

# Tennessee

## UNIFORM APPLICATION

### FY 2020/2021 Community Mental Health Services Block Grant Plan

## COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022  
(generated on 10/24/2019 3.33.53 PM)

Center for Mental Health Services  
Division of State and Community Systems Development

## State Information

### State Information

#### Plan Year

Start Year 2020

End Year 2021

#### State DUNS Number

Number 878890425

Expiration Date

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

Agency Name Tennessee Department of Mental Health and Substance Abuse Services

Organizational Unit Division of Planning, Research and Forensics

Mailing Address 5th Floor Andrew Jackson Building 500 Deaderick Avenue

City Nashville

Zip Code 37243

#### II. Contact Person for the Grantee of the Block Grant

First Name Marie

Last Name Williams

Agency Name Tennessee Department of Mental Health and Substance Abuse Services

Mailing Address 6th Floor Andrew Jackson Building 500 Deaderick Street

City Nashville

Zip Code 37243

Telephone 615-253-3049

Fax

Email Address Marie.Williams@tn.gov

#### III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

#### IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

**V. Date Submitted**

Submission Date 8/30/2019 3:15:17 PM

Revision Date 10/24/2019 3:32:54 PM

**VI. Contact Person Responsible for Application Submission**

First Name Avis

Last Name Easley

Telephone 615-253-6397

Fax

Email Address Avis.Easley@tn.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

# State Information

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

### Fiscal Year 2020

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
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Title XIX, Part B, Subpart III of the Public Health Service Act		
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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Marie Williams, LCSW

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Commissioner

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

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

#### **5. Certification Regarding Environmental Tobacco Smoke**

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

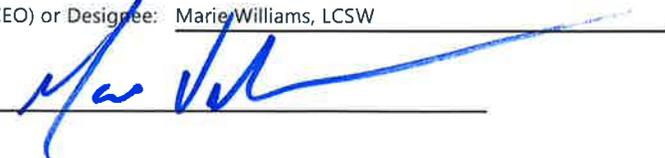
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Marie Williams, LCSW

Signature of CEO or Designee<sup>1</sup>: 

Title: Commissioner

Date Signed: 7-25-19  
mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



**BILL LEE**  
GOVERNOR  
STATE OF TENNESSEE

August 21, 2019

Odessa F. Crocker  
Branch Chief, Formula Grants Branch  
Division of Grants Management, Office of Financial Resources  
Substance Abuse and Mental Health Services Administration  
5600 Fishers Lane, 17E22  
Rockville, MD 20857

Dear Ms. Crocker:

As the Governor of the State of Tennessee, for the duration of my tenure, I delegate authority to the current Commissioner of the Department of Mental Health and Substance Abuse Services, Marie Williams, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) and Mental Health Block Grant (MHBG).

Contact information for Commissioner Williams is as follows:

Marie Williams  
Commissioner  
Tennessee Department of Mental Health and Substance Abuse Services  
6<sup>th</sup> Floor, Andrew Jackson Building  
500 Deaderick Street  
Nashville, TN 37243  
615-532-6500 (Office)  
615-532-6514 (Fax)  
[Marie.Williams@tn.gov](mailto:Marie.Williams@tn.gov)

Thank you for your assistance.

Sincerely,

Bill Lee



**STATE OF TENNESSEE**  
**DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

6th FLOOR, ANDREW JACKSON BUILDING  
500 DEADERICK STREET  
NASHVILLE, TENNESSEE 37243

**BILL LEE**  
GOVERNOR

**MARIE WILLIAMS**  
COMMISSIONER

October 22, 2019

Substance Abuse and Mental Health Services Administration (SAMHSA)  
Division of Grants Management  
5600 Fishers Lane, #17E-77C  
Rockville, MD 20857

**Re: MJ Attestation Statement**

I certify that the grantee organization/recipient, State and all sub-recipients will comply with the following NoA language:

*Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.*

This attestation statement certifies that the Tennessee State Department of Mental Health and Substance Abuse Services and all sub-recipients (contractors & sub-awardees) will comply with this Special Term/Condition for all applicable SAMHSA Awards.

Sincerely,

Marie Williams, LCSW  
Commissioner

## State Information

### Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

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Name

Marie Williams, LCSW

Title

Commissioner

Organization

Tennessee Department of Mental Health and Substance Abuse Services

---

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

This form is not applicable.

## Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public 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 M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## **Strengths and Organizational Capacity of the Service System**

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

### **Planning and Policy Council System, Research, and Data**

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

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

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

In addition to the needs assessment, the Councils also review and provide input on the Block Grant plans and funding, the annual budget for TDMHSAS, ideas and other Departmental reports and initiatives.

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

## **Organization of TDMHSAS**

**Office of the Commissioner** is made up of the Commissioner, Deputy Commissioners, and Executive Administrative staff. This Office oversees and leads the Department in its vision to be the nation's most innovative and proactive state behavioral health authorities for Tennesseans dealing with mental health and substance abuse problems. The Office is responsible for system planning; setting policy and quality standards; system monitoring and evaluation; disseminating public information; and advocating for people of all ages who have mental health issues, serious emotional disturbances, and/or substance abuse disorders. Annually the office assesses the public's needs for mental health and substance abuse services and supports. This function is carried out in consultation and collaboration with current or former service recipients; their families, guardians, or conservators; advocates; provider agencies; and other affected people and organizations.

**Division of Administrative and Regulatory Services (DARS)** oversees fiscal monitoring of Department grants, general services, procurement, major maintenance and capital construction projects, licensing of all Tennessee agencies providing mental health, substance abuse, and personal support services, investigating complaints of abuse, neglect or fraud against licensed organizations, and coordinates facility administration of the Regional Mental Health Institutes with the Division of Hospital Services.

**Division of Mental Health Services (DMHS)** administers and supports a diverse array of services and supports for individuals of all ages living with mental illness, co-occurring disorders, and/or serious emotional disturbances. DMHS creates and oversees community-based programs and community support services for adults and children, housing, crisis services, suicide prevention and peer-to-peer recovery services.

**Division of Substance Abuse Services (DSAS)** is responsible for planning, developing, administering, and evaluating a statewide system of prevention, treatment, recovery support services for the general public, persons at risk for substance abuse, persons abusing substances, and recovery courts.

**Division of Hospital Services (DHS)** provides oversight of operation of the four Regional Mental Health Institutes (RMHIs) and three private contracted hospitals in East Tennessee for administrative, quality management, program services, and nursing services.

**Office of Forensics and Juvenile Court Services (OFJCS)** provides oversight of forensic evaluations for adult and juvenile courts and mandatory outpatient treatment services.

**Division of General Counsel (DGC)** includes the Offices of Legal Services, Investigations, Contracts, and Special Counsel that provide department-wide services in support of the Governor and Commissioner's mission and goals. The General Counsel serves as the chief legal advisor to the Commissioner and senior leadership.

**Division of Clinical Leadership (DCL)** is responsible for providing clinical oversight and policy development for the regional mental health institutes (RMHIs) and clinical consultation to various divisions within the Department. The Chief Pharmacist also acts as the State Opioid Treatment Authority. The Division oversees Tennessee's opioid treatment programs (OTPs); coordinates training and support for suicide prevention initiatives in the African American faith communities; and manages Title VI compliance for the Department. DCL further pilots substance abuse initiatives designed to benefit either individuals and/or families.

**Division of Planning, Policy, and Legislation (DPPL)** coordinates departmental legislative and rulemaking activities, provides planning and support for the Statewide and Regional Planning and Policy Councils, and prepares the Mental Health Block Grant Application, SAMHSA Annual Report, Joint Annual Report to the Governor, Three-Year Plan, and the Annual Needs Assessment.

**Office of Communications (OC)** develops internal and external communications including the drafting, production, and distribution of news releases and statements to the media, publication of Department newsletters, and manage the Department's website.

**Office of Fiscal Services** oversees general accounting functions including accounts receivable and payable and interactions with state and federal funding sources.

**Office of Human Resources (OHR)** works to ensure the Department has a workforce capable of fulfilling its mission and objectives through policy advice and technical assistance to managers and staff at the Central Office and Regional Mental Health Institutes on matters such as Americans with Disability Act, Equal Employment Opportunity; employee relations; benefits; recruiting; training; performance evaluations; and personnel actions.

### **Organization of the Service Delivery System at the State Level**

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

1. Efficient and effective management of the Regional Mental Health Institutes (RMHIs)
2. Maintain and improve community mental health and substance abuse services
3. Provide effective education and prevention services
4. Lead in partnership with state agencies and community partners to prevent and treat prescription drug abuse epidemic in Tennessee

Each Division of TDMHSAS (listed on page 2) develops strategies for programming and/or direct services based on each of the above-referenced goals and also reports bi-annually on the outcomes of the programs (new and existing) or the plans in progress based on these main goals. The Division of Mental Health Services (DMHS) is responsible for implementing programming that utilizes Mental Health Block Grant dollars. The Division of Substance Abuse Services (DSAS) is responsible for the programming that utilizes the Substance Abuse Block Grant dollars.

TennCare, the state's Medicaid agency, operates under the purview of the Tennessee Department of Finance and Administration. TDMHSAS acts in collaboration with, and consultation for, TennCare and provides services and programs that fill the gaps for those services for SMI/SED/SUD and others diagnosed with mental health concerns not covered by TennCare. For example, TennCare and TDMHSAS jointly fund the crisis system for the state of Tennessee to respond/serve/treat publically funded individuals who are experiencing a mental health crisis. Tennessee's efficient and effective crisis continuum is the result of the shared partnerships between TDMHSAS, TennCare, community mental health center crisis providers and local hospital systems, as well as the statewide behavioral health community at large. The preponderance of direct behavioral health care is funded through Medicaid (TennCare) benefits for the population served by TennCare and TDMHSAS. TDMHSAS provides funding for ancillary services not covered by TennCare, Medicare or another insurance plan.

The First Episode Psychosis Initiative (FEPI) is one direct service program operated through the Division of Mental Health Services. Funding for treatment portion of the program is a collaborative effort between TennCare and TDMHSAS. Planning, development, training, outreach, public information and implementation are funded through Block Grant dollars. Some direct service is also funded by the Mental Health Block Grant in the event that a patient fits the parameters of the program but is unable to pay for services or there are co-pays that the patient is unable to pay. Otherwise, the provider bills the patient's insurance company for services rendered.

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

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

**Organization of the Service System at the Local Level**

In Tennessee, there are a full range of facilities licensed by the TDMHSAS for mental health and substance abuse delivery purposes.

At the time of this application there are licensed agencies as follows (not the total list of licenses-- see <https://mh.tn.gov/CTS4/Inquiry.aspx?RPT=TDMHSAS%20License%20Inquiry> to view the total list and categories at the local level):

Type of Agency	Number of Licensees and Sites
Crisis Stabilization Units (CSUs)	8 Licensees with 11 sites
Mental Health Supportive Living	127 Licensees with 221 sites
Outpatient Facilities	178 Licensees with 482 sites
Mental Health (only) Hospitals (includes state hospitals)	18 Licensees with 18 sites
Residential Rehabilitation Treatment SA	36 Licensees with 64 sites
Residential Treatment SA Children and Youth	14 Licensees with 25 sites
Residential Detox Center SA	29 Licensees with 36 sites

For the above categories and licenses, and other services offered locally through the service delivery system, TDMHSAS establishes contracts for services according to funding and program with some organizations. TennCare contracts with four statewide Managed Care Organizations (MCOs) which then subcontract for services within the three grand regions of the state (East, Middle, and West). Some medical hospitals which are licensed through the Department of Health also offer psychiatric care as part of the service milieu. Medical hospitals offering psychiatric beds have such beds included in the

need calculations for the State (for psychiatric beds) as new or altered facilities are reviewed and approved, but are not licensed by TDMHSAS. Overall, the review, monitoring, and licensing of behavioral health providers are shared tasks (among Tennessee Departments) depending on the service offered and the context in which it is offered.

Licensed and contracted agencies are required to comply with state and federal law related to serving persons who may need an interpreter (for deaf and hard of hearing and for individuals for whom English may not be the native language). Each contracted provider receiving federal Block Grant dollars must provide culturally sensitive services that meet the needs of all specific populations required by federal law.

Services and corresponding funding are distributed to the seven Planning and Policy Council Regions based on a number of factors including the following: Annual needs assessment conducted by the Regional Planning and Policy Councils; anecdotal information available to the public in general; data gathered that illustrates a need for services in a particular region; the discretion of the Commissioner to place services; the discretion of the Governor to place services; the appropriations approved by the State Legislature; and recommendations from the Statewide Planning and Policy Council.

### **Comprehensive Community-Based Mental Health Service Systems**

TDMHSAS and its Division of Mental Health Services (DMHS) continues to provide a comprehensive community-based mental health system. DMHS is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness, co-occurring disorders, and/or serious emotional disturbances. This is accomplished through the creation, expansion, and oversight of community-based programs and community support services. Initiatives include: affordable housing programs; homelessness prevention services; 24-hour crisis services; wellness and recovery services; peer recovery services; suicide prevention services; geriatric services; disaster emergency services; and comprehensive System of Care-based child, youth, and family supports services.

The Department supports a number of recovery services that are intended to increase the recovery capital of people with mental health and co-occurring disorders. The Wellness & Employment Office provides Individual Placement and Support (IPS) Supported Employment services which are recovery services to help people reintegrate into their communities through competitive, steady employment. The Peer Wellness Initiative prioritizes physical health as a tool to improve mental health recovery.

The Behavioral Health Safety Net of TN is a state funded program that provides vital mental health services to uninsured Tennesseans who are eligible. The services provided through the BHSN of TN are intended to reduce hospitalizations and the recidivism rate. The services consist of: assessment, evaluation, diagnostic, therapeutic intervention, case management, transportation, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination. Individuals actively enrolled in BHSN are less likely to require inpatient psychiatric care. In FY18, approximately 2% of individuals enrolled in BHSN were admitted to a Regional Mental Health Institute (RMHI) within 90 days of a BHSN service.

Crisis response services are the single point of entry to a continuum of behavioral health services and supports needed by someone experiencing a behavioral health crisis. Tennessee Crisis Services

incorporate a continuum of crisis services, including mobile crisis, crisis stabilization, respite and walk-in center services. The philosophy is based on determining the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. Tennessee is fortunate to have 24/7 access to crisis services across the state, making several diversionary alternatives available such as medically monitored crisis detoxification, crisis stabilization units, walk-in centers and respite services. The crisis system serves as the gate keeper to inpatient care.

Through the First Episode Psychosis Initiative, five OnTrackTN teams provide individualized services to youth and young adults experiencing a first episode of psychosis. Youth and young adults involved in these programs experience a large reduction in number and length of hospital stays. System of Care Across Tennessee provides high-intensity wraparound services, using High Fidelity Wraparound to families of children with an SED/SMI with the intent of reducing out-of-home placements, including hospitalizations. The Healthy Transitions(2)-Improving Life Trajectories initiative will utilize a young adult peer stabilizer that will be partnering with the child and adult mobile crisis teams at a local lab site, with the goal of reducing hospitalizations and increasing engagement in community-based services.

Tennessee rules and statues are designed to protect individuals from unnecessary involuntary hospitalization by requiring evaluation by two qualified mental health professionals. The first evaluation must be done by a professional employed with the inpatient service and the second must be completed by a physician. Individuals who do not meet commitment criteria for involuntary hospitalization are offered less restrictive alternatives to involuntary care and treatment.

