baseline Measurement:	New program in FY2015.
First-year target/outcome measurement:	Establish a baseline in FY2016.
Second-year target/outcome measurement:	Maintain or increase number of transition-aged youth and young adults served in FY2016.

Data Source:

Information tracked and disseminated for the Healthy Transitions program by the TDMHSAS Office of Children and Youth Mental Health.

Description of Data:

Number of transition-aged youth and young adults served each fiscal year.

Data issues/caveats that affect outcome measures::

None noted.

Priority #:	2
Priority Area:	Early screening, assessment and referral to services for citizens diagnosed with, or at risk of developing, SMI, SED.
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

Make early identification, screening and referral to age- and acuity-appropriate treatment common practice.

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of children at risk of SED with early access to mental health services via services offered by TDMHSAS.
Baseline Measurement:	Number of children with access in FY2015
First-year target/outcome measurement:	Maintain the number of children with access to mental health services in FY2016.
Second-year target/outcome measurement:	Maintain the number of children with access to mental health services in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Children and Youth Mental Health.

Description of Data:

Number of children served in the Child Care Consultation program, the Early Connections Network, Project BASIC, Renewal House Early Intervention program, Planned Respite and Respite Voucher, the Regional Intervention Programs and School Based Mental Health Liaison program as reported and compiled by contracted providers and TDMHSAS staff.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	2
Indicator:	Number of families with children at risk of SED with early access to mental health information and educational programming offered by TDMHSAS.
Baseline Measurement:	Number of families and children reached in FY2015.
First-year target/outcome measurement:	Number of families and children reached in FY2016.
Second-year target/outcome measurement:	Number of families and children reached in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Children and Youth Mental Health.

Description of Data:

Number of children served in the Erase the Stigma program, the Child and Family Mental Health Education program, the Family Support and Advocacy program as reported and compiled by contracted providers and TDMHSAS staff.

Data issues/caveats that affect outcome measures::

None noted.

Priority #:	3
Priority Area:	Excellent services are delivered through the implementation of Evidence-based practices and program evaluation.
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

Increase the number of EBPs in operation under TDMHSAS purview, and ensure that programs are reviewed, monitored and evaluated 100% of the time.

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of new or improved housing or supported living opportunities available in Tennessee
Baseline Measurement:	Number of housing units presently available in Tennessee.
First-year target/outcome measurement:	500 new or improved housing or supported living opportunities available in FY2016
Second-year target/outcome measurement:	500 new or improved housing or supported living opportunities available in FY2017

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Housing and Homelessness Services.

Description of Data:

Number of new and improved opportunities each fiscal year.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	2
Indicator:	Number of chronically homeless individuals in Tennessee.
Baseline Measurement:	Number of chronically homeless individuals in Tennessee in FY2015
First-year target/outcome measurement:	Reduce the number of chronically homeless individuals by 2% in FY2016.
Second-year target/outcome measurement:	Reduce the number of chronically homeless individuals by 2% in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Housing and Homelessness Services.

Description of Data:

Point-in-time counts of homeless individuals and information compiled by other local and national resources regarding the number of homeless persons.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	3
Indicator:	Number of SMI-SUD individuals who are being discharged from the hospital and/or are low income or lacking in financial resources who are receiving assistance to obtain supportive housing and financial assistance.
Baseline Measurement:	Number of housing individuals who received assistance last fiscal year.
First-year target/outcome measurement:	780 adults will be assisted with finding supportive housing and 2550 adults will be assisted in receiving financial assistance in FY 2016.
Second-year target/outcome measurement:	780 adults will be assisted with finding supportive housing and 2550 adults will be assisted in receiving financial assistance in FY 2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Housing and Homelessness Services.

Description of Data:

Data compiled by report of contracted providers and the TDMHSAS Office of Housing and Homelessness Services.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	4
Indicator:	Number of service recipients served as part of supported employment programming.
Baseline Measurement:	Number of service recipients served as part of supported employment programming in FY2015: 223 served.
First-year target/outcome measurement:	Maintain or increase the number of service recipients served as part of supported employment programming in FY2016.
Second-year target/outcome measurement:	Maintain or increase the number of service recipients served as part of supported employment programming in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Consumer Wellness and Employment Programs, data and evaluation compiled by the TDMHSAS Office of Research.

Description of Data:

Data compiled by report of contracted providers and the TDMHSAS Office of Consumer Wellness and Employment Programs

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	5
Indicator:	Number of collaborations with other organizations to establish a children and youth, family driven and youth guided, culturally and linguistically competent system of care for children at risk of SED statewide.
Baseline Measurement:	The number collaborations in FY2015.
First-year target/outcome measurement:	Increased collaborations in FY2016.
Second-year target/outcome measurement:	Increased collaborations in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Children and Youth Mental Health.

Description of Data:

Number of collaborative efforts each fiscal year.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	6
Indicator:	In upper West Region 6 (Lake, Obion, Weakley, Carroll, Benton, Henry, and Gibson counties) young adults with access to age appropriate best-practice treatment for First Episode Psychosis.
Baseline Measurement:	Ten young adults age 15 to 30 who are experiencing their first episode of psychosis will be served in the First Episode Psychosis Initiative in FY2015.
First-year target/outcome measurement:	Ten young adults age 15 to 30 who are experiencing their first episode of psychosis will be

served in the First Episode Psychosis Initiative in FY2016.

Second-year target/outcome measurement: Ten young adults age 15 to 30 who are experiencing their first episode of psychosis will be served in the First Episode Psychosis Initiative in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Children and Youth Mental Health, data and evaluation compiled by the TDMHSAS Office of Research.

Description of Data:

Data compiled by report of contracted providers and the TDMHSAS Office of Children and Youth Mental Health.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #: 7

Indicator: Number of peer-to-peer training and informational opportunities pertaining to holistic health management, substance use, and wellness.

Baseline Measurement: 175,172 of peer-to-peer opportunities in FY2015.

First-year target/outcome measurement: Increased or maintained peer-to-peer training and informational opportunities by 4828 in FY2016.

Second-year target/outcome measurement: Increased or maintained peer-to-peer training and informational opportunities by 5000 in FY2017.

Data Source:

Information tracked, disseminated and compiled by the TDMHSAS Office of Consumer Affairs and Peer Recovery Services.

Description of Data:

Count of peer-to-peer care opportunities each fiscal year including peer support center attendance, peer-to-peer training and informational via the My Health My Choice My Life program, Chronic Disease Self-Management Program, the Diabetes Self-Management Program, Tobacco Free, Well Body, Motivational Interviewing and Peer Wellness Coaching administered through the TDMHSAS Office of Consumer Affairs and Peer Recovery Services .

Data issues/caveats that affect outcome measures::

None noted.

Indicator #: 8

Indicator: Number of peer-to-peer care opportunities in Tennessee for use by service recipients.

Baseline Measurement: 257,056 of peer-to-peer opportunities in FY2015.

First-year target/outcome measurement: Increased or maintained peer-to-peer care opportunities by 2944 in FY2016.

Second-year target/outcome measurement: Increased or maintained peer-to-peer care opportunities by 1500 in FY2017.

Data Source:

Information tracked, disseminated and compiled by the TDMHSAS Office of Consumer Affairs and Peer Recovery Services.

Description of Data:

Count of peer-to-peer care opportunities each fiscal year including peer support center attendance, peer-to-peer support with patients in State Hospitals, peer-to-peer interactions via the TDMHSAS call center and the peer-run call center, piloted programs in which peer-to-peer care is contracted and provided, and other peer-to-peer care programming administered through the TDMHSAS Office of Consumer Affairs and Peer Recovery Services.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	9
Indicator:	Number of service recipients or former service recipients trained and certified as peer recovery specialists.
Baseline Measurement:	Number of service recipients or former service recipients trained and certified as peer recovery specialists in FY2015: 129
First-year target/outcome measurement:	Maintain or increase the number of service recipients or former service recipients trained and certified as peer recovery specialists in FY2016 to 130
Second-year target/outcome measurement:	Maintain or increase the number of service recipients or former service recipients trained and certified as peer recovery specialists in FY2017 to 135.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Consumer Affairs and Peer Recovery Services, data and evaluation compiled.

Description of Data:

Data compiled by report of contracted providers and the TDMHSAS Office of Consumer Affairs and Peer Recovery Services.

Data issues/caveats that affect outcome measures::

None noted.

Priority #:	4
Priority Area:	Crisis services and suicide prevention
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

Improve the effectiveness of the Crisis Services network of services statewide and reduce the numbers of suicides in Tennessee through information dissemination and education and training of the general population.

Objective:

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of suicides in Tennessee each year.
Baseline Measurement:	Suicide rate among the general population in FY2015
First-year target/outcome measurement:	Maintain or reduce the number of suicides in FY 2016.
Second-year target/outcome measurement:	Reduce the number of suicides in FY2017.

Data Source:

TDMHSAS Office of Crisis Services and Suicide Prevention database and data tracked, aggregated and disseminated by the Tennessee Department of Health (TDOH).

Description of Data:

Count of deaths by suicide.

Data issues/caveats that affect outcome measures::

There is an approximate 18 month lag in the availability of suicide death data provided by TDOH.

Indicator #:	2
Indicator:	Standards of Care development and implementation for Crisis Services delivery system.
Baseline Measurement:	No baseline measurement.
First-year target/outcome measurement:	Collaborate with service providers to develop Standards of Care for Crisis Services delivery system in FY 2016.
Second-year target/outcome measurement:	Implement Standards of Care in Crisis Services delivery system in 2017.

Data Source:

TDMHSAS Office of Crisis Services and Suicide Prevention database, tracking and record keeping.

Description of Data:

Information regarding the nature of the Standards, publication of the Standards, and method for implementation.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	3
Indicator:	Through collaboration with TennCare, development of a plan to implement a Children and Youth Crisis Stabilization Unit (CSU).
Baseline Measurement:	Presently there are no CSUs for children and youth in Tennessee.
First-year target/outcome measurement:	Development of the collaborative effort with TennCare including budgeting and CSU service parameters in FY 2016.
Second-year target/outcome measurement:	Development of a plan to implement a CSU for children and youth in Tennessee in FY 2017.

Data Source:

TDMHSAS Office of Crisis Services and Suicide Prevention database, tracking and record keeping.

Description of Data:

Information regarding the collaboration and the development of the plan.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:	4
Indicator:	Number of collaborative efforts and information sharing systems for suicide prevention and intervention.
Baseline Measurement:	Collaborative efforts and information sharing systems in place in FY2015
First-year target/outcome measurement:	Establish one collaborative effort and one information sharing arrangement in FY2016.
Second-year target/outcome measurement:	Establish one collaborative effort and one information sharing arrangement in FY2017.

Data Source:

Information tracked and disseminated by the TDMHSAS Office of Crisis Services and Suicide Prevention, data and information tracked and shared by other State agencies or private organizations, and internal record keeping.

Description of Data:

Contracts, letters of agreement, official collaborative or consortia with other State agencies and private organizations pertaining to information sharing and/or collaborative efforts.

Data issues/caveats that affect outcome measures::

None noted.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$19,423,000	$0	$0
6. Other 24 Hour Care		$2,467,825	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$5,952,619	$0	$0	$50,107,626	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$371,000	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$467,802	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$467,802	$0	$0	$0	$0	$0
13. Total	$0	$9,356,048	$0	$0	$69,901,626	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

TennCare and TennCare Select spent the following dollar amount on mental health services, in total, minus pharmacy costs, in FY 2015: $408,094,042. The total proposed budget for TennCare for FY 2016 is $10.2B, medical, surgical, mental health, substance abuse treatment, crisis services, pharmacy, long-term care and all budgetary concerns included. Federal discretionary grants are not included in the numbers

on this table. Discretionary funds can be added after submission upon request.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	$371,000

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	$2,900,500
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$24,457,802
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$8,527,650
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	$5,683,100
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$2,064,011
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	$3,875,600
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$14,431,495
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$16,946,516
Total	$79,257,674

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	$444,412
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$444412

Comments on Data:

Council activities are paid for via the allowed 5% administrative portion of the Block Grants.

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

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

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q1 Health Care System and Integration

The SMI/SED focused services covered under Tennessee's Block Grant funding are ancillary and fill gaps by providing services not covered by insurance. Few of the services purchased by Mental Health Block Grant are covered by TennCare or by qualified health plans. There has been no initiative yet developed that will monitor access to behavioral health services in Tennessee. The TennCare program supports a comprehensive benefit array that is provided through subcontracts between three Managed Care Organizations (MCOs) and providers in all three grand regions of Tennessee. At present, both TDMHSAS, the Bureau of TennCare, and the Tennessee Department of Commerce and Insurance are reviewing the proposed regulations pertaining to parity, and meetings are scheduled to discuss the ways in which the new regulations will be implemented in Tennessee. At the time of this application, final regulations for Medicaid and CHIP had not been issued by CMS.

The questions, this item, pertaining to nicotine dependence will be answered via the Substance Abuse Prevention and Treatment Block Grant.

A program called My Health, My Choice, My Life (MHMCML) is administered through TDMHSAS and provides programming designed to enable participants to build self-confidence to take part in maintaining mental and physical health and managing chronic health conditions. TDMHSAS encourages overall wellness for those individuals living in recovery from mental health and substance use disorders. As a result of MHMCML hundreds of Tennessee's most vulnerable population receives the self-directed tools and support needed to reverse the trend of early mortality for individuals with mental illness and substance use disorders. MHMCML assists participants in improving their overall well-being and resiliency to live healthy and purposeful lives.

MHMCML focuses on wellness and good general health promotion for Tennesseans who live with mental health and substance use disorders. The holistic health initiative integrates a medical model that emphasizes recovery and resiliency resulting in an initiative that centers on overcoming physical and mental health symptoms through strengths and personal empowerment. The program is facilitated by individuals who have first hand, lived experience with psychiatric and/or co-occurring disorders. MHMCML is comprised of three specific services: Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP) and Peer Wellness Coaching (PWC). MHMCML provides individuals with self-directed tools, empowerment by means of acquiring the knowledge, skills and resources to improve overall well-being and resiliency to make it possible for individuals to live healthy and purposeful lives.

The MHMCML program serves adult Tennesseans who live with mental health and/or substance use conditions. MHMCML delivers services in peer support centers, addictions disorder peer recovery support centers, psychosocial facilities, and intensive long-term support programs.

MHMCML generally focuses on problems common to individuals suffering from chronic diseases. Individuals are taught to manage symptoms through the following techniques (but not limited to):

- Breathing techniques;
- Sleep;
- Healthy eating;
- Communication;

- Action planning;
- Weight management;
- Understanding emotions;
- Medication management;
- Problem solving;
- Physical activity;
- Using the mind;
- Thinking activities;
- Stress management;
- Disease management (diabetes, heart disease, etc.); and
- Communication with health care providers.

Each individual who participates in the CDSMP and peer wellness coaching must participate in a pre-, post-, and re-assessment. The assessment includes the NOMS, Recovery Assessment Scale, Health and Self-Management Questionnaire, and Additional Health Behaviors Questionnaire and is completed by a MHMCML regional peer wellness coach.

Other Tennessee Organizations Understanding the Value of Integration

On April 15, 2013, Centerstone Health Partners joined forces with Physician Health Partners to develop integrated healthcare clinics. Centerstone clinics, now recognized as CARF accredited Health Homes, are located in Nashville (Frank Luton Center and the Dede Wallace Campus), in Clarksville (Harriet Cohn Center), in Shelbyville, and in Madison. The Clinics located in these Tennessee cities provide holistic healthcare including behavioral and primary health care. Centerstone notes a full range of ages served.

Cherokee Health Systems offers integrated care models of services in several of the 14 counties of east Tennessee (in which Cherokee offers services) at 15 different sites. One of the sites offers basic dental care. Cherokee Health Systems, based in East Tennessee, offers a unique training opportunity for clinicians and other professionals to learn about healthcare integration. Cherokee provides the Primary/Behavioral Health Integrated Training Academy that teaches the constructs of integrated care ranging from services to administrative functions.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

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

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

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

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

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q2 Health Disparities

Tennessee tracks enrollment for direct mental health services through intake formatting provided to service providers by TennCare (Medicaid benefit provided through managed care organizations). This information is submitted to SAMHSA each year, as tracked, through the Uniform Reporting System tables as a part of the SAMHSA Annual Report. TDMHSAS tracks ancillary services funded through the Mental Health Block Grant dollars through various formats and databases. In the main, age, gender, race and ethnicity are tracked when client-level data is gathered for ancillary services. Tennessee does not track LGBT population trends except through federal census data sources.

Information to assist providers with communicating with Limited English Proficient (LEP) enrollees or those classified as having a low level of health care literacy is available on the TennCare website at http://www.tn.gov/tenncare/topic/cultural-competency.

Interpretation and translation services and assistance for enrollees with LEP are available for providers through TennCare's managed care organizations. TennCare offers tools to assist with patients during intake using I Speak Cards which can assist with identifying a patient's primary language. Also, medical interpreters are available to providers linked through the same website link noted above. TennCare suggests that providers use plain language communication even for individuals for whom English is the first and primary language. Assistance is available to providers for converting to medical communication in plain language, a model of assistance offered by the Centers for disease control. This model is also available on the above-referenced website.

