DRAFT

FY 2020 - 2021
Substance Abuse Prevention and Treatment Block Grant

Behavioral Health Assessment and Plan
Strengths and Organizational Capacity of the Service System

Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the five criteria that must be addressed in state mental health plans. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide 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. This narrative must include a discussion of the current service system’s attention to the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for FY 2018 HIV-designated states, Persons at Risk for HIV.

The Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as Tennessee’s substance use disorders, mental health and opioid authority. The Department is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, substance abuse and mental health services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who have a substance use, mental or co-occurring disorder, including serious emotional disturbance. TDMHSAS also provides inpatient psychiatric services for adults, including acute, subacute, and secure forensic beds, through its operation of four fully accredited Regional Mental Health Institutes (RMHIs). Listed below and hereafter is Tennessee’s substance abuse system.

Tennessee’s Substance Abuse System

Substance abuse is a pervasive public health issue. It has roots in individual, family, peer, and community conditions that shape risk for experiencing substance abuse and its consequences. It negatively impacts families and children; increases crime and threatens public safety; and imposes tremendous social and economic cost to society. Not surprisingly, these pervasive social manifestations prompt responses across our public and private institutional systems. While it is difficult to paint a precise picture of the entire system for serving individuals experiencing substance abuse and its consequences, the information below helps to establish the parameters of the role currently played by TDMHSAS, Division of Substance Abuse Services (DSAS) within the entire state system. Understanding the context of this information is important for making realistic strategic decisions about how DSAS’ role may be defined more effectively in the future, and how that role may be coordinated with other components of the full system of service for substance abuse and related problems.
The Division of Substance Abuse Services receives and administers federal block grant and state funding for substance abuse services. Our mission is to improve the quality of life of Tennessee citizens by providing an integrated network of comprehensive substance use disorders services, fostering self-sufficiency, and protecting those who are at risk of substance abuse, dependence, and addiction. One of DSAS’ strengths is its’ integrated substance abuse system. This system consists of: providers, state departments, state agencies, judicial courts, grassroots organizations, and faith-based organizations that are collaborating to provide an effective and efficient delivery of mental health and substance abuse services to Tennesseans.

According to the National Survey of Substance Abuse Treatment Services (N-SSATS), in 2017, the overall Tennessee treatment system included 217 facilities. 64.5% were private non-profit facilities and 32.5% were private for-profit agencies. DSAS purchases services directly from
non-profit and for-profit providers; and has established a partnership that is transparent and respectful.

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Number of Facilities</th>
<th>Total Number of Clients</th>
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<tbody>
<tr>
<td>Private non-Profit</td>
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<td>7,580</td>
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<td></td>
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<td>6</td>
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<td></td>
<td>2.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Total</td>
<td>217</td>
<td>16,765</td>
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</tbody>
</table>

DSAS works closely with its’ Sister Division, Mental Health Services, to provide community-based programs and services. The Division of Mental Health Services is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness and/or serious emotional disturbances. The Divisions collaborate on activities to train and educate the community on suicide prevention and the linkage to substance use disorder; provide support for the certified peer recovery specialists program and work to employ individuals with lived experiences; and criminal justice diversion strategies to help prevent individuals from re-entry into and/or out of jail or prison.

The opioid crisis has afforded DSAS the opportunity to partner with private substance abuse treatment providers and Opioid Treatment Programs (OTPs). TDMHSAS organized a Public Private Partnership Workgroup that consisted of for-profit and non-profit substance abuse providers, Tennessee Hospital Association, and Medicaid Managed Care Organizations. The overarching goal is to “Create No Wrong Door to Access for Opioid Addiction in Tennessee”. Multiple meetings were held and subcommittees established to address how public/private collaborations can improve Tennessee’s behavioral health system. A joint plan of action was developed to address Tennessee’s Psychiatric Care Delivery System.

In Tennessee, Opioid Treatment Programs (OTPs) are for-profit agencies. TDMHSAS licensed Opioid Treatment Programs and the State Opioid Treatment Authority (SOTA) provides administrative, medical, and pharmaceutical oversight to certified opioid treatment programs. Through the federal opioid funding and state appropriations, DSAS has expanded its medication assisted treatment network to include OTPs.

DSAS has forged vital relationships with other state departments and agencies to improve coordination of care for individuals with substance use disorders. Formal partnerships have been established with the Departments of Agriculture, Correction, and Health; and Tennessee Bureau
of Investigation. These partnerships allow for data sharing, prevention education and treatment services. Over the last couple of years, TDMHSAS’ working relationship has grown with TennCare, Tennessee’s Medicaid program. DSAS has worked collaboratively to sponsor two MAT Summits for substance abuse treatment providers, Managed Care Organizations and the Criminal Justice System. Also, DSAS serves as the subject matter experts for the Department of Children’s Services Zero To Three Court Initiative to improve outcomes for infants, toddlers and families involved in the child welfare system. The community coalitions partner with the Tennessee Department of Environment and Conservation to place permanent drug collection boxes in law enforcement agencies. The Office of Criminal Justice Programs allocated $1 million to DSAS to distribute and train law enforcement agencies on naloxone, opioid use disorder, and stigma.

Grassroots organizations are the foot soldiers of the community. DSAS has brought a formal structure to existing organizations, assisted communities establish coalitions, and provided technical assistance on how to develop strategies, utilizing the Strategic Prevention Framework (SPF), to help prevent substance use and abuse. SPF ensures that the strategies are culturally appropriated and sustainable for the community. Local/county entities also assist with the delivery of prevention services. Many of the entities that serve as fiscal agents for our state-funded community coalitions are county entities that are donating space and other resources to ensure that their community coalition is effective and sustained into the future.

Establishing a relationship with the Judicial System and local law enforcement agencies has been essential to developing a structure for coordinating a system of care for non-violent offenders incarcerated or at risk of incarceration due substance use and abuse. There are thirty-one (31) Judicial Districts in Tennessee. DSAS has joined forces with the General Sessions, Circuit, Criminal, Juvenile, Drug, Mental Health, Veteran, Family Court, and Human Trafficking Courts, to coordinate behavioral health care for adult and juvenile offenders. Partnerships with law enforcement agencies have been essential for the community coalitions to assist with Take Back events, disposal of drugs collected, and training on overdose prevention and naloxone.

DSAS has built a cohesive prevention, treatment, and recovery network with Faith-Based Congregations/Organizations to support a common goal of strengthening individuals and families dealing with substance use disorders; and ultimately, restoring our communities. The goals of the Faith-Based Initiative are to:

- Connect individuals struggling with addiction to treatment
- Increase knowledge of what addiction is
- Facilitate understanding of substance use disorder treatment and recovery
- Understand the continuum of care and collaborate with it
- Spread awareness of the Faith-Based Initiative certification and its requirements
- Help groups understand and implement the best practice model
- Promote and improve effectiveness of the faith-based initiative and how it connects the community with recovery and support services
To understand how substance abuse services are delivered in Tennessee, it is important to understand the nature of the substance abuse problem and characteristics of the state’s residents—including where populations are concentrated and how many people are approximately at risk. Tennessee is located in the South Eastern portion of the U.S. and is the 16th most populous state in the nation, with an estimated 6,600,299 residents (Census 2015 estimate). The population is predominantly White (80.2 percent) or African American (17.5 percent) with persons of other races comprising approximately two percent of the total resident population. Nearly one-quarter (22.7 percent) of the overall population are under the age of 18. This presents the possibility of substantial cohort effects if substance abuse intervention and treatment among youth can be implemented effectively. Cohorts whose rates of use are lowered tend to keep those lower rates throughout the aggregated lifetimes of their members. That is, a group of 18 year olds who have their use rates lowered should keep comparatively lower rates compared to other cohorts even when they are in middle age or become elderly. However, both the 12–17 and 18–25 age cohorts represent the smallest population size.¹

There are also seven geographic regions across Tennessee that have been established as state behavioral health planning or sub-State Planning areas. These regional designations allow for geographic analysis of survey data on prevalence rates and needs for treatment, as well as service utilization information provided by the State of Tennessee, Division of Substance Abuse Services. The seven (7) Mental Health Planning Regions in Tennessee are displayed below.

¹ Statewide Assessment of Substance Use Disorders Prevention & Treatment Needs, A Profile of Priority Needs for Prevention and Treatment, Current System Capacity and Services, and Implications for Service Priorities and Development, State of Tennessee, 2013.
State funding resources have remained stable for many years. Therefore, DSAS worked to develop and implement “low cost, high impact” programs to expand, enhance and strengthen DSAS’ substance abuse services and state and community partnerships. Examples of “low cost, high impact” programs include:

- Community Coalitions
- DUI Schools
- Oxford Houses
- Faith-Based Recovery Network
- Lifeline Peer Program
- Alcohol and Drug Addiction Treatment Program
- Supervised Probation Offender Treatment Program
- Community Treatment Collaborative
- Recovery Courts
- Criminal Justice Liaisons Program

In 2016, it was estimated that 372,000 Tennesseans, age 18 years and older, have a substance use disorder. Of that 372,000, 39,804 (10.4%) are estimated not to have insurance (NDSUH 2015-16). Recognizing the increasing need for substance abuse prevention, treatment and recovery services, DSAS proactively sought out federal discretionary grant funds to leverage the SABG Block Grant and state appropriations with the goal of helping to close the gap of the number of Tennesseans needing substance abuse services. Since 2018, DSAS has received seventeen (17) state and federal grants, including the State Targeted Response (STR) and State Opioid Response (SOR) grants.
Prevention Services
DSAS’ Prevention structure has three service components to address the prevention needs of individuals, communities, regions, and the State. This structure provides the essential framework and resources necessary to reach Tennessee’s high need communities to increase protective factors while decreasing risk factors. Prevention service components include: provider agencies, prevention coalitions, and regional workgroups. Within this system, high need communities and populations are identified by a State Epidemiological and Outcomes Workgroup (SEOW) assessment. **Provider agencies** deliver culturally appropriate selected and indicated programs per an assessment through the Tennessee Prevention Network program. A network of county-level **coalitions** whose work is governed by the Strategic Prevention Framework (SPF) is the cornerstone of the prevention structure. They work to reduce underage alcohol use, underage tobacco use, and prescription drug use across the lifespan by working within their home communities to implement data-based plans that endeavor to solve the problems in their community through environmental and community-based strategies. Additionally, the Coalition for Healthy and Safe Campus Communities serves the Higher Education Institutions in Tennessee, a population known to be at great risk of alcohol and drug misuse. There are currently 48 anti-drug coalitions that are serving 75% of Tennesseans. Regional Overdose Prevention Specialists (ROPS) have been embedded in county coalitions to provide a regional hub to plan and coordinate evidenced-based and emerging practices to maximize community involvement. ROPS work collaboratively with coalitions and communities to ensure that key stakeholders across the state receive training on: opioid overdose, opioid use disorder, harm reduction, stigma, and naloxone use. In addition to providing training, ROPS distribute naloxone to individuals at high risk of overdose and other key stakeholders in the community. **Regional Workgroups** deliver universal indirect interventions, which leverage the efforts of individual coalitions and program providers by implementing environmental strategies in all areas of the state, including those areas without direct funding or a stand-alone program or coalition.