The Tennessee Move Initiative began in state FY2017 with primary purpose of successfully transitioning identified individuals from long-term units to community based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. Three community mental health agencies provide recovery-focused, intensive, and customized care coordination services through four teams to identified individuals in long-term units within the TDMHSAS Mental Health Institutes. The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on the individual need. Each partner agency has developed and implemented recovery-oriented programming to ensure individual, family, and housing provider supports while connecting and coordinating with natural and formal supports within the individual's home community.

### **Mental Health System Data Epidemiology**

TDMHSAS has separate data systems for collecting mental health and substance abuse service data. The mental health data systems are listed below. Behavioral health data systems are completely separate from data systems in other agencies including Medicaid and child welfare.

The Tennessee data for Client-Level Data (CLD) reporting is from the five data sources listed below. Each system includes data for clients, programs, and providers.

- State-operated psychiatric hospitals
- Private psychiatric hospitals under contract with the State
- Crisis Management Information System
- Behavioral Safety Net Information System
- Transactional data and survey data collected by the Tennessee Association of Mental Health Organizations

TDMHSAS developed a data warehouse to automate client-level data reporting and to support the generation of dynamic key performance indicators for public facing data dashboards. The data warehouse includes data from TDMHSAS mental health management information systems listed above.

### **Children’s Services**

TDMHSAS oversees a variety of children and youth programs, including areas such as advocacy, school-based liaisons, transition age youth, System of Care (SOC), anti-stigma, violence and bullying prevention, respite, faith-based mental health, prevention and early intervention. These programs are financed through multiple funding sources, including state and federal discretionary grants, such as the Mental Health Block Grant (MHBG) and Substance Abuse Prevention Treatment Block Grant (SAPTBG).

The Council on Children’s Mental Health (CCMH) works to design a comprehensive plan for a statewide SOC for children and families that is family-driven, youth-guided, community-based, and culturally and linguistically competent. This Council is co-chaired by the Commissioner of the Tennessee Department on Mental Health and Substance Abuse Services (TDMHSAS) and the Executive Director of the Tennessee Commission on Children and Youth (TCCY) and membership represents a focused, diverse and integrated community of Tennessee child-serving agencies, community providers, advocates, families, children and youth.

CCMH is a collaborative effort focused on growth and development with emphasis over the past year on cutting-edge topics in children’s mental health, including statewide trauma initiatives, trauma-informed care, education initiatives, and, most recently an emphasis on CCMH’s future direction to further support the comprehensive plan for a statewide SOC for children and families in Tennessee. CCMH participants provide the state with a centralized community of knowledgeable members participating in ad hoc workgroups, providing technical assistance activities, and supporting conferences and trainings conducted by TDMHSAS’ Office of Children, Young Adults, and Families.

### **Targeted Services to Rural and Homeless Populations and to Older Adults**

TDMHSAS maintains numerous initiatives that address specific challenges unique to rural communities. Tennessee Governor Bill Lee issued his first executive order in January 2019, requiring all state executive departments to issue a statement of rural impact and provide recommendations for better serving rural Tennessee. TDMHSAS provided the Statement of Rural Impact to the governor’s office in May 2019. Some of the targeted programs and services offered to rural communities include the following: The Community Supportive Housing Program, Individual Placement and Support (IPS) Supported Employment, Behavioral Health Safety Net, Crisis Continuum of Services, System of Care, and Older Adult Program.

Homeless populations within the State of Tennessee who are experiencing mental illness, substance abuse, or co-occurring disorders have a variety of programs available to provide permanent supportive housing and other financial services to facilitate independence in the community and increased access to behavioral health care. Most of these programs geographically span a wide array of communities in our state, including many of our rural counties. Two programs, the Projects for Assistance in Transition from Homelessness (PATH) and the Children and Youth Homeless Outreach Project (CYHOP), have the

primary objective of conducting quality outreach efforts to individuals who are homeless or at risk for homelessness and facilitate opportunities for mental health, substance abuse, care coordination, and housing support services.

Individual Placement and Support (IPS) Supported Employment is a model of employment with research indicating that it is a successful model for rural communities. Currently, IPS is offered in 37 counties, 27 of which are IPS Providers in rural communities. IPS is delivered in 18 programs across the state with currently one provider in middle TN specifically targeting the homeless population. There are seven Peer Wellness Coaches and one Statewide Peer Wellness Coach and Trainer in TN and programming is offered to clients regardless of their housing status throughout the state.

The Behavioral Health Safety Net of TN is available to eligible uninsured adult Tennesseans who are homeless and in rural areas of the state.

The Crisis Continuum of Service is available to all Tennesseans. Crisis assessments are community based and are available statewide in both rural and urban areas. Crisis services are available to all age groups and to individuals including those that reside in the state's jails and/or are homeless.

The Office of Children, Young Adults, and Families uses a system of care approach to ensure services and supports are tailored to the unique needs of children, young adults, and families in communities all across Tennessee. Our behavioral health providers establish Memorandums of Understanding (MOU) with local community services, supports, and schools, creating a continuum of care that is accessible to families regardless of where they live. Team-based, wraparound services and supports are provided in the home and community to engage families in more rural areas of the state. In fact, Tennessee's First Episode Psychosis Initiative (FEPI) in rural west Tennessee has been recognized as one of the first FEPI program in the nation to target rural communities. For children, young adults, and families who might not have access to a nearby community mental health center, Telehealth is used to complete mental health assessments and engage them in care.

The Older Adult Program provides care management to individuals over 50 who would not otherwise be eligible for services. Services may include assessment, outreach, linkage, in home therapy and other supportive resources. In addition, community mental health education is provided to promote awareness regarding geriatric issues. These services are provided to improve quality of life and to develop skills to enable the older adult to continue to live independently in the community.

#### **Criterion 5: Management Systems**

TDMHSAS is responsible for system planning; setting policy and quality standards; licensing mental health and substance use services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who live with serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), and/or co-occurring disorder (COD). Through the operation of four (4) fully accredited Regional Mental Health Institutes (RMHIs), TDMHSAS also provides inpatient psychiatric services for adults, including acute, sub-acute, and forensic.

Through the department Offices and Divisions, TDMHSAS provides a quality spectrum of services across the lifespan. Collaborative efforts are offered across a variety of service systems, both public and private, including but not limited to mental health, substance use, health, education, criminal justice, veterans, and child/family organizations. Such efforts create a cross-systems approach and promote the most effective outcome for care.

TennCare, the state's Medicaid agency, operates under the purview of the Tennessee Department of Finance and Administration. TDMHSAS acts in collaboration and consults with, TennCare and provides services and programs that fill the gaps for those services for SMI/SED/SUD and others diagnosed with mental health concerns not covered by TennCare.

## **Conclusion**

Tennessee's Department of Mental Health and Substance Abuse Services is charged with: operating the State's Regional Mental Health Institutes (state hospitals); developing a service array for Substance Abuse and Mental Health services that seeks to comply with state and federal law; meeting the needs of Tennesseans; and serving as the opiate treatment authority for the state.

TDMHSAS operates Block Grant funded, state funded, and discretionary grant funded programs that meet the needs of the SMI/SED population. Cultural competence and linguistic sensitivity is considered and embedded into the programming requirements. Communities and populations that may have limited access to mental health care are considered and have needs addressed including rural populations, diverse racial, ethnic, and sexual and gender minorities, with a need for an innovative approach to care.

## Planning Steps

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

#### Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD 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 the unmet service needs and gaps.

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

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>16</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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<sup>16</sup> <http://www.healthypeople.gov/2020/default.aspx>

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#### Footnotes:

## **Step 2: Identify Unmet Service Needs and Critical Gaps within the Current System**

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

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

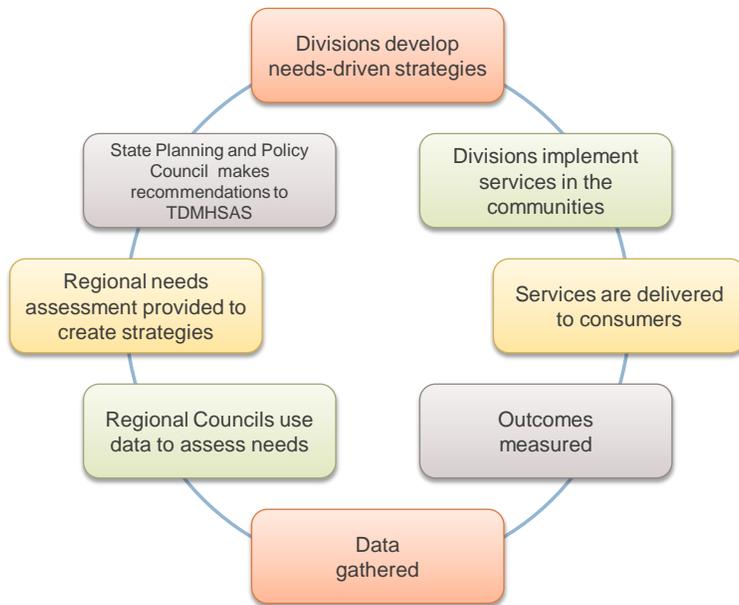
### **Needs Assessment Process**

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

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

The goals of the needs assessment model are to identify unmet needs and critical gaps, and to allocate limited resources more efficiently. The model is also designed to help Regional Councils prioritize local needs, direct state level planning and resource allocation efforts, and assure compliance with federal block grant funding requirements. The needs assessment model outlines eight steps as part of a cyclical process that begins with implementing needs-driven services in communities, proceeds to collecting and analyzing indicators of prevalence, service use, quality, and outcomes, and results in formulating recommendations for service strategies that reflect emergent regional needs and preferences. These recommendations are further shaped by outside considerations, such as federal and state policy initiatives and priorities, legal requirements, and funding constraints. The TDMHSAS needs assessment model is described in detail in Exhibit 1.2.

**Exhibit 1.2  
TDMHSAS Needs Assessment Model**



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

**Data Sources**

To inform the needs assessment process, TDMHSAS developed a number of data products (i.e. reports, interactive dashboards) comparing state-specific and national data, as well as providing Regional Planning and Policy Councils with regional and county-level data. Data products are posted on the department website.

TDMHSAS utilized various data sources to inform the regional and county data products including, but not limited to:

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

In addition to the data products which are provided to the Statewide and Regional Councils, the Office of Research provided a Needs Assessment Data Report to provide program specific data to councils about needs identified in the statewide needs assessment. The Report is posted on the department's website at <https://www.tn.gov/behavioral-health/research/data--research--and-planning/planning/planning/needs-assessment.html>

TDMHSAS has also developed a data warehouse to automate client-level data reporting and to support the generation of dynamic key performance indicators for a public facing data dashboard. The data warehouse includes data from the following TDMHSAS mental health management information systems:

- State-operated psychiatric hospitals
- Private psychiatric hospitals under contract with the State
- Crisis Management Information System
- Behavioral Safety Net Information System
- Transactional data and survey data collected by the Tennessee Association of Mental Health Organizations

The 2019 Need Assessment Summary includes needs and critical gaps identified by the Regional Councils, Statewide Children and Adult Committee, and the Consumer Advisory Board (CAB). The multiple needs identified by regions include: crisis stabilization units (CSUs) and crisis respite centers (CRCs) for children and youth and/or adults; increase appropriate and affordable supportive housing; and increase services (both housing and care management) for individuals who do not qualify for the Behavioral Health Safety Net of TN. The Summary is posted on the on the department's website at <https://www.tn.gov/behavioral-health/research/data--research--and-planning/planning/planning/needs-assessment.html>

While there is no funding available for CSUs for children and youth, TDMHSAS, TennCare, and Manage Care Organizations (MCOs) have worked in collaboration and explored the option of expanding services to include Children and Youth (C&Y) CSUs. This includes engaging providers, stakeholders, and community partners across the state in an effort to assess children and youth service needs. TDMHSAS, TennCare, MCO's, and state agencies will continue to work collaboratively to address the treatment needs of children and youth through TennCare initiatives aimed at expanding/enhancing intensive in-home treatment services (e.g., Home-based Treatment/Intensive Care Coordination), where we expect to produce more robust outcomes for children/youth and their families.

The TDMHSAS Housing and Homeless Services Office oversees the Inpatient Targeted Transitional Support program. This program provides the opportunity for individuals discharging from the Regional Mental Health Institutes, Crisis Stabilization Units, and State-Contracted Facilities to secure safe, affordable, permanent supportive housing with skill-building, educational, and life skills trainings offered to increase the functionality of each service recipient outside of the institutional setting.

The Behavioral Health Safety Net of TN (BHSNT) is a state funded program that provides vital mental health services to uninsured Tennesseans who are eligible. The services provided through the BHSNT are intended to reduce hospitalizations and the recidivism rate. The services consist of: assessment, evaluation, diagnostic, therapeutic intervention, case management, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination. Individuals actively enrolled in BHSNT are less likely to require inpatient psychiatric care.

TDMHSAS recently received an additional \$5M in state funding to increase the BHSNT that would expand services to up to 7,000 additional Tennesseans moving the eligibility from at or below 100% of Federal Poverty Level (FPL) to 138% FPL. The BHSNT is also available to older adults in Tennessee that will cover behavioral health services not covered by Medicare Part B, including Case Management, Medication Training and Support, Peer Support, Psychosocial Rehabilitation Services, and Transportation.

Older Adults care management services provide outreach, screening, assessment, linkage, in home therapy and other supportive services, as needed. Additionally, community mental health education is provided to promote awareness and knowledge about geriatric mental health concerns.

TDMHSAS has made a concerted effort to align the Mental Health Block Grant and Three-Year Plan to ensure that strategic planning is consistent regardless of funding source. The Three-Year Plan is required by Title 33 to inform the public of the Department's goals, objectives, and strategies for the next three years. The Plan includes prevention, early intervention, treatment service, and supports for people living with mental illness, serious emotional disturbance, and/or substance use disorders. An annual assessment of need for services and supports is used to develop the Plan. The Plan is updated annually to reflect milestones in the achievement of Department goals and objectives.

# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

**Priority #:** 1  
**Priority Area:** Maintain and improve services  
**Priority Type:** MHS  
**Population(s):** SMI, SED, ESMI

**Goal of the priority area:**

Maintain and improve community mental health services.

**Objective:**

Assist Tennesseans to access high quality and effective mental health services.

**Strategies to attain the objective:**

Program strategies supporting objective include: crisis services continuum network; Behavioral Health Safety Net; Older Adults Program; First Episode Psychosis Initiative; Tennessee Move Initiative; TDMHSAS Helpline; Targeted Transitional Support Services; Creating Homes Initiative; Community Supportive Housing; Emerging Adults; Intensive Long-Term Support; Supportive Living; Supported Employment; Peer Support Centers; and Peer Wellness Coaches.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Number of calls to the statewide crisis hotline (855-CRISIS-1) (all ages) providing access and referral to crisis services to individuals experiencing a mental health crisis.  
**Baseline Measurement:** In state FY2019, there were 125,983 of calls to the statewide crisis hotline.  
**First-year target/outcome measurement:** Maintain or increase the total number of calls to the statewide crisis hotline during state FY2020.  
**Second-year target/outcome measurement:** Maintain or increase the total number of calls to the statewide crisis hotline during state FY2021.

**Data Source:**

The state Crisis Management System will track and report data related to the total number of telephonic crisis assessments completed by crisis triage personnel when calling the statewide crisis phone number, or the crisis provider agency phone number. The twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) toll-free telephone triage and intervention call center is answered in real time (within five (5) rings and/or thirty (30) seconds), whenever possible, by trained crisis triage personnel who provide a telephonic crisis assessment and intervention, and then determine a mode of response for assistance.