TDMHSAS Programs Addressing Healthcare Disparities in Mental Health Services

The Behavioral Health Safety Net of Tennessee

The Behavioral Health Safety Net of Tennessee (BHSNTN) provides services for adults who are not eligible for Medicaid and who are uninsured. Core psychiatric services are made available statewide through BHSNTN funding. In order to qualify for the Behavioral Safety Net Program, an individual must have a qualifying mental health diagnosis, a household income at or below 100% of the Federal Poverty Level, be a Tennessee resident 19 years of age or older, be a U.S. Citizen or qualified alien not currently in an inpatient facility or nursing home, not be an inmate or incarcerated, be ineligible for VA benefits, TennCare, have private health insurance which does not cover behavioral health benefits, or be in a situation in which all behavioral health benefits have been exhausted for the year. Additionally, effective September 2013, individuals who have Medicare Part B, or who are 65 years of age or older, and meet all other eligibility requirements for the BHSNTN program may be enrolled. Medicare Part B recipients may receive case management services, medication training and support services, peer support services, and psychological rehabilitation services.

In addition to these services, funds are available to provide prescription assistance through CoverRx (a state prescription assistance program). CoverRx provides discounts on generic and brand name drugs plus one atypical antipsychotic drug per month with a $5 co-pay. Currently, CoverRx offers over 250 generic and brand name drugs with a $3 or $5 co-pay. Each Provider also has a Pharmacy Assistance Coordinator(s) who assists service recipients in applying for CoverRx and accessing brand drugs through Pharmaceutical Manufacturer's Patient Assistance Programs. BHSNTN staff in the TDMHSAS central office may also provide assistance in connecting patients with the proper resource to access help with obtaining a prescription.

At the time of submission of this application, service had been provided to 32,410 individuals.

Emotional Fitness Centers

Emotional Fitness Centers (EFC) operate in Shelby County and contiguous areas and are contracted through the faith community. The purpose of the program is to provide culturally competent and linguistically sensitive screening for African American residents in the Memphis area. In Shelby County, the United States Census Bureau notes that 52% of the population of Shelby County is African American.

The faith community is able to build quick rapport with individuals who may need help but feel uncomfortable seeking assistance on their own. EFCs offer "programs designed to equip individuals to break through the strongest barriers to wholeness." In the vernacular of the program, the services can assist individuals, friends and family in "getting emotionally fit."

The following services are offered:

1. Pre-screen for emotional distress.
2. Refer for further emotional evaluation as needed.
3. Pre-screen for physical symptoms.
4. Provide group sessions for grief recovery, anger management, depression, aftermath of family violence and youth forums.
5. Assign PAL (an assistant or sponsor) to each client to ensure appointments are made and kept.

The benefits of the EFCs' programming and services are as follows:

- Address emotional issues that lead to mental breakdowns.
- Ensure those needing emotional healing receive it.
- Reduce the number of people not receiving emotional help needed.
- Lower stress on families associated with family members not getting needed care.

Older Adult Services

In Sullivan, Shelby, Davidson, Bledsoe, Clay, Cumberland, Dekalb, Fentress, Grundy, Jackson, Macon, Marion, McMinn, Meigs, Overton, Polk, Pickett, Putnam, Rhea, Sequatchie, Smith, VanBuren, Warren, and White Counties in Tennessee, the Older Adult Services Program provides care management services including outreach, screening, assessment, linkage, in-home therapy and other supportive services to older adults (age 50 and older). Services are provided in addition to others which may be available through the BHSNTN, TennCare and Medicare for those who are eligible. The purpose of the program is to assist older adults who are diagnosed with mental illness with obtaining and maintaining proper services to help avoid hospitalization, allow individuals to continue living in their communities, and fill service gaps for individuals who may have a need that is not being met.

Other programming addressing health disparities

TDMHSAS also contracts for the First Episode Psychosis Initiative in rural upper west Tennessee, an evidence-based model developed by the National Institute for Mental Health called Recovery After an Initial Schizophrenia Episode (RAISE). The geographic area is located in Region 6 of Tennessee's seven Planning and Policy Council Regions and is significant in terms of healthcare disparity in that it is largely rural with large geographical distances between patients and services.

The provider has named the program OnTrackTN in honor of the urban-focused model in New York City called OnTrack NY. OnTrack TN has been modified to interface with the provider's existing

electronic health record (EHR), and has established a technology arrangement that would allow for the use of telemedicine and other technologies to connect with clients in ways that meet the unique needs of the client and specified age group. Technology was also used to mitigate the effect of the rural implementation.

In addition, the Healthy Transitions program and other programming offered through the Office of Children and Youth Mental Health address the needs of children who are of transition age. Youth may be aging out of the foster care system or need assistance with adult activities such as finding a job, finding an apartment, meal preparation, opening a bank account or managing money in general. Healthy Transitions also works in tandem with other programs such as OnTrack TN in identifying youth who may be struggling and need mental health services.

TMDHSAS Office of Children and Youth Mental Health offers the System of Care initiative as a part of the effort in Tennessee to end healthcare disparities. The system of care (SOC) model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth. The purpose of SOC is to improve services and access and expand the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with serious emotional disturbance and their families. Training is provided for anyone involved in the SOC initiatives to assist with cultural competency in all areas of the service delivery system.

The system of care philosophy is built upon these core values and guiding principles:

- Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Finally, TDMHSAS has implemented the Therapeutic Intervention, Education, and Skills (TIES) program which addresses the complex needs of children, from birth to age 17, who are at-risk of out-of-home placement due to parent or caretaker substance abuse. TDMHSAS partners with the Tennessee Department of Children's Services (TDCS) and Centerstone, a community behavioral health treatment center, to provide Intensive Family Preservation Services and Seeking Safety treatment for children and families affected by substance abuse and trauma. Evaluation services are available for families who live in Bedford, Cannon, Coffee, Davidson, Marshall, Rutherford, and Warren counties. TIES services help keep families together and children safe and healthy.

Services include:

- In-home counseling
- Access to crisis intervention 24/7
- Basic skills education
- Psychosocial education
- Seeking Safety

- Connecting participants to social and community services
- Connecting participants to substance abuse treatment programs and recovery support

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] Ibid, 47, p. 41

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

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

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

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

[64] http://psychiatryonline.org/

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

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Item 3: Use of Evidence in Purchasing Decisions

TDMHSAS program staff is primarily responsible for ensuring that contracted providers adhere to program models. There are also program evaluation services available through the TDMHSAS Office of Research. Both substance abuse and mental health services programs are monitored for contract adherence and fidelity to the model of the program. Emerging and promising practices used in Tennessee are evaluated for effectiveness and appropriate use of limited funding resources.

A needs assessment is conducted annually by the TDMHSAS Regional Councils to assist TDMHSAS with planning for resource allocation. Data is provided to the Regional Councils to assist members with identifying and prioritizing needs. Prioritized needs are shared with TDMHSAS staff to inform the development of strategies for meeting the need and then to report progress annually. The needs assessment process creates a data-informed method for Regional Councils to influence the design of the mental health and substance use service delivery system by identifying each region's needs and targeting limited state resources to more effectively and efficiently meet identified needs. This information is used to communicate and integrate results into a strategic planning and action process that ensures assessment information is used in meaningful ways.

In much of the state, the MH service delivery system and much of the substance abuse service delivery system operates by means of a medical model because they are largely funded through Medicaid, Medicare, and commercial health care plans. The model of service delivery generally follows the model and purpose of the lion's share of the money that funds it. The preponderance of evidence-based practices utilized in the medical model of mental health programming includes tried and true therapies such as Cognitive Behavioral Therapy, medication management, case management, etc.

For ancillary mental health programming that is funded through other resources such as the Behavioral Health Safety Net of Tennessee, and foundation, discretionary or block granting sources, the ability to purchase programs based on evidence based practice is much more flexible. In Tennessee, there are programs implemented using alternative dollars that include, but are not limited to, the Regional Intervention Program, Project BASIC, the TIES program, an original curriculum for suicide prevention called the Shield of Care, and a holistic health and wellness program operated through the peer recovery support centers called My Health, My Choice, My Life. All of these programs are designed to fill the service gaps for those needed services not covered by insurance. The aforementioned programs are also carefully chosen to meet the recovery needs of children at risk of, or diagnosed with, a serious emotional disturbance and adults who are diagnosed with serious mental illness.

Substance Abuse treatment and prevention programming is funded through the Substance Abuse Treatment and Prevention Block Grant and through discretionary grants designed to fill the gaps for services not covered by the Block Grant or by other payors. Best and promising practices included in the ancillary services offered for citizens in need of substance abuse services include Peer to Peer Recovery Services, pregnant women's services, recovery housing, the Lifeline program, and various recovery courts including courts for veterans, co-occurring disorders, and a rural recovery court expansion project. All programs are monitored by program staff for adherence to the contract and the model of the program.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q4: Prevention for Serious Mental Illness

Primary prevention for mental illness is not eligible for Block Grant funding. However, Tennessee has recognized the value of early intervention in addition to the the First Episode Psychosis Initiative.

The NAMI website paraphrases the President's New Freedom Commission on Mental Health (http://www2.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/New_Freedom_Commission/Goal_4_Early_Mental_Health_Screening.htm): "For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems. Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability."

In light of the value associated with preventing disability caused by mental illness, TDMHSAS has sought grants and funded programs that address early intervention for children, adults, and individuals for whom stigma associated with mental illness may be a barrier to obtaining the necessary treatment.

Tennessee has been awarded the Healthy Transitions Grant. The purpose of this program is to improve access to treatment and support services for youth and young adults ages 16-25 that either have, or are at risk of developing a serious mental health condition or are at high risk for suicide. This program is available to youth in the following Tennessee counties: Benton, Carroll, Gibson, Hamilton, Henry, Lake, Obion, and Weakley.

Healthy Transitions service goals:

- Targeting adolescents at-risk of mental health issues age 16-25,
- Collaborating with local agencies to raise public awareness about mental health,
- Providing education and employment support,
- Utilizing peer-to-peer specialists to provide wrap around care to our clients,
- Establishing and maintain a comprehensive continuum of care,
- Providing youth-guided, family-driven, and culturally competent services,
- Increasing public awareness,
- Expanding and enhancing the array of specialized services, and
- Improving outcomes for service recipients.

Also in Tennessee, a program entitled Emotional Fitness Centers (EFC) performs a double purpose of serving an underserved population in Memphis and surrounding areas and providing early identification and intervention for young people as they transition from late childhood to young adulthood. The Emotional Fitness Centers are operated through the African-American Faith Community and have ten sites in west Tennessee.

The program offers the following services, described here in language that is culturally sensitive:

- Emotional fitness Screening (5 years Old - Adult)
- Physical Screening
- Individual/Family/Marital Counseling
- Referral to Agencies/Physician As Needed
- Support Groups

The EFCs also provide an array of information to individuals who present for services.

- Pre-screen for emotional distress.
- Refer for further emotional evaluation as needed.
- Pre-screen for physical symptoms.
- Provide group sessions for grief recovery, anger management, depression, aftermath of family violence and youth forums.
- Assign an assistant to each client to ensure appointments are made and kept.

The main goal of the pre-screening for the EFCs is to refer individuals needing care to the proper service.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q5 First Episode Psychosis Initiative in Tennessee: OnTrack Tennessee

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) began planning for the implementation of the 5% set aside (FY2014 MHBG) to address early intervention programming as soon as the 2014 budget legislation passed. The proposal approved by SAMHSA included provisions for a First Episode Psychosis (FEP) treatment program focusing on a rural area of Tennessee using the RAISE model. The proposal provided a beginning budget, staffing, and implementation model designed to be flexible in the face of the challenges of implementing an urban program in a rural area. With innovations focusing on the use of technology and a one-provider arrangement, the proposal was approved and implementation began within 30 days following approval.

Implementation

Carey Counseling Center, Inc. (Carey) is the primary provider in the seven-county area chosen for the implementation of the OnTrack Tennessee (OnTrackTN) program. In the months following the approval of the proposal, TDMHSAS contracted with Carey to implement the program in a seven-county area in the northwest corner of Tennessee. The counties in the service area are Lake, Obion, Weakley, Benton, Carroll, Gibson, and Henry. This area is located in Region 6 of Tennessee's seven Planning and Policy Council Regions. The contract included all of the proposed aspects of the program including team development, hiring, training, technology and outreach into the community.

Carey immediately set out to implement the necessary hiring, training, establishing the modifications to include the OnTrackTN program on the organization's existing electronic health record (EHR), and establishing a technology arrangement that would allow for the use of telemedicine and other technologies to connect with clients in ways that meet the unique needs of the client and specified age group. Technology was also used to mitigate the effect of the rural implementation. In addition, outreach to the communities served began immediately once the contract was finalized in August 2014.

Training was provided by OnTrack New York, both in person and online. The Carey team adopted the name of the program associated with Dr. Lisa Dixon's program by naming the Carey program OnTrackTN.

Carey hired or transitioned existing staff into five positions:

1. Team Leader and Primary Clinician
2. Outreach and Recruitment Coordinator
3. Supported Employment and Education Specialist
4. Prescriber
5. Program Administrator and Clinical Director

Carey's outreach was so effective that, even in a rural area with long distances between the Carey offices and the patients, Carey was able to achieve the goal of admitting 10 patients to the program in advance of the first anniversary of the program's start date.

Other tasks, including technology modifications and financial considerations have been completed by existing organizational staff and TDMHSAS staff.

Training was provided by Dr. Lisa Dixon and the OnTrack New York staff. In person and online training and information was also purchased with Block Grant dollars and continues to assist with ongoing implementation of the program.

Expansion

TDMHSAS Commissioner believes that the FEPI has been very successful. There is hope regarding expansion of the program into other areas of the state in the coming 2016 and 2017 fiscal years. The areas under discussion at the time of this application are Davidson County (Nashville) and Hamilton County (Chattanooga). Hamilton County is unique in that it is one of the sites where the programming resulting from the Healthy Transitions grant is being implemented. The two programs, Healthy Transitions and OnTrackTN, go hand in hand to ensure that young people get the treatment needed to avoid a lifetime of debilitating serious mental illness.

Partnerships

The interest in the program has grown in areas other than in just the implemented areas. Partnership with Carey was immediate and very effective at creating an operational and successful program in a short period of time. Partnership with Vanderbilt University came later when a discussion of evaluation and development of a conference. Other partnerships include the Tennessee Association of Mental Health Organizations and the Healthy Transitions program.

Conference

On September 3 and 4, 2015, TDMHSAS, in partnership with Vanderbilt University, will present the First Episode Psychosis conference entitled Developing New Directions in Tennessee. The conference is partially funded by Block Grant dollars and is free of charge to attendees. The purpose of the conference is to raise consciousness about the treatability of psychosis when it is caught early and when the patient is experiencing her or his first episode. The content of the conference is educational for professionals and includes sessions on pharmacological management of first episode psychosis patients, engagement techniques, and supported employment. Speakers include Lisa Dixon, MD from Columbia School of Medicine, Susan Azrin, PhD from the National Institutes for Mental Health, and Stephan Heckers, MD from Vanderbilt University. There are continuing education credits available.

If left untreated, these thoughts, feelings, and behaviors can become worse over time.

The good news:
You can feel better.

Care and treatment can help.

TDMHSAS
Tennessee Department of Mental Health and Substance Abuse Services

This project is funded under an agreement with the State of Tennessee

kidcentral tn
KIDCENTRALTN.COM

Carey Counseling Center, Inc.

For Questions regarding OnTrackTN or to make a referral:

Contact the OnTrackTN Team at:
ontrack@careyinc.org
or our Access Center at
1-800-611-7757

Crisis Services:
Adult Mobile Crisis Line 18+
1-800-353-9918

Youth Crisis Line
1-866-791-9227

OnTrack TN
My health. My choices. My future.

Have you or someone you know:

- started withdrawing from family and friends?
- recently had thoughts that seem strange to you or others?
- become fearful or suspicious of others?
- started hearing or seeing things that others don't?

OnTrack TN
My health. My choices. My future.

Carey Counseling Center, Inc.

Who?

OnTrackTN is for people who:

- Are between the ages of 15 and 30
- Are experiencing symptoms such as, unusual thoughts and behaviors, hearing or seeing things that others do not, or disorganized thinking, for over a week but less that 18 months.
- Are willing to work with a diverse team of healthcare professionals

What?

- Care and support services from a specialized team for up to 2 years, based on your needs and preferences
- Medication treatment if you or your doctor decide it is needed
- Help finding a job or completing school

OnTrackTN is an innovative treatment for adolescents and young adults who recently have had unusual thoughts and behaviors or who started hearing or seeing things that others don't. OnTrackTN helps people achieve their goals for school, work, and relationships.

OnTrackTN is a service available through Carey Counseling Center, Inc. to the following counties in West TN:

- ***Benton***
- ***Carroll***
- ***Gibson***
- ***Henry***
- ***Lake***
- ***Obion***
- ***Weakley***

Carey Counseling Center, Inc. *Access Line 1-800-611-7757*

OMB No. 0930-0168 Approved: 06/12/2015 Expires: 06/30/2018

An Innovative New Program For Early Psychosis

Carey Counseling Center, Inc.

OnTrackTN is an innovative treatment program for adolescents and young adults who recently have had unusual thoughts and behaviors or who have started hearing or seeing things that others don't.

Goal

OnTrackTN helps people achieve their goals for school, work, and relationships.