The planning process allows different programs to meet the needs of the predominant high-risk populations within their community. One unique program is the Deaf and Hard of Hearing program which serves the selective population of deaf and hard of hearing youth ages 6-20 and their families. Other prevention services programs include: School-Based Substance Abuse Liaisons, Comprehensive Alcohol, Tobacco and other Drugs Program, Synar, and Partnerships for Success. All programs work to understand the unique diversity of the participants they are serving and have cultural humility in their relationships. Cultural humility incorporates a consistent commitment to learning and reflection, but also an understanding of power dynamics and one’s own role in society. It is based on the idea of mutually beneficial relationships rather than one person educating or aiding another in attempt to minimize the power imbalances in client-professional relationships.

DSAS also supports prevention programs that address the needs of diverse racial, ethnic, sexual, gender, minorities, and military personnel. One example is “Just Us”, a program that focuses on LGBT youth in the Middle Tennessee area. This program provides a safe place for LGBT youth to come and be validated for their authentic selves; to learn how to use their voices to create change; and to be empowered with the tools to safely navigate the world that is uniquely theirs.
Other populations identified as at-risk include, youth with low school performance, delinquency, and/or high school dropouts, rural populations, and college students. The planning process allows different programs to meet the needs of the predominant high risk populations within their community.

The purpose of implementing the SPF process is to ensure that the strategies and practices implemented as part of the SAPT Block Grant are effective, culturally appropriate, and sustainable. The SPF is a 5-step planning process that includes a comprehensive community assessment that guides the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The assessment helps communities discern what their community looks like in terms of who makes up their community as well as the community consumption patterns or the way people drink, smoke, and use illicit drugs. This information ensures that the strategies that are implemented are designed specifically to prevent others from using substances in a similar manner. The ultimate goal of SPF implementation is outcomes based prevention that focuses on population level change, emphasizing data-driven decision making. Cultural competence is a key portion of the SPF. It is part of each step of the process and is always a key consideration.

The State coordinates prevention activities through the Tennessee Prevention Advisory Council (TN-PAC). TN-PAC expands and strengthens prevention resources, reduces barriers, and increases communication throughout the prevention system. TN-PAC’s members are comprised of state agencies; statewide organizations; regional prevention providers (including coalitions); and the Director of Prevention Services. Its structure and membership intentionally reflects the diverse racial, ethnic, faith, socioeconomic, and professional sectors of the State. The Evidence-Based Practices Workgroup has operationalized the definition of Evidence Based Practice (EBP) in Tennessee and serves as the expert panel to determine the viability of proposed interventions through a rigorous review and approval process. The SEOW profiles and prioritizes population needs, resources, service gaps, and readiness capacity. It provides guidance to the comprehensive strategic planning process at state and community levels, and makes data-informed recommendations to the TN-PAC.

The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State.

The Office of Prevention Services coordinates with several state agencies to best deliver prevention services. The Tennessee Department of Health (TDH) is very interested in many of the substance misuse and abuse issues because they impact the physical health of many Tennesseans. TDH is also interested in the prescription drug problem and has partnered with the TDMHSAS on legislation to increase the utility of the Controlled Substance Monitoring Database (CSMD). The Office of Prevention collaborates with TDH on a project that combines law enforcement data to the CSMD and overdose data. This project allows state departments and
community partners to better identify and react to emerging and existing hotspots, as well as changes in the opioid crisis. Additionally, they have partnered with coalitions to deliver key prevention messages at physician training events across the state regarding how to safely prescribe opioids.

DSAS, in collaboration with the Tennessee Department of Agriculture (TDOA), addresses the issue of underage tobacco access through Synar. The TDOA is responsible for coordinating and implementing the Synar survey. Tobacco compliance checks are completed statewide in establishments that sell tobacco products and are accessible to minors. Synar targets all youth under the age of 18.

DSAS continues its partnership with the National Guard, Counter Drug Task Force; Civil Operations Unit to provide well-trained and adaptable forces capable of developing anti-drug coalitions while implementing effective prevention practices.

While Tennessee’s primary prevention system has several strengths, there are opportunities for growth. One key area is funding. The resources available do not allow for a comprehensive prevention system in all areas of the state. For instance, 46 of Tennessee’s 95 counties have county level coalitions. Ideally, every county would have access to a funded coalition.

Through adherence to Culturally and Linguistically Appropriate Services (CLAS) Standards, TDMHSAS funded prevention programs are well-equipped to serve diverse communities:

a. Diverse cultural health beliefs and practices- As described above, the SPF process begins with assessment. This assessment will uncover the unique health beliefs and practices of the communities that receive TDMHSAS funding. The funded agencies then implement plans that are based on their knowledge of cultural health beliefs and practices for their respective communities.

b. Preferred languages- Again, as described above the SPF process allows for agencies to assess their communities and have a grasp on the specific languages that are unique to their area. TDMHSAS-funded providers understand that if they are truly going to make community-level change, it will be essential to reach people of all languages. Providers are encouraged to translate key informational materials or provide evidence based programming into languages that are reflective of their community.

Inherent in the work of all TDMHSAS-funded providers is the importance of strategic partnership and collaborations with diverse groups that truly represent the population and needs in their respective communities. TDMHSAS continues to collaborate with community partners who understand that making change involves support and buy-in from all members of a community and work to make decisions that are built on collaboration and a spirit of win-win on a daily basis.

**Early Identification**

**DUI Schools** in Tennessee provide educational intervention services based on ASAM Level 0.5, Early Intervention, to individuals that are mandated by the court to receive this service or want to reinstate their driver’s license privileges. Offenders receive an assessment, education, and, if
indicated, appropriate treatment referral. DUI Schools use the *Prime for Life* curriculum as the statewide standardized curriculum. *Prime for Life* curriculum is recognized by the National Registry of Evidence-Based Programs and Practices (NREPP) as a Promising Practice. The core focus is on improving attitudes of the student and creating a positive outlook to decrease dependency by using the latest research on brain chemistry and addiction.

Through the **Tennessee Suicide Prevention Network (TSPN)**, substance abuse professionals are trained on evidence-based suicide prevention strategies to eliminate and reduce the incidence of suicide across the life span, reduce the stigma of seeking help associated with suicide, and educate communities throughout Tennessee about suicide prevention and intervention. SABG treatment counselors are required to participate in the training. The goals of the training are:

a. To reduce the incidence of suicide and suicide attempts.
b. To educate the general public about suicide prevention and intervention.
c. To reduce the stigma associated with mental illness and suicide.
d. To be a resource for information about suicide.
e. To educate mental health and substance abuse counselors and program administrators about the high incidence of mental health and substance abuse disorders and suicide attempts and suicide deaths.
f. To promote the use of evidence-based practices and guidelines for suicide prevention education and training.

DSAS received the **Tennessee Opioid SBIRT (TOS)** grant to provide opioid and other drug screening, brief intervention, and referral to treatment services for individuals residing in East, Middle, and West Tennessee. The overarching mission of this project is to reduce OUD and SUD across the state leading to reductions in alcohol and other drug misuse and associated consequences including overdose, health problems, and social and economic problems for persons suffering from these disorders.

**Treatment Services**

DSAS’ Treatment structure has four (4) service components to address the needs of individuals, communities, and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for the treatment of persons whose use of alcohol and/or other drugs has resulted in patterns of abuse or dependence. Treatment Services’ components include: provider network, recovery courts, coalitions, and the TN RedLine. The *provider network* is the backbone of DSAS’ treatment structure. They offer a full continuum of care based on the American Severity Index (ASI) screening tool and the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM PPC-2R) to assess adults, pregnant women and women with dependent children; and the T-ASI and ASAM for adolescents. 98% of all treatment providers have been certified Co-Occurring Disorders Capable or Co-Occurring Enhanced Disorders. Utilizing state-funds, **Recovery Courts** provide treatment services on-site or refer individuals to DSAS-funded treatment agencies. **Coalitions** work to provide marketing and community linkages to promote resources. The **TN RedLine** operates a twenty-four hours per day/seven days per week (24/7) toll-free telephone line (TN-Redline) to
answer questions and give referrals to individuals seeking information relative to substance use and abuse prevention, treatment, and recovery as well as co-occurring disorders and problem gambling. Callers who would like to communicate directly with a treatment provider can receive a warm handoff or if they prefer to receive the information via text message, the RedLine has that capability. Other treatment services include: Medical Detoxification (state-funded); Medically Monitored Withdrawal Management; Tele-Treatment Program; HIV/AIDS Early Intervention Program; Problem Gambling Outreach, Education, Referral and Treatment Program; Opioid Treatment Program; and Medication Assisted Treatment.

DSAS’ Pregnant Women and Women with Dependent Children (PWWDC) programs are rooted in the Recovery-Oriented System of Care model. PWWDC targets women and pregnant women with a substance use disorders or a co-occurring substance use and psychiatric disorder. Providers are required to publicize the availability of services. If a provider does not have capacity, they notify the State and the State assists with locating a treatment facility and/or ensure that interim services are provided until a facility is located. Services offered included, but are not limited to: preference in admission to treatment; referral for primary medical care; childcare and prenatal care, including immunization; gender specific treatment and other therapeutic interventions for women; referral for therapeutic interventions for children in custody of women in treatment; case management; and transportation.

Due to the opioid epidemic, Tennessee has seen an increase in heroin treatment rates in the past five years. Injecting drug users (IVDUs) are a priority population for substance abuse treatment services and all block grant treatment providers are contractually required to give preference in admission. Other contractually required provisions of services for IVDUs included, but are not limited to: notify the State upon reaching 90% capacity; admit an individual who request treatment no later than 14 days after request or within 120 days if treatment facility does not have capacity; notify the State to assist with placement if there isn’t capacity; and provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment.

Policies and procedures were developed in conjunction with the Tennessee Department of Health, Tuberculosis Elimination Program, to identify and prevent active *Tuberculosis* (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the *Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs*. DSAS has an agreement with all public health departments to provide TB testing for DSAS funded treatment agencies that do not have the capacity to perform the test. In addition, DSAS offers an on-line training course on the risk factors and symptoms of TB.

DSAS contracts with nine (9) agencies to provide services to individuals at risk for contracting and/or transmitting *HIV/AIDS* including those in alcohol and drug abuse treatment programs with substance abuse and addiction disorders, their families and alcohol and drug treatment professionals. Services include:

1. Short-term counseling services to individuals and/or families;
2. Educational activities to groups;
(3) Oral Rapid HIV testing to individuals, including pre- and post-test counseling; and Hepatitis testing to individuals.
(4) Ongoing training activities to increase the knowledge of HIV and AIDS for professional staff at each alcohol and drug abuse treatment service provider and recovery support provider in the Grantee’s region; and
(5) Training of service recipients from alcohol and drug abuse treatment and recovery support service providers in the Grantee’s region using information gathered in the course entitled “The Fundamentals of HIV Prevention Counseling”, or the most current successive training course endorsed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC).

Identifying and enhancing services to populations who are vulnerable to disparities; and understanding differences in culture and the need to recognize and focus on those differences are an important part of the work for the DSAS’ leadership and staff. Through the Tennessee Web-based Information Technology System (TN WITS), DSAS has the capability of tracking enrollment in services, type of services received and outcomes based on demographics. Individuals can be identified by race, gender, ethnicity, preferred language and sexual orientation; therefore, giving us an overall picture as to who is seeking treatment and recovery support services in our substance abuse system. Individuals who have experienced violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences are assessed utilizing a trauma screener and a treatment plan is developed that includes trauma specific services and referral for other community support services.