**Description of Data:**

Aggregate data for this indicator will be compiled from the Crisis Management System from providers statewide to include the following services: telephonic crisis assessments, as reported by the Division of Mental Health, Office of Crisis Services and Suicide Prevention.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:** 2  
**Indicator:** Number of Tennesseans (all ages) accessing emergency psychiatric crisis services and assessment from a mobile crisis responder or at a crisis walk-in center.  
**Baseline Measurement:** In state FY2019, there were 79,285 individuals that received a face to face crisis assessment.

**First-year target/outcome measurement:** Maintain or increase the total number of individuals receiving face to face crisis assessments during state FY2020.

**Second-year target/outcome measurement:** Maintain or increase the total number of individuals receiving face to face crisis assessments during state FY2021.

**Data Source:**

The state Crisis Management System will track and report data related to the total number of face to face assessments conducted by mental health crisis responders as a result of a mobile crisis call or visit to a TDMHSAS supported crisis walk-in center. Mobile crisis services are non-hospital, community-based services offered twenty four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) for behavioral health crisis situations. Children and Youth Mobile Crisis Services are provided to children and youth who are 17 years of age and younger. There are four (4) Children and Youth serving Mobile Crisis Response Teams. Adult Mobile Crisis Services are provided to adults who are 18 years of age and over. There are twelve (12) adult-serving Mobile Crisis Response Teams. The eight (8) crisis Walk-in Centers across the State are non-hospital, facility-based services, affiliated with each of the Crisis Stabilization Units, offered twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365). Crisis Walk-in Services include a face-to-face evaluation, access to a psychiatric medication prescriber, access to 24/7 nursing assessments, access to 23-hour observation services, other needed services and supports, and follow-up services.

**Description of Data:**

Aggregate data for this indicator will be compiled from the Crisis Management System from providers statewide to include the following services: mobile crisis face to face assessments (adults and youth), walk in center crisis face to face assessments, as reported by the Division of Mental Health, Office of Crisis Services and Suicide Prevention.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:** 3

**Indicator:** Number of admissions to the eight Crisis Stabilization Units (adults).

**Baseline Measurement:** In state FY2019, there were 9,864 individuals admitted to a state supported Crisis Stabilization Unit (CSU) for treatment services.

**First-year target/outcome measurement:** Maintain or increase the total number of individuals receiving treatment services at a CSU during state FY2020.

**Second-year target/outcome measurement:** Maintain or increase the total number of individuals receiving treatment services at a CSU during state FY2021.

**Data Source:**

CSU admissions data is collected monthly from each of the eight CSU providers across TN. The crisis deliverables reports are submitted to the Office of Crisis Services and Suicide Prevention by each provider via an excel template. CSUs are licensed by the State to offer twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) intensive, short-term stabilization and behavioral health treatment for those persons whose behavioral health condition does not meet the crisis for involuntarily commitment to a psychiatric hospital or other treatment resource and who cannot be appropriately and/or safely managed in a less restrictive environment. There are eight (8) Crisis Stabilization Units in operation across the state, with a total of one hundred and nineteen (119) beds.

**Description of Data:**

Data collected in the crisis deliverables report spreadsheet includes: total CSU admits by month; total admits by referral source; total admits by payor source; total uninsured served; average daily bed utilization; average length of stay by payor source; and discharge dispositions. The provider data is then entered into a master spreadsheet that captures various information from each provider agency. The master spreadsheet also includes statewide comparisons.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:** 4

**Indicator:** Number of uninsured/indigent Tennesseans having a serious mental illness, living at or below 138% of the FPL, able to access outpatient mental health care from Behavioral Health

Safety Net that otherwise would not have the ability to receive core behavioral health services (adults).

- Baseline Measurement:** In state FY2019, there were 34,450 served by the Behavioral Health Safety Net of TN.
- First-year target/outcome measurement:** Serve as many uninsured individuals as are eligible and apply to the Behavioral Health Safety Net of TN during state FY 2020.
- Second-year target/outcome measurement:** Serve as many uninsured individuals as are eligible and apply to the Behavioral Health Safety Net of TN during state FY 2021.

**Data Source:**

Behavioral Health Safety Net of TN (BHSNTN) grantee billing and services data is tracked monthly and reported by Behavioral Health Safety Net of TN database.

**Description of Data:**

The Behavioral Health Safety Net provides core, essential, out-patient, mental health services to uninsured Tennesseans who meet program eligibility criteria through a network of 15 participating community mental health centers. This includes community-based services offering vital services that people with SMI must retain to continue leading functional productive lives including: assessment and evaluation, individual and group therapeutic intervention, case management, transportation, peer support services, psychosocial rehabilitation services, psychiatric medication management, laboratory tests related to medication management, pharmacy assistance and coordination.

**Data issues/caveats that affect outcome measures::**

The BHSN was expanded in FY2020 to add additional state funds and revise eligibility standards related to FPL and minimum age eligibility to 18 years old to expand services.

- Indicator #:** 5
- Indicator:** Number of older adults served annually with care management services such as outreach, screening, assessment, linkage, in home therapy and other supportive services .
- Baseline Measurement:** In state FY2019, there were 466 served by the older adults program.
- First-year target/outcome measurement:** Maintain or increase the total number of older adults receiving care management services during state FY2020.
- Second-year target/outcome measurement:** Maintain or increase the total number of older adults receiving care management services during state FY2021.

**Data Source:**

Providers report quarterly on the number of older adults served by the program.

**Description of Data:**

Geriatric services use a variety of methodologies including: agency and in-home counseling to seniors unable to access services outside of their home; care management, clinical social work, and geriatric psychiatry assisting seniors and their families to meet their behavioral health needs; agency and in-home depression screenings; collaboration with the Area Agency on Aging; and consultations to Adult Protective Services in the local community.

**Data issues/caveats that affect outcome measures::**

None noted.

- Indicator #:** 6
- Indicator:** Number of youth and young adults will receive treatment and recovery support services through First Episode Psychosis Initiative (FEPI).
- Baseline Measurement:** In state FY2019, 134 youth and young adults experiencing first episode psychosis received evidence-based treatment and recovery support services.
- First-year target/outcome measurement:** Maintain or increase the total number of youth and young adults receiving treatment and recovery support services during state FY2020.

**Second-year target/outcome measurement:** Maintain or increase the total number of youth and young adults receiving treatment and recovery support services during state FY2021.

**Data Source:**

Number of youth and young adults who have experienced first episode psychosis and received treatment and recovery support services by the First Episode Psychosis Initiative (FEPI) program as reported by the Office of Children and Youth Mental Health.

**Description of Data:**

The First Episode Psychosis Initiative is designed to provide early intervention services for youth and young adults fifteen through thirty (15-30) years of age in selected Tennessee counties who have experienced first-episode psychosis. This comprehensive intervention model (OnTrackTN) is a team of mental health professionals and support services, focusing on helping people work toward recovery and meeting personal goals. The program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, peer support, psychopharmacology, and care coordination and management.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

7

**Indicator:**

Number of individuals to receive recovery-focused, intensive, and customized care coordination services through the Tennessee Move Initiative (TMI).

**Baseline Measurement:**

In state FY2019, 89 individuals received recovery-focused, intensive, and customized care coordination services by a TMI team in the community.

**First-year target/outcome measurement:**

Maintain or increase the total number of individuals actively working with TMI teams in the community during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the total number of individuals actively working with TMI teams in the community during state FY2021.

**Data Source:**

The total number of individuals served by the TMI teams is reported monthly to the TDMHSAS Office of Research. The total served includes information about patients that have been referred to the program but not yet discharged from the hospital, individuals that are active in the community and working with the TMI team, and those individuals that have graduated/separated from the program.

**Description of Data:**

The Tennessee Move Initiative provides recovery-focused, intensive, and customized care coordination services to identified individuals in long-term units (on average 90 + days and individuals who have had multiple points of entry over a 90-120 day period) within the TDMHSAS Mental Health Institutes for the purpose of transitioning individuals to the least restrictive and most integrated setting appropriate to individual need. TMI teams develop and implement recovery-oriented programming which ensures individual, family, and housing provider support while connecting and coordinating with natural and formal supports within the individual's home community.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

8

**Indicator:**

Number of Tennessee citizens each year who receive help with resources, assistance in navigating the behavioral health systems, and assistance with complaints from the TDMHSAS Helpline Advocates.

**Baseline Measurement:**

In state FY2019, there were 2,739 served by TDMHSAS Helpline Advocates.

**First-year target/outcome measurement:**

Maintain or increase the total number receiving resources and support during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the total number receiving resources and support during state FY2021.

**Data Source:**

The Office of Consumer Affairs (OCA) database provides information on the total number of individual cases that were supported by TDMHSAS Helpline Advocates.

**Description of Data:**

The TDMHSAS Helpline is available weekdays to support callers by providing mental health and substance abuse resources in the callers area; answering questions about insurance; offering housing resources options; helping callers understand their rights; assisting with filing complaints; and providing information about the Certified Peer Recovery Specialist program. If the Helpline Advocates are not able to answer a question, they help the caller connect to the appropriate resource.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

9

**Indicator:**

Number of individuals (adults) experiencing mental illness or co-occurring disorders who receive short term-financial support for services such as rental assistance, utilities, medical support, and other costs associated with living independently and maintaining stable housing

**Baseline Measurement:**

In state FY2019, 5,113 individuals experiencing mental illness or co-occurring disorders received short term-financial support for services aimed at living independently and maintaining stable housing.

**First-year target/outcome measurement:**

Maintain or increase the total number of individuals able to live independently and/or maintain stable housing with short-term financial support during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the total number of individuals able to live independently and/or maintain stable housing with short-term financial support during state FY2021.

**Data Source:**

Number of individuals receiving short-term financial housing support is reported by Community Targeted Transitional Services (CTTS) and Inpatient Targeted Transitional Services (ITTS) programs on a monthly basis to the DMHS Office of Housing & Homeless Services.

**Description of Data:**

The CTTS program provides specific, temporary financial assistance, allowing service recipients to live independently in the community by providing funding for rental deposits, rental assistance, utility deposits, utility payments, vision care, dental care, and other associated services on behalf of service recipients that increase familial stability and prevent homelessness. The ITTS program assists persons awaiting discharge from the State's Regional Mental Health Institutes (RMHIs) and Crisis Stabilization Units (CSUs) by providing them temporary financial assistance until their regular Social Security Administration (SSA) benefits, employment opportunities or other benefits can be restored, thereby enabling them to move into community settings with clinically ready.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

10

**Indicator:**

Number of safe, affordable mental health and/or recovery housing opportunities that are created, improved, or preserved for people with a history of mental illness or co-occurring disorders as a result of the Regional Housing Facilitators and Consumer Housing Specialists supporting the Creating Homes Initiative (CHI).

**Baseline Measurement:**

In state FY2019, there were 2,202 housing or opportunities available statewide through the Creating Homes Initiative (CHI).

**First-year target/outcome measurement:**

Maintain or increase the total number of housing opportunities available through CHI during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the total number of housing opportunities available through CHI during state FY2020.

**Data Source:**

Number of new or improved housing opportunities available as a result of the Creating Homes Initiative (CHI) is reported by Regional Housing Facilitators and Consumer Housing Specialists to the Office of Housing & Homeless Services.

**Description of Data:**

Regional Housing Facilitators are located within the 7 mental health planning regions to plan, develop and maintain permanent supportive housing opportunities for people with mental illness or co-occurring disorders through community coalitions and partnerships. Consumer Housing Specialists ensure people with mental illness or co-occurring disorders find affordable housing by helping them access the housing listing on the Recovery Within Reach website, access benefits and other income, and address systemic barriers that prevent access to housing.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

11

**Indicator:**

Number of individuals (adults) experiencing mental illness or co-occurring disorders who reside in community-based TDMHSAS provider housing facilities (independent living, group homes, supportive housing) and/or receive services and supports to maintain long-term supportive housing.

**Baseline Measurement:**

In state FY2019, there were 1,672 individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and supports to maintain long-term supportive housing.

**First-year target/outcome measurement:**

Maintain or increase the total number of individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and supports to maintain long-term supportive housing during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the total number of individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and supports to maintain long-term supportive housing during state FY2021.

**Data Source:**

Data is reported to the Office of Housing & Homeless Services by housing providers funded by the Community Supportive Housing, Intensive Long-term Support, Emerging Adults, and Supportive living programs.

**Description of Data:**

Community Supportive Housing provides flexible funding to agencies to provide supported housing for adults diagnosed with mental illness and co-occurring disorders. Staff is hired by contract agencies to provide on-site supervision for residents and as-needed supervision to non-supervised group homes and apartments; coordinate outside activities for the residents; and work one-on-one to develop a housing plan that identifies the consumer's ideal housing goal and more independent living. This program includes housing developed through the Creating Homes Initiative (CHI), a strategic plan to partner with local communities on a grassroots level to create permanent housing options for Tennesseans with mental illness. There are over 700 beds at over 85 locations statewide. The Emerging Adults program in Nashville, TN provides a comprehensive array of supportive housing and habilitation services for youth ages 18 to 25 living with serious emotional disturbances (SED) who have recently graduated out of the State's foster care system and/or adolescent residential recovery for mental illness or co-occurring disorder; includes mental health and substance abuse treatment, recovery and resiliency skills training; education and employment training and support; and life skills training such as financial management, wellness and nutrition, personal grooming and hygiene, leisure and community engagement, relationship building, and household management. As the youth demonstrate their ability to live more independently, they move to neighboring housing with decreased supervision before transitioning to fully independent living. The Intensive Long-Term Support (ILS) facilities provide intensive long-term, wrap-around support services to allow people to be discharged from RMHIs into supportive living facilities in the community. There are 100 beds statewide for ILS. Funding for Supportive Living facilities as described in TN Code Annotated 12-4-330 directs TDMHSAS to reimburse certain supportive living facilities in 11 TN counties. There are approximately 400 beds in the eligible counties.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

12

**Indicator:**

Number of eligible individuals will become certified as peer workforce annually from programs including: Certified Peer Recovery Specialists (CPRS), Certified Family Support

Specialist (CFSS), and Certified Young Adult Peer Support Specialist (CYAPSS).

- Baseline Measurement:** In state FY19, 226 peer specialists were certified
- First-year target/outcome measurement:** Maintain or increase the NUMBER of peer specialists certified during FY2020.
- Second-year target/outcome measurement:** Maintain or increase the NUMBER of peer specialists certified during FY2021.

**Data Source:**

The number of individuals that will become Certified Peer Recovery Specialists is reported by the Office of Consumer Affairs and Peer Recovery Services. The number of individuals that will become Certified Family Support Specialists or Certified Young Adult Peer Support Specialists is reported by the Office of Children, Young Adults, and Families.

**Description of Data:**

CPRS and CYAPSS have lived experience of mental illness or substance use disorder.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:** 13

**Indicator:** Percentage rate employment for of the individuals served through the evidence-based Individual Placement and Support (IPS) Supported Employment initiative will be employed in competitive and integrated work for at least one day.

**Baseline Measurement:** In state FY2019, 983 individuals were served through the evidence-based Individual Placement and Support Supported Employment initiative and 43% were employed in competitive and integrated work for at least one day.

**First-year target/outcome measurement:** Maintain or increase the percentage of the individuals served through the evidence-based Individual Placement and Support Supported Employment initiative will be employed in competitive and integrated work for at least one day during state FY2020.

**Second-year target/outcome measurement:** Maintain or increase the percentage of the individuals served through the Individual Placement and Support Supported Employment Initiative employed in competitive and integrated work for at least one day during state FY2021.