Eligibility

The program is for adolescents and young adults between the ages of 15-30, who have recently begun experiencing psychotic symptoms such as hallucinations, unusual thoughts or beliefs, or disorganized thinking for more than a week but less than 18 months.

OnTrackTN is available in the following counties of West TN:

Benton, Carroll, Gibson, Henry, Lake, Obion, and Weakley

Participation

OnTrackTN utilizes a "shared decision making" model and involves:

- **Comprehensive care using evidence-based practices delivered by an integrated clinical team specializing in early psychosis.**
- **Services include psychiatric treatment, employment and educational support, substance abuse treatment, family education and support, and other services as needed.**

For Questions regarding OnTrackTN or to arrange a presentation at your facility:

Contact the OnTrackTN Team at:

1-800-611-7757

ontrack@careyinc.org

"Our Mission"

To provide competent, proactive and holistic mental health care services to the community, attending particularly to maximizing the independence of the SPMI (Severely and Persistently Mentally Ill) population, but also including innovative preventive and intervention services in the least restrictive setting clinically appropriate, and in a manner which will assure the greatest level of dignity and respect for the consumer.

OnTrack TN

My health. My choices. My future.

kidcentral tn

This project is funded under an agreement with the State of Tennessee

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q6 Participant Directed Care

At the present time, Tennessee has chosen not to pursue a voucher program. There are other focused efforts under way to encourage participant directed care.

7. Program Integrity

Narrative Question:

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse 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 SABG and MHBG. 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 substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q7 Program Integrity

TDMHSAS carries out an annual contracting process, a rigorous review process, and monitoring of programs that includes on-site review, written reporting, data management and fiscal audit for all Block Grant funded programs.

TDMHSAS General Counsel serves as the Department's Chief Compliance Officer (CCO). The role of the CCO and his/her designee (the Director of Compliance) includes the following:

- review and facilitate compliant contracting and monitoring of programs for fidelity and integrity (with state, federal and accreditation requirements),
- quality assurance and improvement for all programs, contractees, and vendors,
- chairing the compliance review committee, and
- ensure that quality and compliance-related activities proceed as required for the Department at large.

Departmental program staff is responsible for review and monitoring of the programs administered within and contracted through each Division. Department fiscal staff is responsible for financial audits and coordination of the Department's monitoring process.

Providers' contracts require that other sources of funding are used prior to drawing of dollars from Block Grant funding. Contract language includes a requirement that eligibility for Medicaid and other funding is verified before utilizing Block Grant dollars for services that may be covered by insurance. In addition, providers' contracts include language pertaining to compliance with the law, compliance with the reporting of outcomes, and the specifics of program operations and payment requirements. Department staff monitors contract compliance and is responsible for audit, compliance check-ins, and communicating quality and safety standards including credentialing and selection of staff associated with the program. Staffing credentials including background checks and certification or licensing needs are also included in the contract language.

TDMHSAS issues announcements of funding for programs that include the specifics of the program, the scope of services and the amounts of funding available, and what purchases can be made with the funding amounts noted. Providers may apply for participation in the program noted in the announcement with full knowledge of the expectations of the dollars available and conditions for payment. Payment is made to providers on a reimbursement and invoice basis according to a billing schedule that is established in the Fiscal Services Office of the TDMHSAS. Fiscal Services provides claims and payment adjudication; expenditure report analysis; and audits of payment and financial transactions as they pertain to programs and payments.

Each Division of TDMHSAS works collaboratively with other Divisions, providers, stakeholders and the community at large to publicize best practice information including the best practice guidelines produced in house and statutory requirements concerning cultural competency and Title VI requirements. TDMHSAS also undertakes an annual contracting process, a rigorous review process, and monitoring of programs that includes on-site review and written reporting for all Block Grant, state and grant funded programs. Division staff also provides technical assistance when needed.

Tennessee provides "gap" programming for those services or individuals not covered by Medicaid. With the exception of the Behavioral Health Safety Net of Tennessee (BHSNTN) services and the First Episode Psychosis Initiative, there are few direct-service programs (direct psychiatric care, therapy care, or case management care) synonymous with those covered under Tennessee's

Medicaid programs or other third-party payor coverage. Further, the Behavioral Health Safety Net of Tennessee is funded by state dollars and does not receive MHBG funding. MHBG dollars cover those services that are not covered by BHSNTN, Medicaid, Medicare, employer-sponsored insurance or other third-party payor coverage. All programs are designed to address the needs of individuals who are diagnosed with, or at risk of being diagnosed with, serious mental illness or serious emotional disturbance.

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

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

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Tennessee has no federally recognized Tribal nations.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education 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 capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process 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 Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. 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 abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Footnotes:

This section of the submission will be covered separately with submission of the Substance Abuse Prevention and Treatment Block Grant.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

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

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Since the inception of the attached plan, the Compliance Director has convened the Compliance Committee three times, developed the required report that focuses on activities of the RMHIs and Central Office operations, and has operationalized the Plan. The process continues to develop and the Plan will be updated as needed.

TDMHSAS Corporate Compliance/QAQI Plan

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) is required by funder reporting requirements and Federal law to develop a Quality Assurance and Quality Improvement Plan (QAQIP) for the Department at large. The purpose of this QAQIP is to assist the TDMHSAS in designing, implementing, and enforcing a systemic process to detect and prevent criminal, civil, and administrative violations of the Patient Protection and Affordable Care Act (PPACA). All Divisions in the TDMHSAS are subject to the overarching aspects and properties of this QAQIP. This QAQIP is subject to the provisions of Tenn. Code Ann. § 68-11-272, the "Tennessee Patient Safety and Quality Improvement Act"; Tenn. Code Ann. § 33-3-103, Confidentiality of Mental Health Records; 45 CFR Parts 160 and 164, the "Health Insurance Portability and Accountability Act" (HIPAA); and the TDMHSAS Departmental Compliance Policy (13-1).

1. The purpose of an effective QAQIP

The purpose of a QAQIP is to demonstrate TDMHSAS' commitment to honest and reputable business practices both for TDMHSAS direct service operations and externally for contracted and licensed agencies. The six goals of this effective QAQIP are:

1.1 To increase the likelihood of preventing, identifying, and correcting unlawful and unethical behavior at an early stage;

1.2 To ensure that all claims, applications, and other requests for payment from federal health care programs (Medicaid, Medicare, Block Grant, etc.) are complete and accurate and adhere to all applicable laws and regulations;

1.3 To ensure that claims reflect reasonable and necessary services ordered by an appropriately licensed medical professional who is a participating provider in Medicare or Medicaid;

1.4 To ensure that personnel have the ability to report potential problems and/or violations both internally and for contracted agencies or individuals to allow for appropriate investigation and corrective action;

1.5 To promote early detection and subsequent reporting, minimizing financial loss to the government and taxpayers, as well as any financial loss to the TDMHSAS; and

1.6 To ensure that quality services and programming are provided to and available to individuals who are the recipients or eligible recipients of services funded by the TDMHSAS and utilized by the RMHIs, licensed and contracted agencies.

2. Elements of this QAQIP

There are ten elements to the TDMHSAS QAQIP:

2.1 **A Chief Compliance Officer:** The General Counsel Assistant Commissioner for the TDMHSAS will serve as the Chief Compliance Officer (CCO). The CCO shall appoint a Director of Compliance from Central Office who shall report directly to the CCO. The CCO and Director of Compliance will convene a Quality Assurance Quality Improvement Committee (Compliance Committee) comprised of those Department employees with areas of expertise that contribute to the purpose of the Compliance Committee. The CCO shall serve as the chair of the Compliance Committee and has the authority to take any and all action

necessary to effectuate this QAQIP or to create Department-wide consistency. In short, the purpose of the Compliance Committee is to review semi-annual reporting developed as the result of this plan and make recommendations for correction.

2.2 **Director of Compliance:** The Director of Compliance shall be responsible for conducting meetings of the Compliance Committee and for drafting an annual state of compliance report to be submitted to the Commissioner and to the RMHI Governing Body.

2.3 **Policies and procedures:** An overarching policy addressing QAQI and other types of compliance will be developed and reviewed annually for the TDMHSAS. Each TDMHSAS operation and/or Division affected by this QAQIP will develop and maintain procedures for QAQI including, but not limited to, internal audits for quality and compliance with Joint Commission and other required or related standards, an external review of contracted and licensed agencies for compliance with State and Federal law and contract/license requirements.

2.4 **Personnel screening, education, and training:** The TDMHSAS will utilize reasonable efforts to exclude any individual from direct service personnel or personnel in authority who is documented to have engaged in illegal activities or other conduct inconsistent with an effective QAQI and/or ethics standard. The TDMHSAS will implement periodic, effective education and training programs or requirements for programs for the RMHI Governing Body and all employees, including high-level personnel, and the organization's agents, licensed and contracted agencies' personnel.

2.5 **Disciplinary action:** The TDMHSAS, in cooperation with other state or federal agencies when appropriate, will continue to maintain a system to respond to allegations of improper conduct and the enforcement of appropriate disciplinary action against employees or agencies who have violated, condoned or failed to detect or mitigate an offense involving internal compliance and/or contracted policies, applicable statutes, regulations or state and/or federal health care program requirements.

2.6 **Communication:** The TDMHSAS will participate in or maintain a process to receive complaints and adopt procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation. A hotline is presently maintained and staffed by the Tennessee Comptroller of the Treasury to report fraud, waste and abuse, 1-800-232-5454, or reports may be submitted online at www.comptroller.tn.gov.

2.7 **Internal monitoring and auditing:** The TDMHSAS will develop and maintain the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas for internal direct service programming (e.g. RMHI operations, peer support operations, training functions, prevention functions, compliance functions, etc.) executed by state employees or independent contractors.

2.8 **External audit and monitoring:** The TDMHSAS will develop, maintain, and participate in the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of non-compliant activities for contracted agencies and licensed agencies including the background, activities and training of agency employees.

2.9 **Audits in general:** Financial audits are to be conducted in accordance with auditing standards generally accepted in the United States of America and the standards that apply to financial audits contained in the Government Auditing Standards issued by the Comptroller General of the United States. Those Standards require that Government organizations plan and perform audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit will include examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessment of the accounting principles used and significant estimates made by management as well as evaluating the overall financial statement presentation.

2.10 **Corrective action:** The TDMHSAS will develop, implement, evaluate and adhere to a corrective action model for contracted and licensed agencies. The TDMHSAS will develop and maintain investigation and remediation procedures of identified systemic problems including making any necessary modifications to the organization's compliance and ethics programming and planning.

3. Responsibility for the QAQIP

The development and implementation of a QAQIP for the TDMHSAS will be entrusted to the TDMHSAS Chief Compliance Officer and the TDMHSAS Director of Compliance located in the Central Office. The TDMHSAS will create the Compliance Committee chaired by the TDMHSAS CCO. Other Compliance Committee members will include the TDMHSAS Director of Compliance, the TDMHSAS Assistant Commissioner of Hospital Services or designee, the TDMHSAS Director of Fiscal Services or designee, representatives from the TDMHSAS Office of Human Resources, and representatives from all of the TDMHSAS Divisions affected by this QAQIP, including the Division of Mental Health Services (DMHS), the Division of Substance Abuse Services (DSAS), the Division of Planning, Research and Forensics (DPRF), and the Division of Clinical Leadership (DCL). The TDMHSAS Commissioner or designee shall serve as an ex-officio member of the Compliance Committee and has the authority to overturn, alter, or amend any action taken by the Committee at any time as well as to remove any member from the Committee and to designate someone else to service in that person's place.

3.1 TDMHSAS Chief Compliance Officer

The TDMHSAS Chief Compliance Officer will oversee the QAQIP and will provide updates and reports on an annual (summary) basis to the RMHI Governing Body and the Commissioner. To carry out this additional responsibility, the CCO will be given full staff support and cooperation, travel funds as well as appropriate authority and direct access to the TDMHSAS Executive Staff and the RMHI Governing Body. The TDMHSAS CCO will have the responsibility for:

3.1.1 Overseeing and monitoring the implementation of the QAQIP to reduce the TDMHSAS' vulnerability to fraud, unethical and unlawful behavior and to improve quality of services and programming supported by the general operation of the TDMHSAS.

3.1.2 Developing and monitoring internal systems and controls.

3.1.3 Periodically revising the QAQIP to respond to changes in the needs of the organization, and to changes in law or policies or procedures of government funding sources and private payor health plans.

3.1.4 Developing and maintaining documentation of compliance activities and results including, but not limited to, complaints and actions taken across all affected TDMHSAS Divisions and contracted and licensed agencies.

3.1.5 Maintaining a current list of TDMHSAS compliance policies published on the TDMHSAS' intranet and website.

3.1.6 Developing and implementing a compliance training program for TDMHSAS employees.

3.1.7 Standardizing and monitoring the implementation of the QAQIP at the RMHIs, affected Divisions of the TDMHSAS, and affected contracted agencies and licensed agencies.

3.1.8 Chairing a Compliance Committee as described in item (3).

3.1.9 Ensuring that, under the auspices of the compliance policy, reports of alleged violations of the law or the compliance policy shall be given to the CCO for investigation. The CCO will assign the appropriate compliance officer and/or staff for investigation.

3.2 RMHI Compliance Officers

The Chief Executive Officer (CEO) at each RMHI will designate a Compliance Officer for each hospital who will assume responsibility for overseeing the hospital's compliance process and program and will have authority and the staff resources to carry out this responsibility. Each RMHI Compliance Officer will have responsibility for:

3.2.1 Convening and chairing semi-annual meetings, or more often if necessary, of persons designated by the CEOs as a compliance contact person for the respective RMHI.

3.2.2 Ensuring that independent contractors and agents who furnish medical services to the hospital are aware of the hospital's QAQIP including, but not limited to, coding, billing, and marketing.

3.2.3 Coordinating with the RMHI's Office of Human Resources and medical staff to ensure that the National Practitioner Data Bank (NPDB) and List of Excluded Individuals/Entities have been checked against the staffing rolls for all employees, medical staff and independent contractors.

3.2.4 Communicating compliance standards and procedures to all affected employees, physicians, and independent contractors by requiring participation in training programs or disseminating publications, if appropriate, to explain all requirements in a practical and understandable manner.

3.2.5 Ensuring that each RMHI's Office of Human Resources maintains adequate records of training of employees, including attendance logs and material distributed at training sessions, as well as documentation of periodic (annual) credentialing for certain hospital personnel.

3.2.6 Directly supervising (or designating the supervision of) financial management including coordinating internal compliance review and monitoring activities (annual assessment of management risks, internal controls, etc.).

3.2.7 Independently investigating and acting on matters related to compliance, including designing and coordinating internal investigations (e.g., responding to reports of fraud, illegal or unethical behavior or suspected violations).

3.2.8 Taking corrective action with hospital staff, providers, agents and independent contractors as recommended by the TDMHSAS Office of Human Resources and/or the QAQI committee.

3.2.9 Maintaining documentation of complaints of fraud, illegal or unethical behavior and corrective action including the nature of any investigation and its results.

3.2.10 Providing periodic reports and evaluations to the Compliance Committee in writing or in person as requested or as needed depending on the contents of the report.

4. Policies and procedures

The TDMHSAS will maintain a uniform set of policies and procedures related to compliance and QAQI. Presently, state policies related to compliance are maintained by the Tennessee Office of the Comptroller, the Tennessee Departments of Finance and Administration (F&A), General Services (DGS), the TDMHSAS, the Bureau of TennCare and the RMHIs. Policies shall be clearly identified, reviewed, organized, and accessible to all RMHIs, DMHS, DSAS and TDMHSAS employees at large and in total.

4.1 All TDMHSAS employees will be held accountable for following TDMHSAS policies and procedures.

4.2 The TDMHSAS will be clear and concise regarding expectations about employees' responsibility for reporting fraud, illegal acts and unethical business practices during new employee orientation.

4.3 The TDMHSAS will report fiscal summary results of the RMHI fiscal risk assessment to the Compliance Committee annually. The risk assessment report is prepared for the Tennessee Department of Finance and Administration and the Tennessee Office of the Comptroller of the Treasury.

4.4 The TDMHSAS will develop a procedure to ensure that the billing software used by the RMHIs is compliant with Medicare and Medicaid billing requirements.

4.5 RMHIs shall develop and adhere to procedures that:

4.5.1 Ensure that physicians and other practitioners make diagnoses that are consistent with a patient's condition.

4.5.2 Ensure that procedure codes accurately reflect the services provided to a patient.

4.5.3 Ensure that diagnostic codes are entered correctly for reimbursement.

4.5.4 Ensure that the Medicare reports on bad debts and credit balances are consistent with Medicaid and Medicare guidelines.

4.5.5 Ensure implementation of the QAQIP, including any changes that may occur with time.

4.6 RMHIs shall report the results of any external audit of the Medicare Cost Report to the RMHI Governing Body.

4.7 Each RMHI will follow the records retention and disposal policies and procedures of the Tennessee Department of General Services.

4.8 Each affected Division of the TDMHSAS will develop, maintain and adhere to a semi-annual reporting process for providing information to the Compliance Committee in compliance with the QAQIP the specifics of which will be shared with and approved by the Compliance Committee prior to application.

4.9 Each affected Division of the TDMHSAS will develop, maintain and implement a process of review and/or audit for each contracted agency and/or licensed agency, specific to the applicable program and laws/statute/regulation/contract requirements the specifics of which are included in the requirements of the contract or license.