DSAS expects its partners to be or become proficient in the cultural needs of shared constituents through recruitment and retention of diverse staff, through ongoing participation in focus groups, training, and planning activities. The provisions of services are clear and concise to ensure that service recipients receive services that are effective and efficient. Treatment agencies are required to provide services that are gender and culturally responsive. Recovery services are supported by a network of faith-based congregations and organizations that provide services and work as advocates to decrease stigma and support a common goal of strengthening individuals and families.

**Recovery Services**
Recovery Services promotes client engagement in the recovery process and provides services needed for support of continued recovery. Its structure has three service components to address the needs of individuals, communities and the State – provider network, faith-based congregations/organizations, and lifeline peer coordinators. Approximately one hundred-twenty (120) faith-based and non-faith based agencies provide recovery services through the provider network to keep individuals engaged in treatment or to provide continued recovery support. Services include transportation, transitional housing, health and wellness, employment skills and recovery activities. DSAS actively engage faith-based congregations/organizations as a means of increasing outreach, educational activities, access, and visibility to people seeking substance abuse services. Lifeline Peer Coordinators work to reduce stigma related to the disease of addiction, increase the number of recovery groups and meetings, and assist individuals in accessing treatment and/or recovery options in their community.
Most recently, DSAS added a recovery app to assist clients in their recovery. **TN Recover** is a recovery application designed to share updates, allow providers and clients to ask questions, support others, and stay connected throughout recovery through invite only. The app allows for peers and coaches to be able to share updates, ask questions, and offer support. It also allows individuals who have completed treatment or are in the process of completing treatment to receive inspirational messages, updates for onsite events, and prompts to join a dialog around certain topics. There is also a recovery tracker where individuals can share their recovery date as well as a gratitude journal that they can keep private or share with others. Other recovery support programs are: Recovery Housing, Addictions Disorder Peer Recovery Support Centers, and Peer Recovery Specialist Certification.

Treatment and recovery services are coordinated through the Tennessee Treatment and Recovery Advisory Council (TNTRAC). TNTRAC meets quarterly to provide guidance to the Division regarding programmatic (including the use of evidence-based practices), funding, and administrative decisions, as well as strategic planning. The Council is comprised of service providers and other stakeholders, as well as key Division staff. As needed, ad hoc committees are formed to address specific areas of concern/need. Each committee is co-chaired by members of TNTRAC with Division staff representation and 4 – 6 additional individuals representing provider agencies, advocates and consumers. There is an HIV, Women’s Treatment and Recovery Committee and Adolescent Committee that meet at least annually or as often as needed. These committees are comprised of representatives from provider organizations as well as the State.

**Criminal Justice**
Criminal Justice is an integral part of Tennessee’s substance use disorder system. Its’ structure has two service components to address the needs of individuals, communities, regions, and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for persons incarcerated or at-risk of incarceration due to the use of alcohol and/or other drugs. The criminal justice components are diversion programs and recovery courts. DSAS has worked persistently to increase the **diversion programs** offered to offenders with substance use and mental health disorders. The Criminal Justice Behavioral Health Liaison Program works directly with the local jails and court system to facilitate access to service recipients with serious mental illness (SMI), mental illness (MI), co-occurring disorders (COD) or substance abuse disorders who come in contact with the criminal justice system due to incarceration or at risk of incarceration in order to determine what services are needed and what referrals are necessary to divert the service recipient from jail and the court system. Other diversion programs are: Alcohol and Drug Addiction Treatment (ADAT) for DUI offenders, Supervised Probation Offender Treatment program and Community Treatment Collaborative for at-risk probation and parole technical violators.

**Recovery Courts** are specialized courts or court calendars that incorporate intensive judicial supervision; treatment services; sanctions; and incentives to address the needs of non-violent offenders with addiction and/or co-occurring mental health disorders. A recovery court team, composed of the judge; prosecutor; defense attorney; recovery court coordinator; probation
officer; treatment providers; and other program staff, works in concert to ensure that defendants have the support of the justice system and treatment services to address their substance use issues and mental health needs. Drug Courts, Mental Health Courts, Veterans Treatment Courts, Family Treatment Courts, Juvenile Recovery Courts, DUI courts, and a Human Trafficking Court are all part of the recovery court umbrella.

The Recovery Court Advisory Committee works with TDMHSAS in reviewing program criteria, certification process and application, makes recommendations concerning implementation of programs, and advises the Commissioner on the allocation of funds when funds are available. By law, the Recovery Court Advisory Committee is made up of the following representatives: two (2) judges who are currently presiding or have presided over a recovery court program for at least 2 years; two (2) recovery court coordinators who have functioned as a drug court coordinator in actively implemented recovery courts for at least 2 years; and at least two (2) additional members representing recovery court stakeholders (treatment/recovery support providers, court administrator, etc.). Staggered terms with initial appointments are established by the Commissioner. A member serves a four-year term and a member may be appointed to serve one additional consecutive term. Each member appointed represents a different region in the state (East, Middle, and West).

The Criminal Justice System serves a very diverse population. Effectively communicating with offenders is essential to providing successful behavioral health care coordination. Recovery courts in the State of Tennessee are required to have policies addressing their processes for engaging diverse populations. Programs are tasked with ensuring that they are appropriately addressing the needs of minority groups, including racial, ethnic, and sexual gender minorities. Assessment tools are provided for recovery courts to utilize to gauge their effectiveness in this area, and DSAS provides technical assistance for the process.

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

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 data-driven processes. This could include data that is available through a number of different sources such as SAMHSA’s NSDUH, TEDS, NSSATS, the Behavioral Health Barometer, and state data. This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for HIV-designated states, Persons at Risk for HIV. In addition, this narrative must include a description of the composition of the State Epidemiological Outcomes Workgroup and its contribution to the state planning process.
The Tennessee Substance Use Disorders Prevention and Treatment Needs Assessment process is used to facilitate and inform decisions about state priorities for policy making and resource allocation to ensure accountability and promote the achievement of intended results with respect to behavioral health problems in Tennessee. The decision process incorporates the use of criteria and data to prioritize issues and appropriate strategies for addressing behavioral health problems. To establish need, the assessment follows a more comprehensive evidence-based process that includes: a) using research-generated knowledge, i.e.; substance use prevalence, consumption patterns, and trends in local or national populations, about the epidemiology and consequences of substance use disorders to target those circumstances and behaviors that are particularly associated with consequences and social cost; b) state and county level data sources are used to document incidence, prevalence and trends in consumption patterns and use consequences in Tennessee. Data is drawn from multiple sources, such as state wide school surveys (e.g., CDC’s Youth Risk Behavior Survey), crime and health indicators, and reports; and c) identifying those accessible populations that are at high risk for substance use disorders and/or have constrained access to services. A variety of data sources and existing research was used to identify and rank priority needs for substance use disorders in Tennessee. These data sources consist of the U.S. Census; Healthy People, 2010; National Center on Addiction and Substance Abuse (CASA); National Institute of Drug Abuse (NIDA); Youth Risk Behavior Surveillance System; National Survey on Drug Use and Health; Treatment Episode Data Set (TEDS); etc. Interviews and focus groups were conducted with treatment and recovery support providers and other community stakeholders to determine local gaps and needs; program development issues; and concerns and technical assistance needs. DSAS Leadership utilized the needs assessment, data generated from the Tennessee Web-based Information Technology System (TN WITS), SAMHSA’s Strategic Initiatives and reports from TDMHSAS’ Division of Research, Planning and Forensics. The state priorities were presented to the Statewide Planning and Policy Council for review and comment.

Development of the needs assessment was closely guided by the State Epidemiological and Outcomes Workgroup (SEOW). Tennessee’s SEOW is composed of representatives of the Tennessee Department of Mental Health and Substance Abuse Services, the Tennessee Bureau of Investigation, the Tennessee Department of Health, the Tennessee Department of Safety and Homeland Security, the Tennessee Department of Correction, the Tennessee Department of Military, the Tennessee Division of Health Care Finance and Administration, the Tennessee Department of Children’s Services, the Tennessee Department of Education, East Tennessee State University, Oasis Center, Inc., and Allies for Substance Abuse Prevention of Anderson County. The SEOW profiled and prioritized population need, resources, service gaps and readiness capacity. They provided guidance to the comprehensive strategic planning process at the state and community levels; and made data-informed recommendations. A list of recommended priorities was provided to the Tennessee Prevention Advisory Council for consideration. The priorities are listed below in Exhibit 2.1 in the Column entitled “Prevention Service Needs” by Age Cohort.

Substance use disorder services are important because those disorders produce serious consequences for individuals, families and society. Need is not determined simply by substance use or abuse, but by those behavior patterns (i.e., disorders) that are highly associated with negative consequences, and by those vulnerable populations that are most likely to exhibit these patterns of behavior and remain underserved or unserved. Data concerning the incidence and
prevalence of use in a population becomes much more useful if there is a focus on those indicators that are most highly associated with the negative consequences that are the cause for concern. Data on problems is also more useful if it provides guidance on who is most likely to experience these problem behaviors, and how they can be identified for outreach and improved service access. To support a service system that helps apportion services according to need, data and findings are organized according to seven age cohorts (see Exhibit 2.1). Utilizing this approach associates the indicator data with consequences, prevalence in Tennessee and the presence of vulnerable populations at high risk for developing substance use disorders in the cohort.

**Exhibit 2.1. Lifelong Indicators and Targets of Substance Use Disorder Needs for Tennessee: Behaviors and Vulnerable Populations**

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Priority Cohort Problem Indicators</th>
<th>Relevant Target Populations</th>
<th>Prevention Service Needs</th>
<th>Treatment Service Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neo-natal to 5 years</td>
<td></td>
<td>• Female substance abusers&lt;br&gt;• Families experiencing Domestic Violence&lt;br&gt;• Families experiencing substance related Health Problems&lt;br&gt;• Families in low service rural areas</td>
<td>• Family programs,&lt;br&gt;• Community awareness and system improvements</td>
<td>• Female treatment access and orientation&lt;br&gt;• Anger management&lt;br&gt;• Domestic violence interventions</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>Early initiation</td>
<td>• Female substance abusers&lt;br&gt;• Families experiencing Domestic Violence&lt;br&gt;• Families experiencing substance related Health Problems&lt;br&gt;• Families in low service rural areas,&lt;br&gt;• Youth with low school performance/truancy&lt;br&gt;• Homeless families</td>
<td>• Family programs&lt;br&gt;• Community awareness and system improvements&lt;br&gt;• Age appropriate selective prevention (e.g., mentoring)</td>
<td>• Female treatment access and orientation&lt;br&gt;• Anger management&lt;br&gt;• Domestic violence interventions&lt;br&gt;• School outreach programs</td>
</tr>
<tr>
<td>11 to 13 years</td>
<td>Early initiation&lt;br&gt;• Inhalant use&lt;br&gt;• Mental health disorders</td>
<td>• Youth with low school performance/truancy&lt;br&gt;• Youth in Foster Care System</td>
<td>• Community programs for youth development&lt;br&gt;• Age appropriate selective and indicated prevention&lt;br&gt;• Family programs</td>
<td>• Counseling services&lt;br&gt;• Mental health counseling&lt;br&gt;• Family counseling</td>
</tr>
<tr>
<td>14 to 17 years</td>
<td>Binge drinking&lt;br&gt;• Prescription drug use&lt;br&gt;• Mental health disorders&lt;br&gt;• High risk illicit drug use</td>
<td>• Youth in Juvenile Justice System&lt;br&gt;• High School Dropouts</td>
<td>• Selective and indicated programs&lt;br&gt;• Brief interventions&lt;br&gt;• Community awareness and systems improvement&lt;br&gt;• Age appropriate indicated prevention&lt;br&gt;• Age appropriate environmental policies</td>
<td>• Adolescent treatment&lt;br&gt;• Recovery support services&lt;br&gt;• Recovery high schools</td>
</tr>
<tr>
<td>18 to 25 years</td>
<td>Binge drinking&lt;br&gt;• Methamphetamine use&lt;br&gt;• Prescription drug use&lt;br&gt;• DUI&lt;br&gt;• Substance abuse and dependence</td>
<td>• Transition-aged Youth&lt;br&gt;• Victims of Trauma&lt;br&gt;• Veterans&lt;br&gt;• Smokers</td>
<td>• Environmental policies&lt;br&gt;• College focused programs</td>
<td>• Young adult oriented treatment and outreach&lt;br&gt;• Comprehensive treatment and recovery support services&lt;br&gt;• Collegiate recovery</td>
</tr>
</tbody>
</table>
The identification of vulnerable populations with high risk for specific disorders and/or challenges in accessing services provides a practical and credible approach to effectively targeting outreach for treatment and prevention services.