**Data Source:**

Percentage of total individuals served through Individual Placement and Support Supported Employment initiative who are employed in competitive and integrated work for at least one day as reported by the Office of Wellness and Employment.

**Description of Data:**

Supported Employment Initiative assists individuals with a serious mental illness and/or co-occurring disorders work at competitive and integrated jobs of their choosing, following the Individual and Placement Support (IPS) Supported Employment evidence-based model of supported employment.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:** 14

**Indicator:** Number of unique individuals who attend one of the state's 45 Peer Support Centers will create and maintain a Wellness Recovery Action Plan (WRAP®) to help in managing their recovery from mental illness or co-occurring disorder.

**Baseline Measurement:** In state FY2019, estimated 450 attendees at a Peer Support Center created and/or maintained a Wellness Recovery Action Plan.

**First-year target/outcome measurement:** Maintain or increase the number of attendees at a Peer Support Center created and/or maintained a Wellness Recovery Action Plan during FY2020.

**Second-year target/outcome measurement:** Maintain or increase the number of attendees at a Peer Support Center created and/or maintained a Wellness Recovery Action Plan during FY2021.

**Data Source:**

Monthly data is collected across the State's 45 peer support centers by the Office of Consumer Affairs and Peer Recovery Services.

**Description of Data:**

Each Peer Support Center submits a monthly report (Excel spreadsheet), which includes the number of people who received WRAP.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

15

**Indicator:**

Number of individuals (adults) with serious mental illness, substance abuse diagnoses, and co-occurring disorders who receive support from self-management workshops or one-on-one peer wellness coaching delivered by Peer Wellness Coaches.

**Baseline Measurement:**

In state FY2019, 1,013 individuals participated in self-management workshops or received one-on-one peer wellness coaching.

**First-year target/outcome measurement:**

Maintain or increase the total number of individuals participating in self-management workshops or receiving one-on-one peer wellness coaching during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the total number of individuals participating in self-management workshops or receiving one-on-one peer wellness coaching during state FY2021.

**Data Source:**

Number of individuals served through self-management workshops or one-on-one peer wellness coaching delivered by state-funded Peer Wellness Coaches as reported by the Office of Wellness and Employment.

**Description of Data:**

Peer Wellness Initiative program is a component of the statewide, peer-led health and wellness initiative, which promotes chronic disease prevention and self-management programming for individuals with mental illness, substance use disorders, and co-occurring disorders. Statewide Peer Wellness Coaches and Trainer provide mental health and co-occurring treatment and recovery services providers with health and wellness training, technical assistance, and ongoing support in implementing health and wellness programming.

**Data issues/caveats that affect outcome measures::**

None noted.

**Priority #:**

2

**Priority Area:**

Promote early intervention

**Priority Type:**

MHS

**Population(s):**

SMI, SED, ESMI

**Goal of the priority area:**

Provide effective education and prevention services.

**Objective:**

Educating Tennesseans and working to improve their understanding of mental health and getting people to early intervention services.

**Strategies to attain the objective:**

Program strategies supporting objective include: Tennessee Suicide Prevention Network and Jason Foundation; School Based Behavioral Health Liaisons, Project B.A.S.I.C. (Better Attitudes and Skills in Children), Violence and Bullying, and Youth Screen programs; Regional Intervention Program; and Juvenile Justice Reform Local Diversion programs.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Number of individuals receiving suicide prevention and post-vention training to increase public awareness and knowledge of suicide warning signs and risk factors, reduce the stigma associated with mental illnesses and, identify potential mental health and/or alcohol and drug use concerns in students.

**Baseline Measurement:** In state FY2019, 94,561 individuals received mental health awareness in Tennessee, through the provision of mental health and suicide prevention training, and/or public awareness activities.

**First-year target/outcome measurement:** Maintain or increase the total number of individuals receiving mental health awareness in Tennessee, through the provision of mental health and suicide prevention training, and/or public awareness activities during state FY2020.

**Second-year target/outcome measurement:** Maintain or increase the total number of individuals receiving mental health awareness in Tennessee, through the provision of mental health and suicide prevention training, and/or public awareness activities during state FY2021.

**Data Source:**

Number of individuals will receive suicide prevention and post-vention training as reported by Tennessee Suicide Prevention Network (TSPN) state quarterly reports; number of teachers will receive suicide prevention training as reported by Jason Foundation state quarterly reports; number of middle and high school students will receive mental health/suicide prevention training as reported by Mental Health Association of East TN state quarterly reports to the Office of Crisis Services and Suicide Prevention.

**Description of Data:**

Tennessee Suicide Prevention Network (TSPN) is a statewide coalition of agencies, advocates and consumers that oversee continuing implementation of suicide prevention strategies in Tennessee to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma of seeking help associated with suicide, and to educate communities throughout Tennessee about suicide prevention and intervention strategies. Project Tennessee provides a 2-hour educational curriculum for teachers, students and parents about the signs of suicide. The program provides tools and resources needed to identify at-risk youth.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:** 2

**Indicator:** Number of students receiving targeted behavioral health services and supports such as screening, individualized classroom consultation, or therapeutic interventions in schools through school based programming.

**Baseline Measurement:** In state FY2019, 6,621 students received mental health screening, services, or supports in schools.

**First-year target/outcome measurement:** Maintain or increase the total number of students receiving mental health screening, services, or supports in schools during state FY2020.

**Second-year target/outcome measurement:** Maintain or increase the total number of students receiving mental health screening, services, or supports in schools during state FY2021.

**Data Source:**

Number of students served by the School Based Behavioral Health Liaisons from [Tier 2 or 3 services, A.9.c], Project B.A.S.I.C. (Better Attitudes and Skills in Children) [individuals or group, A.9.4], Violence and Bullying [A.9.a.2], and Youth Screen [screenings completed] programs.

**Description of Data:**

School Based Behavioral Health Liaisons (SBBHL) use the Multi-Tiered Systems of Supports (MTSS) framework to provide face-to-face consultation with classroom teachers to enhance trauma-informed learning environments for children and youth who have or are at-risk for SED, behavior problems, or substance use disorders. Liaisons provide training and education for the classroom teachers regarding mental health and substance abuse topics, as well as behavioral interventions. Liaisons provide a connection between the child's family and school to ensure collaboration and proper communication; assists with transitions between alternative school/classroom placements; supports school staff/families in navigating mental health transitions between alternative school/classroom placements; supports school staff/families in navigating mental health and other needed services; and provides

mental health screenings and brief therapy for the child or youth as needed. Project B.A.S.I.C. (Better Attitudes and Skills in Children) is a school-based, mental health prevention and early intervention service that focuses on the promotion of mental health in children in the earliest school grades (K-3rd grade). A child development specialist (CDS), employed by a community mental health agency, works full-time in an elementary school to promote Pyramid Model practices and implementation. The program includes: identification and referral of children with serious emotional disturbance (SED), teacher consultation, student consultation, positive school climate activities, and classroom mental health promotion presentations, all guided by the Pyramid Model framework. Violence prevention and resiliency for youth in grades 4-8; uses the Second Step curriculum, an evidence-based practice that teaches empathy, impulse control, decision-making skills and anger management. The School & Communities Youth Screen Program uses a scientifically-based screening tool designed to identify at-risk youth; provide effective interventions to assist with their treatment. Youth Screen is a national mental health and suicide risk-screening program for youth.

**Data issues/caveats that affect outcome measures::**

The SBBHL Tiers II & III target number for each agency was calculated by taking a percentage of students in each school. For example, if a school had 300 students enrolled, we would expect that 20% (or 60) students would be served through Tiers II & III. The number of students in a school can change over the course of a year, the SBBHL may need to change schools for some reason, or there might be staff vacancies over the year—all variables that can impact numbers served.

**Indicator #:**

3

**Indicator:**

Number of children under the age of 6 and their families will receive prevention and early intervention services and supports through Regional Intervention Program (RIP).

**Baseline Measurement:**

In FY2019, 412 children under the age of 6 and their families receive prevention and early intervention services and supports through Regional Intervention Program (RIP) to ensure that young children and their families experiencing challenging behaviors receive services and support.

**First-year target/outcome measurement:**

Maintain or increase the number of children under the age of 6 and their families receiving prevention and early intervention services and supports during state FY2020.

**Second-year target/outcome measurement:**

Maintain or increase the number of children under the age of 6 and their families receiving prevention and early intervention services and supports during state FY2021.

**Data Source:**

Number of young children and siblings (under 6 years old) experiencing challenging behaviors served by the Regional Intervention Program as reported by the DMHS Office of Children, Young Adults, and Families.

**Description of Data:**

The Regional Intervention Program is a parent-implemented, professionally-supported program for young children (2-6 years old) and their families experiencing challenging behaviors. RIP has been serving families with young children since 1969. This unique, internationally recognized program guides parents in learning the skills necessary to work with their own children, while they receive training and support from other RIP families. There are 11 program sites across Tennessee.

**Data issues/caveats that affect outcome measures::**

None noted.

**Indicator #:**

4

**Indicator:**

Number of juvenile justice involved youth diverted to evidence-based, community-based services.

**Baseline Measurement:**

In FY2019, 373 juvenile justice involved youth have been served in the community.

**First-year target/outcome measurement:**

Increase the number of juvenile justice involved youth have been served in the community during state FY2020

**Second-year target/outcome measurement:**

Maintain or increase the number of juvenile justice involved youth have been served in the community during state FY2021.

**Data Source:**

Providers report data monthly on program outcomes to the Office of Juvenile Justice Programming. Service providers are currently collecting data to show cost savings, improvements in quality of life outcomes, and reductions in recidivism and out of home placements. As implementation continues and youth are being successfully discharged from services, this data will be used to show

program effectiveness.

**Description of Data:**

The primary purpose of the Juvenile Justice Reform Local Diversion Grant program is to expand community-based services and training to provide treatment options for juvenile courts to utilize across the state, specifically services and training that are evidence-based and outcomes oriented. In addition, the JJR Grant aims to support Building Strong Brains (Tennessee's ACEs Initiative) by supporting youth served by the JJR Grant in building resiliency and educating professionals on responding in a trauma-informed manner.

**Data issues/caveats that affect outcome measures::**

The grant program started in FY2019. There is only six months of data to report in FY2019. As implementation continues and youth are being successfully discharged from services, this data will be used to show program effectiveness.

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**Footnotes:**

# Planning Tables

**Table 2 State Agency Planned Expenditures**

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019      Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention <sup>†</sup>		\$6,473,886	\$0	\$860,334	\$5,593,100	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) <sup>**</sup>		\$2,621,848	\$0	\$0	\$380,000	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$35,354,000	\$10,950,000	\$254,730,400	\$2,791,200	\$5,392,600
7. Other 24 Hour Care		\$7,800,578	\$232,287,650	\$0	\$73,708,650	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$8,209,172	\$667,830,134	\$8,224,466	\$86,378,230	\$299,400	\$274,724
9. Administration (Excluding Program and Provider Level) <sup>***</sup>		\$1,113,000	\$0	\$2,259,400	\$29,162,824	\$0	\$3,761,000
<b>10. Total</b>	<b>\$0</b>	<b>\$26,218,484</b>	<b>\$935,471,784</b>	<b>\$22,294,200</b>	<b>\$449,953,204</b>	<b>\$3,090,600</b>	<b>\$9,428,324</b>

\* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

\*\* Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

\*\*\* Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

**Footnotes:**

## Planning Tables

**Table 6 Non-Direct-Services/System Development [MH]**

MHBG Planning Period Start Date: 07/01/2019      MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	\$0
2. Infrastructure Support	\$0
3. Partnerships, community outreach, and needs assessment	\$0
4. Planning Council Activities (MHBG required, SABG optional)	\$549,118
5. Quality Assurance and Improvement	\$0
6. Research and Evaluation	\$0
7. Training and Education	\$1,946,000
<b>8. Total</b>	<b>\$2,495,118</b>

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**Footnotes:**

MHBG funds are not spent on remaining items.

# Environmental Factors and Plan

## 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

### Narrative Question

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>22</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>23</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>24</sup>

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>25</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>26</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>27</sup>

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>28</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>29</sup> 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. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>30</sup> Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>31</sup> and ACOs<sup>32</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD 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.<sup>33</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>34</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>35</sup> Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>36</sup> SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.<sup>37</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.<sup>38</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>39</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

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.<sup>40</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>41</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

<sup>22</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

<sup>23</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>24</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

<sup>25</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

<sup>26</sup> <http://www.samhsa.gov/health-disparities/strategic-initiatives>

<sup>27</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>28</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. [https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>29</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

<sup>30</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

<sup>31</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>32</sup> New financing models, <https://www.integration.samhsa.gov/financing>

<sup>33</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

<sup>34</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>35</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>36</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

<sup>37</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>38</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>39</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORR/PEP13-RTC-BHWORR.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

<sup>40</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

<sup>41</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

**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.

The Tennessee Department of Mental Health & Substance Abuse Services "My Health, My Choice, My Life" program promotes integrated care; this 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 psychiatric 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.

Additionally, the Tennessee Department of Mental Health and Substance Abuse Services with the National Alliance for Mental Illness (NAMI) Tennessee and the Tennessee Association of Mental Health Organizations (TAMHO) jointly created the Tennessee Co-Occurring Disorders Collaborative (TNCODC). The TNCODC mission is to create a common understanding of the impact and treatment of co-occurring disorders in our communities, to share knowledge about the conditions and available resources, reduce stigma, and accurately direct people to timely and effective prevention, treatment, and support for co-occurring mental health and substance use disorders.

2. Describe how the state provide 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. Encouraging co-occurring competent and co-occurring friendly programs is key value present in all grant contracts administered by the Division of Mental Health Services. 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 include (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 ongoing 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. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  Yes  No

b) and Medicaid?  Yes  No

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

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

ii) heart disease  Yes  No

iii) hypertension  Yes  No

iv) high cholesterol  Yes  No

v) 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?

The Division of Mental Health, Office of Wellness and Employment, supports the implementation of five evidence-based health and wellness programs by providing ongoing training and up to date licensing of curriculum for: Chronic Disease Self-Management Program, Diabetes Self-Management Program, Tobacco Free Program, NEW-R Program, and Whole Health Action Management Program. These curricula are provided by trained peers in the state's 45 Peer Support Centers.

Please indicate areas of technical assistance needed related to this section

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**Footnotes:**

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>42</sup>, [Healthy People, 2020](#)<sup>43</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>44</sup>, 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 (i.e., 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)<sup>45</sup>.

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 "assess 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."<sup>46</sup>

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<sup>47</sup>. 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<sup>48</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, 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.

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<sup>42</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>43</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>44</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

<sup>45</sup> <http://www.ThinkCulturalHealth.hhs.gov>

**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, gender identity, 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 sub-population?  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?

Please indicate areas of technical assistance needed related to this section

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**Footnotes:**

The WebBGAS system does not allow us to edit or change this answer.

## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

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

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.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions 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,<sup>49</sup> The New Freedom Commission on Mental Health,<sup>50</sup> the IOM,<sup>51</sup> NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).<sup>52</sup> 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."<sup>53</sup> 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**)<sup>54</sup> 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**)<sup>55</sup> was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. 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.

<sup>49</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>50</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>51</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

<sup>52</sup> National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

<sup>53</sup> <http://psychiatryonline.org/>

<sup>54</sup> <http://store.samhsa.gov>

<sup>55</sup> <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

**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.

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**Footnotes:**

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## Environmental Factors and Plan

### 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

#### Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention\* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

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

#### Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?  Yes  No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?  Yes  No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

TDMHSAS has chosen to implement the OnTrackNY model, which was developed through the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program. This model utilizes the Coordinated Specialty Care (CSC) evidence-based practice to provide early intervention services for youth and young adults experiencing a first episode of psychosis. Treatment is provided by coordinated teams who focus on helping individuals work toward personal goals and lead full and productive lives. More broadly, the CSC model helps individuals navigate the road to recovery from a first episode of psychosis, including supporting efforts to function well at home, at work or school, and in the community. The CSC program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology, and care coordination and management.