5. Personnel screening, education and training.

5.1 The TDMHSAS will develop, coordinate, and participate in an educational and training program that focuses on the elements of the QAQIP, and seeks to ensure that all affected employees and management are knowledgeable of, and comply with, pertinent Federal and State standards. The training program will target new employees, fiscal staff, and require annual updates for existing staff depending on job responsibilities.

5.2 The Compliance Committee will compile a list of existing policies related to compliance that will be reviewed by all staff on a periodic basis including, but not limited to, policies on background checks (97-6), conflicts of interest (89-1), and reporting fraud (07-1).

5.3 Under the leadership of the CCO, the Compliance Committee will identify categories of staff, training topics, training requirements, and the time such training will take place (pre-service, annual, bi-annual, etc.). Examples of compliance topics include, but are not limited to, the following:

5.3.1 Government and private payor reimbursement principles;

5.3.2 General prohibitions on paying or receiving remuneration to induce referrals;

5.3.3 Proper confirmation of diagnoses;

5.3.4 Services when rendered by a non-physician (i.e., the "incident to" rule and the physician physical presence requirement);

5.3.5 Signing a form for a physician without the physician's authorization;

5.3.6 Alterations to medical records;

5.3.7 Prescribing medications and procedures without proper authorization;

5.3.8 Proper documentation of services rendered;

5.3.9 Duty to report misconduct;

5.3.10 Contract compliance review practices;

5.3.11 Professional code of ethics reviews for physicians/psychiatrists, physician assistants, pharmacy, social work, psychology, counselors, marriage-family therapists, etc.; and

5.3.12 Common violations found in licensed agencies.

5.4 The TDMHSAS Office of Human Resources will ensure that all employees' performance plans require adherence to TDMHSAS policies and procedures and will electronically track all training provided.

5.5 Each RMHI and affected Division will provide regular updates on compliance efforts and requirements to pertinent RMHI and Division staff.

5.6 The Division of General Counsel will incorporate language about compliance with Federal billing, coding, and marketing requirements into contracts and Direct Purchase Authority Authorize to Vendor documents.

5.7 The TDMHSAS Office of Human Resources will periodically conduct a review of employee files to ensure that employees, direct service contractors, medical and clinical staff members are not listed on government sanction lists including the National Practitioner Data Bank (NPDB) and the List of Excluded Individuals/Entities subsequent to initial hire.

5.8 The TDMHSAS Office of Human Resources will ensure that licensed and certified staff have maintained an active license or certification as required by the duties of the position for which staff were hired.

6. Disciplinary action

The Compliance Committee will follow the Tennessee Department of Human Resources (TDOHR) guidelines when taking disciplinary action for violations of policies and procedures related to compliance.

6.1 All disciplinary actions for violations will follow procedures established by the TDOHR.

6.2 The TDMHSAS Office of Human Resources and the TDMHSAS Chief Compliance Officer or the TDMHSAS Director of Compliance will be available to consult with the RMHI Compliance Officer about appropriate disciplinary action for violations of the rules and standards of code of conduct, contracts, laws, regulations and Joint Commission standards.

7. Communication

7.1 Each RMHI and Division will ensure that employees know about the Tennessee Comptroller of the Treasury's Fraud Hotline by posting this information in prominent locations. A hotline is presently maintained and staffed by the Tennessee Comptroller of the Treasury to report fraud, waste and abuse, 1-800-232-5454, or reports may be submitted online at www.comptroller.tn.gov.

7.2 Each RMHI and Division will implement a complaint hotline and post notices about the hotline.

7.3 A log will be maintained by the TDMHSAS Director of Compliance or designee that records hotline calls and complaints, including the nature of the investigation and its results.

8. Corrective action

The Chief Compliance Officer will take reasonable steps to respond promptly and appropriately to fraud, illegal or unethical conduct including:

8.1 Taking prompt action to impose disciplinary action when indicated.

8.2 Taking appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

8.3 Seeking consultation from the Commissioner and the TDMHSAS Division of General Counsel about actions necessary to respond and report probable violations of criminal, civil or administrative law.

8.4 Reporting credible allegations of misconduct that may violate criminal, civil, or administrative law within 60 days of discovery to state and federal authorities along with evidence and cost information.

8.5 Returning promptly any overpayment from Medicare or other health care program.

8.6 Reporting the results of an investigation to the appropriate government authority including impact of the alleged violation on the operation of the applicable health care programs or their beneficiaries.

8.7 Making necessary modifications to all compliance and ethics programs.

8.8 Monitoring compliance with modifications to the TDMHSAS compliance and ethics program.

9. Internal auditing and monitoring for the RMHIs

9.1 RMHIs will use the annual risk assessment report to review, investigate, and mitigate risks by strengthening internal controls to prevent fraud, unethical or illegal behavior. Letters attesting to each RMHI's compliance with the risk assessment are sent by the CEO to the TDMHSAS Commissioner and the Compliance Committee in December of each year. The four RMHI risk assessment reports are kept on file in the TDMHSAS Fiscal Services.

9.2 The RMHI Compliance Officer will present written evaluative reports on compliance activities to the RMHI Chief Executive Officer, RMHI Governing Body, and members of the Compliance Committee periodically no less than biannually or twice a year. This report will specifically identify areas where corrective actions are needed.

9.3 The RMHI Fiscal Directors will meet at least annually to review and share major issues and recommendations.

9.4 RMHIs will present to the RMHI Governing Body the results of Federal audits of compliance with Medicare Conditions of Participation and the results of any audits by the Comptroller of the Treasury. Such information and results will be included in any and all reporting to the QAQI committee.

9.5 RMHI Fiscal Directors will develop detailed annual monitoring plans targeting high risk areas identified in the annual risk assessment. This plan will address areas of concern identified in the annual risk assessment and findings from previous audits as well as the hospital's compliance with laws governing kickback arrangements, physician self-referral, CPT/HCPSC ICD-10 coding, claim development and submission, reimbursement, cost reporting and monitoring.

Approved:

Commissioner

5/13/13
Date

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

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

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

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

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q11 Trauma

Tennessee is involved in multiple initiatives and collaborations to ensure that contracted providers implement strategies to satisfy the need for trauma-informed care. In June of 2013, the Council on Children's Mental Health (CCMH) made recommendations to the Governor and State Legislature regarding the importance of trauma-informed care specifically for children's services including behavioral therapy and strategies for implementing trauma screening, trauma treatment, and trauma-informed approaches to care.

The TDMHSAS's Crisis Continuum fully embraces a trauma-informed philosophy. This is evidenced by a specialized training requirement for staff who conduct assessments for consideration of a history of trauma. Consideration will be made for those with a history of military service and children who may have involvement with child welfare agencies. Presently, there is a statewide effort led by TDMHSAS staff to ensure that individuals who are interacting with the crisis services system are humanely transported to receive the care they need.

In January, 2013, the TDMHSAS's Division of Planning, Research and Forensics, in collaboration with the Division of Clinical Leadership, compiled the Best Practices Behavioral Health Guidelines for Children and Adolescents: Birth-17 years of age. The TDMHSAS maintains a systems-focused approach in regards to trauma-informed care of children and youth (See Trauma-informed Care Best Practice Guidelines, page 46, http://www.tn.gov/behavioral-health/article/behavioral-health-guidelines-for-children). This philosophy is further demonstrated by the recommended interventions outlined within the guidelines document, which refers providers to the National Child Traumatic Stress Network for core components of trauma-informed interventions, as well as to SAMHSA's National Center for Trauma Informed Care (NCTSN) for care models and treatments.

The TDMHSAS promotes trauma-informed care through involvement in multiple collaborations to guarantee that direct service providers are delivering the highest quality, early assessment and treatment to children and families identified as having experienced trauma. The grant-funded Statewide System of Care Expansion Initiative (SOC-EXP), an organizational philosophy and framework, involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. One SOC-EXP goal addresses the use of trauma-informed approaches across the children's mental health system in Tennessee for sustainable training and technical assistance strategies that facilitate ongoing learning, coaching and practice improvement, and support fidelity to SOC values, principles, and practices.

Objective B of the SOC-EXP is to increase availability of an array of System of Care (SOC) related trainings and workforce development opportunities to expand and sustain widespread adoption of the SOC philosophy and increase the competency and capacity of Tennessee's workforce. The array of training includes strategies for implementing trauma screening, trauma treatment, and trauma-informed approaches to care.

To that end, TDMHSAS has agreed to partner with the Tennessee Centers of Excellence for Children in State Custody (COE) to integrate statewide SOC efforts into their existing infrastructure and expand their efforts where appropriate to accomplish TDMHSAS' SOC expansion goals. "The mission of the Centers of Excellence is to improve the quality of physical and behavioral health services provided to children in or at-risk of entering Tennessee state custody by providing direct

clinical services, disseminating evidence-based practices, and implementing quality improvement projects" (Vanderbilt University, 2013).

The following list identifies three existing collaborative projects relevant to the SOC-EXP that exemplify TDMHSAS's commitment to promoting the capacity of mental health providers within Tennessee to deliver trauma-informed care:

1. The Tennessee COE Network has established a Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) Learning Collaborative to train community mental health providers to deliver TF-CBT with fidelity. TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.
2. The Tennessee COE Network has established an Attachment, Self-Regulation and Competency (ARC) Learning Collaborative to train community mental health providers in the ARC model. ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their caregivers, while recognizing that a one-size-model does not fit all. ARC is designed for youth from early childhood to adolescence and their caregivers or caregiving systems.
3. The Child and Adolescent Needs and Strengths Comprehensive Multisystem Assessment (CANS) is a multi-purpose assessment tool developed to support decision making and monitor outcomes in child-serving systems. The Vanderbilt COE maintains a statewide infrastructure to train and certify TDCS staff to reliably use the CANS, and deploys a staff of Master's-level consultants in each TDCS region to support use of the information for services planning.

The Tennessee Coalition to End Domestic and Sexual Violence also produces a Trauma Informed Care policy and best practice approach document for adults who are survivors of domestic violence. See http://www.tncoalition.org/documents/trauma-informed-care-best-practices-tn.

Department of Psychiatry, Vanderbilt University School of Medicine. (2013). Center for Excellence for Children in State Custody. Retrieved on March 15, 2013 from (https://medschool.vanderbilt.edu/coe/).

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

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

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q12 Criminal and Juvenile Justice

In addition to the criminal and juvenile justice descriptions in this narrative answer, there is description added regarding the recovery courts and the forensics programming in Tennessee. All of the noted programs work together to ensure that individuals in need of screening, evaluation, treatment, inpatient care and incarceration are referred to the proper environment.

Tennessee's Regional Mental Health Institutes, in cooperation with the TDMHSAS Central Office staff and Director of Forensic and Juvenile Court Services, evaluate and treat forensic patients when referrals are made by the local courts. Tennessee's forensic mental health system includes the traditional services of evaluation and treatment of pre-trial criminal defendants and defendants found not guilty by reason of insanity (NGRI). Tennessee averages 2,100 outpatient pre-trial evaluations of competence to stand trial and mental condition at the time of the offense and 480 inpatient evaluations per year. At any point in time, forensic cases occupy 18%-20% of state facility beds (100-115 of 562 beds). Tennessee's forensic mental health system is primarily community-based and decentralized: between 75% and 80% of all pre-trial evaluations are completed on an outpatient basis with no referral for inpatient services, and of those cases referred for inpatient evaluations, 80% are completed in the Regional Mental Health Institutes and only 20% are admitted to the maximum security unit. The average daily census for forensic cases in the maximum security unit is 17.

Tennessee State Law also directs that court-ordered evaluation of a criminal defendant's competence to stand trial and/or mental condition at the time of the offense be conducted by a community mental agency or private practitioner designated by the Commissioner of TDMHSAS on an outpatient basis, whether that's in a jail setting or at the agency's office. The TDMHSAS therefore has contracts with nine different agencies across the state to cover all jurisdictions; each court has an assigned outpatient forensic mental health evaluation provider. The TDMHSAS Office of Forensic and Juvenile Court Services provides training, certification, and ongoing technical assistance to professionals designated at each provider to conduct forensic mental health evaluations and associated services. In Fiscal Year 2013-2014 (FY 14), 1,899 outpatient evaluations were conducted.

TDMHSAS holds a Memorandum of Understanding with the Board of Parole (BOP) for TDMHSAS to provide risk assessment evaluations on certain parole eligible Department of Corrections inmates as requested by the BOP. Statute requires psychiatric evaluation of inmates convicted of certain sex offenses prior to consideration by the BOP (see T.C.A. § 40-28-116), but the majority of requests from the Board are on violent non-sex offenders for an assessment of propensity for violent re-offense. There have been 168 evaluations conducted since the beginning of FY 11, 65 (39%) sex offender evaluations and 103 (61%) violent offender risk assessments. All offenders were male until FY2014 during which there was one female offender evaluated under the sex offender statute and one female offender evaluated as a violent offender. Evaluations are conducted by a psychiatrist from the Vanderbilt University Medical School Department of Psychiatry who has completed the TDMHSAS Forensic Evaluator certification and the Sex Offender Treatment Board training. Evaluations include the use of at least one actuarial risk assessment instrument (e.g. the Violence Risk Appraisal Guide).

TDMHSAS also administers both the Tennessee Integrated Court Screening and Referral Project (TICSRP) and the Mandatory Outpatient Treatment (MOT) program. TISCRP began in 2009 through a Criminal Justice/Mental Health Collaboration Grant awarded by the Bureau of Justice Assistance to implement a process of conducting mental health and substance abuse screenings on youth

referred to juvenile courts as unruly or delinquent. Originally a two-and-a-half year grant, the program was extended. The project was intended to improve access to mental health and substance abuse services for youth in juvenile court, increasing the opportunities for diversion from the juvenile justice system and reducing recidivism. The project trains juvenile court staff, typically the courts' youth service officers (YSOs), to complete a 33-item juvenile justice screening version of the Child and Adolescent Needs and Strengths inventory (CANS) on youth at the point of intake into juvenile court for youth alleged to be unruly or delinquent. Those youth who appear to need mental health or substance abuse services are then referred to locally available services by the Department of Children's Services (DCS) court liaisons.

The purpose of mandatory outpatient treatment (MOT) is to provide a less restrictive alternative to inpatient care for service recipients with a mental illness who require continued treatment to prevent deterioration in their mental condition and who will respond to a legal obligation to participate in outpatient treatment. For forensic patients, there are two types of MOT in Tennessee law: Type one starts with an individual in the hospital, expires in six months, can be modified by the provider, and non-compliance can mean a return to the hospital. Type two begins in the community, does not expire, can only be terminated by the court, and non-compliance may result in contempt of court charges. For other patients not admitted under the forensic umbrella, MOT is also an alternative and can begin, as noted, with the patient in the hospital or in the community.

The Division of Substance Abuse Services also administers Criminal Justice programs. The TDMHSAS Office of Criminal Justice serves the needs of people involved in court cases who struggle with substance abuse and mental health issues. A variety of resources are available to help individuals access treatment and recovery services.

The Criminal Justice Behavioral Health Liaison Program is available to individuals with serious mental illness and substance abuse issues who are incarcerated or who are at risk of being incarcerated. Drug or Recovery Courts in Tennessee offer treatment and recovery services in place of a jail sentence for non-violent offenders. At the time of this application, there are 43 recovery courts, three Veterans courts, one family court and three juvenile recovery courts. The Driving Under the Influence (DUI) School, offered throughout Tennessee, is available to individuals charged with DUI as a treatment option to decrease dependency on alcohol and drugs. In partnership with the Department of Correction, former offenders on parole who struggle with mental health and substance abuse issues and risking probation or parole violations can obtain outpatient services and supervised treatment. Alcohol and Drug Addiction Treatment is available to those convicted of DUI and ordered by the court into treatment. Residential and outpatient treatment costs are covered for individuals who are unable to pay. Supervised probation offender treatment pays for court-ordered alcohol and drug treatment on a residential rehabilitation, halfway house, and outpatient basis. More detailed information about these programs can be found in the Substance Abuse Services Block Grant application.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

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

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q13 State Parity Efforts

Regulations issued in May 2015 (not finalized at the time of this application) pertain to CHIP and Medicaid and greatly affect the population whose needs are met by the services funded through Medicaid and TDMHSAS. TDMHSAS Divisions of General Counsel and Planning, Research and Forensics have worked together to develop Departmental understanding related to parity. TDMHSAS and TennCare are collaborating to ascertain changes needed, if any, to ensure parity compliance in Tennessee related to CHIP and Medicaid benefits.

The Tennessee Department of Commerce and Insurance (TDCI) is responsible for private plan parity compliance enforcement. TDMHSAS Commissioner has consulted with the Commissioner of TDCI with regard to private and exchange plans.

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

This question will be answered with the submission of Tennessee's Substance Abuse Prevention and Treatment Block Grant Application.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

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

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q15 Crisis Services

TDMHSAS Division of Mental Health Services, Office of Crisis Services and Suicide Prevention administers a statewide, large and robust system of care for crisis intervention, care management, and aftercare support for individuals diagnosed with SMI, SED and SUD.