DSAS leadership analyzed data from the needs assessment, TN WITS, and the SEOW in conjunction with SAMHSA’s Strategic Initiatives to prioritize which vulnerable populations, including the SABG priority populations, will be addressed in SFY 2020 and SFY 2021.

**Female Substance Abuse – Pregnant Women and Women with Dependent Children (PWWDC)**

Through an agreement with seventeen (17) non-profit providers, Tennessee ensures the following services for PWWDC:

- Preference in admission to treatment
- Referral for primary medical care
- Childcare and prenatal care; including immunization
- Gender specific treatment and other therapeutic interventions for women
- Referral for therapeutic interventions for children in custody of women in treatment
- Case management
- Transportation

Providers are required to publicize the availability of services for PWWDC. If the provider does not have capacity, they notify the State and the State assist with locating a treatment facility and/or ensure that interim services are provided until a facility is located.
Although comprehensive services are offered for PWWDC and enrollment numbers have more than doubled since SFY16, the percentage of discharges due to success (e.g., no further care needed, treatment completed) or neutral reasons (e.g., participant moved) have decreased in the past few years, while the percentage of unsuccessful discharges (e.g., treatment not completed) increased. The most common reason for unsuccessful discharge in this population has consistently been that the treatment provider lost contact with the patient and/or the patient left against medical advice. Though DSAS has had great success in increasing enrollment numbers, serving 297 pregnant women in SFY 2019 compared to 133 in SFY 2016, retaining this population in treatment has been a challenge.

2018 was a pivotal year for Tennessee as it relates to overdose deaths with a record 1,818. There were 1,304 overdose deaths associated with all opioids and it’s estimated that 40% of those individuals were women. The growth of the opioid crisis further complicates DSAS treatment efforts for this population because it has led to more intense treatment needs. An analysis of DSAS services for pregnant women in SFY19 revealed that a higher proportion of women whose treatment was successful had received recovery services such as child care and recovery housing. In SFY 2020 and 2021, DSAS intends to serve the growing number of pregnant women seeking treatment and address the treatment complications presented by opioid use through a pilot recovery coach program and expanding the service array to include medication assisted treatment.

Through the technical assistance, one of the gaps that the providers indicated was the need for more comprehensive treatment services for the whole family. The consultants provided training on Family-Centered Treatment: Defining What “Good Care” Looks Like for Women and Their Families. Through the training, DSAS learned that women place high values on their relationships and families, treatment should focus on promoting and supporting healthy attachment and relationships between parents and children and on women’s relationships with others. Family-centered treatment helps not only the woman dealing with adverse outcomes of drug use — it also helps her family and their needs.

Research on women’s substance use, dependence, and treatment shows that relationships, especially with family and children, has been shown to play an important role in women’s substance use, treatment and relapse. Therapeutic services and improved parenting increase the prognosis and outcomes for mothers and their children. When whole families are treated, outcomes for each individual member improve while simultaneously the communication,
coordination, and ability of adult members to support one another and the children increase. It has been shown that Family-Centered Treatment results in improved treatment retention/outcomes for individual women as well as improved outcomes for children and other family members. Relational outcomes include improvements in parenting, family functioning, and the number of families reunified or remaining intact and improved communication. As families transform, parenting improves, family norms shift, and economic and social well-being can increase.²

Family-Centered Treatment includes five levels of family-based services with Level 1 focusing on the woman but addressing family relationships as an integral part of the treatment process up to Level 5 which provides services for women, their children, and the children’s fathers or other family members. Some of the characteristics of Family-centered treatment are:

- Comprehensive
- Women define their families
- Treatment is based on the unique needs and resources of individual families
- Families are dynamic and thus treatment must be dynamic
- Conflict is inevitable, but resolvable
- Meeting complex family needs requires coordination across the systems
- Substance use disorders are chronic, but treatable
- Services must be gender responsive and specific and culturally competent
- Family-centered treatment requires an array of staff professionals as well as an environment of mutual respect and shared training
- Safety comes first
- Treatment must support creation of healthy family systems

Therefore, DSAS has decided to incorporate family-centered treatment into its women’s services program. In SFY 2018, DSAS will identify the level of family-centered services currently offered by its women’s providers and community assets and resources that are available to them. In SFY 2019, DSAS will work with women providers to add family-centered services; and assist them with forging partnerships with community resources, including faith-based organizations, to increase retention and engagement in treatment.

**Individuals with a Diagnosis of Opioid or Heroin Use Disorders – Injecting Drug Users**

The opioid use disorder (OUD) epidemic is a national problem that requires partnerships among federal, state, and local organizations to address prevention, treatment and recovery services. According to reports from the Centers for Disease Control (CDC), drug overdose deaths in the United States rose 28.9%, from 2015 (52,623) to 2018 (67,830). While drug overdose deaths decreased by 4% in the U.S. between January 2018 and January 2019, overdose deaths increased by 5.2% in Tennessee over the same time period.³ Additionally, the percentage of drug overdose deaths involving opioids has risen in Tennessee along with the overall drug overdose death rate.


In 2013, 64.7% of the 1,166 drug overdose deaths involved opioids; 2017, 71.4% of the 1,776 deaths involved opioids. Of the 21,462 unduplicated individuals DSAS served in SFY 19, 50.1% (10,743) had an opioid as a substance of use.

TN data from the National Survey on Drug Use and Health (NSDUH 2016-2017) reveals that in the past year 8% of 18-25 year-olds and 3.7% 26+ year-olds used pain relievers for non-medical purposes. Although the Tennessee rate of past-year opioid use disorder is 35% higher than that of the U.S. overall, Tennessee residents are 39% less likely to receive medication-assisted treatment than the U.S. overall. These use rates and the consequences associated with them are devastating to individuals, families, communities, regions and to the State of Tennessee and must be addressed.

Data collected as of March 31, 2017 by the National Survey of Substance Abuse Treatment Services (NSSATS) indicates that Tennesseans are unlikely to be in treatment compared to other states. Tennessee’s rate of 303 individuals in treatment per 100,000 population 18 and older compares to the U.S. rate of 507, meaning U.S. residents overall are 67% more likely to seek treatment. Chart 1 compares the percentages of Tennesseans who needed treatment for illicit drug use but did not receive it across age categories, based on 2016–17 annual averages. Tennessee performs on average in providing treatment services for illicit drug use when compared to other states, and the state rate of individuals who need but don’t receive treatment for illicit drug use is similar to that of the nation overall. However, the rate of 12- to 17-year olds who needed but did not receive treatment in the previous year is 71% higher than the same rate among Tennesseans ages 26 and older, indicating that more outreach to adolescents is crucial to preventing the long-term effects of illicit drug use in the future.

The OUD issue in Tennessee is statewide but depending upon the type of opioid the use pattern can differ greatly. Data for heroin related indicators shows greater rates in the urban areas and moving to suburban areas, while prescription opioid related indicators show greater rates in rural areas of the state.

All block grant treatment providers are required to treat individuals who inject drugs. They are contractually required to do the following:
- Notify the State upon reaching 90% capacity to admit individuals in its programs
- Admit an individual who request treatment no later than 14 days after request or within 120 days after request has been made if the treatment facility does not have capacity
- If there isn’t capacity to admit the individual, notify the State to assist with placement

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6 SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016.
• Provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment

As a response to the increase in opioid use disorders and overdose deaths, Tennessee formed an Opioid Working Group that was charged with reviewing state departments activities regarding the opioid epidemic, trends and outcomes. As a result of this Working Group, the Tennessee Together initiative was formed—a comprehensive state plan aimed at addressing the opioid crisis in Tennessee through expanded opioid prevention, treatment, and enforcement strategies. This initiative allowed DSAS to increase access to medication assisted treatment (MAT) and offer all three forms of FDA approved medication for opioid use disorder. In addition, the Initiative continued the pilot program of naltrexone in the recovery courts. In SFY 2020 and 2021, DSAS plans to continue increasing access to MAT.

**Individuals at Risk for Tuberculosis**

Through consultation with the Tennessee Department of Health, Tuberculosis Elimination Program, DSAS developed policies and procedures to identify and prevent active tuberculosis (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the *Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs* Requirements for TB screening and testing include:

- Testing and medical evaluation to determine the presence or absence of active TB disease or TBI in employees and volunteers of alcohol and drug treatment programs and recipients of alcohol and drug treatment services must conform to current guidelines of the Tuberculosis Elimination Program of the Tennessee Department of Health.
- A&D treatment facilities must provide baseline screening of all new employees and new volunteers for symptoms of active TB disease and appropriate testing for TBI prior to employment or provision of volunteer services.
- A&D treatment facilities must ensure that all employees and volunteers who provide direct care services are screened annually for symptoms of active TB disease and appropriately tested for TBI.
- A&D treatment facilities must counsel all employees and volunteers annually regarding the symptoms and signs of active TB disease.
- Any A&D treatment program employee or volunteer with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to return to work in the facility or provision of direct care services.
- Any A&D treatment program employee or volunteer reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from the facility and from provision of direct care services until the employee or volunteer is determined to be non-infectious by the local health department.
- All A&D treatment facilities must screen all prospective service recipients for symptoms suggestive of active TB disease prior to each admission for A&D treatment services.
• Prospective service recipients presenting with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to admission for A&D treatment services.

• Any service recipient reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from services until the service recipient is determined to be non-infectious by the local health department.

• Prospective recipients of all A&D treatment services who present without symptoms of active TB, and have no documentation of a previous positive TB test and have no documentation of testing for TBI within the past six (6) months must be appropriately tested for TBI within five (5) business days of initiation of A&D treatment services. The exceptions for testing are Outpatient ASAM Levels 1, 2.1 and 2.5; however, all service recipients must be screened for symptoms of active TB disease.

• A&D treatment facilities must counsel all service recipients about the symptoms and signs of active TB disease during each admission for A&D treatment services.

• All A&D treatment facilities must provide case management activities to ensure that employees, volunteers, and service recipients diagnosed with TBI receive appropriate medical evaluation, counseling about the risk of TBI progressing to active TB disease, and TBI treatment if such treatment is recommended to and accepted by the employee, volunteer, or service recipient.