TDMHSAS has contracted with four providers to implement a coordinated specialty care (CSC) program for youth and young adults experiencing a first episode of psychosis using the OnTrackNY model. These programs also utilize the Individual Placement and Support (IPS) model for supported employment and education as well as peer support through

Certified Peer Recovery Specialists /Certified Young Adult Peer Support Specialists. Carey Counseling Center, Inc. provides services in the rural northwest Tennessee counties of Benton, Carroll, Gibson, Henry, Lake, Obion, and Weakley Counties. Mental Health Cooperative provides services in Davidson County. Alliance Healthcare Services provides services in Shelby County. Helen Ross McNabb Center provides services in Knox and Hamilton Counties.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

TDMHSAS contracts with Vanderbilt University Medical Center to employ a statewide trainer that provides training, technical assistance, and fidelity monitoring to CSC/OnTrackTN teams across the state. To ensure the promotion of evidence-based best practices with individuals with ESMI, the statewide trainer also partners with OnTrackUSA for ongoing training and consultation.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?  Yes  No

5. Does the state collect data specifically related to ESMI?  Yes  No

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

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Coordinated Specialty Care/OnTrack teams also utilize the Individual Placement and Support (IPS) model for supported employment and education as well as peer support through Certified Peer Recovery Specialists/Certified Young Adult Peer Support Specialists. In addition, all OnTrackTN programs teams are provided opportunities for further training on youth and young adult engagement (e.g. Transition to Independence Process model (TIP) through the TDMHSAS Training & Technical Assistance Center (TTAC).

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

In FFY2019, multiple agency budgets were reduced to reflect sustainability efforts through alternative reimbursement methods. In FY 2020 and 2021, the state will continue to increase its efforts to ensure sustainability of the OnTrackTN programs, including ongoing training, consultation, and fidelity monitoring. The statewide trainer will finalize and implement fidelity measures that can be used across teams.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Currently, TDMHSAS collects a Quarterly Program Report from each OnTrackTN program that tracks data on items such as staffing, outreach and engagement activities, team meetings, numbers served, etc. In addition, TDMHSAS collects semi-annual client-level data pulled from Admission, Follow-Up, and Discharge Forms that capture items such as education and employment status, hospitalizations, global functioning, medication side effects, services received, etc. TDMHSAS develops semi-annual reports based on this data. The state is in the process of further developing and finalizing a fidelity scale to determine each OnTrackTN team's adherence to the Coordinated Specialty Care model.

10. Please list the diagnostic categories identified for your state's ESMI programs.

- Be between fifteen through thirty (15-30) years of age;
- Be currently living and physically present in Davidson, Shelby, Benton, Carroll, Gibson, Henry, Lake, Obion, Weakley, Knox, or Hamilton Counties; and
- Currently have, or anytime in the past twenty four (24) months had, a diagnosable psychosis spectrum condition including schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, or other serious mental illness that warrants psychosis interventions such as depression with psychosis, bipolar disorder with psychosis, or others that meet diagnostic criteria in the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5), or more current edition.

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

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**Footnotes:**

## Environmental Factors and Plan

### 5. Person Centered Planning (PCP) - Required MHBG

#### Narrative Question

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

1. Does your state have policies related to person centered planning?  Yes  No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

If a person has developed a Wellness Recovery Action Plan (WRAP), cross system crisis plan or crisis management plan prior to the current crisis situation and/or has a Declaration for Mental Health, the crisis service provider will attempt to locate and follow the plan to the extent possible, including bringing in those people identified to assist with the plan.

Tennessee has 45 peer-run Peer Support Centers throughout the state where Certified Peer Recovery Specialists work with consumers on self-management of their health, including making health care decisions and communicating with their providers. Certified Peer Recovery Specialists provide self-management classes in the Chronic Disease Self-Management System, Diabetes Self-Management System, NEW-R, Tobacco Free, and the Wellness Recovery Action Plan (WRAP). In addition, the statewide consumer organization, Tennessee Mental Health Consumers' Association, provides peer support throughout the state that engages consumers in managing their health.

The state has a Certified Family Support Specialist certification program in which parents can become certified to provide peer-to-peer support services to parents or caregivers of a child with a Social Emotional Disturbance (SED). The State also has a Certified Peer Recovery Specialist program and is working on adding a CPRS Transition Age designation for youth and young adults living with an SED or Serious Mental Illness, the Certified Young Adult Peer Support Specialist program (CYAPSS). This program is in its final stages of development and the certification will be available for young adults ages 18-30. Within the Office of Children, Young Adults, and Families, the System of Care Across Tennessee lab sites employ Family Support Specialists, and the Clinical Risk for Psychosis (CHR-P), On Track TN (FEPI) and Healthy Transitions lab sites employ Peer Support/Recovery Specialists who collaborate with the consumer's Care Coordinator and Therapist to ensure person-centered planning.

Through the state's Behavioral Health Safety Net, 34 unique billable behavioral health treatment and recovery services are offered. Through person-centered planning at the Community Mental Health Provider level, individuals enrolled in BHSN determine, along with their support people and their providers, which services and treatment options are the best option for the individual.

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

Person-centered planning is imbedded within all contracts through the Division of Mental Health Services, from housing services to crisis services, peer support to System of Care.

Tennessee's crisis continuum utilizes a person centered approach in all aspects of the crisis assessment. Families and other support individuals are asked to collaborate and provide observations to help define a reasonable person centered plan for crisis resolution. A crisis management plan is a documented intervention tool that itemizes and describes information and actions intended to sustain resolution of the recent crisis episode and reduce the potential for a subsequent crisis episode. When possible, the crisis management plan is a collaborative product between the crisis professional and the person in crisis and/or their designated support person(s). Similarly, all individuals and their involved supports participate in developing a safety plan that includes supports needed to remain in the community and safety checks or information on creating a safe environment.

Another example is through the Community Supportive Housing program which requires provider agencies to enact a person-centered approach to the housing process, including the requirement to have a housing and services plan that is client-driven

and person-centered. The Emerging Adult Services program requires the provider agency to conduct an assessment to detail the service recipient's individual strengths and needs, and subsequently develop a transitional plan to guide services and transition to adulthood.

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

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**Footnotes:**

## Environmental Factors and Plan

### 6. Program Integrity - Required

#### Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD 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 M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

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#### Please respond to the following items:

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?

All contracts are subject to fiscal and programmatic monitoring as part of TN State Policy (2013-007) Grant Management and Subrecipient Monitoring Policy and Procedures. The Office of Contracts, within the TDMHSAS Division of General Counsel, includes prohibitions within sub-recipient grant contracts. The State Procurement Commission has incorporated the sections into the pro forma statewide grant contract template as optional language. Sub-recipient contracts that are supported with Mental Health Block Grant funds include the following language within Section E. Special Terms and Conditions. E.#) Prohibitions on Use of Federal Mental Health Block Grant (MHBG) Funds. Pursuant to federal laws and regulations, the Grantee shall not use any federal Community Mental Health Services Block Grant (now MHBG, formerly CMHS BG) funds made available under this Grant Contract for any of the following purposes: a. to provide inpatient services; b. to make cash payments to intended recipients of health services; c. to purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or to purchase major medical equipment; d. to satisfy any requirement for the expenditure of non-federal funds for the receipt of federal funds; e. to provide financial assistance to any entity other than a public or non-profit private entity. And E.#) Prohibition on Supplantation of Federal Mental Health Block Grant (MHBG) Funds. Pursuant to federal laws and regulations, the Grantee shall not use any funds paid or services rendered under the federal Community Mental Health Services Block Grant (now MHBG, formerly CMHS BG) to supplant any other funds available for the services provided under this Grant Contract. Additionally, the scope of services and deliverables for all programs within Division of Mental health services

include a section within the program structure that states, "Grantees are strongly encouraged to seek compensation from third party payers, such as Medicaid, when possible for reimbursable services and supports delivered under this contract therefore allowing this contract to help offset the activities and expenses that are non-reimbursable by third party payers."

The For Providers, Grants Management section of the TDMHSAS web site includes extensive information and guidance for sub-recipients around the issue of federal funds including Uniform Guidance, Allowable Vs. Non-Allowable Costs, FFATA, and more. Web site link: <https://www.tn.gov/behavioral-health/for-providers/grants-management.html>.

Grantees report on deliverables and program progress to the TDMHSAS on a monthly or quarterly basis. TDMHSAS program staff works collaboratively with the contracted provider throughout the fiscal year to monitor performance. Additionally, programmatic monitoring provides a more formalized process for program oversight and review for compliance of the of the contract deliverables, including outcomes and performance standards. Performance standards are revisited annually as part of the MHBG performance indicator reporting and as updates are made annually to the TDMHSAS Three (3) Year Plan. There is also an annual review of individuals and families served by the programs which would speak to program deliverables.

A large portion of the internal controls related to oversight of programs and services administered by the Divisions of Mental Health and Substance Abuse Services are by way of the Budget, Contracts, and Monitoring System (BCMS). The BCMS was developed internally by the office of Information Technology and began in 2015. BCMS is designed to track the following: Grants, Grant Budgets (Notice of Award), and Grant Reporting (fiscal and program); Edison Projects; Program Codes; Budgets for all funding sources (State and Grants), Programs, Agencies; Contracts and Payments (Reimbursements) for contracts; Monitoring (fiscal and program). The system provides the ability to upload documents/reports, whereby such files are stored in a secure environment and can be viewed from a single, central location by all users. Several sections of BCMS are designed to be updated in real-time to allow other users within the organization to see status updates of budgets, contracts and monitoring. BCMS is used to document federal grant requirements, pay invoices and track spend rates of contracts and programs, store contracts and contract amendments, track program monitoring of contracts, and store important information about sub-recipient providers.

Please indicate areas of technical assistance needed related to this section

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## 7. Tribes - Requested

### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>56</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>56</sup> <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

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

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### Footnotes:

# Environmental Factors and Plan

## 9. Statutory Criterion for MHBG - Required for MHBG

### Narrative Question

#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

### Please respond to the following items

#### Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

TDMHSAS and its Division of Mental Health Services (DMHS) continues to provide a comprehensive community-based mental health system. DMHS is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness, co-occurring disorders, and/or serious emotional disturbances. This is accomplished through the creation, expansion, and oversight of community-based programs and community support services. Initiatives include: affordable housing programs; homelessness prevention services; 24-hour crisis services; wellness and recovery services; peer recovery services; suicide prevention services; geriatric services; disaster emergency services; and comprehensive System of Care-based child, youth, and family supports services.

An example from the Housing and Homeless Services Office within DMHS is the Inpatient Targeted Transitional Support program. This program provide the opportunity for individuals discharging from the Regional Mental Health Institutes, Crisis Stabilization Units, and State-Contracted Facilities to secure safe, affordable, permanent supportive housing with skill-building, educational, and life skills trainings offered to increase the functionality of each service recipient outside of the institutional setting.)

Individual Placement and Support (IPS) is the supported employment model promoted by the department. It is a model of supported employment for people with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression). IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. There are currently 14 behavioral health agencies who use this model across the state.

Peer Wellness Coaching is offered statewide. Adults living with serious mental illness die on average 25 years earlier than other Americans largely due to treatable medical conditions. The My Health, My Choice, My Life (MHMCML) Initiative, led by PWCs, includes evidence-based, self-management workshops along with one-on-one wellness coaching. The initiative promotes health and wellness activities such as healthy eating and physical activities. MHMCML also trains agency staff in health and wellness curriculum and provides technical assistance and support in promoting health and wellness within mental health and substance use services.

The Tennessee Move Initiative began in state FY2017 with primary purpose of successfully transitioning identified individuals from long-term units to community based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. Three community mental health agencies provide recovery-focused, intensive, and customized care coordination services through four teams to identified individuals in long-term units within the TDMHSAS Mental Health Institutes. The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on the individual need. Each partner agency has developed and implemented recovery-oriented programming to ensure individual, family, and housing provider supports while connecting and coordinating with natural and formal supports within the individual's home community. The goals of TMI include: decreasing prolonged hospitalizations and repeated readmissions that impose negative implications on an individuals' quality of life, including their path to recovery; delivering recovery-focused, intensive, and customized care coordination services which support identified individuals in the least restrictive and most integrated setting appropriate to individual need; ensuring a continuity of care which leads to sustained hope, personal empowerment, respect, social connectedness, and self-responsibility relative to the individuals served; providing services are centered on the individual, sensitive to the family, culturally and linguistically competent, and founded in community resources.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
  - a) Physical Health  Yes  No
  - b) Mental Health  Yes  No

- c) Rehabilitation services  Yes  No
- d) Employment services  Yes  No
- e) Housing services  Yes  No
- f) Educational Services  Yes  No
- g) Substance misuse prevention and SUD treatment services  Yes  No
- h) Medical and dental services  Yes  No
- i) Support services  Yes  No
- j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  Yes  No
- k) Services for persons with co-occurring M/SUDs  Yes  No

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

TDMHSAS will be partnering with Tennessee Department of Education on a SAMHSA Project AWARE-SEA (Advancing Wellness and Resiliency in Education-State Education Agency) grant, which will expand school-based mental health services to students in high-need school districts in Tennessee.

**3. Describe your state's case management services**

Case Management is offered as a service in the Behavioral Health Safety Net of Tennessee. Case management is defined as care coordination for the purpose of linking safety net individuals to clinically indicated services or to benefits that would provide an alternative payer source for these services. Case management may be delivered through face-to-face encounters or may consist of telephone contacts, mail or email contacts necessary to ensure that the service recipient is served in agency office, in the community setting or through methods outlined in the Centers for Medicaid and Medicare Services' (CMS') guidance on case management, including but not limited to assessment activities; completing related documentation to identify the needs of the individual; and monitoring and follow-up activities which may include making necessary adjustments in the care plan and service arrangements with providers. Case management is tied to access to services related to follow-up activities such as individual/group therapy, psychiatric medication management, pharmacy assistance and coordination and labs related to medication management; services that promote community tenure. Case management is offered to safety net individuals with a current assessment of severe and persistent mental illness and other clinical considerations.

Multiple child, youth, and young adult programs utilize a team-based approach to service provision, which is facilitated through care coordination. Specifically, the System of Care Across Tennessee uses the High Fidelity Wraparound (HFW) process to support, stabilize, and keep children, youth, and young adults with their families and in their communities.

Older Adults care management services provide outreach, screening, assessment, linkage, in home therapy and other supportive services, as needed. Additionally, this program provides community mental health education to promote awareness and knowledge about geriatric mental health concerns.

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

There is an array of programs offered by TDMHSAS providers to supported reduced hospitalization and hospital stats.

The Inpatient Targeted Transitional Support program provides the opportunity for individuals discharging from the Regional Mental Health Institutes, Crisis Stabilization Units, and State-Contracted Facilities to secure safe, affordable, permanent supportive housing with access to temporary financial assistance to obtain and maintain residence and related supports as they transition to community living. The Community Supportive Housing program provides flexible funding to provider agencies to offer supported housing for adults with mental illness or co-occurring disorders. The program incorporates access to community-based services such as peer recovery support, supported employment and SOAR (SSI/SSDI Outreach, Access and Recovery), each of which is intended to increase or sustain recovery and independence while living in the community. Individual housing plans are developed for each service recipient to guide continued transition to independent community living. The Intensive Long-term Support program provides supportive housing for individuals discharging from the Regional Mental Health Institutes, who need enhanced supportive services while living in the community. These enhanced services include on-site access to mental health care personnel, and access for opportunities in skill-building, educational, and life skills trainings and activities, to increase the functionality of each service recipient outside of the institutional setting.