Crisis Prevention and Early Intervention

- Wellness Recovery Action Plan (WRAP) Crisis Planning – WRAP is utilized in the development of crisis plans. Crisis services workers develop the plans in collaboration with service recipients and their support persons after a behavioral health crisis episode, during the face-to-face crisis encounter and during a stay in a Crisis Stabilization Unit. Because many individuals have a significant potential to require subsequent encounters with crisis services, these plans are implemented by service recipients and their support system as a means of either preventing a future crisis episode or having an action plan to intervene before the episode becomes severe enough that crisis services is needed.
- Psychiatric Advance Directives – Responding clinicians in the statewide Mobile Crisis system and at the Walk-In Centers identify whether each service recipient has established psychiatric advance directives and is expected to implement accordingly and as directed. Education regarding the Declaration for Mental Health Treatment is provided during Mandatory Prescreening Agent training.
- Family Engagement – Family engagement is highly encouraged and implemented whenever possible during a crisis services encounter, whether in person or via phone. Family and other identified primary support persons provide much needed support for the service recipient during a crisis, and provide collateral information that is crucial to a comprehensive and thorough crisis assessment. Family is engaged by crisis services during the safety, follow-up, and longer-term planning for individuals assessed, regardless of level of treatment plan.
- Safety Planning – As part of the face-to-face encounter during a behavioral health crisis, crisis service responders create or modify a plan that ensures the individual has adequate safety supports and knows what to do to prevent a future crisis from occurring. Safety plan development and/or modification are/is required for all individuals except those referred for hospitalization.
- Peer-Operated Warm Lines – Crisis call centers often receive calls and call transfers from warm lines, including those that are operated by peer professionals. These calls are triaged and fielded with the same integrity as those that are received from more traditional referral sources. Peer operated warm lines are often recommended to individuals calling the crisis line as a support resource if the individual's needs do not rise to the level of a crisis response.
- Peer-Run Crisis Respite Programs – Respite programs operated within the crisis continuum utilize peer recovery specialists to support the individual during their respite admission.
- Suicide Prevention –Mobile crisis and walk-in triage services are available 24 hours a day, 7 days a week across the state for individuals experiencing a suicidal crisis. Suicide prevention objectives and principles are implemented within the crisis services continuum, including having the Columbia Suicide Severity Rating Scale embedded within the Tennessee Standardized Crisis Assessment. This ensures every person receiving a face-to-face encounter with crisis services is screened for suicide risk. Suicide prevention training is provided for all staff operating within the Crisis Stabilization Units. Crisis staff is also required to take Counseling on Access to Lethal Means (CALM) training to ensure they have the skills needed to provide assistance to families who may need to discuss the removal of a lethal means from the proximity of an individual who has threatened or attempted suicide.

The Office of Crisis Services and Suicide Prevention administers two SAMHSA grant-funded suicide prevention projects, both of which incorporate the Zero Suicide initiative components to reduce deaths by suicide in Tennessee. The Office oversees and collaborates with the Tennessee Suicide Prevention Network (TSPN), Project Tennessee, Mental Health 101, and Youth Screen programs, all aimed at suicide prevention. TSPN is a statewide public-private organization responsible for implementing the Tennessee Strategy for Suicide Prevention as defined by the 2001 National Strategy for Suicide Prevention. Project TN ensures all teachers receive suicide prevention training. MH 101 is provided to students to reduce the stigma associated with reporting suicidality. Youth Screen provides assessment of school aged youth for the purpose of early identification of mental health and substance abuse related disorders.

Crisis Intervention/Stabilization

- Assessment/Triage (Living Room Model) – Several of the crisis respite providers employ a Living Room Model in the design of the respite program; however, the concept has not yet been fully integrated into the crisis continuum.
- Open Dialogue – The approach of inclusivity that is practiced in Open Dialogue is utilized during face-to-face assessments when family, primary support persons and providers are all available and present.
- Crisis Residential/Respite – Crisis Respite services are utilized to provide a means to promote de-escalation, removal of environmental triggers for crisis, resource identification and referrals, and development of safety plans to promote a safe and successful transition to the community. Four crisis respite sites are available within the Tennessee crisis services continuum. Eight Crisis Stabilization Units (CSU) allow individuals to voluntarily receive services for up the 120 hours for each admission. CSUs provide medication management, individual and group counseling, and individualized treatment planning.
- Crisis Intervention Team/ Law Enforcement – Many of Tennessee's counties have specially trained Crisis Intervention Officers but even when CIT officers are not available, the crisis system collaborates with law enforcement to address the mental health needs of individuals within the community.
- Mobile Crisis Outreach – Mobile crisis services are available 24 hours a day, 7 days a week, 365 days a year to respond to individuals experiencing a behavioral health crisis, regardless of payer source. This service is rendered wherever needed to meet the needs of the individual and their support system, including but limited to residences, emergency departments, outpatient clinics and community mental health centers. Mobile crisis' objective is to provide a thorough assessment to determine the least restrictive means of treatment and stabilization, provide safety planning and promote continuity of care.
- Collaboration with Hospital Emergency Departments and Urgent Care Systems – Crisis services providers partner with community emergency departments and urgent care systems to respond to patients who presented at the hospital or urgent care with a behavioral health crisis to determine the most appropriate level of treatment and care. The emergency departments and urgent care systems provide means to help rule out medically-related conditions that may either be a cause for the psychiatric symptoms or be a barrier to facilitating the most appropriate level of behavioral health care. While coordination of services between emergency departments and crisis services help to streamline dispositions, efforts are continuously being made to reduce reliance on unnecessary emergency department visits. Routine meetings occur across the state to ensure a system of care approach is taken with law enforcement, emergency departments, inpatient psychiatric providers and behavioral health service providers all involved in the care of an individual in need of emergency psychiatric services.

Post Crisis Intervention/Support

- WRAP Post-Crisis – The statewide Mobile Crisis system and Walk-In Triage Centers utilize the WRAP crisis planning model in the development of safety and crisis plans during the face-to-face crisis encounters to identify triggers, warning signs, removal of access to lethal means, coping tactics, contact persons and action steps. Additionally, WRAP training is provided to individuals admitted to a Crisis Stabilization Unit.
- Peer Support/Peer Bridgers – Peer support services are utilized at CSUs and Crisis Respite as a means to provide relatable direct support during the acute care stabilization period as well as during discharge and safety planning. TDMHSAS is the recipient of a grant that will pilot Peer Bridgers at two CSU locations and within the RMHIs. Peer Bridgers will assist with discharge planning, navigation of the mental health system and transition into the community
- Follow-Up Outreach and Support – Crisis providers are required to provide one telephonic follow-up contact within 12-24 hours of the face to face assessment for individuals that were not referred for hospitalization to determine the effectiveness of the crisis intervention and ensure service linkage. Additionally, for individuals discharged from a CSU, a follow-up call, e-mail, text or letter is made to the individual within one (1) business day to ascertain well-being and another follow-up call, e-mail, text or letter is made within ten (10) business days to ascertain if appointments were kept and to resolve any barriers that the individual encountered for keeping discharge appointments.
- Family-to-Family engagement – Children and youth crisis services have access to the utilization of family support specialist services from Tennessee Voices for Children as a means to facilitate support and connection to families with similar experiences.
- Connection to care coordination and follow-up clinical care for individuals in crisis – The crisis services continuum prioritizes continuity of care by ensuring contact is made with behavioral health services providers, including therapists, medication providers and case managers, both during the face-to-face encounter and the referral process to treatment. Follow-up medical management and case management appointments are scheduled, and behavioral health services providers are consulted to encourage a stable and structured transition to the community after discharge from the location of recommended treatment.
- Follow-up crisis engagement with families and involved community members - Crisis services provides follow-up contact with service recipients and, when available, their primary support persons within 12-24 hours of the crisis assessment. Additionally, a customer satisfaction survey is conducted with a random sampling of individuals served through the child and youth crisis system and a stakeholder survey is conducted with systems relying on the services provided through the child and youth crisis services system.

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q16 Recovery

The Tennessee Department of Mental Health and Substance Abuse Services subscribes to a progressive view of recovery as a way of life for those living with mental illness or substance use disorders. The view includes the following tenets:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs from many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship, social networks, families and communities;
- Recovery is culturally based and influenced;
- Recovery addresses trauma;
- Recovery builds individual, family and community strengths; and
- Recovery is based on mutual respect.

An individual (even those presenting with more complex disorders) can experience recovery although the illness is not "cured". Recovery is a way of living a satisfying, hopeful life as a contributing member of one's community in spite of the presence of any symptoms of mental illness. In Tennessee, recovery is the accepted goal of all treatment for all individuals living with mental illness and/or substance abuse problems.

These tenets are passed on to providers receiving funding from all sources, including Block Grant funds, state and other federal funds.

The State's Definition of Recovery

The Tennessee Department of Mental Health and Substance Abuse Services defines recovery: the process in which service recipients diagnosed with mental illness and/or alcohol and drug abuse dependency disorders live, work, learn, and participate fully in their communities. Recovery services help service recipients live a full or productive life with a disability and may result in the reduction or complete remission of problems or abstinence from addictive behaviors. Recovery services include: basic education about mental illness or addictive disorders, case management, drug testing, employment support, family support, pastoral support/spiritual support, social activities, relapse prevention, housing transportation and consumer/peer support.

The State's Certification Program for Peer Recovery Specialists

In 2005, to further its commitment to recovery, Tennessee joined a handful of other states in identifying peer support services as a Medicaid-reimbursable service as provided by a trained peer recovery specialist certified by the state. Peer recovery support is a best practice model of recovery for supporting people with lived experience of mental illness. This model relies on individuals who live with mental illness to provide peer-to-peer support to others while drawing on their own experiences to promote wellness and recovery. The principles of peer recovery support include identification and empathy, recovery and resiliency modeling, personal responsibility, and instilling hope ("I'm doing it. So can you!") The peer recovery support model is fostered in Tennessee through the Tennessee Peer Recovery Specialist Certification Program, which began in 2007 and is administered by the Office of Consumer Affairs and Peer Recovery Services.

A Tennessee Certified Peer Recovery Specialist has self-identified as a person with a mental illness or co-occurring disorder and has successfully navigated the service system to access treatment and resources necessary to build personal recovery and success with his or her life goals. This individual undergoes training recognized by the department on how to assist other persons with mental illness in fostering their own wellness, based on the principles of self-directed recovery. Tennessee Certified Peer Recovery Specialists deliver unique services in the mental health system, provide Medicaid-billable services through provider agencies, assist service recipients by promoting self-directed recovery goals, and function as role models, advocates, teachers and group facilitators. To date, Tennessee has certified 222 Peer Recovery Specialists and continues to expand the professional employment opportunities for peers statewide.

Tennessee Peer Recovery Centers

Tennessee also promotes recovery and peer support through its 43 peer support centers throughout the state. For the past 21 years, peer recovery support centers have served as places where adults with lived experience of mental illness or co-occurring disorders develop their own programs of recovery to supplement existing mental health services. Tennessee's peer recovery support centers offer individuals the recovery education, information and support they need to manage their own recovery process and acquire the necessary skills for the utilization of resources within the community. The peer-run centers are places where people can become educated about their mental illness and its treatment and also learn about the resources they need to achieve their own individualized recovery goal plan. The centers offer a range of skill-building and recovery activities developed and led by peer staff members, who are trained in the recovery process and in how to engage peers in their own recovery process. The individuals who come to the centers have an opportunity to develop peer leadership skills that enable them to participate in various roles within the center. Peer recovery support center participation reduces social isolation, improves self-concept, increases independence, increases one's ability to ask for help, reduces likelihood of hospitalization, and increases control over one's life.

Family Support Specialist Certification Program

The Family Support Specialist Certification Program (FSSCP) provides State certification for individuals who provide direct caregiver-to-caregiver support services to families of children and youth with mental, emotional, behavioral, or co-occurring disorders. Because of their life experience in caring for children with these disorders and navigating child-serving systems, Certified Family Support Specialists (CFSSs) are able to use their unique experience to inspire hope and provide support to others who are facing similar challenges. This program will allow Certified Family Support Specialists to provide a level of service and support beyond that of clinical staff. The Certified Family Support Specialist can perform a wide range of tasks to assist caregivers in managing their child's illness and fostering resiliency and hope in the recovery process. Direct caregiver-to-caregiver support services include, but are not limited to:

- developing formal and informal supports,
- assisting in the development of strengths-based family and individual goals,
- serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, and/or
- providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

Direct caregiver-to-caregiver support services provided by a Certified Family Support Specialist are a vital resource to assist families and others who are caring for children and youth with emotional, behavioral, or co-occurring disorders. To achieve the resiliency and recovery goals of the child and family, the CFSS promotes self-determination, personal responsibility, the skills, knowledge and confidence to be an effective advocate for his/her child, and inspires a sense of hope that resiliency and recovery are achievable goals.

TMHCA and NAMI Warmlines and Other Services

Another way that Tennessee also fosters recovery by providing funding to the Tennessee Mental Health Consumers' Association (TMHCA) and NAMI Tennessee. Both organizations provide recovery education and support to its members statewide through warmlines, websites, training opportunities, support groups, and advocacy. Both organizations initially began with money and support from the Department; NAMI Tennessee began in 1985, TMHCA in 1987. They have both grown significantly since their beginnings and today serve as a widely recognized source of recovery throughout Tennessee.

TDMHSAS Consumer Advisory Board (CAB)

In 1986, Congress passed the Protection and Advocacy for Mentally Ill Individuals Act, requiring that protection and advocacy agencies establish consumer advisory boards consisting of at least 50 percent mental health consumers or family members. Consumer advisory boards, however, need not be limited to protection and advocacy agencies. In 2003, the President's New Freedom Commission on Mental Health report emphasized the importance of having consumers lead the design, implementation, and evaluation of mental health service systems. These key benchmarks are important to the consumer movement in that the needs of consumers are front and center as the delivery system is planned rather than as it is executed. In the effort to actualize this vision, the TDMHSAS Consumer Advisory Board has been a voice for mental health consumers in Tennessee since 1994.

TDMHSAS CAB Mission Statement: to voice an informed perspective on policy and planning issues that impact the recovery, resiliency, and rights of persons with mental illness.

The Consumer Advisory Board serves two roles:

1. Advise the Office of Consumer Affairs (OCA) and Peer Recovery Services Director
   - Gathers input from consumers statewide on issues of concern
   - Provides input to OCA with an annual report
   - Develops policy position papers on consumer issues

2. Represent consumers on the Statewide Planning and Policy Council and each of the seven regional councils.
   - Identifies and reports to the Councils issues of concern to consumers
   - Makes recommendations on actions to be taken to address issues
   - Ensures increased consumer participation on the Planning Councils

The Consumer Advisory Board's major achievement over the last three years includes two annual Peer Recovery Specialist Conferences. The Conferences were instrumental in promoting peer specialist work throughout the state and has helped to educate stakeholders regarding the value of hiring trained Peer Specialists in their agencies. As the direct result, the TDMHSAS continues to help

reduce stigma associated with those who live with mental health and substance abuse disorders, and create better community mental health services.

Some of the CAB's educational and advocacy projects include:

- appropriate ways to contact legislators and advocate for causes;
- consumer access to dental and visual care, and;
- board and care homes throughout the state.

The CAB's monthly conference calls have included excellent guest speakers provided by the State, a practice that helps keeps the membership well informed on such issues as budget concerns and new concepts such as "one stop shopping" in which most services can be accessed at one site. Educational information about the operation of the Behavioral Health Safety Net of Tennessee has also been included as part of the CAB's conference calls. The CAB focuses on programs that consumers need, the rights of consumers, and the effect of projecting a voice for consumers throughout the State.

The **Creating Homes Initiative (CHI)** In the year 2000, TDMHSAS began the Creating Homes Initiative (CHI). The CHI commenced the process of integrating Tennesseans who are diagnosed with serious mental illness or substance use disorders into the community setting of the individual's choice. Since the year 2000, more than 14,000 housing opportunities have been created leveraging federal, state and local money with other types of funding. CHI was launched in August of 2000 utilizing the expertise of TDMHSAS executives and a volunteer team of housing experts to conduct a review of current housing, support services, and resources for persons diagnosed with mental illness. The team met one-on-one with consumers and collaborated with mental health stakeholders as well as community citizens to ensure that TDMHSAS began development of the project with the appropriate need and goal in mind. What resulted was a targeted, grassroots, local community, multi-agency strategic plan founded in a statewide and community-based collaborative partnership.

Members of the task forces identified the housing needs in their local community, solicited proposals, and recommended the best proposals to receive funding assistance from TDMHSAS. The Tennessee Housing Development Agency (THDA) provided additional funding to increase the number of projects that could be completed in this first CHI funding cycle.

The overall mission of the initiative is to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable and permanent housing options for people with mental illness and co-occurring disorders. The goal is to create safe, affordable housing for adults with mental illness and co-occurring disorders along a continuum beginning with 24/7 supervised living facilities to home ownership. Goals set by the consortium in 2001 have been met up to the present day; 14000 total housing opportunities have been realized for TDMHSAS constituents in Tennessee, over 80% of which are independent rental or rental voucher opportunities and 8% are home-ownership situations.

Since the inception of the CHI, individuals with mental illness have benefited from the range of quality, safe, affordable, permanent housing from home ownership to 24/7 supervised group settings. These options are being developed in partnership with local CHI communities that determine the local needs and implement the plans to address these needs. Dollar allocated to the CHI assist in the development and leveraging of new federal, other state, local, and private funds producing permanent housing in the following categories:

1. homeownership,
2. private and public market rental housing,
3. partially supervised group housing, and
4. supervised group housing with 24-hour on-site care.