• Testing for TBI may be conducted by qualified medical personnel at an A&D treatment facility or by referral to a licensed medical provider.

• All TB screening and testing records of employees, volunteers, and service recipients are considered personal medical information protected by HIPAA and must be archived accordingly.

DSAS has an agreement with all public health departments to provide testing for DSAS funded treatment agencies that do not have the capacity to perform the TB test. Individuals present DSAS’ screening tool to the health department and gives consent to communicate the test results to the treatment agency.

To increase provider’s knowledge about the risk factors and symptoms of TB, DSAS provides an on-line training course and examination. When the individual passes the exam, a certificate is provided acknowledging their success. To increase individual’s knowledge, DSAS added questions to the HIV pre- and post-test to gauge the effectiveness of the training offered at the treatment facilities. In SFY 2020 and 2021, DSAS intends to continue offering the on-line training course and training at the substance abuse treatment facilities.

**Individuals in Need of Primary Substance Abuse Prevention**

The Office of Prevention will utilize the TN Together Student survey, SEOW, and DSAS SEOW analyst to identify gaps in services, unmet needs, and potential new target populations.
The 2018-2019 Tennessee Together Student Survey captured data on substance use attitudes and behaviors among Tennessee public eighth-, 10th-, and 12th-grade students. The final survey sample included more than 21,000 respondents from five Behavioral Health Planning Regions, 28 counties, and more than 150 schools statewide.

The Tennessee Together Student Survey represents the largest survey of youth alcohol and other drug use ever undertaken in the state. It fills a critical information gap by providing locally representative data that have been previously unavailable for most Tennessee counties or regions.

The comprehensive state report represents the culmination of this survey effort. The report presents aggregated weighted data on alcohol, tobacco, and other drug use among 8th-, 10th-, and 12th-grade students. The report includes data comparisons across demographic subgroups and Behavioral Health Planning Regions. The 2018-19 survey is the first in a series of biennial administrations that will be used to monitor trends in substance use behaviors and attitudes over time; identify emerging alcohol, tobacco, and drug use patterns; and inform state and local prevention planning and evaluation efforts to reduce substance use and related consequences throughout the state of Tennessee.

The Tennessee Together Student Survey measurement tool comprises 24 core questions and 70 sub-questions, covering each of the following constructs:

- Lifetime and past 30-day alcohol, tobacco (including e-cigarettes), illicit drug, and prescription drug misuse;
- Age of onset of alcohol, tobacco, marijuana, and prescription drug misuse;
- Ease of access to alcohol, tobacco, marijuana, and prescription drugs, and methods of obtaining alcohol or prescription drugs;
- Peer substance use;
- Riding in a car with someone under the influence of alcohol or prescription drugs;
- Personal, peer, and parental approval of alcohol, tobacco, marijuana, and prescription drug misuse;
- Perceived risk of alcohol, tobacco, marijuana, and prescription drug misuse;
- Family communication about tobacco, alcohol, illicit drug, and prescription drug misuse; and
- Exposure to prevention messaging regarding the dangers of prescription drug misuse.
In 2018, Tennessee was ranked 42nd of 50 U.S. states and the District of Colombia by the United Health Foundation on measures of overall health. Tennessee ranked poorly on measures of premature death (potentially due to an increase in opioid related overdoses), chronic health concerns, such as heart disease and diabetes, and a high prevalence of smoking. Although Tennessee was ranked sixth lowest in the nation on measures of binge drinking and excessive alcohol use, indicating low overall prevalence of alcohol-related problems, this was in improvement from the second lowest ranking on this measure in 2015. Additionally, the state was ranked 38th out of 50 states on measures of drug-related deaths, highlighting the serious health consequences of drug misuse and abuse.

The Tennessee population is also diverse, with numerous subgroups defined based on characteristics that place them at elevated risk for experiencing alcohol and drug disorders. These populations of focus include, but are not limited to, youth and young adults, seniors and older adults, active military and military veterans, lesbian, gay, bisexual, or transgender (LGBT) populations, rural and homeless populations, and people who are disabled. For example, young adults 18–25 years of age, who account for about 9 percent of the total state population, often experience substantially higher rates of alcohol and prescription drug misuse than the general population as they transition between youth and adulthood. Rural populations, which account for about 30 percent of the state population, also experience high relative rates of substance use disorders, influenced by factors such as lower educational attainment, unemployment, and poverty. Rural areas also have more limited access to resources addressing alcohol and drug prevention, treatment, and recovery needs. LGBT populations are also at heightened risk for disparities and have been historically under-represented and underserved in mainstream prevention planning efforts. Research studies estimate that as many as 20–30 percent of gay and transgender people abuse substances, compared to 9 percent of the general population (Center for American Progress, 2012).

The difficulty of obtaining estimates of alcohol and other drug prevention need within these subpopulations and communities presents an ongoing data challenge is a critical gap within the prevention system. For this reason, an important focus of continuing work will be to enhance data system capacity to determine where subpopulations are concentrated and to better document sub-population needs, to inform state level prevention planning efforts, and ensure that resources are allocated to regions and communities where priority needs are greatest. Other gaps include lack of funding for prevention services and statewide coalition coverage.

In 2016 DSAS applied for and received the Strategic Prevention Framework for Prescription drug (SPR Rx) grant. The SPF-Rx grant was granted to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) in fiscal year 2017. The overarching purpose of this project is to reduce opioid use and overdose among Tennesseans. Specifically to reduce opioid use among Tennesseans 12 – 25 years old by 25%, reduce prescription drug related car crashes and injuries by 5%, reduce prescription drug related crime by 4%, reduce prescription drug related emergency room visits by 4%, reduce the number of babies born in TN with Neonatal Abstinence Syndrome by 5%, and reduce the number of overdose deaths by 4%. SPF-Rx concentrates on counties that both have high levels of opioid morphine milligram equivalents

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(MMEs) dispensed and reported to the CSMD (Controlled Substance Monitoring Database, Tennessee’s Prescription Drug Monitoring Program) as well as a current state-funded coalition that do not currently receive PFS-Rx funding. Grantees are working on several strategies to impact the following goals: Incorporate CSMD data into TDMHSAS practices, implement a public education plan throughout the counties, strengthen prevention capacity and infrastructure at the State and community level in support of prevention, and reduce the non-medical use of prescription drugs among Tennesseans of all ages by 25%. Some of the current strategies coalitions are implementing are: town hall meetings and medical forums within their counties, the distribution of lock boxes, education on proper storage practices, education on proper prescribing practices, education on the proper use of the CSMD, trainings within their community using the SAMHSA overdose prevention toolkit, collaboration with Regional Overdose Prevention Specialists to educate on opioid overdose prevention and Naloxone training, as well as mentoring other communities within their regions to expand prevention capacity. These coalitions have already been very successful in many of these areas within their communities and look to do more in the remaining years of this grant.

Through TN Together TDMHSAS added five new community anti-drug coalitions to its statewide network. Counties added to the system included Carroll, Claiborne, Cumberland, Loudon, and Maury counties. The addition raised the total number of TDMHSAS-funded coalitions to 46. Based on the population in the covered areas, more than 75% of Tennesseans have a coalition in their county. These coalitions will work toward the goals of decreasing non-medical use of pain relievers such as opioid medications and preventing underage drinking and tobacco use.

In addition DSAS is working closely with the Evidence-Based Practice Workgroup (EBPW) operationalized the definition of Evidence Based Practice (EBP) in TN to assist coalitions in determining the viability of proposed interventions through a rigorous review process. The purpose of EBPWs is to (1) understand the State’s Partnership for Success/ Block Grant prevention priorities and logic models; (2) identify and select evidence-based interventions; and (3) review and make recommendations on communities’ comprehensive plans. Utilizing this resource enhances services of the states limited resources responsibly.

In SFY 2020 and 2021 to close data gaps DSAS intends to utilize recurring funds to expand the TN Together Survey to expand counties beyond the 28 initially surveyed. Also, DSAS will continue to collaborate with the Tennessee Department of Health, SEOW partners, and other departments to identify data resources that can be used by community partners.

**Prioritize State Planning Activities**

*Using the information in Step 2 (Identify the unmet service needs and critical gaps within the current system), states should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the core federal goals and aims of the MHBG and SABG programs: target populations (those that are required in legislation and regulation for each block grant) and other priority populations described in this document. States should list the*
priorities for the plan in Plan Table 1 and indicate the priority type (i.e., substance use disorder prevention (SAP), substance use disorder treatment (SAT), or mental health services (MHS).

**Step 4: Develop goals, objectives, performance indicators, and strategies**

For each of the priorities identified in Step 3, states should identify the relevant goals, measureable objectives, and at least one-performance indicator for each objective for the next two years.

For each objective, the state should describe the specific strategy that will be used to achieve the objective. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, and system improvements that will address the objective.

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**Priority 1**

**Priority Area:** Prevention

**Priority Type:** Substance Abuse Prevention (SAP)

**Population:** Primary Prevention (PP)

**Goal:** Decrease non-medical use of pain relievers for young adults, age 12-25

**Objective:** Reduce prescription drug misuse and abuse among youth age 12-25

**Strategy:** Substance Abuse Prevention Coalitions will address prescription drug misuse in their communities through implementation of data-based plans that include environmental and community-based strategies.

**Indicator:** Percentage of young adults, ages 18-25, who report using pain relievers for non-medical use in the past year

**Baseline Measurement:** 8.03%

**1st yr target/outcome:** 7.75%

**2nd yr target/outcome:** Maintain baseline
Data Source: National Survey on Drug Use and Health prevalence estimates on Pain Reliever Misuse in the Past Year for Tennessee

Description of Data: Conducted by the federal government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Data issues/caveats that affect outcome: No issues are currently foreseen that will affect the outcome measure

Priority 2

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: Substance Abuse Treatment (SAT)

Population: PWID

Goal: All contracted providers will provide treatment services to individuals who inject drugs

Objective: To increase the availability of Medication-Assisted Treatment (MAT) Services in the community

Strategy: Ensure individuals who inject drugs have access to MAT services

Indicator: Percentage of individuals who disclose they inject drugs and receive MAT services

Baseline Measurement: 30%

1st yr target/Outcome: 31%

2nd yr target/Outcome: 32%
**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description of Data:**
Clients who identify their route of administration as “injection” and receive services

**Data issues/caveats that affect outcome:**
Potential budget reductions and route of administration

<table>
<thead>
<tr>
<th>Priority 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Priority Area:</strong> Pregnant Women and Women with Dependent Children (PWWDC)</td>
</tr>
<tr>
<td><strong>Priority Type:</strong> Substance Abuse Treatment (SAT)</td>
</tr>
<tr>
<td><strong>Population:</strong> PWWDC</td>
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<tr>
<td><strong>Goal:</strong> Access to quality Substance Use Disorder (SUD) treatment for pregnant women and women with dependent children with an Opioid Use Disorder (OUD)</td>
</tr>
<tr>
<td><strong>Objective:</strong> Increased access to SUD treatment for pregnant women and women with dependent children with an OUD</td>
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<tr>
<td><strong>Strategy:</strong> Provide training and technical assistance to SUD treatment providers on opioid and other substance use during pregnancy, access to gender-related responsive services, and other related information.</td>
</tr>
<tr>
<td><strong>Indicator:</strong> Increase number of PWWDC with OUD accessing SUD treatment</td>
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<tr>
<td><strong>Baseline Measurement:</strong> 1,167</td>
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<tr>
<td><strong>1st yr target/Outcome:</strong> 1,190</td>
</tr>
<tr>
<td><strong>2nd yr target/Outcome:</strong> 1,216</td>
</tr>
</tbody>
</table>