Crisis response services are the single point of entry to a continuum of behavioral health services and supports needed by someone experiencing a behavioral health crisis. Tennessee Crisis Services incorporate a continuum of crisis services, including Mobile Crisis, Crisis Stabilization, Respite and Walk In Center services. The philosophy is based on determining the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. Additionally, the TDMHSAS and Tennessee Hospital Association (THA) brought together a public/private

collaboration among community partners and formed a work group to review Tennessee's current psychiatric care delivery system. These efforts include a key emphasis on providing treatment immediately at the point of entry into the system. The work group has developed a recommended set of Psychiatric Treatment Protocols for EDs and encourages all EDs across the state to implement these psychiatric protocols in their hospitals. Additionally, a Child/Adolescent Taskforce was convened, which included representatives from TennCare, the Department of Children's Services, the TN College of Emergency Physicians and the Children's Hospital Alliance of Tennessee (CHAT). The workgroup created tools and resources for hospital EDs to better care for children in mental health crisis, including safety protocols, seclusion and restraint guidelines, and psychiatric medication protocols. The CHAT hospitals continue to pilot the resources which, once finalized, will be made available to all hospitals EDs to help them care for these patients and their families while an available inpatient or community mental health service is being identified.

The Behavioral Health Safety Net of TN is a state funded program that provides vital mental health services to uninsured Tennesseans who are eligible. The services provided through the BHSN of TN are intended to reduce hospitalizations and the recidivism rate. The services consist of: assessment, evaluation, diagnostic, therapeutic intervention, case management, transportation, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination. Individuals actively enrolled in BHSN are less likely to require inpatient psychiatric care. In FY18, approximately 2% of individuals enrolled in BHSN were admitted to a Regional Mental Health Institute (RMHI) within 90 days of a BHSN service.

Through the First Episode Psychosis Initiative, five OnTrackTN teams provide individualized services to youth and young adults experiencing a first episode of psychosis. Youth and young adults involved in these programs experience a large reduction in number and length of hospital stays. System of Care Across Tennessee provides high-intensity wraparound services, using High Fidelity Wraparound to families of children with an SED/SMI with the intent of reducing out-of-home placements, including hospitalizations. The Healthy Transitions(2)-Improving Life Trajectories initiative will utilize a young adult peer stabilizer that will be partnering with the child and adult mobile crisis teams at a local lab site, with the goal of reducing hospitalizations and increasing engagement in community-based services.

The Division of Mental Health Services also supports a number of recovery services that are intending to increase the recovery capital of people with mental health and co-occurring disorders. Individual Placement and Support (IPS) Supported Employment services are recovery services to help people reintegrate into their communities through competitive, integrated employment. IPS is offered statewide in 37 of the state's 95 counties. The Peer Wellness Initiative prioritizes physical health as a tool to improve mental health recovery. Through this initiative, evidence-based, self-management workshops along with one-on-one wellness coaching are offered to clients. Staff members are also Certified Peer Recovery Specialist (CPRS) and as such, they use peer support principles to teach and model the value of every individual's recovery experience, inspire hope, provide support and guidance to accomplish goals, and encourage effective coping techniques. Individuals who attend the state's 45 Peer Support Centers have reported that because of their participation at the Peer Support Center, they are less likely to require psychiatric hospital services.

## Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

## Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	368,378	207,417
2.Children with SED	92,527	102,640

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

- A) The Target population is adults with Severe Mental Illness (SMI) and children with Severe Emotional Disturbance (SED).
- (B) Tennessee uses the upper limit of 2017 NRI statewide prevalence estimates of adults with SMI. Tennessee also uses the upper limit of 2017 NRI statewide prevalence estimates for the Level of Functioning score  $\leq 60$  for ages 9-17 as an estimate of children with SED.
- (C) Tennessee uses the URS tables for FY2018 to estimate the incidence of SMI and SED, because the URS tables contain aggregate data provided by the State Medicaid Authority, in addition to individuals served by the Tennessee Department of Mental Health and Substance Abuse Services.
- (D) The department uses prevalence data when developing budget requests.

**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

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

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

**a.** Describe your state's targeted services to rural population.

TDMHSAS maintains numerous initiatives that address specific challenges unique to rural communities. Tennessee Governor Bill Lee issued his first executive order in January 2019, requiring all state executive departments to issue a statement of rural impact and provide recommendations for better serving rural Tennessee. TDMHSAS provided the Statement of Rural Impact to the governor's office in May 2019. Some of the targeted programs and services offered to rural communities include the following.

The Community Supportive Housing program provides opportunities for permanent housing in residential settings that are supplemented with access to support services, such as peer recovery, supported employment, and support staffing. Several of these residences are located in rural counties. The Targeted Transitional Support programs are designed to provide temporary financial assistance to individuals to obtain housing or related supports; this helps to avert homelessness during a time in which an individual is in the process of acquiring permanent financial means to sustain housing. The Creating Homes Initiative seeks to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable, and permanent housing options for people with mental illness and co-occurring disorders; for this initiative Regional Housing Facilitators work in collaboration with the state's Continuum of Care and many community stakeholders to create and develop these quality, safe, affordable and permanent housing opportunities.

Individual Placement and Support (IPS) Supported Employment is a model of employment with research indicating that it is a successful model for rural communities. Currently, IPS is offered in 37 counties, 27 of which are IPS Providers in rural communities. IPS is delivered in 18 programs across the state and currently one provider in middle TN specifically targeting the homeless population. There are seven Peer Wellness Coaches and one Statewide Peer Wellness Coach and Trainer in TN and programming is offered to clients regardless of their housing status throughout the state.

The Behavioral Health Safety Net of TN is available to eligible uninsured Tennesseans who live in rural areas of the state. There are 146 sites across the state in 71 counties, with 54 of those counties considered rural. In FY18, a BHSN pilot project was implemented to help with transportation needs, especially in rural communities, to behavioral health services for individuals enrolled in BHSN. In FY 19, transportation was added as a permanent service to the program.

The crisis continuum of service is available to all Tennesseans. Crisis assessments are community based and are available statewide in both rural and urban areas. Crisis services are available to all age groups and to individuals including those that reside in the state's jails and or are homeless. Technology-assisted crisis assessments help to ensure timely response to community locations, reducing average length of stay in emergency rooms and improving overall efficiency of limited crisis resources.

The Office of Children, Young Adults, and Families (OCYAF) uses a system of care approach to ensure services and supports are tailored to the unique needs of children, young adults, and families in communities all across Tennessee. Our behavioral health providers establish Memorandums of Understanding (MOU) with local community services, supports, and schools, creating a continuum of care that is accessible to families regardless of where they live. Team-based, wraparound services and supports are provided in the home and community to engage families in more rural areas of the state. In fact, Tennessee's First Episode Psychosis Initiative (FEPI) in rural west Tennessee has been recognized as one of the first FEPI program in the nation to target rural communities. For children, young adults, and families who might not have access to a nearby community mental health center, Telehealth is used to complete mental health assessments and engage them in care. Because 60-80% of children who receive mental health services do so in schools (Burns et al., 1995; Green et al., 2013), the OCYAF continues to expand promotion, prevention, and early intervention services and supports in schools to reduce barriers and increase access to care. In addition to using various social media platforms for statewide outreach and education, the Training & Technical Assistance Center offers behavior health-related trainings in multiple counties across the state, increasing access to reputable resources and information for families and professionals.

The following programs will be supported with this block grant application:

- The Art for Recovery program is a recovery-focused art education program that supports persons with mental illness and/or substance use disorder.
- Certified Peer Recovery Specialist Training program provides peer-led training throughout the state for people with lived experience of mental illness, substance use disorder or co-occurring disorder who are seeking state certification as Peer Recovery Specialists.
- Child Care Consultation provides training for Project B.A.S.I.C. Child Development Specialist (CDS) staff to develop their capacity to incorporate mental health coaching regarding Pyramid Model strategies (related to the social-emotional development of children) as part of their existing practices.
- Community Supportive Housing provides flexible funding to agencies to provide supported housing for adults diagnosed with mental illness and co-occurring disorders. Staff is hired by contract agencies to provide on-site supervision for residents and as-

needed supervision to non-supervised group homes and apartments; coordinate outside activities for the residents; and work one-on-one to develop a housing plan that identifies the consumer's ideal housing goal and more independent living.

- Community Targeted Transitional Support provides specific, temporary financial assistance allowing consumers to live independently in the community by providing funding for rental deposits, rental assistance, utility deposits, utility payments, eye care, and dental care.
- CSU Peer Link provides peer Bridger services are provided in the Crisis Stabilization Units (CSU) across the state to assist individuals to return to the local communities successfully.
- First Episode Psychosis Initiative (FEPI) is designed to provide early intervention services for youth and young adults fifteen through thirty (15-30) years of age in selected Tennessee counties who have experienced first-episode psychosis.
- Inpatient Targeted Transitional Support assists persons awaiting discharge from the state Regional Mental Health Institutes (RMHI) by providing them temporary financial assistance until their regular SSI or other benefits can be restored, thereby enabling them to move into community settings when clinically ready.
- Intensive Long-Term Support provides intensive long-term, wrap-around support services to allow people to be discharged from RMHIs into supportive living facilities in the community.
- The Tennessee Move Initiative provides recovery-focused, intensive, and customized care coordination services to identified individuals in long-term units within the RMHIs for the purpose of transitioning individuals to the least restrictive and most integrated setting appropriate to individual need.
- Older Adults Program provides geriatric services offered in a wide spectrum of locations, using a variety of methodologies including: agency and in-home counseling to seniors unable to access services outside of their home; care management, clinical social work, and geriatric psychiatry assisting seniors and their families to meet their behavioral health needs; agency and in-home depression screenings; collaboration with the Area Agency on Aging; and consultations to Adult Protective Services in the local community and primary care providers.
- Peer to Peer Support and Education provides emotional support, recovery education, and information through peer support. This effort helps reduce stigma and also promotes mental health advocacy, wellness, and recovery.
- The Peer Wellness Initiative is component of the statewide, peer-led health and wellness initiative, that promotes chronic disease prevention and self-management programming for individuals with mental illness, substance use disorders, and co-occurring disorders.
- Project B.A.S.I.C. (Better Attitudes and Skills In Children) is a school-based, mental health prevention and early intervention service that focuses on the promotion of mental health in children in the earliest school grades (K-3rd grade).
- Regional Intervention Programs (RIP) is a parent-implemented, professionally-supported program for young children (2-6 years old) and their families experiencing challenging behaviors. This unique, internationally recognized program guides parents in learning the skills necessary to work with their own children, while they receive training and support from other RIP families.
- Respite Voucher Program provides respite vouchers for families. Parents choose their own respite provider, negotiate rate of pay, and are reimbursed for the respite service. The Respite Helpline maintains a list of known respite providers across the state.
- School & Communities Youth Screen Program is scientifically-based screening tool designed to identify at-risk youth; provide effective interventions to assist with their treatment. TeenScreen is a national mental health and suicide risk-screening program for youth.
- School Based Behavioral Health Liaisons use the Multi-Tiered Systems of Supports (MTSS) framework to provide face-to-face consultation with classroom teachers to enhance trauma-informed learning environments for children and youth who have or are at-risk for SED, behavior problems, or substance use disorders. Liaisons provide training and education for the classroom teachers regarding mental health and substance abuse topics, as well as behavioral interventions.
- Supported Employment is an initiative that helps individuals with a serious mental illness and/or co-occurring disorders work at competitive and integrated jobs of their choosing, following the Individual Placement and Support (IPS) Supported Employment evidence-based model of supported employment.

**b.** Describe your state's targeted services to the homeless population.

Homeless populations within the State of Tennessee who are experiencing mental illness, substance abuse, or co-occurring disorders have a variety of programs available to provide permanent supportive housing and other financial services to facilitate independence in the community and increased access to behavioral health care. Most of these programs geographically span a wide array of communities in our state, including many of our rural counties. Two programs, the Projects for Assistance in Transition from Homelessness (PATH) and the Children and Youth Homeless Outreach Project (CYHOP), has the primary objective of conducting quality outreach efforts to individuals who are homeless or at risk for homelessness and facilitate opportunities for mental health, substance abuse, care coordination, and housing support services.

The Behavioral Health Safety Net of TN is available to eligible uninsured Tennesseans who are homeless.

The crisis continuum of service is available to all Tennesseans. Crisis assessments are community based and are available statewide in both rural and urban areas. Crisis services are available to all age groups and to individuals including those that reside in the state's jails and or are homeless.

**c.** Describe your state's targeted services to the older adult population.

The Older Adult Program provides care management to individuals over 50 who would not otherwise be eligible for these services. Services may include assessment, outreach, linkage, in home therapy and other supportive resources. In addition, community mental health education is provided to promote awareness regarding geriatric issues. These services are provided to improve quality of life and to develop skills to enable the older adult to continue to live independently in the community.

The Behavioral Health Safety Net of TN is available to older adults in Tennessee. The BHSN will cover behavioral health services not covered by Medicare Part B, including Case Management, Medication Training and Support, Peer Support, Psychosocial Rehabilitation Services, and Transportation.

Criterion 5: Management Systems

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

**Criterion 5**

Describe your state's management systems.

TDMHSAS was able to expand workforce development and training availability for mental health services providers during FY2019 and additional funding was added to the block grant award for the purpose of technical assistance. Funds were used to support an array of training opportunities for behavioral health professionals. Some of the trainings and ongoing workforce development initiatives are included in this section.

The Individual Placement and Support Statewide Conference hosted over 120 participants in May 2019. The conference is a collaborative effort between DMHSAS and DHS-VR and provides opportunity for direct service staff, VR counselors, IPS statewide leadership, and IPS community affiliates to celebrate progress made in serving individuals who pursue competitive work opportunities through the IPS Supported Employment initiative. Additionally, TDMHSAS supports a Statewide Peer Wellness Coach and Trainer to provide and coordinate 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 supports assists providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

Statewide Crisis Phone Line receives more than 128,000 calls annually from Tennessee adults and youth. To increase awareness of the crisis line and increase call volume, we developed the Crisis Services Media Campaign. The Crisis Services media campaign of early 2019 was a statewide effort to increase awareness of Tennessee's Statewide Crisis Line and promote more positive outcomes in psychiatric emergencies. The messages of the campaign were carried through:30 and :15 second video commercials that were displayed on television and social media. To date, the campaign received more than 9.4 million impressions statewide in television and social media. The crisis continuum also assures that all crisis responders are adequately trained in all skills required for successful crisis intervention that also increases awareness and utilization of the most clinically appropriate and least restrictive services available. Crisis responders are required to successfully complete a self-study, web based crisis training and complete a booster training every three years. Additionally, a six hour specialized training is provided to qualified mental health professional that in part, qualifies them as Mandatory Pre-screening Agents (MPA), certified to write the first "Certificate of Need" after conducting the first assessment for involuntary psychiatric hospitalization. "Suicide Prevention in the Emergency Department" is a free online interactive training developed by the TDMHSAS, Mental Health America of Middle Tennessee, and the Tennessee Suicide Prevention Network to increase education for hospital emergency department staff about mental health and suicide, the screening, assessment, and referral process of patients at risk for suicide, environmental risk factors for suicide in the hospital setting, means reduction, and referral materials to provide to patients upon discharge. The fourth annual statewide crisis services conference was held in June 2019 and hosted over 200 crisis services staff for a day of learning, sharing best practices, networking and hope.