Regional Housing Facilitators are located in each of the statewide mental health planning regions for the purpose of enhancing and expanding housing options for persons with mental illness, providing a local extension of the TDMHSAS Office of Housing and Homeless Services. Quality reviews of the housing created through the CHI are conducted to ensure that quality standards are being upheld while the number of units created increases.

Therapeutic Intervention, Education, and Skills (TIES)

The Therapeutic Intervention, Education, and Skills (TIES) program addresses the complex needs of children, from birth to age 17, who are at-risk of out-of-home placement due to parent or caretaker substance abuse. The Department of Mental Health & Substance Abuse Services partners with the Department of Children's Services and Centerstone, a community behavioral health treatment center, to provide Intensive Family Preservation Services and Seeking Safety treatment for children and families affected by substance abuse and trauma.

Services are available for families who live in Bedford, Cannon, Coffee, Davidson, Marshall, Rutherford, and Warren counties. TIES services help keep families together and children safe and healthy. Services available are:

- In-home counseling
- Access to crisis intervention 24/7
- Basic skills education
- Psychosocial education
- Seeking Safety
- Connecting participants to social and community services
- Connecting participants to substance abuse treatment programs and recovery support

Housing

TDMHSAS operates a number of programs targeted toward integrating those who may have been hospitalized into community settings. For adult individuals diagnosed with a mental illness or co-occurring disorder, Intensive Supportive Living and Community Supportive Housing offers a range of housing types, from group homes to independent living, in communities across Tennessee that offer support and supervision as needed. Staff is available to help residents develop the necessary skills to live independently, reducing the likelihood of hospitalization and increasing the chances of securing employment. Residences provide a welcome support system. In this way, TDMHSAS facilitates recovery for those who might need extra support to further their recovery experience.

17. Community Living and the Implementation of Olmstead

Narrative Question:

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

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

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

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q17 Community Living and Olmstead

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) operates four Regional Mental Health Institutes (RMHI). In July of 2012, TDMHSAS closed the fifth RMHI in Knoxville known as Lakeshore Mental Health Institute (Lakeshore). Patients who were located at Lakeshore were, through a careful process of care management, transferred into community settings that ranged from home, family, group home, independent living to other inpatient facilities. State funding saved by the closure of Lakeshore was reinvested in community-based programming that included the development and funding of a peer-run call center operated through Mental Health America in Knoxville; providing increased funding to crisis services in the area previously covered by Lakeshore to help avert the need for hospitalization; and creation of 28 new community-based supportive living opportunities. On the other end of the State in Memphis, TDMHSAS downsized the Memphis Mental Health Institute and reinvested the saved dollars into community services, namely crisis services and services designed to prevent those presently living in the community from becoming hospitalized and 14 community supportive living opportunities.

In the year 2000, TDMHSAS began the Creating Homes Initiative (CHI). The CHI commenced the process of integrating Tennesseans who are diagnosed with serious mental illness or substance use disorders into a community setting. There was great emphasis placed on giving service recipients a choice about the housing needed and desired. Since the year 2000, more than 14,000 housing opportunities have been created leveraging federal, state and local money with other types of funding. CHI was launched in August of 2000 utilizing the expertise of TDMHSAS executives and a volunteer team of housing experts to conduct a review of current housing, support services, and resources for persons diagnosed with mental illness. The team met one-on-one with consumers and collaborated with mental health stakeholders as well as community citizens to ensure that TDMHSAS began development of the project with the appropriate need and goal in mind. What resulted was a targeted, grassroots, local community, multi-agency strategic plan founded in a statewide and community-based collaborative partnership.

The first step of the CHI was to establish and facilitate task forces in four communities with the greatest need. The task forces included representation from the following entities: Tennessee Mental Health Consumers' Association (TMHCA), Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), Fannie Mae, Homebuilders Association, United Way, Mental Health Centers and Mental Health Social Service Agencies, National Alliance for the Mentally Ill (NAMI), Housing Authority, Statewide/Regional Mental Health Planning Councils, Habitat for Humanity, Department of Housing and Urban Development (HUD), Association of Realtors, Office of Economic and Community Development, Development Districts, Local Government, Foundations, Business Community, Tennessee Housing Development Agency (THDA), Tennessee Association of Mental Health Organizations (TAMHO), Behavioral Health Organizations, Faith-based community organizations, local banks, landlords, housing counselors, supportive living/group home operators, Federal Home Loan Bank, Federal Reserve Bank, architects and builders, and other interested community persons.

Members of the task forces identified the housing needs in their local community, solicited proposals, and recommended the best proposals to receive funding assistance from TDMHSAS. The Tennessee Housing Development Agency (THDA) provided additional funding to increase the number of projects that could be completed in this first CHI funding cycle.

The overall mission of the initiative was to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable and permanent housing

options for people with mental illness and co-occurring disorders. The goal was to create safe, affordable housing for adults with mental illness and co-occurring disorders along a continuum beginning with 24/7 supervised living facilities to home ownership. Goals set by the consortium in 2001 have been met up to the present day; 14000 total housing opportunities have been realized for TDMHSAS constituents in Tennessee, over 80% of which are independent rental or rental voucher opportunities and 8% are home-ownership situations.

Currently, the TDMHSAS Office of Housing and Homelessness Services contracts across the State for six Regional Housing Facilitators. The Facilitators have the following as part of their responsibilities with regard to developing community living opportunities:

- Facilitate the local task force meetings;
- Aggressively seek out and collaborate with potential funding entities to leverage and funnel housing funds to local communities;
- Identify and recommend financing strategies and grants that will provide support for the development of permanent housing options and associated support services;
- Collaborate with all available local resources through the local community planning groups to increase the availability of and access to housing;
- Coordinate with other public agencies and the private sector to stimulate the preservation, development, and enhancement of housing options;
- Direct new resources and develop plans, as funds become available, to increase housing options;
- Uphold the quality of the current housing utilized for those persons diagnosed with mental illness and co-occurring disorders.

Since the inception of the CHI, persons with mental illness have benefited from the range of quality, safe, affordable, permanent housing from home ownership to 24/7 supervised group settings. These options are being developed in partnership with local CHI communities that determine the local needs and implement the plans to address these needs. Dollar allocated to the CHI assist in the development and leveraging of new federal, other state, local, and private funds producing permanent housing in the following categories:

1. homeownership,
2. private and public market rental housing,
3. partially supervised group housing, and
4. supervised group housing with 24-hour on-site care.

Regional Housing Facilitators are located in each of the statewide mental health planning regions for the purpose of enhancing and expanding housing options for persons with mental illness, providing a local extension of the TDMHSAS Office of Housing and Homeless Services. Quality reviews of the housing created through the CHI are conducted to ensure that quality standards are being upheld while the number of units created increases.

The TDMHSAS strongly supports the full choice and participation of persons with mental illness in all aspects of community life. This belief necessarily entails creating opportunities for individuals to have access to community housing in the most appropriate setting, consistent with their needs and choice. It has been evidenced through the work of the CHI that once individuals live in community settings with proper supports in place, a rapid transformation begins to occur, leading to the questions: How can one truly be in recovery without a home? How can one participate in community life without a home? The CHI provides a real strategy with which to address this much

needed source of strength--home. With this new-found confidence and security, individuals assisted through the CHI find themselves more willing to take an active, contributing role in the communities in which they live through volunteer work and/or through employment.

In addition to the CHI, TDMHSAS operates a number of programs targeted toward integrating those who may have been hospitalized into community settings. For adult individuals diagnosed with a mental illness or co-occurring disorder, Intensive Supportive Living and Community Supportive Housing offers a range of housing types, from group homes to independent living, in communities across Tennessee that offer support and supervision as needed. Staff is available to help residents develop the necessary skills to live independently, reducing the likelihood of hospitalization and increasing the chances of securing employment. Residences provide a welcome support system.

Community Targeted Transitional Support (CTTS), offers financial and service assistance to very low income individuals with a serious mental illness. One month's rent, utility bills, and dental and eye care can be provided through local community mental health agencies that administer the program. Similarly, Inpatient Targeted Transitional Support (ITTS) offers rental and utility assistance plus any other financial assistance needed for up to six months for individuals being discharged from inpatient psychiatric care to ensure prompt discharge when clinically appropriate and to enhance successful community integration.

Veterans who are diagnosed with mental illness, substance use disorder, or a co-occurring mental illness and who are experiencing homelessness, as well as other people experiencing chronic homelessness can receive specialized case management services, outreach, and help finding permanent affordable housing. Currently, help is available in Davidson and Shelby County. This program will be expanded beginning in October 2015 to include 20 additional counties in East Tennessee.

TDMHSAS also administers and funds the Emerging Adults program designed to assist young people who are leaving foster care or leaving a mental health residential treatment facility. The Emerging Adults program includes life skills classes and partially-supervised housing, including employment preparation, support to complete and further education, budgeting and financial education, meal planning and preparation, and information about caring for one's physical health. At present, Emerging Adults is operating in Davidson County (Nashville) in the Region 4 Planning Council Region. In tandem with Emerging Adults, TDMHSAS funds the Supported Employment program statewide. Having a job helps pay the bills and provides an individual with a sense of pride and belonging. Having a job adds structure to daily life, increases social contacts and support, and enhances opportunities for personal achievement. Statewide Supported Employment programs assist individuals in obtaining employment, and once employed, provide supports to assist in maintaining the job.

Future efforts include a new community care bridgers program that will be operational by the end of FY2016. Peer Bridgers will operate in the RMHIs to assist individuals being discharged from the hospitals with obtaining proper housing and aftercare. Peer support services is utilized at CSUs and Crisis Respite as a means to provide relatable direct support during the acute care stabilization period as well as during discharge and safety planning. TDMHSAS is the recipient of a grant that will pilot Peer Bridgers at two CSU locations and within the RMHIs. Peer Bridgers will assist with discharge planning, navigation of the mental health system and transition into the community.

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health 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.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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

[91] 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.

[92] 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.

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

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[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q18 Children and Adolescents Behavioral Health Services

In the past two years, TDMHSAS has reorganized children and youth efforts in the Division of Mental Health Services. The Office of Children and Youth Mental Health encompasses all mental health programming and services associated with children and youth. Information related to adolescent services for substance abuse will appear in the Substance Abuse Prevention and Treatment Block Grant application with one exception: the System of Care initiative offers an embedded program for children whose families are impacted by substance use or abuse.

System of Care Programming and Philosophy in Tennessee

The system of care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access to care. System of Care initiatives are focused on expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. The system of care philosophy is built upon these core values and guiding principles:

- To be family-driven and youth-guided with the strengths and needs of the child/youth/young adult and family determining the types of services and supports provided;
- To be community-based with the primary services as well as the system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level; and
- To be culturally and linguistically competent with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve in order to help people access and use the correct services and supports and to remove inequalities in care.

Aspects of SOC efforts in Tennessee

1. Technical Assistance Center--provides resources, training, and consultation to community partners, family members/caregivers, youth, and young adults statewide on topics such as trauma-informed care, family-driven/youth-guided services, care coordination, advocacy skills, family engagement, cultural and linguistic competence, early childhood development, and collaboration strategies.
2. Family Support Specialist Certification Training-- For families with a child experiencing emotional, mental, or behavioral disturbances, the opportunity to get certified as a family support specialist can be very beneficial. Family Support Specialists provide unique services in the children's mental health system, provide direct caregiver-to-caregiver support, and serve as an advocate mentor and facilitator. The Family Support Specialist training from the Department of Mental Health and Substance Abuse Services offers an opportunity for loved ones to draw upon their experience. Additionally, individuals gain support from other caregivers.
3. West Tennessee SOC Pre-school Aged Program-- Engages community and agency leaders, families, and youth to share responsibility, resources, and services necessary to meet the needs of young children in the targeted communities. The West Tennessee program works to build strong community collaboration to serve young children and their families, gives family and youth a voice, is community-based, and culturally and linguistically competent. The service provider assesses the needs of children and families and works with them to engage with community resources to help them decrease potential risk; develops a plan to increase access

and decrease barriers to effective use of resources; and meets the family where they are most comfortable in their natural setting and creates plans with the family which support the child and family's strengths.

4. Chattanooga Care Connection--helps students in the alternative school programs in Hamilton County with services such as prevention, early intervention, treatment, and recovery support delivered from a family-driven perspective in which parents/caregivers partner with providers in a supportive and interactive collaboration. Families offer one another support to express concerns and to build supportive relationships. Youth mentoring and peer-led services bring an added dimension. Building and sustaining a strong family support system is the foundation of this project.
5. K-Town Youth Empowerment Network--a mental health initiative in Knox County, Tennessee, serving youth who are transitioning to adulthood (ages 12-21) with Serious Emotional Disturbance (SED) and their families. K-Town offers an effective approach to delivering mental health services and system transformation through an enhanced culturally competent, family-driven, youth-guided and coordinated System of Care.
6. Early Connections Network (ECN) -- a System of Care in Cheatham, Robertson, Dickson, Sumner or Montgomery Counties and the Ft. Campbell Army Post for very young children (ages 0-5) with social, emotional, and behavioral needs and for their families. ECN brings together families, caregivers, teachers, providers, governmental agencies, and natural supports to improve access to quality care for those with mental health challenges and to prepare children for school and for life. ECN also works with the children and families of military service members and veterans.

TDMHSAS also supports five SOC expansion sites as portrayed by the following chart:

Initiative	Ages served	Population served	Area (s) served	Service delivery model
Frontier Health (FH)	0-10	Children in grades kindergarten through fourth grade enrolled in Mountain View Elementary or who have been diagnosed with a serious emotional disturbance, their siblings and families of military personnel within the Johnson City School System.	Johnson City Washington Unicoi Carter	School based program led by mental health provider in elementary school. (1 community team)
Ridgeview Psychiatric Hospital and Center (RV)	0-17	Children and youth with behavioral health issues, or those who are at risk of developing such issues, and whose parents have a history of substance abuse.	Anderson Campbell Morgan Roane Scott	Mental Health provider partnering with the Department of Children's Services Community Advisory Boards (CABs). (5 community teams)
Tennessee Voices for Children (TVC)	11-21	Youth who are transitioning out of the foster care system and their families or have a diagnosis of mental or behavioral disorder that impairs functioning at home, school or community and requires multi-system involvement	Rutherford Hickman Williamson	Family organization providing Wraparound and opportunities for engagement in Youth MOVE. (1 community team)
Professional Care Services (PCS) of West TN	0-5	Children who are at "imminent risk" for developing a serious emotional disturbance and their families or are impaired of functioning at home, school or community or are at risk of inpatient treatment or state custody	Lauderdale Fayette Haywood	Mental Health provider partnering with early care centers and pediatricians. (3 community teams)
Volunteer Behavioral Healthcare (VBH)	9-17	Children and youth with behavioral health issues, or those who are at risk of developing such issues, and who are participating in The Bethlehem Center programming.	Hamilton	Mental Health provider partnering with The Bethlehem Center (1 community team)

The Milieu of Children's Services in Tennessee

The TDMHSAS Office of Children and Youth Mental Health contracts with provider agencies, schools and other organizations to provide a wide array of services for children and youth across the state. Some services are funded through MHBG dollars and others are funded through grants or state dollars.

- Project B.A.S.I.C.—operates in 42 elementary schools to provide mental health education and to assist teachers with managing behavior issues in students. The program's focus is to promote mental health in K-3 children, and to identify and refer children at risk of SED to mental health services. Project B.A.S.I.C. seeks to produce socially and emotionally competent children who then become productive adults. Project B.A.S.I.C. is a Mental Health Block Grant funded program.
- Mental Health 101 and Erasing the Stigma--offer support and educational materials to any group making a request for such support or materials. Groups served include professional groups, schools, civic groups, churches and any group serving middle and high school students. Materials and presentations are designed to help reduce the stigma associated with mental illness and to increase awareness of mental health concerns. Erase the Stigma is a state funded program.
- Child and Family Mental Health Education--provides support groups for parents or caregivers of children who are diagnosed with SED. Groups help parents and caregivers by offering parenting skills, communication skills and diagnostic information. Child and Family Mental Health Education is a state funded program.
- Violence and Bullying Prevention--offers elementary and middle school children in Middle Tennessee programming that will help to decrease the number of disciplinary referrals in the classroom including in-school suspensions and expulsions for students who participate. The ultimate goal is to reduce the incidence of violent behavior and bullying in schools and increase the graduation rates for middle Tennessee schools. Violence and Bullying Prevention is a state funded program.
- Emotional Fitness Center--a faith-based initiative that provides mental health screenings for African American children and families. The screenings are ethnicity-sensitive and are provided in a warm and welcoming environment. The purpose of the program is to improve access to mental health services to African Americans in the Memphis area. Emotional Fitness Center is a state funded program.
- The Juvenile Court Screening Program--permits juvenile court youth services officers to be trained to administer the juvenile justice screening version of the Child and Adolescent Needs and Strengths (CANS) survey to those juveniles who present at the juvenile courts with evidence of a mental health concern. The program is a collaborative effort between the TDMHSAS, the Administrative Office of the Courts, Tennessee Department of Children's Services, and the juvenile court system to ensure that juveniles are referred for needed treatment.
- Child Care Consultation--provides coaching and training on Pyramid Model social-emotional development strategies to Project B.A.S.I.C. staff, and to K and 1st grade teachers in schools served by Project B.A.S.I.C. The purpose is to encourage socially and emotionally competent children who become good students as they progress through school. Child Care Consultation is funded with state dollars.
- Renewal House of Nashville--provides early intervention and prevention services for the children of mothers who are residing in the facility for treatment for addiction. Mental

health services not otherwise funded for these children are provided. Services are funded with state dollars.