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description of Data:**
Individuals who identify opioids as a substance of use at intake and having at least one dependent child
Priority 4

Priority Area: Medication-Assisted Treatment (MAT) Services

Priority Type: Substance Abuse Treatment (SAT)

Population: Other - MAT

Goal: Increase number of individuals receiving MAT for Opioid Use Disorder (OUD)

Objective: Increasing number of individuals receiving MAT services

Strategy: Provide MAT services (methadone, naltrexone, and buprenorphine) for individuals with OUD

Indicator: Number of individuals receiving MAT services

Baseline Measurement: 1,120

1st yr target/Outcome: 2,200

2nd yr target/Outcome: 2,200

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Individuals with a group enrollment or service of MAT

Data issues/caveats that affect outcome: Reduction in funding

Priority 5

Priority Area: Human Immunodeficiency Virus (HIV) and Tuberculosis (TB)
### Priority 5

**Priority Area:** Substance Abuse Treatment (SAT)

**Population:** Early Intervention Services (EIS) HIV

**Goal:** Increase the number of individuals who receive training on HIV and TB

**Objective:** To address needs of individuals with or at risk of contracting HIV and TB

**Strategy:** Make available programs that provide education and training on HIV and TB

**Indicator:** Number of individuals trained

<table>
<thead>
<tr>
<th>Baseline Measurement</th>
<th>16,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong>&lt;sup&gt;st&lt;/sup&gt; yr target/Outcome</td>
<td>16,200</td>
</tr>
<tr>
<td><strong>2</strong>&lt;sup&gt;nd&lt;/sup&gt; yr target/Outcome</td>
<td>16,500</td>
</tr>
</tbody>
</table>

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description Of Data:** The number of individuals who attend and receive services through HIV/ EIS/ TB/ HCV outreach

**Data issues/ caveats that Affect outcome:** Not having a status as a designated state

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### Priority 6

**Priority Area:** Criminal Justice

**Priority Type:** Substance Abuse Treatment (SAT)

**Population:** Other – Criminal Justice
| **Goal:** | Increase the number of individuals screened for mental health and Substance Use Disorders (SUD) who are incarcerated or at risk of incarceration |
| **Objective:** | Link substance abuse and co-occurring treatment services that are culturally responsive to individuals involved in or at risk of involvement in the criminal justice system |
| **Strategy:** | Provide linkage and referral to behavioral health and recovery support services to individuals integrating from incarceration into the community. |
| **Indicator:** | Number of individuals screened by Criminal Justice Liaisons (CJLs) for diversion services |
| **Baseline Measurement:** | 2,560 |
| **1st yr target/Outcome:** | 3,500 |
| **2nd yr target/Outcome:** | 4,000 |
| **Data Source:** | Tennessee Web-based Information Technology System (TN-WITS) |
| **Description Of Data:** | Offenders who have a group enrollment in the CJL Liaison Program |
| **Data issues/caveats that Affect outcome:** | No issues are currently foreseen that will affect the outcome measure |

**Priority 7**

**Priority Area:** Criminal Justice

**Priority Type:** Substance Abuse Treatment (SAT)

**Population:** Other – Criminal Justice

**Goal:** Increase the number of adults completing services in recovery courts
Objective: To provide substance abuse and co-occurring treatment services that are culturally responsive to individuals involved in or at risk of involvement in the criminal justice system

Strategy: Increase retention rates for individuals participating in recovery courts

Indicator: Retention rate for adults in recovery courts

Baseline Measurement: 49%
1st yr target/Outcome: 50%
2nd yr target/Outcome: 51%

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Percentage of recovery court participants that complete the recovery court program

Data issues/ caveats that affect outcome: Program is voluntary

Priority 8

Priority Area: Workforce Development

Priority Type: Substance Abuse Prevention (SAP)

Population: Other – Prevention, Treatment and Recovery Support Workforce

Goal: Increase the knowledge of evidence-based programs and strategies for the prevention, treatment, and recovery support workforce

Objective: Enhance professional growth of the substance abuse prevention, treatment and recovery support workforce

Strategy: Provide on-line and regional face-to-face educational and training opportunities for prevention, treatment and recovery support professionals
Indicator: Number of substance abuse professionals receiving training on prevention, treatment, and recovery support services

Baseline Measurement: 1,000 persons
1st yr target/ Outcome: 1,000 persons
2nd yr target/ Outcome: 1,000 persons

Data Source: Attendance sheets of training classes, on-line training records

Description Of Data: Attendance sheets are maintained during training courses and are used to determine the number of individuals that attended training. Additionally, online training is tracked through a report generated from the on-line systems

Data issues/ caveats that affect outcome: Potential budget reductions

Priority 9

Priority Area: Recovery Support

Priority Type: Substance Abuse Treatment (SAT)

Population: Other – Persons in need of recovery support services

Goal: Provide recovery services that promote long-term recovery

Objective: Provide culturally responsive opportunities for individuals to access recovery support services

Strategy: Provide an array of adult and adolescent recovery services to increase their chances of long-term recovery

Indicator: Number of individuals enrolled in recovery support services

Baseline Measurement: 7,600 individuals
| Priority 10 |
|---|---|
| **Priority Area:** | Trauma |
| **Priority Type:** | Substance Abuse Treatment (SAT) |
| **Population:** | Other: Individuals who have experienced trauma |
| **Goal:** | Treatment agencies will provide assurance that individuals who have experienced trauma are receiving trauma informed care services |
| **Objective:** | Address the needs of individuals who have experienced trauma |
| **Strategy:** | Provide trauma informed care services to individuals who have disclosed experience with trauma |
| **Indicator:** | Number of individuals who have been screened for trauma |
| **Baseline Measurement:** | 13,000 |
| **1st yr target/Outcome:** | 8,000 individuals |
| **2nd yr target/Outcome:** | 8,000 individuals |
| **Data Source:** | Tennessee Web-based Information Technology System (TN-WITS); TN Recover App |
| **Description Of Data:** | Individuals who receive recovery support services |
| **Data issues/caveats that Affect outcome:** | Potential budget reductions |
**Outcome:** 13,000

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description Of Data:** Individuals who, during the intake process, responded “yes” to Violence or Trauma

**Data issues/caveats that Affect outcome:** Budget reductions

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**Priority 11:**

**Priority Area:** Recovery Housing

**Priority Type:** SAT

**Population:** Other: Homeless

**Goal:** Expand self-supporting and drug free homes through Oxford House International for individuals in recovery

**Objective:** Provide recovery housing for individuals in recovery from drug and alcohol addiction

**Strategy:** Establish new recovery homes statewide

**Indicator:** Number of new recovery homes

**Baseline Measurement:** 91 houses

**1st yr target/Outcome:** 101 houses

**2nd yr target/Outcome:** 111 houses

**Data Source:** Monthly reports

**Description**
Monthly reports give details on established and newly established homes; i.e., location, number of bedrooms, numbers of individuals residing in home, etc.

Data issues/caveats that affect outcome: Potential budget reductions

The Health Care System, Parity and Integration - Questions 1 and 2 are Required

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders.

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.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

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. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, 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.

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

*TennCare*, State Medicaid Authority, launched an initiative called “Tennessee Health Link” (THL). The primary objective of THL is to coordinate health care services for TennCare members with the most significant behavioral health needs. THL is built to encourage the integration of physical and behavioral health, as well as mental health recovery, giving every individual a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community. TDMHSAS and the majority of Community Mental Health Centers (CMHCs) within the state are THL providers. TDMHSAS has worked and will continue to work closely with TennCare and the provider network as this comprehensive integration effort is fully implemented.

Integrated care is promoted through the My Health, My Choice, My Life program. This program is a peer-led health promotion and wellness initiative for Tennesseans who live with mental health and substance use conditions. The holistic health initiative integrates a medical model with recovery and resiliency, resulting in an initiative that focuses on overcoming physical and mental health symptoms through strengths, personal empowerment and resiliency. It is led by peer wellness coaches who have firsthand, lived experience with mental health and substance use disorders and are employed by community mental health providers. My Health, My Choice, My Life provides individuals with self-directed tools, empowering them with the knowledge, skills and resources to improve their overall well-being and resiliency and live healthy and purposeful lives.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

TDMHSAS continues to provide leadership for advancing integrated systems of care for individuals with co-occurring disorders. This is evident through the department’s support of the Tennessee Co-Occurring Disorders Collaborative (TNCODC). This multi-agency effort aims to create a common understanding of the impact and treatment of co-occurring disorders in Tennessee communities. The primary goals of TNCODC includes: (1) to share knowledge about the conditions and available resources, (2) reduce stigma, and (3) accurately direct people to timely and effective prevention, treatment, and support.

In addition, TDMHSAS supports its Certified Peer Recovery Specialist program, which currently has 470 CPRS’s trained in co-occurring peer support. CPRS have lived experience of mental illness or substance use disorder. A program example of supporting integrated systems of care is
through the Statewide Peer Wellness Coach and Trainer program. This program provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and support assists providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?
   a) ☒ Yes □ No Medicaid?
   b) ☒ Yes □ No

4. Who is responsible for monitoring access to M/SUD services by the QHPs?

The SMI/SED focused services covered under Tennessee’s Block Grant funding are ancillary and fill gaps by providing services not covered by insurance. There has been no initiative yet developed that will monitor access to all 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.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?
   ☒ Yes □ No

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education?
      ☒ Yes □ No
   b) Health risks such as:
      i) heart disease, ☒ Yes □ No
      ii) hypertension, ☒ Yes □ No
      iii) high cholesterol ☒ Yes □ No
      iv) diabetes ☒ Yes □ No
   c) Recovery supports?
      ☒ Yes □ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?
   ☒ Yes □ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?
   ☒ Yes □ No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Tennessee successfully passed legislation that aligns state statute with federal parity law and strengthens state enforcement efforts. Now the Tennessee Department of Commerce and Insurance, which has the statutory authority to regulate insurance markets and the responsibility to ensure that plans sold in the state are in compliance with parity laws, is required to collect additional parity information from health plans showing that their standards and procedures are designed and applied fairly.

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

Please indicate areas of technical assistance needed related to this section

**Health Disparities Requested**

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

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS 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 HHS Secretary’s top 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.”

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. 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.
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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

Please respond to the following items:

1) Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, and age?
   a) race ☒ Yes ☐ No
   b) ethnicity ☒ Yes ☐ No
   c) gender ☒ Yes ☐ No
   d) sexual orientation ☐ Yes ☒ No
   e) gender identity ☒ Yes ☐ No
   f) age ☒ Yes ☐ No

2) Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?
   ☐ Yes ☒ No
3) Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?
   ☒ Yes ☐ No

4) Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
   ☐ Yes ☒ No

5) If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?
   ☒ Yes ☐ No

6) Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?
   ☐ Yes ☒ No

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

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

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**Innovation in Purchasing Decisions Requested**

*While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:*

\[
\text{Health Care Value} = \frac{\text{Quality}}{\text{Cost}}, \quad (V = \frac{Q}{C})
\]

*SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.*

*There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse 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 IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

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, The New Freedom Commission on Mental Health, the IOM, NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). 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.”

SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. 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 Protocol Series (TIPS) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

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

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, 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 M/SUD services.