Each agency serving Older Adults has a designated allotment of funds to train staff in behavioral health issues facing Older Adults, in addition to systemic issues. These are to be used in a manner which will best fit their agency's operations and their regional population needs. In 2019, the fifth annual Behavioral Health and Aging seminars were held across the three grand divisions of TN with over 250 attendees learning about the aging brain, the impact of addictions, local resources, and best practices for serving this special population.

Approximately 200 eligible individuals become certified as peer workforce annually from TDMHSAS certified programs including: Certified Peer Recovery Specialists (CPRS), Certified Family Support Specialist (CFSS) , and Certified Young Adult Peer Support Specialist (CYAPSS). Supporting ongoing training for peer workforce is also a focus with the upcoming annual Certified Peer Recovery Specialist Training in Fall 2019. This training has 200-250 peers attending annually.

The Training and Technical Assistance Center (TTAC) (<https://socacrosstn.org/resources-trainings/>) promotes system of care values and principles through providing quality resources, training, and consultation to youth and young adults with behavioral health needs, their families, and those who serve them. The TTAC provides trainings on a variety of topics relating children, youth, and young adult mental health based on need or request by the community, organization, or individual. Specialized trainings are offered to teams working with Early Interventions to Address Early Serious Mental Illness. In 2019, TDMHSAS worked with Vanderbilt University and the OnTrackUSA trainers to provide a two-day training for implementation of Coordinated Specialty Care.

The following programs will be supported with this block grant application:

- The Art for Recovery program is a recovery-focused art education program that supports persons with mental illness and/or substance use disorder.
- Certified Peer Recovery Specialist Training program provides peer-led training throughout the state for people with lived experience of mental illness, substance use disorder or co-occurring disorder who are seeking state certification as Peer Recovery

Specialists.

- Child Care Consultation provides training for Project B.A.S.I.C. Child Development Specialist (CDS) staff to develop their capacity to incorporate mental health coaching regarding Pyramid Model strategies (related to the social-emotional development of children) as part of their existing practices.
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- School Based Behavioral Health Liaisons use the Multi-Tiered Systems of Supports (MTSS) framework to provide face-to-face consultation with classroom teachers to enhance trauma-informed learning environments for children and youth who have or are at-risk for SED, behavior problems, or substance use disorders. Liaisons provide training and education for the classroom teachers regarding mental health and substance abuse topics, as well as behavioral interventions.
- Supported Employment is an initiative that helps individuals with a serious mental illness and/or co-occurring disorders work at competitive and integrated jobs of their choosing, following the Individual Placement and Support (IPS) Supported Employment evidence-based model of supported employment.

**Footnotes:**

## Environmental Factors and Plan

### 11. Quality Improvement Plan- Requested

#### Narrative Question

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

#### Please respond to the following items:

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

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

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#### Footnotes:

The WebBGAS system does not allow us to edit or change this answer.

# Environmental Factors and Plan

## 12. Trauma - Requested

### Narrative Question

**Trauma**<sup>57</sup> 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<sup>58</sup> paper.

<sup>57</sup> Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

<sup>58</sup> Ibid

### 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.

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

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#### Footnotes:

The WebBGAS system does not allow us to edit or change this answer.



# Environmental Factors and Plan

## 13. Criminal and Juvenile Justice - Requested

### Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring 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.<sup>59</sup>

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.<sup>60</sup>

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.

<sup>59</sup> Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

<sup>60</sup> <http://csgjusticecenter.org/mental-health/>

### 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
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.

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#### Footnotes:

The WebBGAS system does not allow us to edit or change this answer.

# Environmental Factors and Plan

## 15. Crisis Services - Requested

### Narrative Question

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.<sup>61</sup> 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](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)<sup>62</sup>,

"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.

<sup>61</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>62</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

### Please 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.

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**Footnotes:**

## Environmental Factors and Plan

### 16. Recovery - Required

#### Narrative Question

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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.

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#### **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.

Tennessee has a rich system of recovery and recovery support services throughout the state for adults through peer support. Peer support, which is 100% recovery focused, is provided by Certified Peer Recovery Specialists in the state's 45 Peer Support Centers, in Crisis Stabilization Units, in the Regional Mental Health Institutes (state psychiatric hospitals), in peer wellness programs, a Peer Recovery Call Center, and in training and advocacy programs.

Recovery and recovery support services for children with SED in TN are being implemented through the Statewide and regional Young Adult Leadership Councils which are comprised of youth and young adults with lived experience, as well as the Family Support Specialist Advisory Council, comprised of parents of a child with an SED and child-serving agency stakeholders. Council members provide meaningful input and feedback on services and supports that impact themselves and their peers. Tennessee is currently working on creating a Transition-Age Designation of the Certified Peer Recovery Specialist, the Certified Young Adult Peer Support Specialist program (CYAPSS). This program is in its final stages of development and the certification will be available for young adults ages 18-30. In addition, several programs within the Office of Children & Youth employ peers to provide recovery -focused services, including: Clinical High Risk for Psychosis (CHR-P), On Track TN (FEPI) and Healthy Transitions, which utilize Peer Recovery/Support Specialists, and System of Care Across Tennessee which utilizes Family Support Specialists.

TDMHSAS provides certification for peer recovery/support specialists in Tennessee.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Tennessee offers an array of recovery support services for individuals with substance use disorders. Recovery Services promotes client engagement in the recovery process and provides needed supports for 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.

Addiction Recovery Programs provide recovery support services to service recipients that are recovering from life impairments because of substance use disorder(s) only or co-occurring disorders. The Addiction Disorder Peer Recovery Centers provide peer support services to individuals on a wait-list for State-funded treatment services for a SUD or COD or are discharged for SUD or COD treatment services and will benefit from additional support.

The Faith-Based Initiative is partnering with and leveraging Tennessee's faith-based communities to increase outreach, build recovery pathways, and provide an educated, welcoming, and supportive place for individuals struggling with substance abuse issues so that they may find help and hope on their pathway to recovery.

The Lifeline Peer Project was established to reduce the stigma related to the disease of addiction and increase community support for policies that provide for treatment and recovery services. There are ten Lifeliners that serve in regions covering all 95 counties of Tennessee. Tennessee Recovery Navigators were established in July of 2018, as peers in long-term recovery who connect people who present in emergency rooms after overdose or have a substance use disorder with treatment & recovery resources in the community. Navigators are people in long-term recovery (minimum 2 years) and have completed the certified peer recovery specialist training to learn to use their experience with addiction to help others find recovery.

In the coming year, the Office of Housing and Homeless Services intends to expand housing solutions for Tennesseans with mental illness and/or substance abuse disorders, which increases the opportunity for further attention to rural communities in Tennessee, while also placing more emphasis on recovery housing. This initiative may expand the use of Oxford Housing, which are self-run, self-supporting homes for individuals in recovery from drug and alcohol addiction.

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

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

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**Footnotes:**

## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

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

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

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

#### Please respond to the following items

- Does the state's Olmstead plan include :
  - Housing services provided.  Yes  No
  - Home and community based services.  Yes  No
  - Peer support services.  Yes  No
  - Employment services.  Yes  No
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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#### Footnotes:

The WebBGAS system does not allow us to edit or change this answer.

## Environmental Factors and Plan

### 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

#### Narrative Question

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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.<sup>63</sup> Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>64</sup> 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.<sup>65</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started 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.<sup>66</sup> Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance 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.<sup>67</sup>

According to data from the 2015 Report to Congress<sup>68</sup> 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).

<sup>63</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>64</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>65</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>66</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>67</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

<sup>68</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED?  Yes  No
  - The recovery and resilience of children and youth with SUD?  Yes  No
- 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:
  - Child welfare?  Yes  No
  - Juvenile justice?  Yes  No
  - Education?  Yes  No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization?  Yes  No
  - Costs?  Yes  No
  - Outcomes for children and youth services?  Yes  No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult M/SUD system?  Yes  No
  - for youth in foster care?  Yes  No
- 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.)

The State of 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 that 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, Young Child Wellness Council, Association for Infant Mental Health in Tennessee, and the Tennessee Council on Autism Spectrum Disorder. 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 the department’s children and youth programs offer integrated services at the local level by working with schools, the juvenile justice system, and child welfare services. TDMHSAS will be partnering with Tennessee Department of Education on a SAMHSA Project AWARE-SEA (Advancing Wellness and Resiliency in Education-State Education Agency) grant, which will expand school-based mental health services to students in high-need school districts in

Tennessee.

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

The work of system of care in Tennessee has been occurring for the last twenty years and remains strong throughout the state and its values and principles are infused in multiple programs within TDMHSAS. System of Care Across Tennessee provides for a comprehensive training and technical assistance center which assists in moving the system of care philosophy forward in Tennessee through training, support, and resources for families, providers, and community members.

The Children and Youth Homeless Outreach Project aims to identify and provide outreach services for the purpose of linking children with Serious Emotional Disturbance (SED) who are experiencing homelessness, or children with SED who are at risk of homelessness, and their caregivers to mental health and housing services. Assistance to find or restore secure housing includes temporary financial assistance with rent, utilities, and other needs that will assist the child with SED and help keep the family intact.

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

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**Footnotes:**

## Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

#### Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

#### Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.

The Tennessee Suicide Prevention Network (TSPN) is a contract between TDMHSAS and Mental Health America of the MidSouth, and TSPN's Suicide Prevention Plan is overseen by TDMHSAS to ensure a comprehensive plan with a focus on Universal, Selective and indicated interventions. Mental Health America of the MidSouth employs TSPN staff, ensures TSPN is fiscally responsible and compliant, follows recommended best practices for nonprofit organizations, and is governed by the MHA board of directors. TSPN's effectiveness is greatly enhanced by a very active, Governor-appointed advisory council. TSPN provides/coordinates with the state to provide gatekeeper training and postvention activities. TSPN established a new regional outreach model, that includes seven additional regional suicide prevention directors, expanding its statewide infrastructure platform. The state also increased efforts to focus on interventions at the community level using evidence-based practices. The Youth and Young Adult Suicide Prevention and Mental Health Awareness activities expands and enhances existing, outcome-based suicide prevention activities in Tennessee for individuals up to 25 years of age.

3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  Yes  No

If so, please describe the population targeted.

TDMHSAS established a new initiative to reduce suicide in working age adults called Be The One: Suicide Prevention in the Workforce. The Be The One campaign is a component of Tennessee's Zero Suicide Initiative and specifically designed for public and private sectors. The campaign is based on the premise that staff, collectively, can build a supportive workforce which values and affirms life. Be The One includes suicide prevention training, suicide awareness, social marketing strategies and postvention activities.

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

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#### Footnotes:

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

#### Narrative Question

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

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

#### Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

Since the last planning period, TDMHSAS continues to add new partners and/or enhance existing partnerships that help support the mission of the department. Examples include the Tennessee Hospital Association (THA), who partnered with the department in creating emergency department protocols for those experiencing a psychiatric emergency. Other partners include the Tennessee Emergency Communications Board (partnered with the department to train 911 operators in suicide prevention and crisis de-escalation), the Tennessee Commission on Children and Youth (who is formally partnering with the department on its new System of Care grant), as well as Tennessee Office of Criminal Justice Programs, who is partnering with the department to help support mental health training for local domestic violence and sexual assault centers. TDMHSAS participates on the Interagency Task Force of Housing and Health Integration, led by the Tennessee Housing Development Agency (THDA) and the Tennessee Commission on Aging and Disability (TCAD), to discuss aligning efforts to improve health through housing opportunities. The Healthy Transitions State Transition Team is made up of state and local partners working to support policy to assist youth and young adults with or at risk of mental illness and co-occurring disorders.

In response to "The Suicide Prevention Act of 2018", TDMHSAS partnered with the Tennessee Department of Health and other relevant stakeholders to review existing data and programs and identify opportunities to improve data collection, analysis and programming. The goals of the program are to 1) compile existing data on suicide deaths; 2) review existing resources and programs related to suicide deaths; 3) identify evidence-based or promising programs related to the prevention of suicide; and to submit a report to the general assembly no later than June 30, 2020 recommending any necessary programs or policies to prevent suicide death in Tennessee.

Tennessee Hospital Association and TDMHSAS convened a Child/Adolescent Taskforce, which included representatives from

TennCare, the Department of Children's Services, the TN College of Emergency Physicians and the Children's Hospital Alliance of Tennessee (CHAT). The workgroup created tools and resources for hospital EDs to better care for children in mental health crisis, including safety protocols, seclusion and restraint guidelines, and psychiatric medication protocols. The CHAT hospitals continue to pilot the resources which, once finalized, will be made available to all hospitals EDs to help them care for these patients and their families while an available inpatient or community mental health service is being identified.

TDMHSAS's Office of Behavioral Health Safety Net has an ongoing partnership with CoverRx, a prescription drug program operated by TennCare designed to assist those who have no pharmacy coverage but have a need for medication. CoverRx provides participants affordable access to more than 200 generic medications in addition to some name brands of insulin and of mental health medications. A high percentage of individuals enrolled in BHSN are also enrolled in CoverRx. In FY20, TDMHSAS increased the BHSN eligibility criteria for enrollment to 138% of the Federal Poverty Level. CoverRx, the state's prescription drug assistance program, in alignment with TDMHSAS's BHSN Program, is increasing their FPL enrollment criteria to 138% in FY20.

TDMHSAS has partnered with the Tennessee Department of Correction to launch a Certified Peer Recovery Specialist program in the state prison system. TDMHSAS-trained peer leaders go into the prison and provide CPRS training to eligible inmates, who can then become Certified Peer Recovery Specialists and provide peer support to their fellow inmates.

The Office of Housing and Homeless Services intends to establish and nurture partnerships with recovery housing providers to expand the breadth of housing opportunities for Tennesseans experiencing substance use disorders. Through the Creating Homes Initiative, Tennessee's Regional Housing Facilitators will utilize their expertise in leveraging partnerships and resources to develop safe, quality, affordable recovery housing.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Office of Housing and Homeless Services participates on the Interagency Task Force of Housing and Health Integration, led by the Tennessee Housing Development Agency (THDA) and the Tennessee Commission on Aging and Disability (TCAD), to discuss aligning efforts to improve health through housing opportunities. Through this task force, the office partners with other state agencies, including but not limited to THDA, TCAD, the Tennessee Department of Health, the Bureau of TennCare, and the Tennessee Department of Commerce and Insurance to focus on innovative means to integrate health and housing for Tennessee's older adult population.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), in partnership with the Tennessee Department of Human Services, Division of Vocational Rehabilitation (TDHS) support 14 agencies statewide who use IPS, in thirty-seven of the state's ninety-five counties. IPS is offered in all Vocational Rehabilitation (VR) and TDMHSAS regions. The division and VR have an interagency agreement that helps to streamline services for persons participating in the Individual Placement and Support (IPS) program. This helps to outline responsibilities between the two agencies. The division remains actively involved in the Governor's Employment First Task Force, a result of Executive Order 28 to expand community employment opportunities for Tennesseans with disabilities. Division representatives serve on the Task Force, the Employment Roundtable made up of key state agency partners, and chairs the Mental Health Work Group. The Employment First Task Force - Mental Health Workgroup was created to address the small penetration rate of evidence-based employment services for people with mental health and co-occurring disorders, to increase opportunities for individuals with mental health and intellectual/developmental disabilities, and to create resources for those individuals who do not have access to IPS.

Employment First State Leadership Mentoring Program (EFSLMP) – for the eighth year in a row, Tennessee was selected to receive guidance from the Office of Disability Employment Policy (ODEP) through their EFSLMP grant as a Core State and for the third year in a row, Tennessee was selected to receive guidance from ODEP through the Vision Quest grant. The focus areas for 2019 are: Vision Quest: IPS funding/expansion; Core State: increasing support for people with disabilities at American Job Centers, and increasing access to supported employment for people with a Dual Diagnosis (IDD + mental health diagnosis).

The Department's Office of Children, Young Adults, and Families continues to provide leadership in maximizing the efficiency, effectiveness, and quality of services through its rich System of Care history. System of Care values and principles are infused in multiple programs, including SOCAT, ESMI/FEPI, Clinical High Risk for Psychosis (CHR-P), and Healthy Transitions. This office also coordinates services by participating on various councils, including Council on Children's Mental Health, Youth Transitions Advisory Council, Young Child Wellness Council, the Healthy Transitions State Transition Team, the Department of Intellectual and Developmental Disabilities Employment Round Table, the State Interagency Coordinating Council for the TN Early Intervention System, Department of Education's Project AWARE State Management Team. The office supports provider partners working with local school systems to provide school-based mental health early intervention and prevention services through Project B.A.S.I.C. (Better Attitudes and Skills in Children) and School-Based Behavioral Health Liaisons, as well as school-based mental health educational presentations through the Violence & Bullying Prevention and Erase the Stigma programs. TDMHSAS will be partnering with Tennessee Department of Education on a SAMHSA Project AWARE-SEA (Advancing Wellness and Resiliency in Education-State Education Agency) grant, which will expand school-based mental health services to students in high-need school districts in Tennessee.

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

**Footnotes:**

## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>69</sup>

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

<sup>69</sup> <https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The statewide and regional Councils participate in the development of the Mental Health and Substance Abuse Block Grant state plan by reviewing, monitoring, and evaluating adequacy of services for individuals with substance use and mental health disorders within the state. The Council reviews and makes recommendations on the Block Grant application and the annual Report.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

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

TDMHSAS operates a structured planning process with multiple layers of Planning and Policy statewide and regional Council involvement to ensure citizen participation in policy development and delivery-system planning. The Department also oversees seven regional Planning and Policy Councils from which local and regional mental health needs and information are funneled to the State Planning and Policy Council and ultimately to the Department. Needs assessment priorities and recommendations from the Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department's Three-year Plan for the service-delivery system. The Three-year Plan is then updated annually by TDMHSAS with input from all eight Councils.

Membership includes: service recipients, representatives of recipients and their families; advocates for children, adults and the elderly; service providers; and stakeholder agencies and organizations. The majority of each Council's membership is current or former service recipients and members of service recipient families living with serious mental illness (SMI), serious emotional disturbances (SED), and substance use disorders (SUDs). With this membership mix, TDMHSAS ensures that planning for the service-delivery system meets the needs of the citizens of the state at large.

Advocates, providers, individuals, and family members of individuals with substance use disorders are members of the statewide and seven regional Councils. The Council system in Tennessee is fully integrated and collaborative between the mental health and substance use provider, treatment, advocate and service recipient communities. The percentage of representation from mental

health and substance use services communities is monitored and maintained by the Office of Planning.

The Statewide and Regional Councils also collaborate with the Statewide Young Adult Leadership Council (YALC) under the TDMHSAS Office of Youth and Young Adult Initiatives. The YALC is a place for young people to gain professional development, community service, and leadership skills while sharing experiences of mental illness, substance abuse, and/or systems involvement in a non-judgmental place where they can grow in their recovery and wellness journeys. YALC members are invited to attend all quarterly council meetings.

Per T.C.A. §33-1-402, responsibilities of council members include advising the Commissioner regarding plans and policies to be followed in the service system and the operation of the Department's programs and facilities; providing recommendations to the General Assembly legislation and appropriations for such programs and facilities; and, publicizing generally the situation and needs of persons with mental illness, serious emotional disturbance, substance use disorders, and their families. With the Commissioner, the TDMHSAS Statewide Planning and Policy Council also reports annually to Governor on the service system, including the Department's programs, services, supports, and facilities.

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

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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**Footnotes:**

August 1, 2019

Marie Williams, Commissioner  
Tennessee Department of Mental Health and Substance Abuse Services  
Andrew Jackson Building, 6th Floor  
500 Deaderick Street  
Nashville, TN 37243

RE: FY 2020 Mental Health Block Grant Application

Dear Commissioner Williams:

The Tennessee Department of Mental Health and Substance Abuse Planning and Policy Council (TDMHSAS P&PC) is proud to support the Department in its work to serve people of all ages who have mental illness, serious emotional disturbance, and substance abuse disorders through an application for the FY 2020 Mental Health Block Grant.

The members of the Statewide Council, along with its seven Regional Planning and Policy Councils, meet at least quarterly throughout the year to share information across regions and with TDMHSAS leadership and staff. Each year the Council requests and receives information and data from the regional councils about the mental health needs, substance abuse needs, and service gaps across the state. These needs are then prioritized and communicated to TDMHSAS to support the development of the Department's Three-Year Plan and block grant application. TDMHSAS also provides annual reporting on progress made on prior year's identified needs. Once a draft of the Block Grant application is prepared, Council members review, ask questions, and provide feedback to TDMHSAS.

The Councils represent the diverse geographic areas of the state and are comprised of a wide range of service providers and individuals with lived experience of mental illness, and substance abuse disorders. The diverse representation helps insure TDMHSAS has a deep understanding of the needs and gaps in Tennessee.

As a partner and support system for the Department's work, we gladly support TDMHSAS in pursuing this grant.

Best regards,



Kim Parker  
Council Chair

## Environmental Factors and Plan

### Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency  
 State Vocational Rehabilitation Agency  
 State Criminal Justice Agency  
 State Housing Agency  
 State Social Services Agency  
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address, Phone, and Fax	Email(if available)
Bartholomew Allen	Providers	Lowenstein House	6590 Kirby Center Cove Memphis TN, 38115 PH: 901-334-3200	bartholomew.allen@lowensteinhouse.com
Cicely Alvis	Providers	Frontier Health	1167 Spratlin Park Drive Gray TN, 37615 PH: 423-416-8885	calvis@frontierhealth.org
Richard Barber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Aspell Recovery Center	331 North Highland Avenue Jackson TN, 38301 PH: 731-694-0252	rbarber@aspellrecovery.com
Laura Berlind	Family Members of Individuals in Recovery (to include family members of adults with SMI)	The Sycamore Institute	150 4th Avenue North Nashville TN, 37219 PH: 615-495-2670	lberlind@sycamoreinstitutetn.org
Renee Bouchillon	State Employees	Dept. of Human Services (Social Service Agency)	1400 College Park Drive Columbia TN, 38401 PH: 931-380-4636	renee.bouchillon@tn.gov
Libby Byler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1900 Acklen Avenue Nashville TN, 37212 PH: 615-415-0227	libby.neutrino@gmail.com
Jim Casey	State Employees	Tennessee Department of Correction	320 6th Avenue North Nashville TN, 37243 PH: 615-253-8163	jim.casey@tn.gov
Amy Dolinky	Providers	Knox County Health Department	140 Dameron Avenue Knoxville TN, 37917 PH: 865-215-5706	amy.dolinky@knoxcounty.org
Lynn Fritz	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1835 Brentwood Pointe Franklin TN, 37067 PH: 614-537-2937	lynnmfritz@gmail.com

Paul Fuchcar	Persons in recovery from or providing treatment for or advocating for SUD services	CADAS	207 Spears Avenue Chattanooga TN, 37405 PH: 423-667-3311	paul.fuchcar@cadass.org
Amber Hampton	Providers	Mental Health America of Middle TN	446 Metroplex Drive Nashville TN, 37211 PH: 615-312-3113	ahampton@mhamt.org
Ben Harrington	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health Association of East TN	PO Box 32731 Knoxville TN, 37930 PH: 865-584-9125	ben@mhaet.com
Rikki Harris	Others (Advocates who are not State employees or providers)	Tennessee Voices for Children	500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	rharris@tnvoices.org
Clarkton Harrison	Others (Advocates who are not State employees or providers)	U.S. Department of Veterans Affairs	1310 24th Avenue South Nashville TN, 37212 PH: 615-427-5207	clarkton.harrison@va.gov
Kelsey Herbers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2328 Castleman Drive Nashville TN, 37215 PH: 513-608-1371	kelsey.herbers@gmail.com
Mike Herrmann	State Employees	Tennessee Department of Education	710 James Robertson Parkway Nashville TN, 37243 PH: 615-741-8468	mike.herrmann@tn.gov
Debbie Hillin	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Buffalo Valley, Inc	5465 Village Way Nashville TN, 37211 PH: 615-975-0196	debbiehillin@buffalovalley.org
Brittney Jackson	Parents of children with SED/SUD	Tennessee Voices for Children	500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-856-0531	bjackson@tnvoices.org
Amanda Johnson	State Employees	Vocational Rehabilitation	400 Deaderick Street Nashville TN, 37243 PH: 615-770-5496	mandy.1.johnson@tn.gov
Jennifer Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		6000 Westfork Drive Smyrna TN, 37167 PH: 615-995-6069	celtic_path@comcast.net
Lynn Julian	Family Members of Individuals in Recovery (to include family members of adults with SMI)		110 Bon Air Circle Jackson TN, 38305 PH: 731-695-2276	virginia.julian@crestwynbh.com
Deanna King	Providers	Youth Villages	6236 Airpark Drive Chattanooga TN, 37421 PH: 423-954-8844	deanna.king@youthvillages.org
Wayne King	Family Members of Individuals in Recovery (to include family members of adults with SMI)		18752 Alberta Street Oneida TN, 37841 PH: 423-215-2607	trulight@live.com

Linda Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 474 McKenzie TN, 38201 PH: 731-418-9307	llewis38201@yahoo.com
Gayle Lodato	Providers	Helen Ross McNabb Center	9862 Baker Boy Drive Ooltewah TN, 37363 PH: 423-664-2849	gayle.lodato@mcnabb.org
Emma Long	Family Members of Individuals in Recovery (to include family members of adults with SMI)		94 Labelle Street Jackson TN, 38301 PH: 731-326-2041	emmalong@aol.com
Senator Becky Massey	Others (Advocates who are not State employees or providers)		425 5th Avenue North TN, 37243 PH: 615-741-1648	sen.becky.massey@capitol.tn.gov
Claudia Mays	Providers	CM Counseling & Consulting Services	PO Box 70344 Nashville TN, 37218 PH: 615-256-8641	cmayscounseling@att.net
Debbie Miller	State Employees	Tennessee Department of Children's Services	315 Deaderick Street Nashville TN, 37243 PH: 615-741-9206	debbie.miller@tn.gov
Michael Myszka	State Employees	Tennessee Bureau of TennCare (Medicaid)	310 Great Circle Road Nashville TN, 37243 PH: 615-507-6630	michael.myszka@tn.gov
Mary Neal	Providers	Lakeside Behavioral Health Systems	2911 Brunswick Road Memphis TN, 38133 PH: 901-633-5602	mary.neal@uhsinc.com
Robin Nobling	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Davidson County	329 Harding Place Nashville TN, 37211 PH: 615-891-4724	rnobling@namidavidson.org
Jeff Ockerman	State Employees	Tennessee Department of Health	710 James Robertson Parkway Nashville TN, 37243 PH: 615-532-3188	jeff.ockerman@tn.gov
Mary Nelle Osborne	Providers	Peninsula Sevier Clinic	1104 Foxwood Drive Sevierville TN, 37862 PH: 865-970-9800	mosborn1@CovHlth.com
Ben Overby	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Centerstone	230 Ventura Circle Nashville TN, 37228 PH: 615-460-4182	benoverby@yahoo.com
Kim Parker	Providers	Pathways	238 Summar Drive Jackson TN, 38301 PH: 731-541-8988	kim.parker@wth.org
Tim Perry	Providers	Frontier Health	2106 Moccasin Street South Kingsport TN, 37660 PH: 423-245-4263	tperry@frontierhealth.org
Representative Bob Ramsey	Others (Advocates who are not State employees or providers)		425 5th Avenue North Nashville TN, 37243 PH: 615-741-3560	rep.bob.ramsey@capitol.tn.gov

Albert Richardson	Providers	C.A.A.P.	4041 Knight Arnold Road Memphis TN, 38118 PH: 901-360-0442	arichardson@caapincorporated.com
Susan Seabourn	Providers	Centerstone	2400 White Avenue Nashville TN, 37204 PH: 615-460-4451	susan.seabourn@centerstone.org
Pamela Sessions	Providers	Renewal House	3410 Clarksville Pike Nashville TN, 37218 PH: 615-255-5222	psessions@renewalhouse.org
Patrick Starnes	Family Members of Individuals in Recovery (to include family members of adults with SMI)		4325 Shady Dale Road Nashville TN, 37218 PH: 615-330-1832	trucare10@yahoo.com
Jack Stewart	Family Members of Individuals in Recovery (to include family members of adults with SMI)		14374 Asheville Highway Greeneville TN, 37743 PH: 423-787-1663	bluespringsdc@yahoo.com
Wendy Sullivan	Parents of children with SED/SUD	Tennessee Voices for Children	500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	wsullivan@tnvoices.org
Bettie Teasley	State Employees	Tennessee Housing Development Agency	404 James Robertson Parkway Nashville TN, 37243 PH: 615-815-2125	bteasleysulmers@thda.org
Angie Thompson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Metro Public Health Department	2500 Charlotte Avenue Nashville TN, 37209 PH: 615-340-8602	angie.thompson@nashville.gov
Libby Thurman	Others (Advocates who are not State employees or providers)	Tennessee Primary Care Association	3109 Wingate Avenue Nashville TN, 37211 PH: 615-497-4942	libby.thurman@tnpca.org
Marie Williams	State Employees	Tennessee Department of Mental Health and Substance Abuse Services	500 Deaderick Street Nashville TN, 37243 PH: 615-532-6500 FX: 615-532-6514	marie.williams@tn.gov
Evelyn Yeargin	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health Cooperative	275 Cumberland Bend Nashville TN, 37228 PH: 615-743-1467	eryeargin@mhc-tn.org

\*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

Additional ex-officio members include: the Governor of TN, an employee of the Tennessee Department of Intellectual and Developmental Disabilities (TDIDD), an employee of Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), an employee of Tennessee Council on Children and Youth (TCCY), and a member of the TN Council on Developmental Disabilities.

# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
<b>Total Membership</b>	<b>49</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	11	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	5	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>26</b>	<b>53.06%</b>
State Employees	9	
Providers	14	
Vacancies	0	
<b>Total State Employees &amp; Providers</b>	<b>23</b>	<b>46.94%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>0</b>	
Youth/adolescent representative (or member from an organization serving young people)	0	

\* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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**Footnotes:**

# Environmental Factors and Plan

## 22. Public Comment on the State Plan - Required

Narrative Question

[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.

### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings?  Yes  No

b) Posting of the plan on the web for public comment?  Yes  No

If yes, provide URL:

The draft plan was posted on the Tennessee Department of Mental Health and Substance Abuse Services website in the Planning and Policy Council area and on the home page. That area is located at the following link:

<https://www.tn.gov/behavioral-health/research/data--research--and-planning/planning/planning/mental-health-block-grant.html>

Comments, changes, and questions were invited via email to the Director of Planning (author of the plan). The draft Plan was also sent to statewide and regional Council members to review and comment.

c) Other (e.g. public service announcements, print media)  Yes  No

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**Footnotes:**