- Regional Intervention Program (RIP)--program in which parents who have learned behavior management skills to consolidate that learning by teaching other parents. Parents, supported by a small professional staff, serve as primary teachers and behavior change agents for their own child, and as daily operators of the overall program. Requirements for parents entering the RIP program are that parents have a troubled child under age six with a behavior disorder and participate in the program with their child. Parents receive parenting education, skills and support in managing the behavior of the child. The RIP program is contracted with five non-profit mental health agencies and operates in urban areas statewide. It is funded through Mental Health Block Grant dollars.
- Respite Voucher and Planned Respite--provide a break for caregivers of a child who is diagnosed SED. Almost 400 families annually receive respite services either to help them pay for respite or to help them learn to find and train a respite provider for planned respite. The purpose of the program is to preserve the family and protect the mental health of the child and the parent. Respite also helps to prevent child abuse. The Respite programs are funded with Mental Health Block Grant dollars.
- The School-based Liaison program--assists teachers with managing students with emotional or behavioral problems. The purpose is to reduce discipline referrals, increase the likelihood that children will remain in school and in a community-based setting and decrease classroom behavior problems. School-based Liaison program is funded through interdepartmental dollars including funding from TDOE, Division of Substance Abuse Services, Division of Mental Health Services, and some federal dollars.
- The Family Support and Advocacy program--provides support and advocacy for families with a child who is diagnosed with SED. The program is state funded.
- Suicide Prevention Services--targets the number of suicides among Tennessee's children and increases the ability of adults to recognize the warning signs of suicide and intervene on behalf of a child. Several evidence-based curricula are used including the Shield of Care curriculum. Suicide prevention services are funded through state dollars and grant dollars.
- Therapeutic Intervention, Education, and Skills (TIES)--features programming for children age 17 and younger who are either in out-of-home placement or at risk of removal due to parent/caretaker substance abuse. The TIES program creates a collection of outreach, treatment, education, counseling, and supportive services for children and families affected by substance abuse and trauma. It is operated in conjunction with the Seeking Safety curriculum for victims of trauma and the evidence-based Homebuilders model, which is an intensive, in-home crisis program that has already been used successfully around the nation to help keep children in their homes. TIES is a grant funded program.
- Crisis Continuum---allows community mental health centers across the state to assist children and their families when a crisis situation arises. Mobile crisis providers travel directly to the home and provide intervention for children in crisis. The purpose of the program is to assist families during a crisis, prevent the need for more restrictive services, preserve the family, prevent child abuse, and improve access to care for children in crisis. Crisis Continuum programming is funded through Mental Health Block Grant dollars.

Collaborative Relationships with other Child-Serving Agencies and Groups

Governor's Children's Cabinet

The mission of the Governor's Children's Cabinet is "to create a comprehensive strategy focused on Tennessee children's well-being." The Cabinet consists of representatives of the Tennessee Departments of Health, Children's Services, Mental Health and Substance Abuse Services, Education and TennCare (Tennessee's Medicaid program). The Governor's Children's Cabinet is charged with coordinating, streamlining and enhancing the state's efforts in providing resources and services" to children in Tennessee.

The Children's Cabinet has succeeded in awarding 137 children's computers to public libraries and family childcare programs across Tennessee. The computers will help the counties and childcare centers to focus on early literacy efforts making children less likely to drop out of school later. The Children's Cabinet has also launched two major initiatives: the Tennessee School Readiness Model and kidcentraltn.com. Tennessee School Readiness Model helps to set goals and provide indicators that will help children enter the classroom prepared to learn. The website, www.kidcentraltn.com, is designed to assist parents with a comprehensive directory of state services related to children and their families.

The Children's Cabinet continues to look for ways to improve the well-being of Tennessee's children through collaboration and integration of effort.

Council on Children's Mental Health

Legislation passed in 2008 established the Council on Children's Mental Health (CCMH) with the mission of designing an effective plan for a statewide system of mental health care for children. CCMH is co-chaired by the Commissioner of the Department of Mental Health and Substance Abuse Services and the executive director of the Tennessee Commission on Children and Youth (TCCY).

The plan created by the Council must:

- Provide a service delivery system that focuses on the principles of care for a system of care and enumerates those principles;
- Include a core set of services and supports that appropriately and effectively address the mental health needs of children and families;
- Develop a financial resource map and cost analysis of all federal and state funded programs for children's mental health, updated on an annual basis, to guide and support the plan.

Other Child-related Activities

The purpose for the depth and breadth of collaboration is to ensure that mental health and substance abuse concerns are represented on each of the specialized task forces working daily on children's needs in Tennessee. TDMHSAS participates on the Youth Transitions Advisory Council (YTAC). TDMHSAS is represented on the statewide Children's Justice Task Force, the Early Childhood Comprehensive Systems (ECCS) initiative, the Center for Social and Emotional Foundations of Early Learning (CSEFEL), and the Early Childhood Advisory Council (ECAC). TDMHSAS is a steering committee partner of the Tennessee Infant and Early Childhood Mental Health Initiative. TDMHSAS participates annually in Children's Mental Health Week activities. The Department is also a member of the NASMHPD Child, Youth, and Family Division.

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

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

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

This item will be completed with the submission of Tennessee's Substance Abuse Prevention and Treatment Block Grant.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q20: Suicide Prevention

TDMHSAS aggressively seeks funding sources and programming to prevent suicide in Tennessee. Funding for programs comes from both state and federal sources and addresses the needs of adults, children and Veterans. Suicide awareness and education efforts in Tennessee are robust and ongoing.

The Tennessee Strategy for Suicide Prevention

Originated by the Tennessee Suicide Prevention Network
Adapted and adopted by the Tennessee Department of Mental Health and Substance Abuse Services

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) partners with and funds the Tennessee Suicide Prevention Network (TSPN) to develop annual strategies pertaining to suicide prevention in Tennessee. TSPN is comprised of representatives from many providers, representatives from the TDMHSAS Planning and Policy Councils, and individuals who have great personal interest in preventing suicide and educating others about the warning signs of possible or impending suicide.

The Tennessee Strategy for Suicide Prevention recognizes and affirms the cultural diversity, value, dignity and importance of each person. Suicide is not solely the result of illness or inner conditions. The feelings of hopelessness that contribute to suicide can stem from societal conditions and attitudes. Therefore, everyone concerned with suicide prevention shares a responsibility to help change attitudes and eliminate conditions of oppression, racism, homophobia, discrimination, and prejudice. Suicide prevention strategies must be evidenced- based and clinically sound. They must address diverse populations that are disproportionately affected by societal conditions and are at greater risk for suicide. Individuals, communities, organizations, and leaders at all levels collaborate in the promotion of suicide prevention. The success of this strategy ultimately rests with the individuals and communities across the State of Tennessee.

In the years since the submission of the last Mental Health Block Grant Plan, efforts to increase the reach and scope of suicide prevention in Tennessee have been successful. Two federal grants pertaining to prevention of suicide have been awarded to TDMHSAS by SAMHSA. Tennessee's Target Zero Suicide Initiative is a project to reduce suicide attempts /deaths among working-age adults ages 25-64 by developing and implementing cross-system suicide prevention strategies, including rapid and enhanced follow-up services for individuals experiencing suicidal thoughts and/or behaviors. Also provides prevention training for adult serving organizations. Tennessee Lives Count CONNECT is a youth suicide early prevention/intervention project that is funded through a Federal grant. CONNECT serves youth ages 10 through 24. Prevention /intervention services are provided through suicide gatekeeper training and follow-up services for youth.

The Tennessee Strategy for Suicide Prevention is the guiding document of the Tennessee Suicide Prevention Network (TSPN) and, in the sense of collaboration and community partnership, has been adopted by the TDMHSAS. This document shapes TSPN and TDMHSAS outreach, education, and awareness efforts throughout the state of Tennessee. The strategy for suicide prevention in Tennessee builds upon the fifteen points raised in "The Surgeon General's Call to Action to Prevent Suicide" in 1999, the eleven points raised in the "National Strategy for Suicide Prevention: Goals and Objectives for Action", printed by the U.S. Department of Health and Human Services, United States Public Health Service, Rockville, MD, in 2001, and the thirteen points of the revised edition in

2012. The Tennessee Strategy for Suicide Prevention was adapted from the National Strategy in 2002, with revisions in 2004, 2006, and 2007. Current version was updated in February 2012 and

1. Develop broad-based support for suicide prevention.

A. Form and sustain public-private partnerships with the widest variety possible of community partners in suicide prevention activities, up to and including state departments and agencies.

B. Continue to engage state, county, and city government in the annual Suicide Prevention Awareness Month proclamation effort.

C. Advocate within the General Assembly and state departments for improved access to community-based mental health and substance abuse services.

D. Educate stakeholders about state budgets and legislation that could negatively affect mental health and substance abuse services and encourage an active role in advocating for suicide prevention services.

E. Recruit public figures to promote the cause of suicide prevention and the use of mental health and substance abuse services.

2. Promote awareness that suicide is a public health problem that is preventable.

A. Promote the National Suicide Prevention Lifeline (1-800-273-TALK or 1-800-273-8255) as the statewide suicide prevention hotline and encourage all local crisis centers in Tennessee to join the network of Lifeline call centers.

B. Encourage adequate staffing and funding of local crisis centers and publish their phone numbers on the TSPN website and in regional suicide prevention directories.

C. Secure the cooperation of radio and television stations, newspapers, billboard companies, and all other appropriate media in promoting crisis hotlines and suicide prevention services.

D. Encourage the cooperation of faith-based alliances to publicize suicide prevention services.

E. Maintain updated region-specific resource directories that reference relevant community agencies.

F. Update the TSPN website to aid in communication with the people of Tennessee on at least a quarterly basis.

G. Promote the use of social media in suicide prevention by training community stakeholders in its use.

H. Conduct statewide conferences and symposia to raise public awareness for suicide prevention.

3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

A. Produce public service messages for television and radio in order to reduce the stigma associated with mental health and substance use disorders and promote the concept of recovery.

B. Arrange for survivors, survivors of attempts, and professionals to offer training and speak to groups and individuals who come into contact with at-risk individuals.

4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

A. Monitor references to suicide in locally originating television, radio, news media, and online content, in coordination with the national suicide prevention community, to promote better and more accurate depictions of suicide and mental illness, and to recognize

portrayals that observe recommended guidelines in the depiction of suicide and mental illness.

B. Promote guidelines for responsible coverage of suicide and mental illness to journalism and mass communication schools and to news agencies.

C. Promote guidelines on the safety of online content for new and emerging communication technologies and applications.

5. Develop, implement, and monitor effective programs that promote suicide prevention and general wellness.

A. Encourage the adoption of a suicide risk screening mechanism by mental health and substance abuse providers, first responders, clergy, educators, and others who may come in contact with high-suicide-risk persons.

B. Encourage development of suicide prevention programs in psychiatric hospitals, substance abuse treatment programs, schools, correctional institutions, community service programs, peer support centers, and similar facilities that work with high-suicide-risk population groups.

C. Serve as a resource for agencies that work with young people and elderly, providing suicide prevention education and links to other agencies that promote mental wellness.

D. Work with teachers in public and private schools and with others who work with children to implement suicide prevention and mental health screening programs.

E. Encourage the development of suicide prevention curricula in Tennessee colleges and universities, and the inclusion of suicide prevention training in professional licensure requirements.

6. Promote efforts to reduce access to lethal means of suicide and methods of self-harm among individuals with identified suicide risk.

A. Encourage health care providers, especially those involved in inpatient care, home care, and discharge planning, to assess patients' access to lethal means.

B. Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

C. Encourage discussions of lethal means and safe storage practices in well-child care encounters and in educational programs for young people, parents, and gatekeepers.

D. Partner with local drug coalitions, law enforcement agencies and civic organizations, to develop and/or implement existing educational materials to make people aware of safe ways of storing, dispensing, and disposing of medications.

7. Encourage effective clinical and professional practices regarding suicide prevention for community and clinical service providers.

A. Provide training on suicide prevention to community service provider groups that have a role in the prevention of suicide and related behaviors.

B. Promote crisis intervention, suicide prevention training, and collaborative suicide risk management for teachers in the school systems, police officers, first responders, and other community groups that have a role in the prevention of suicide and related behaviors.

C. Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

D. Develop and/or promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professionals,

including those in graduate and continuing education and persons seeking credentialing and accreditation.

E. Include focused education in suicide risk management and prevention at regional workshops and conferences.

F. Encourage crisis centers, faith communities, community counseling centers, and community helpers throughout the state to implement effective training programs for family members of those at risk.

G. Encourage mental health assessment centers and emergency departments to refer persons treated for trauma, sexual assault, physical abuse, or domestic violence for mental health services.

8. Promote the assessment and treatment of people at risk for suicide as a core component of health care services.

A. Promote the adoption of "zero suicides" as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

B. Adopt, disseminate, and implement guidelines for the assessment of suicide risk and continuity of care for people at suicide risk in all health care and substance abuse treatment settings.

C. Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

D. Establish links, collaboration, and coordination of services between providers of mental health and substance abuse services, community-based and/or peer support programs, health care systems, local crisis centers, and the families of patients to create a comprehensive and seamless network of care for people at risk for suicide.

E. Develop and/or promote guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

A. Create protocols for postvention response following suicide deaths and disasters with the potential for traumatizing survivors.

B. Promote the availability of postvention services by TSPN and others to the general public and institutions that may require such services, up to and including schools, colleges, and businesses.

10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

A. Encourage the development of support groups for survivors of suicide, survivors of suicide attempts, and support group facilitators, and engage the support of these groups by community partners.

B. Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context.

C. Provide and/or promote appropriate debriefing to health care providers, first responders, and others affected by the suicide death of a patient.

11. Increase the timeliness, viability, and scope of statewide surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

A. Improve the timeliness and usefulness of suicide-related vital records data from state medical examiners, coroners, and hospitals.
B. Support the establishment of local task forces that use vital records data to develop targeted prevention efforts.
C. Advocate for Tennessee's inclusion in the National Violent Death Reporting System.

12. Promote and support research on suicide and suicide prevention.

A. Encourage Tennessee colleges, universities, hospitals, and clinics to intensify research related to suicide, including cultural-specific risk factors, interventions, and protective factors, and to present their results at regional, state, and national conferences, as well as publish such results.
B. Conduct evaluations of suicide prevention programs in Tennessee, both those originating within TSPN and those of other agencies.

13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

A. Disseminate information about effective suicide prevention programs and encourage their implementation across the state.
B. Evaluate the impact and effectiveness of the Tennessee Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

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

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

STATE OF TENNESSEE
TENNESSEE COMMISSION ON CHILDREN AND YOUTH
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

July 16, 2015

E. Douglas Varney, Commissioner
Department of Mental Health and Substance Abuse Services
6th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, Tennessee 37243

RE: Federal Substance Abuse and Mental Health Block Grant Application

Dear Commissioner Varney:

The Tennessee Commission on Children and Youth (TCCY) very much appreciates the long and strong collaboration between the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and TCCY. Our collaborative work supporting the Council on Children's Mental Health (CCMH) has made major contributions to expansion of understanding of the principles and benefits of a System of Care approach to children's mental health services. As a result of these efforts, system transformation is truly underway in Tennessee.

The Commission is committed to ongoing collaboration with TDMHSAS and other organizations that support an effective and robust mental health and substance abuse service delivery system for at risk children in Tennessee and their families. While TCCY's primary focus is on children, we know well that outcomes for children are substantially better when the mental health and substance abuse treatment needs of the adults in their lives are adequately addressed. We know the research is clear: Adverse Childhood Experiences (ACEs), including parental mental health and substance abuse, can have life-long implications on physical and mental health and life expectancy.

We are grateful TDMHSAS is a strong and consistent partner with TCCY and other stakeholders in our mutual efforts to ensure children and families receive the mental health and substance services needed for healthy, productive living. We are always honored to work with TDMHSAS toward the accomplishment of this mission.

Sincerely,
Linda O'Neal
Linda O'Neal
Executive Director

STATE OF TENNESSEE
DEPARTMENT OF EDUCATION
NINTH FLOOR, ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-0375

BILL HASLAM
GOVERNOR

CANDICE MCQUEEN
COMMISSIONER

July 17, 2015

Commissioner E. Douglas Varney
6th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243

Dear Commissioner Varney,

The Tennessee Department of Education (TDOE) continues to examine regulations, policies, programs, and key data points in state school districts to ensure that children are safe and supported in their social and emotional development. Children will be exposed to initiatives that target risk and protective factors for mental and substance use disorders. TDOE will ensure that children have the services and supports needed to succeed in school to improve graduation rates and reduce out-of-district placements.

Sincerely,

Candice McQueen

Dr. Candice McQueen
Commissioner of Education

TN Division of
Health Care Finance & Administration

July 20, 2015

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
6th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243

Dear Commissioner Varney,

The Bureau of TennCare wishes to offer our continued support to, and ongoing collaboration with the Department of Mental Health and Substance Abuse Services. Our missions are interrelated, as well as, the people we serve and programs we offer. We will continue to build on the initiatives we have started.