Please respond to the following items:
1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☒ Yes ☐ No

2. Which value based purchasing strategies do you use in your state? (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

Program Integrity - Required

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.

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

Please respond to the following:
1) Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒ Yes ☐ No

2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

☒ Yes ☐ No

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

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

Primary Prevention-Required (SABG only)

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

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

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

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

Please respond to the following questions:

**Assessment**

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   ☒ Yes ☐ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):
   a) ☒ Data on consequences of substance-using behaviors
   b) ☒ Substance-using behaviors
   c) ☒ Intervening variables (including risk and protective factors)
   d) ☐ Other (please list)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply):
   a) ☐ Children (under age 12)
   b) ☒ Youth (ages 12-17)
   c) ☒ Young adults/college age (ages 18-26)
   d) ☒ Adults (ages 27-54)
   e) ☒ Older adults (age 55 and above)
   f) ☒ Cultural/ethnic minorities
   g) ☒ Sexual/gender minorities
   h) ☒ Rural communities
   i) ☒ Other (please list) Veterans

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):
   a) ☐ Archival indicators (Please list)
   b) ☒ National Survey on Drug Use and Health (NSDUH)
   c) ☒ Behavioral Risk Factor Surveillance System (BRFSS)
   d) ☒ Youth Risk Behavior Surveillance System (YRBS)
5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?
   a) ☒ Yes ☐ No
      i) If yes, (if yes, please explain)
      Data on consumption patterns, consequences of use, and risk and protective factors are reviewed to formulate a prevention strategic plan that clearly articulates which substances should be targeted and incorporates this information into contracts with coalitions and other grantees. In addition, the State requires each funded agency and coalition to review the data available at the local level and conduct the Strategic Prevention Framework (SPF).
      
      ii) If no, please explain how SABG funds are allocated:

Capacity Building
6. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?
   a) ☒ Yes (if yes, please describe)
      The Tennessee Certification Board is a statewide entity funded to strengthen the prevention workforce. This entity administers the International Certification and Reciprocity Consortium’s Prevention Specialist certification program and helps ensure a high level of prevention competency among the prevention workforce. Every agency funded with prevention block grant dollars is contractually required to have at least one person on staff that has obtained the IC&RC Prevention Specialist credential.
   b) ☐ No

7. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?
   a) ☒ Yes (if yes, please describe mechanism used)
      The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS uses the regional prevention advisory council meetings as a venue to conduct prevention specific trainings. These training events are conducted
either before or after the regional meetings and the content of the training event is determined by the prevention providers in the region and are consistent with their organizational needs. DSAS also provides online prevention training and requires that each agency funded with block grant dollars complete two courses each year. These courses have been designed by prevention experts and address the latest in prevention research and science.

The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions funded by the State. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State.

DSAS has also worked to ensure that the state prevention office is well grounded in prevention science. All state prevention staff members have participated in the Substance Abuse Prevention Skills Training and staff regularly participates in conferences to best understand the latest in prevention science. Additionally, staff works to ensure that providers have the tools they need to 1. Ensure that the locations of all permanent prescription drop boxes are communicated to coalitions; 2. Work with other State Departments to design a workable plan; and 3. Incinerate substances. The Office of Prevention Services tries to expand the capacity of coalitions and other providers by providing resources that are timely and meet identified needs. We have started offering annual face-to-face provider meetings where contract requirements are reviewed, but there is also a training component. Also, we are working with Strategic Answers and the National Guard to provide technical assistance to coalitions that best meet their needs.

DSAS is also working collaboratively with the National Guard, Counter Drug Task Force; Civil Operations Unity to provide well-trained and adaptable forces capable of developing anti-drug coalitions while implementing effective prevention practices. Their vision is to be the preferred source for Technical Assistance for coalitions across the state and for all state agencies involved with the development and training of prevention coalitions by being a force multiplier in a coalition’s pursuit to drive positive environmental change in their community and continuously seeking new opportunities to develop effective grassroots coalitions in communities without a drug preventative organization.

b) ☐ No

8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

a) ☒ Yes (if yes, please describe mechanism used)

Coalitions and programs are asked to use each of the five steps of the Strategic Prevention Framework in order to ensure that the programs/strategies they are using are responsive to the needs in their community. Community coalitions use the Strategic Prevention Framework as the model for writing their comprehensive strategic plans, which include an Assessment of Need; a Capacity Assessment; a Planning Process; an Implementation Plan;
and an Evaluation Plan. Additionally, programs use the Strategic Prevention Framework to guide their program planning and implementation process.

b) ☒ No

**Planning**

9. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?
   a) ☐ Yes (If yes, please attach the plan in BGAS)
   b) ☒ No

10. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?
    a) ☐ Yes ☒ No
    ☒ Not applicable (no prevention strategic plan)

11. Does your state’s prevention strategic plan include the following components? (check all that apply):
    a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
    b) ☐ Timelines
    c) ☐ Roles and responsibilities
    d) ☐ Process indicators
    e) ☐ Outcome indicators
    f) ☒ Cultural competence component
    g) ☒ Sustainability component
    h) ☒ Other (please list)
    i) ☒ Not applicable/no prevention strategic plan

12. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
    a) ☒ Yes ☐ No

13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
    a) ☒ Yes ☐ No
    b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

    *The EBPW has reviewed training materials and work plan worksheets with TDMHSAS.*

    *The State working with its Evidence-Based Practice Workgroup (EBPW) on an ongoing basis:*
    - Conduct research into health disparities and environmental strategies that are evidence-based for alcohol and establish correlates for impacts on other substances of abuse (e.g. prescription drugs);
• Conduct discussion groups with coalition staff regarding program implementation to ensure that work products align with evidence based practices;
• Develop fidelity models for environmental practices for a variety of substances of abuse;
• Conduct a literature review of evidence based prevention program
• Conduct presentations for coalitions and other groups to describe research and make relevant at the practice level; and
• Develop a menu of evidence-based practices and cite relevant research.

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

15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
   a) Information Dissemination:
      • Tennessee Prevention Network
      • School Based Liaisons
      • Clearinghouse
      • Workforce Training Program
      • Community Based Coalitions
      • In-Home Visitation Services for At-Risk Mothers
      • SAPT Evidence Based Practices Workgroup
   b) Education:
      • Tennessee Prevention Network
      • School Based Liaisons
      • Workforce Training Program
      • Community Based Coalitions
      • In-Home Visitation Services for At-Risk Mothers
c) Alternatives:
   - Tennessee Prevention Network
   - Community Based Coalitions
   - Higher Education Coalition

d) Problem Identification and Referral:
   - Tennessee Prevention Network
   - School Based Liaisons
   - Clearinghouse
   - In-Home Visitation Services for At-Risk Mothers
   - SAPT Evidence Based Practices Workgroup

e) Community-Based Processes:
   - Tennessee Prevention Network
   - Community Based Coalitions
   - Higher Education Coalition
   - SAPT Evidence Based Practices Workgroup

f) Environmental:
   - Community Based Coalitions
   - School Based Liaisons

16. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?
   a) ☑ Yes (if so, please describe)
      
      DSAS ensures that SABG dollars are used to fund primary substance abuse prevention services by including language within prevention contracts that defines “primary prevention” and explicitly stating that prevention funding can only be used for primary prevention. Additionally, training is provided each year to ensure agencies understand the requirement; and agencies are monitored against their contract during regularly scheduled monitoring visits. The Tennessee Department of Mental Health and Substance Abuse Services conduct programmatic and fiscal monitoring visits on all providers at least once over a three year period. Programmatic monitoring visits assess achievement of contract performance benchmarks through the examination of personnel and service recipient records and data management as well as evaluation of conformity with agency policies and procedures and DSAS requirements. The fiscal monitoring visit is conducted in accordance to the Tennessee Department of General Services Policy 2013-007, Subrecipient Monitoring. The objectives for the fiscal review include a test to determine if costs and services are allowable and eligible; and to verify contractual compliance. In addition, there is a special term and condition in all grant contracts prohibiting supplanting of SABG funds.

   b) ☐ No
Evaluation
17. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?
   a) ☐ Yes (If yes, please attach the plan in BGAS)
   b) ☒ No

18. Does your state’s prevention evaluation plan include the following components? (check all that apply)
   a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) ☐ Includes evaluation information from sub-recipients
   c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) ☐ Establishes a process for providing timely evaluation information to stakeholders
   e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) ☐ Other (please describe)
   g) ☒ Not applicable/no prevention evaluation plan

19. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   a) ☒ Numbers served
   b) ☒ Implementation fidelity
   c) ☐ Participant satisfaction
   d) ☒ Number of evidence based programs/practices/policies implemented
   e) ☒ Attendance
   f) ☒ Demographic information
   g) ☐ Other (please describe)

20. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc.
   b) ☒ Heavy use Binge use Perception of harm
   c) ☐ Disapproval of use
   d) ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
   e) ☐ Other (please describe)

Substance Use Disorder Treatment - Required for SABG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services
1. Does your state provide:

a) A full continuum of services:
   i) Screening
      ☒ Yes ☐ No
   ii) Education
      ☒ Yes ☐ No
   iii) Brief intervention
      ☐ Yes ☒ No
   iv) Assessment
      ☒ Yes ☐ No
   v) Detox (inpatient/social)
      ☒ Yes ☐ No
   vi) Outpatient
      ☒ Yes ☐ No
   vii) Intensive outpatient
      ☒ Yes ☐ No
   viii) Inpatient/residential
      ☒ Yes ☐ No
   ix) Aftercare; recovery support
      ☒ Yes ☐ No

b) Services for special populations:
   Targeted services for veterans?
   ☐ Yes ☒ No
   Adolescents?
   ☒ Yes ☐ No
   Older adults?
   ☐ Yes ☒ No
   Medication-Assisted Treatment (MAT)?
   ☒ Yes ☐ No

Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)
1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?
   a) ☒ Yes ☐ No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?
   a) ☒ Yes ☐ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
a) ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services?

a) ☒ Yes ☐ No
5. Has your state identified a need for any of the following:

a) Open assessment and intake scheduling?
☐ Yes ☒ No

b) Establishment of an electronic system to identify available treatment slots?
☒ Yes ☐ No

c) Expanded community network for supportive services and healthcare?
☐ Yes ☒ No

d) Inclusion of recovery support services?
☒ Yes ☐ No

e) Health navigators to assist clients with community linkages?
☒ Yes ☐ No

f) Expanded capability for family services, relationship restoration, and custody issues?
☒ Yes ☐ No

g) Providing employment assistance?
☒ Yes ☐ No

h) Providing transportation to and from services?
☒ Yes ☐ No

i) Educational assistance?
☐ Yes ☒ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State’s approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must
also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Criteria 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)
1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement?
      ☒ Yes ☐ No
   b) 14-120 day performance requirement with provision of interim services?
      ☒ Yes ☐ No
   c) Outreach activities?
      ☒ Yes ☐ No
   d) Syringe services programs?
      ☐ Yes ☒ No
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation?
      ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
   a) Electronic system with alert when 90 percent capacity is reached?
      ☐ Yes ☒ No
   b) Automatic reminder system associated with 14-120 day performance requirement?
      ☐ Yes ☒ No
   c) Use of peer recovery supports to maintain contact and support?
      ☒ Yes ☐ No
   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?
      ☒ Yes ☐ No

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?
   a) ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers?
      ☐ Yes ☒ No
   b) Cooperative agreement/MOU with public health entity for testing and treatment?
      ☒ Yes ☐ No
   c) Established co-located SUD professionals within FQHCs?
      ☐ Yes ☒ No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

**Monitoring.** In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State’s approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

**Early Intervention Services for HIV (For “Designated States” Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

☒ Yes ☐ No

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

   a) Establishment of EIS-HIV service hubs in rural areas?

☐ Yes ☒ No
b) Establishment or expansion of tele-health and social media support services?
☐ Yes ☒ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?
☐ Yes ☒ No

Syringe Service Programs
1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?
☒ Yes ☐ No

2) Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?
☒ Yes ☐ No

3) Do any of your programs use SABG funds to support elements of a Syringe Services Program?
a) ☐ Yes ☒ No
b) If yes, please provide a brief description of the elements and the arrangement

Criteria 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs
1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement?
☒ Yes ☐ No

2. Has your state identified a need for any of the following:
a) Workforce development efforts to expand service access?
☐ Yes ☒ No
b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services?
☐ Yes ☒ No
c) Establish a peer recovery support network to assist in filling the gaps?
☒ Yes ☐ No
d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
☒ Yes ☐ No
e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations
☐ Yes ☒ No
f) Explore expansion of services for:
   i) MAT
      (1) ☒ Yes ☐ No
   ii) Tele-health
(1) ☐ Yes ☒ No

iii) Social media outreach
(1) ☒ Yes ☐ No

Service Coordination

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

☐ Yes ☒ No

2. Has your state identified a need for any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
      ☐ Yes ☒ No
   b) Establish a program to provide trauma-informed care
      ☒ Yes ☐ No
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education
      ☒ Yes ☐ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?
   ☒ Yes ☐ No

2. Does your state provide any of the following:
   a) Notice to Program Beneficiaries?
      ☒ Yes ☐ No
   b) An organized referral system to identify alternative providers?
      ☒ Yes ☐ No
   c) A system to maintain a list of referrals made by religious organizations?
      ☐ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?
   ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
   a) Review and update of screening and assessment instruments?
      ☐ Yes ☒ No
   b) Review of current levels of care to determine changes or additions?
      ☐ Yes ☒ No
   c) Identify workforce needs to expand service capabilities?
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background?
☒ Yes ☐ No

Patient Records
1. Does your state have an agreement to ensure the protection of client records?
 a) ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements?
      ☒ Yes ☐ No
   b) Training on responding to requests asking for acknowledgement of the presence of clients?
      ☒ Yes ☐ No
   c) Updating written procedures which regulate and control access to records?
      ☒ Yes ☐ No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?
      ☐ Yes ☒ No

Independent Peer Review
1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
 a) ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
   a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved
      A minimum of 2 agencies will received an independent peer review each fiscal year for a total of 4
3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan?
      ☐ Yes ☒ No
   b) Establishment of policies and procedures related to independent peer review?
      ☐ Yes ☒ No
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations
      ☐ Yes ☒ No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of
Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

a) ☐ Yes ☒ No

b) If Yes, please identify the accreditation organization(s)
   i) ☐ Commission on the Accreditation of Rehabilitation Facilities
   ii) ☒ The Joint Commission
   iii) ☐ Other (please specify)_______________________

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

Group Homes
1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?
   ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service?
      ☒ Yes ☐ No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?
      ☐ Yes ☒ No

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

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs?
      ☒ Yes ☐ No
   b) Addition of training sessions designed to increase employee understanding of recovery support services?
      ☐ Yes ☒ No
c) Collaborative training sessions for employees and community agencies’ staff to coordinate and increase integrated services?
☒ Yes ☐ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?
☒ Yes ☐ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?
      ☒ Yes ☐ No
   b) Mental Health TTC?
      ☒ Yes ☐ No
   c) Addiction TTC?
      ☒ Yes ☐ No
   d) State Targeted Response TTC?
      ☒ Yes ☐ No

Waivers
Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations Regarding Women
      ☐ Yes ☒ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus
   a) Tuberculosis
      ☐ Yes ☒ No
   b) Early Intervention Services Regarding HIV
      ☐ Yes ☒ No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment
      ☐ Yes ☒ No
   b) Professional Development
      ☐ Yes ☒ No
   c) Coordination of Various Activities and Services
      ☐ Yes ☒ No

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

Rules of the Tennessee Department of Mental Health and Substance Abuse Services
https://publications.tnsosfiles.com/rules/0940/0940.htm
Quality Improvement Plan- Requested

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

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
   a) ☐ Yes ☒ No

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

Trauma -Requested

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening 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 M/SUD 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.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system 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 M/SUD 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. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource
poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

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

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ☒Yes ☐No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?
   ☒Yes ☐No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?
   ☐Yes ☒No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   ☒Yes ☐No

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

   All of TDMHSAS funded providers are required to provide a screening and assessment for trauma and ensure that treatment meets the needs of those identified as having experienced trauma. The provider can use the AC-OK Adult Screen for trauma or another trauma screen from the SAMHSA’s Evidence Based Practices Resource Center on each service recipient upon initial contact. The provider is also required to complete a brief trauma screener in Tennessee Web-based Information Technology System if trauma is identified during the administration of the ASI.

Please indicate areas of technical assistance needed related to this section.
**Criminal and Juvenile Justice - Requested**

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 mental and substance use problems. Youth 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.\(^{59}\)

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.\(^{60}\)

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 M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.

**Please respond to the following items:**

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?
   - Yes ☑️ No ☐

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?
   - Yes ☑️ No ☐

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?
   - Yes ☑️ No ☐
Yes ☐ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?
Yes ☐ No

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

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

**Medication Assisted Treatment – Requested (SABG only)**

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in 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 MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

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.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

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

Please respond to the following:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?
Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?
Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds?
   a) ☐ Methadone
   b) ☒ Buprenorphine; Buprenorphine/naloxone
   c) ☐ Disulfiram
   d) ☐ Acamprosate
   e) ☐ Naltrexone (oral, IM)
   f) ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance use disorders are used appropriately*?
   ☒ Yes ☐ No

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

   DSAS has been able to expand medication assisted treatment through state funding to include all three forms of the FDA-approved medications, naltrexone, buprenorphine and methadone for the indigent population. In addition, in conjunction with our Medicaid agency, TennCare, convened a one day Medication Assisted Treatment Training Institute to promote education and create connections.

   *Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychosocial treatments with approved 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, and advocacy with state payers.

Crisis Services - Requested

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD 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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. 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 M/SUD conditions and their families.

According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises, “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 M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☒ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☒ Psychiatric Advance Directives
   c) ☒ Family Engagement
   d) ☒ Safety Planning
   e) ☒ Peer-Operated Warm Lines
   f) ☐ Peer-Run Crisis Respite Programs
   g) ☒ Suicide Prevention

2. Crisis Intervention/Stabilization:
   a) ☒ Assessment/Triage (Living Room Model)
   b) ☐ Open Dialogue
   c) ☒ Crisis Residential/Respite
   d) ☒ Crisis Intervention Team/ Law Enforcement
   e) ☒ Mobile Crisis Outreach
   f) ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support:
   a) ☒ Peer Support/Peer Bridgers
   b) ☒ Follow-Up Outreach and Support
   c) ☒ Family-to-Family engagement
   d) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
   e) ☒ Follow-up crisis engagement with families and involved community members)
   f) ☐ Recovery community coaches/peer recovery coaches
   g) ☐ Recovery community organization

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

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

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of 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. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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 to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. 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.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:
1. Does the state support recovery through any of the following:
   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
      ☒ Yes ☐ No
   b) Required peer accreditation or certification?
      ☒ Yes ☐ No
   c) Block grant funding of recovery support services?
      ☒ Yes ☐ No
   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?
      ☒ Yes ☐ No

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

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
   Not applicable

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
   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. TDMHSAS considers recovery support to be a vital component in the pathway to recovery for individuals with substance use and co-occurring disorders. Recovery Support Services are services provided to promote individual, program, and system-level approaches that foster health and resilience, increase permanent housing, employment and other necessary supports, and reduce barriers to social inclusion.

5. Does the state have any activities that it would like to highlight?
DSAS provides Recovery Activities that may assist a client in his or her recovery process. Recovery activities can include cultural activities, community events, and other similar activities. Many of the recovery support providers report that the clients are very engaged in choosing these activities and see this as an effective tool in “teaching” that recovery can be fun.

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

Children and Adolescents M/SUD Services –Required for MHBG, Requested for SABG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

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. 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 point person 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 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.
For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.67

According to data from the 2015 Report to Congress68 on systems of care, services:
1 reach many children and youth typically underserved by the mental health system;
2 improve emotional and behavioral outcomes for children and youth;
3 enhance family outcomes, such as decreased caregiver stress;
4 decrease suicidal ideation and gestures;
5 expand the availability of effective supports and services; and
6 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 M/SUD 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
• supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following:

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

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

3. Does the state monitor its progress and effectiveness, around:
a) Service utilization?
☒ Yes ☐ No
b) Costs?
☒ Yes ☐ No
c) Outcomes for children and youth services?
☒ Yes ☐ No

4. Does the state provide training in evidence-based:
a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
☒ Yes ☐ No
b) Mental health treatment and recovery services for children/adolescents and their families?
☒ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:
a) to the adult M/SUD system?
☒ Yes ☐ No
b) for youth in foster care?
☒ Yes ☐ No

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

Tennessee provides integrated services through partnerships that have been developed throughout the state since the adoption of System of Care in 1999. The System of Care in Tennessee is governed by the legislatively mandated Council on Children’s Mental Health (CCMH), which brings together individuals from across the state to discuss systems, projects, and programs that touch the lives of children and youth with mental health concerns. CCMH provides a venue, five times annually, for child serving agencies to discuss current trends within the state as well as potential barriers to service. The council has various ad hoc committees that identify and problem-solve issues around financing, policy, community readiness, marketing, and other areas related to the promotion of System of Care across Tennessee. In addition to CCMH, there are numerous advisory boards, councils, and committees on which System of Care is represented to work toward improving the lives of young children, children, youth, young adults, and families across the state including: the Youth Transition Advisory Council, Healthy Transitions State Transition Team, and the Young Child Wellness Council. System of Care in Tennessee is beginning training on the use
of high fidelity wraparound which will further integrate services by providing wraparound services to children and families by bringing together systems to work toward a single treatment plan among child-serving agencies. Several of our children and youth programs offer integrated services at the local level by working with schools, the juvenile justice system, and child welfare services.

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

Please indicate areas of technical assistance needed related to this section

Public Comment on the State Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?
      ☒ Yes ☐ No
   b) Posting of the plan on the web for public comment?
      ☒ Yes ☐ No
   c) Other (e.g. public service announcements, print media)
      ☐ Yes ☒ No

   if yes, provide URL
   https://www.tn.gov/behavioral-health/substance-abuse-services/blockgrant

   Public comment for the SABG is solicited through both public availability and direct distribution of the draft plan to members of the Tennessee Department of Mental Health Planning and Policy Council, substance abuse prevention and treatment contract providers, TDMHSAS executive staff, any other individuals or organizations requesting access and the general public.

   Copies of the FY 2020-2021 Block Grant draft application was e-mailed to members of the groups mention above and a link was posted on the Tennessee Web-based Information Technology System and Department’s website homepage for general public access, review and comment during the development of the plan and submission to HHS. Comments were directed to the Block Grant Coordinator; although comments could also be directed to either the Council Chair or Department Commissioner.