The Bureau of TennCare will continue to consult with the Department of Mental Health and Substance Abuse Services in the development of SPMI Health Homes for individuals with chronic health conditions. Our agencies will continue to collaborate regarding the benefits available to the Medicaid-eligible population.

On behalf of the Bureau of TennCare, I commit to our departments ongoing practice of a collaborative and supportive relationship.

Sincerely,

Darin J. Gordon
Director

Health Care Finance and Administration • 310 Great Circle Road • Nashville, TN 37243
tn.gov/hcfa • tn.gov/tenncare

BILL HASLAM
GOVERNOR

DERRICK D. SCHOFIELD
COMMISSIONER

STATE OF TENNESSEE
DEPARTMENT OF CORRECTION
SIXTH FLOOR, RACHEL JACKSON BUILDING
320 SIXTH AVENUE NORTH
NASHVILLE, TENNESSEE 37243-0465
OFFICE (615) 253-8139 • FAX (615) 532-8281

July 16, 2015

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
Andrew Jackson Building, Sixth Floor
500 Deaderick Street
Nashville, TN 37243

Dear Commissioner Varney:

The Department of Correction will work with the state and local judicial systems to develop policies and programs that address the needs of individuals living with mental illness and substance use disorders who come in contact with criminal justice system. We will promote strategies that allow for diversion and alternatives to incarceration, provide screening and treatment, and implement services that assist individuals with transitioning back into the community.

My team and I support your efforts. We are appreciative of the opportunity for a continuous collaboration to address mental illness and substance use disorders for the individuals we serve.

Sincerely,

Derrick D. Schofield

DDS:GG

Tennessee Association
TAADAS
Alcohol, Drug & other Addiction Services

RECEIVED
2015 JUL 28 AM 10: 49
COMMISSIONER'S

Recovery Books & Things

7/21/2015

Dear Commissioner Doug Varney,

The Tennessee Association of Alcohol, Drug, & Other Addition Services (TAADAS), on behalf of its membership, is committed to collaboration with organizations that support an effective and robust substance abuse and addiction service delivery system in Tennessee. The Tennessee Department of Mental Health and Substances Abuse Services consistently acts in partnership with TAADAS to work toward that mission.

Please feel free to contact me if you would like more information. I can be reached at 615-780-5901, x-18 or marylinden@taadas.org.

Respectfully,

Mary Linden Salter

Mary Linden Salter
Executive Director

1321 Murfreesboro Road, Suite 155 Nashville, Tennessee 37217
615-780-5901 Fax 615-780-5905 Bookstore 877-863-6914 REDLINE 800-889-9789
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STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

July 29, 2015

E. Douglas Varney, Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville TN 37243

Dear Commissioner Varney:

I am writing in support of the request to the Substance Abuse and Mental Health Services Administration (SAMHSA) for funding to support the Tennessee Department of Mental Health and Substance Abuse Services (TDHMSAS) through the Mental Health and Substance Abuse Block Grant.

I am proud of the coordination and collaboration between our respective organizations and with other state agencies to advance our governor's goal of promoting healthy behavior and providing high quality services to our most vulnerable populations. Here at the Tennessee Department of Health, we consider mental and behavioral health to be integral to overall health, and we see TDMHSAS as a key partner to achieve our mission of protecting, promoting and improving the health and prosperity of people in Tennessee.

It is our belief at TDH that the best strategy to assure optimum health for individuals is to focus on primary prevention; therefore, we have invested resources and encouraged our staff to participate in planning and implementing primary prevention initiatives in their local communities. These activities (over 1000 conducted to date) are designed to focus on the "big three plus one" factors which most heavily influence the leading causes of poor health outcomes in our state: obesity, physical inactivity, tobacco use plus substance abuse. Since these behaviors are often associated with poor mental health, it is our expectation not only that these programs will reduce the incidence of chronic diseases such as diabetes and cardiovascular disease, but also that these prevention programs will reduce the number of children and adults who experience mental and behavioral health issues during their lifetimes.

We appreciate your organization's work to promote the Screening, Brief Intervention and Referral for Treatment (SBIRT) resource, which is used by primary care providers (including those in public health department clinics) in each of Tennessee's 95 counties to identify and connect individuals and families with services, when needed.

5th Floor, Andrew Johnson Tower
710 James Robertson Parkway * Nashville, TN 37243
(615) 741-3111 * www.tn.gov/health

In accordance with the state's strategic plan for preventing and addressing prescription drug abuse, compiled and issued by TDMHSAS, our agencies have worked together to turn the tide on our state's epidemic of prescription drug abuse, including opioids. Through our collective efforts, a state-level Controlled Substance Monitoring Database (CSMD) was established in 2006, and state-level policies were strengthened in 2013 to require mandatory reporting for prescribers and dispensers of controlled substances, resulting in a 6.6% reduction in morphine milligram equivalents (MME) prescribed in 2014, and reversing the decade-long trend in increasing use of opioids. TDMHSAS' contributions, through the investment in public media campaigns and support for local community coalitions to raise awareness and help prevent prescription drug abuse, as well as the provision of behavioral health safety net services for individuals and families in need of treatment, have been important factors in this progress. We are committed to our continuing collaboration to prevent substance abuse, with particular focus on reducing the number of infants born with Neonatal Abstinence Syndrome (NAS) through preventive measures targeting women of child-bearing age who are at risk of becoming pregnant or delivering a baby while using harmful substances.

TDH shares your organization's commitment to performance excellence, including the use of technology to enable efficient service delivery and the use of data to inform decision-making. In addition to the CSMD described above, TDH serves as steward for several other datasets, and is charged with collecting, analyzing and reporting health-related data in accordance with the requirements of statutes and policies. To the extent allowable within these constraints, TDH will continue to provide to TDMHSAS data reports which can be used to guide planning, evaluation and continuous improvement of programs and services, particularly for communities with health disparities and those with limited resources. It is our hope that state-level initiatives to support a "no-wrong door" strategy and to implement a portal that allows us to share data more easily with other state agencies and with the general public, as appropriate, will offer additional opportunities for collaboration and allow us to be even more effective in the coordination and delivery of our services.

There is still much work to be done, if we are to achieve our shared vision of moving Tennessee from the bottom ten to the top ten in national health rankings. We look forward to continuing and strengthening the collaboration that we have experienced to date, and hope that your request for funding is given the highest consideration.

Sincerely,

John D. Dreyzehner, MD, MPH, FACOEM
Commissioner

tamho
tennessee association of
mental health organizations

August 1, 2015

Commissioner Doug Varney
Department of Mental Health and Substance Abuse Services
6th Floor, Andrew Jackson Building
500 Deaderick St.
Nashville, TN 37243

Dear Commissioner Varney,

As the trade association representing community behavioral health providers across the state of Tennessee, TAMHO has seen the tremendous collaboration that occurs between TN Department of Mental Health and Substance Abuse Services (TDMHSAS) and the providers. We know that commitment and collaboration are necessary to have a robust and effective service delivery system in Tennessee and we have seen these qualities on a consistent basis in our interactions with TDMHSAS.

TDMHSAS consistently acts in partnership with TAMHO to help us meet our mission to promote the advancement of effective behavioral health services and advocate for people in need.

We are happy to confirm the excellent collaboration we have experienced and support the block grant application submitted by TDMHSAS.

Sincerely,

Ellyn Wilbur

Ellyn Wilbur
Executive Director
Tennessee Association of Mental Health Organizations

42 Rutledge Street
Nashville, TN 37210-2043

www.tamho.org

(615) 244-2220
(800) 568-2642 toll free in TN
Fax: (615) 254-8331

TN Department of Children's Services

August 5, 2015

Mr. E. Douglas Varney
Commissioner
Dept. of Mental Health and Substance Abuse Services
500 Deaderick St., 6th Floor
Nashville, TN 27243

Dear Commissioner Varney:

The Department of Children's Services wishes to offer our support to, and ongoing collaboration with, the Department of Mental Health and Substance Abuse Services. Our missions, being similar in terms of the citizenry served and services offered, allow us to collaborate seamlessly.

The Department of Children's Services will continue working with local child welfare agencies to address trauma, mental health and substance use concerns in children, youth, and family members that place children and youth at-risk for maltreatment and subsequent out-of-home placement and/or involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, will continue to be addressed for children and youth involved in child welfare.

On behalf of the Department of Children's Services, I confirm that our Departments practice a collaborative and supportive relationship.

Sincerely,

Bonnie Hommrich

Bonnie Hommrich
Commissioner

BH/jv

Commissioner's Office • Cordell Hull Bldg., 7th Floor • 436 6th Ave. North • Nashville, TN 37243
Tel: 615-741-9707 • Fax: 615-532-8079 • tn.gov/dcs

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

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

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Q22 Planning and Policy Council, Input on the Block Grant Application

TDMHSAS administers seven Regional Planning and Policy Councils (Council[s]) from which regional mental health and substance abuse needs and information are funneled to the Statewide Council and to TDMHSAS. Needs assessment priorities and recommendations from the Statewide Planning and Policy Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department's Three-Year Plan. Title 33, Chapter 2, Part 2 of the Tennessee Code Annotated requires the TDMHSAS to develop a Three-Year Plan (Plan) based on input from the TDMHSAS Planning and Policy Council. The plan must be revised at least annually based on an assessment of the public need for mental health and substance use disorders services.

A needs assessment is conducted annually by the TDMHSAS Regional Councils to assist TDMHSAS with planning for resource allocation. Data is provided to the Regional Councils to assist members with identifying and prioritizing needs. Prioritized needs are shared with TDMHSAS staff to inform the development of strategies for the Three-Year Plan and report progress annually. The needs assessment process creates a data-informed method for Regional Councils to influence the design of the mental health and substance use service delivery system by identifying each region's needs and targeting limited state resources to more effectively and efficiently meet identified needs. This information is used to communicate and integrate results into a strategic planning and action process that ensures assessment information is used in meaningful ways.

In addition to the needs assessment, the Councils also review and provide input on the Block Grant plans and funding, the annual budget for TDMHSAS, legislative proposals for review of the Commissioner and possible consideration by the Governor, and other departmental reports and initiatives.

The Council system is large, active, fully-integrated SA-MH with a consistently successful method of integration, and robust in Tennessee. It acts as an independent body and great care is taken by the Planning Program Manager (administrator for the Council system) to avoid influencing the deliberations of, and recommendations made by, the Councils. The Regional Council system serves a secondary purpose that, although not part of the legal requirement, is beneficial to the service delivery system in Tennessee: the Councils allow all participants to become acquainted with each other and with services, events, and other aspects of the service delivery system.

Input from the Council regarding the Mental Health Block Grant Plan

Will be entered at the end of the comment period and will include our response to their suggestions.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Brian Buuck	Providers	Ridgeview Psychiatric Hospital and Center	310 Wooded Lane Knoxville, TN 37922	Buuckbd@ridgeview.com
Perry Pratt	Providers	Youth Town	3641 Youth Town Road Pinson, TN 38301 PH: 731-513-1130	PPratt@youtown.net
Libby Thurman	Others (Not State employees or providers)	Tennessee Primary Care Association	416 Wilson Pike Circle Brentwood, TN 37027 PH: 615-497-4942	libby.thurman@tnpca.org
Laura Berlind	Providers	Renewal House	P.O. Box 280356 Nashville , TN 37228 PH: 615-255-5222	lberlind@renewalhouse.org
Tim Perry	Providers	Nolachuckey Holston Area Mental Health Center	266 North St. Bristol, TN 37620 PH: 423-989-4558	dbowers@frontierhealth.org
Brittney Jackson	Parents of children with SED	Tennessee Voices for Children	701 Bradford Avenue Nashville, TN 37086 PH: 615-856-0531	
Rikki Harris	Others (Not State employees or providers)	TN Voices for Children	701 Bradford Avenue Nashville, TN 37204 PH: 615-269-8914	rharris@tnvoices.org
Jeremy Pitzer	Providers	Compass Intervention Center	7900 Lowrance Rd Memphis, TN 38125 PH: 901-758-2002	Jeremy.pitzer@uhsinc.com
Ashley Evans	Providers	Volunteers in Medicine, Chattanooga, Inc.	P.O. Box 81057 Chattanooga, TN 37421 PH: 423-499-2320	a.wolfevans@gmail.com
Paul Fuchcar	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		207 Spears Avenue Chattanooga, TN 37405 PH: 423-667-3311	paul.fuchcar@cadas.org
Libby Byler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Amerigroup	22 Century Boulevard, Suite 310 Nashville, TN 37214	libby.byler@amerigroup.com
Ben Harrington	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 32731 Knoxville, TN PH: 865-584-9125	ben@mhaet.com
Claudia Avila -Lopez	Others (Not State employees or providers)	Mental Health Association of Middle Tennessee	295 Plus Park Blvd Nashville, TN 37217 PH: 615-269-5355	clopez@mhamt.org
Linda Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		207 Forrest, P.O. Box 474 McKenzie, TN 38201 PH: 731-415-3634	llewis38201@yahoo.com
Emma Long	Family Members of Individuals in Recovery (to include family members of adults with SMI)		94 Labelle Street Jackson , TN 38301 PH: 731-326-2041	emmaelon@aol.com

Melanie Brander	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		250 Apt. E Winters Court Clarksville, TN 37043	Melanie.Brander@centerstone.org
Ginger Naseri	Providers	Nolachuckey Holston Area Mental Health Center	401 Holston Drive Greeneville, TN 37743 PH: 423-639-1104	vnaseri@frontierhealth.org
Emma Johnson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		948 Woodland Street Nashville, TN 37206 PH: 615-246-7607	emma.johnson@Parkcenternashville.org
Jack Stewart	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1101 Kermit Drive, Suite 605 Nashville, TN 37217 PH: 423-329-4355	advocacy@namitn.org
Wendy Sullivan	Parents of children with SED		1302 Oak Grove Road Dickson, TN 37055 PH: 615-975-7021	wsullivan@tnvoices.org
Pat Starnes	Family Members of Individuals in Recovery (to include family members of adults with SMI)		4325 Shady Dale Road Nashville, TN 37218 PH: 615-330-1832	trucare10@yahoo.com
Debbie Hillin	Providers	Buffalo Valley, Inc	5465 Village Way Nashville, TN PH: 615-975-0196	debbiehillin@buffalovalley.org
Tom Starling	Others (Not State employees or providers)	Mental Health Association of Middle Tennessee	295 Plus Park Blvd. Nashville, TN 37217 PH: 615-269-5355	tstarling@mhamt.org
Susan Langenus	Providers	Centerstone Mental Health Center	Centerstone Mental Health Center, 1101 6th Avenue North Nashville, TN 37208-2650 PH: 615-460-4451	Susan.langneus@centerstone.org
Senator Doug Overby	Others (Not State employees or providers)		4 Legislative Plaza Nashville, TN 37243 PH: 615-741-0981	Sen.doug.overbey@capitol.tn.gov
Joe Page	Providers	Frontier Health	26 Midway Street Bristol, TN 37620 PH: 423-989-4691	jpage@frontierhealth.org
Kim Parker	Providers	Pathways	238 Summar Drive Jackson, TN 38301 PH: 731-541-8988	Kim.Parker@wth.org
Albert Richardson	Providers	C.A.A.P.	4023 Knight Arnold Road Memphis, TN 38118 PH: 901-360-0442	ARichardson@caapincorportated.com
Tim Tatum	Providers	Pine Ridge Treatment Center	2800 Westside Drive Cleveland, TN PH: 423-339-4341	Tim_Tatum@chs.net
Jennifer Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Tennessee Mental Health Consumers' Association	3931 Gallatin Road Nashville, TN 37216 PH: 615-250-1176	jjones@tmhca-tn.org
Elizabeth Reeves	Others (Not State employees or providers)	Disabiltiy Rights of Tennessee	2 International Plaza, Suite 825 Nashville, TN 37217 PH: 615-298-1080	elizabethr@disabilityrightstn.org
Dianne Young	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Emotional Fitness Center	3885 Tchulahoma Road Memphis , TN PH: 901-370-4673	YHealer@aol.com
Claudia Mays	Providers	CM Counseling & Consulting Services	Nashville, TN 37207 PH: 615-227-2028	cmayscounseling@att.net

Robin Nobling	Others (Not State employees or providers)	NAMI	1101 Kermit Drive Nashville, TN 37217 PH: 615-891-4724	rnobling@namidavidson.org
Wayne King	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1503 Dexter Laxton Road Oneida, TN 37841 PH: 423-215-2607	trulight@live.com
Kim Batson	Providers	Mental Health Cooperative	Murfreesboro, TN	kbatson@mhc-tn.org
Chris Hargrove	Providers		2486 Topside Road Louisville, TN 37777 PH: 865-384-9580	hargrovefire368@charter.net

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	37	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)	7	
Total Individuals in Recovery, Family Members & Others	21	56.76%
State Employees	0	
Providers	16	
Federally Recognized Tribe Representatives	0	
Vacancies		
Total State Employees & Providers	16	43.24%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Mr. E. Douglas Varney
Tennessee Department of Mental Health
and Substance Abuse Services
5th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243

Dear Mr. Varney:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: M. Suzanne Weed
Paul Fuschar

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory