Tennessee

UNIFORM APPLICATION
FY 2026/2027 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/25/2025 12.09.11 PM)

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State Unique Entity Identification

Unique Entity ID	KNUHYRCNLJC5

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, Policy and Legislation
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	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Avis
Last Name	Easley

Telephone	615-253-6397
Fax	
Email Address	Avis.Easley@tn.gov

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Footnotes:

State Information

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

Fiscal Year 2026

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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).
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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[1]: _____

Title: TDMHSAS Commissioner

Date Signed: _____

mm/dd/yyyy

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

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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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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.

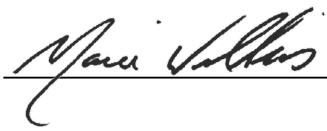
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or 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[1]: 

Title: TDMHSAS Commissioner

Date Signed: 07-23-2025

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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
6th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243
615-532-6500 (Office)
615-532-6514 (Fax)
Marie.Williams@tn.gov

Thank you for your assistance.

Sincerely,

Bill Lee

Bipartisan Safer Communities Act (BSCA) – Tennessee 2026

This plan is a continuation of the previously approved work, building on the foundation and already established grant contacts with community-based mental health providers.

BSCA Funding Area of Focus	Allocation estimated	Community behavioral health provider implementing the program	Summary
Services - Expand Peer Wellness Coaches	$424,290	Alliance Healthcare Services, Park Center, Helen Ross McNabb Center, Ridgeview Psychiatric Hospital and Center, and Tennessee Association of Mental Health Organizations (TAMHO) for the Statewide Peer Wellness Initiative Director supporting the coaches	Peer wellness coaches support adults living with SMI by facilitating evidence-based curriculums to help participants achieve their wellness goals.
Services - Ped offices therapists	$424,291	Alliance Healthcare Services, Helen Ross McNabb Center, Mercy Community Healthcare, TN Voices, Vanderbilt University Medical Center	Psychologist or master's level therapist staffing within the primary care office setting and related operational costs
FEPI – Set-Aside (10%)	$105,760	Park Center	Youth & Young Adult Best Practices Trainers/Consultant and related operational costs
Crisis – Set-Aside (5%)	$52,880	Crisis Center Inc (Memphis)	Additional staffing for the 988 call center and related operational costs
Admin estimated	$50,361		
TOTAL AWARD	**$1,057,582**		

Peer Wellness Coaches

The Peer Wellness Coaches program supports adults living with Serious Mental Illness by facilitating holistic, evidence-based curriculums such as Chronic Disease, Diabetes, and Chronic Pain Self-Management Workshops, Nutrition and Exercise for Wellness and Recovery (NEW-R), Dimensions: Well Body, Whole Health Action Management (WHAM), and Tobacco Free Workshops, First Aid Arts, Enhancing Immune Health, and one-on-one Peer Wellness Coaching to help participants achieve their wellness goals. BSCA supplemental funds increased the number of coaches in the West and Middle

Grand Divisions of Tennessee. All coaches are Certified Peer Recovery Specialist (CPRS). These areas of the state have limited peer wellness coach supports offered through the Peer Support Centers, but do not have access to one-on-one peer wellness coaching and not all My Health, My Choice, My Life workshops can be offered through the Peer Support Centers. Examples of workshops not offered by the Peer Support Centers include, Matter of Balance (MOB), Dimensions: Well Body, Enhancing Immune Health, and First Aid Arts.

Increase the number of therapists imbedded in pediatric offices across Tennessee

BSCA supplemental funds created the Community Mental Health and Primary Care Integration Project to increase the number of therapists to treat SED imbedded in pediatric offices. Therapists working for community mental health centers are imbedded in pediatric offices to work with medical staff and be available to provide immediate therapeutic services to children. Having mental health services on-site at primary care physician offices has reduced barriers for families to receiving behavioral health treatment. BSCA funds allowed for an existing similar program to be represented across all regions.

There were five mental health providers selected for the Community Mental Health and Primary Care Integration Project part of a competitive grant selection process. These grant contracts go through 6/30/2027. Each program embeds clinical mental health services within a primary care setting, including but not limited to screening, assessment, consultation, and/or therapy services that do not currently receive funding for this service. The primary targeted population is Tennessee youth ages birth through eighteen (18) years with social, emotional, or behavioral needs and their families.

First Episode Psychosis Initiative (FEPI) set-aside

Funds are used to support existing FEPI sites to treat SMI/SED utilizing the evidence based OnTrack model to provide Coordinated Specialty Care to youth and young adults ages 15-30 years old who experience a first episode of psychosis. The FEPI Statewide Trainer grant contract is a combination of BSCA funds and MHBG funds. The Youth & Young Adult Best Practices Trainers/Consultants support FEPI sites across Tennessee with training, coaching, technical assistance, consultation, and fidelity monitoring to support the statewide implementation of y/ya best practices.

Crisis set-aside

Funds from the BSCA MHBG 5% set aside support the TN 988 Network in efforts to improve infrastructure needed for 9-8-8 implementation. This funding increased staffing capacity to increase call handle rates and enhanced service monitoring. All funds from the BSCA MHBG 5% crisis set aside support the TN 988 Network in efforts to improve infrastructure needed for 9-8-8 implementation. Tennessee Crisis Services incorporate a continuum of high-quality crisis services, including Crisis Telephonic Triage and Intervention, Mobile Crisis (all ages), Crisis Stabilization Units (CSUs), Crisis Respite, and Walk-In Center (WIC) services. Crisis WIC services may include mental health assessment, referral to services, and follow-up services. Funding for these services is shared between TDMHSAS and the Medicaid authority, TennCare. The approach 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.

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Marie Williams, LCSW

Title

TDMHSAS Commissioner

Organization

Tennessee Department of Mental Health and Substance Abuse Services

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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 prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

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

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS or Department) functions as Tennessee's mental health, substance use services, and opioid treatment authority. It oversees mental health and substance use services for people of all ages, with both adult and child/youth systems. The Department's mission is to create collaborative pathways to resiliency, recovery, and independence for Tennesseans living with mental illness and substance use disorders. TDMHSAS is comprised of the following Department Offices and Divisions: Office of the Commissioner; Office of Communications; Office of Faith-Based Initiatives; Division of Fiscal Services; Office of Forensic and Juvenile Court Services; Office of Human Resources; Office of Strategic Initiatives; Division of Administrative and Regulatory Services; Division of Clinical Leadership; Division of General Counsel; Division of Hospital Services; Division of Mental Health Services; Division of Children and Youth Mental Health Services; Division of Planning, Policy & Legislation; and the Division of Substance Abuse Services. Through the Department Offices and Divisions, TDMHSAS provides a quality spectrum of behavioral health services across the lifespan.

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

The Division of Mental Health Services (DMHS) oversees a full continuum of community-based services, including crisis services (24/7 access to mobile crisis and stabilization units), outpatient safety net services for uninsured adults, housing and homelessness assistance, supported employment services, wellness and peer recovery services, services for older adults, and disaster recovery support.

The Division of Children and Youth Mental Health Services (DCYMHS) administers and supports programs tailored to children, young adults, and families. These programs include school-based interventions; System of Care programming; infant and early childhood programs for families with young children experiencing challenging behaviors; youth and young adults with early SMI, including psychotic disorders; and justice-involved youth and their families.

In addition to inpatient care via state psychiatric hospitals and Regional Mental Health Institutes, overseen by the Division of Hospital Services, all services for adults and children are completed via contracts with community providers.

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

TDMHSAS acts as both the State Mental Health Authority (SMHA) and the Substance Abuse Authority (SSA). It handles planning, funding, quality oversight, workforce development, system monitoring, reporting to the governor and legislature, and advocates for those with mental illness, serious emotional disturbances, or substance use disorders.

There are both formal and informal partnerships with other state agencies to maintain high-quality mental health and substance use services. As part of the annual customer-focused planning and strategic planning processes, TDMHSAS identifies the "enterprise dependencies" to be successful in meeting the needs of Tennesseans. Other state agencies identified in those plans include: TennCare, Department of Human Resources, Department of Health, Department of Human Services- Vocational Rehabilitation, Department of Children's Services, Department of Correction, Department of Education, Safety and Homeland Security, Treasury, and Finance & Administration.

Collaborative efforts, both public and private, involve partnerships with mental health, substance abuse, criminal justice, veterans, and child/family organizations, etc. The result is the creation of a cross-systems approach that promotes the most effective outcome of care.

During each fiscal year, TDMHSAS conducts a Needs Assessment focusing on the Tennessee population to ascertain unmet service needs and delivery system gaps. In the subsequent year, TDMHSAS develops funding and program targets that address the service needs identified by the assessment.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

TDMHSAS's structure includes state-level planning supported by Regional Planning and Policy Councils (seven, one per region) and a Statewide Planning and Policy Council. These bodies conduct annual needs assessments and shape strategy development through grassroots interagency collaboration. TDMHSAS collaborates with the array of community mental health providers, community-based organizations, and local governments to support this work. All program services are delivered via a network of mental health services providers and the substance use provider network from grant contracts to agencies in the community. There is a core group of Community Mental Health Centers (CMHC) and then other mental health providers that implement these services. Overall, there are around 60 agencies that receive grant contracts to support the mental health programming across the 95 counties.

The flagship programs (safety net, crisis, housing, school-based supports, and peer support) are statewide and offered by the CMHCs in their planning region or county catchment area. The Department works closely with the Tennessee Association of Mental Health Organizations (TAMHO) and the Tennessee Association of Alcohol, Drug, and Other Addiction Services, Inc. (TAADAS) when working with the community behavioral health provider network. The TAMHO is a statewide trade association representing CMHCs and other nonprofit corporations that provide behavioral health services. Similarly, the TAADAS is a statewide association of alcohol and drug abuse treatment, prevention, and recovery service professionals.

TDMHSAS operates four Regional Mental Health Institutes: Nashville (Middle), Memphis (West), Chattanooga (Southeast), and Bolivar (West). Additionally, TDMHSAS contracts with private hospitals for emergency psychiatric admissions in East Tennessee.

TDMHSAS and Tennessee's State Medicaid Agency, TennCare, continue to support integrated care and co-occurring competent services through their respective treatment provider networks.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

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

During each fiscal year, TDMHSAS conducts a Needs Assessment that focuses on the population of Tennessee to ascertain unmet service needs and delivery system gaps. In the subsequent year, TDMHSAS develops budget and funding targets that seek to meet the service needs identified by the assessment. TDMHSAS and its providers are aware of barriers that commonly prevent vulnerable populations from accessing services. TDMHSAS providers submit an annual agency civil rights Title VI self-survey to the TDMHSAS Title VI Compliance Officer. This survey reviews the agency's geographical service area population and compares it to program beneficiaries by racial and ethnic data. This survey also reviews the composition of the agency governing board. All grant contracts include a section about Title VI that is monitored by the TDMHSAS Office of Subrecipient Monitoring. The diverse needs of Tennessee are also advocated for by way of the Statewide and Regional Planning and Policy Council, made up of mental health and substance abuse service providers, consumers, family members, caregivers, advocates, and other stakeholders. In addition to the seven (7) regional councils, there is also an Executive Committee, Adult Committee, Children's Committee, and Planning and Budget Committee that advise the Department Leadership of needed supports and services in the community. Additionally, TDMHSAS has the Consumer Advisory Board (CAB) that meets monthly to bring together people from across the state who have lived experience of mental illness and/or substance use disorder. The CAB members share their thoughts about planning and policy issues with the Department and have peer representation on the Statewide and Regional Planning and Policy Council.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations

identified by the state as a priority.

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. 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 are to identify unmet needs and critical gaps and to allocate limited resources more efficiently. This also helps Regional Councils prioritize local needs, direct state-level planning and resource allocation efforts, and ensure compliance with federal block grant funding requirements. The needs assessment 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 2025 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 Summary is posted on the on the department's website at FINAL 2025 NA Summary.pdf (tn.gov)

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

The TDMHSAS Commissioner uses the annual Needs Assessment Summary to have budget discussions with the Executive Leadership Team prior to the department's budget hearings to address the unmet service needs and gaps.

An annual needs assessment update on how the department is addressing the needs identified is provided to the TDMHSAS Planning and Policy Council and department staff in December.

In addition, the state's description of its plans to address these unmet needs and gaps align with the state's priority areas and annual performance indicators addressed in the implementation plan.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Expand access to low-cost, high-quality, outcomes-oriented community mental health services.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Creating a state of resiliency, recovery, and independence in which Tennesseans living with mental illness and substance use disorders thrive.

Strategies to attain the goal:

Program strategies supporting the objective include 988 Call Centers, Crisis Services Continuum, Behavioral Health Safety Net, Older Adults Program, residential supportive housing programs, certification for Peer Recovery Specialists, Individual Placement and Support (IPS) services, suicide prevention training, Peer Support Center participant survey, and SSI/SSDI benefits acceptance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals screened for mental health or related interventions by the Tennessee 988 Call Centers.

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there were 52,948 individuals screened by 988 Call Centers (only calls included).

First-year target/outcome measurement (Progress to the end of 2026): Increase the total number of individuals screened by 988 Call Centers from the prior year.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase the total number of individuals screened by 988 Call Centers from the prior year.

Data Source:

Data collected from Vibrant Emotional Health, the administrator of the National Suicide Prevention Lifeline/988.

Description of Data:

Aggregate data includes information about the 988 calls handled in Tennessee.

Data issues/caveats that affect outcome measures:

Additional data were reviewed from Vibrant Emotional Health, the administrator of the National Suicide Prevention Lifeline, including the average speed to answer, abandonment rate, and the number of calls sent to backup centers.

Indicator #: 2

Indicator: Number of Tennesseans (all ages) receiving emergency psychiatric crisis services assessment from a mobile crisis responder or at a crisis walk-in center.

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there were 72,784 individuals that received a face-to-face crisis assessment.

First-year target/outcome measurement (Progress to the end of 2026): Maintain or increase the total number of individuals receiving face-to-face crisis assessments from the prior year.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase the total number of individuals receiving face-to face crisis assessments from the prior year.

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.

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), and walk-in center crisis face-to-face assessments.

Data issues/caveats that affect outcome measures:

Other outcomes reviewed will include the percentage of individuals receiving a crisis assessment who were diverted to less restrictive community care, the percentage of individuals seen by mobile crisis within two hours of the request for assessment, and the percentage of assessments that were completed using telehealth.

Indicator #:	3
Indicator:	Number of admissions to Crisis Stabilization Units (All Ages) providing 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
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, there were 7,854 individuals admitted to a state supported Crisis Stabilization Unit (CSU) for treatment services.
First-year target/outcome measurement (Progress to the end of 2026):	Increase the total number of individuals receiving treatment services at a CSU from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the total number of individuals receiving treatment services at a CSU from the prior year.

Data Source:

The state Crisis Management System will track and report data related to the total number of CSU admissions. 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).

Description of Data:

Data collected in the Crisis Management System 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.

Data issues/caveats that affect outcome measures:

During FY25, there were ten (10) Crisis Stabilization Units for adults and one (1) CSU for children in operation across the state for a total of 163 beds. Two new CSU/WIC for adults and two new CSU/WIC for children are expected to open in FY26.

Indicator #:	4
Indicator:	Number of uninsured/indigent adult Tennesseans and number of uninsured/underinsured Tennessee children having a serious mental illness, living at or below 138% of the Federal Poverty Level (FPL), are 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.
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, there were 36,582 total served by the Behavioral Health Safety Net.
First-year target/outcome measurement (Progress to the end of 2026):	Serve as many individuals as are eligible and apply to the Behavioral Health Safety Net with a goal of maintaining or increasing the total number of individuals served from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Serve as many individuals as are eligible and apply to the Behavioral Health Safety Net with a goal of maintaining or increasing the total number of individuals served from the prior year

Data Source:

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

Description of Data:

The Behavioral Health Safety Net provides core, essential, outpatient, mental health services to uninsured Tennesseans who meet program eligibility criteria through a network of participating community mental health centers. This includes community-based services offering vital services that people with SMI/SED 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:

Additional data tracked and reviewed for this program include units of service and services delivered via telehealth. The top utilized services for this program are consistently psychiatric medication management, case management, and individual therapy.

Indicator #:	5
Indicator:	Number of older adults served with care management services such as outreach, screening, assessment, linkage, in home therapy and other supportive services to improve their quality of life and to develop skills that will help them to live in the community as independently as possible.
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, there were 413 served by the older adult program.
First-year target/outcome measurement (Progress to the end of 2026):	Maintain or increase the total number of older adults receiving care management services from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the total number of older adults receiving care management services from the prior year.

Data Source:

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

Description of Data:

Older Adults Program providers use a variety of behavioral health measurement tools and depression screenings to assess clients upon entry to the program and throughout their enrollment. The data tracks original baseline scores, how often individuals are assessed, their county of residence, age, specific months enrolled in the OAP, discharge date, Insurance status, and which services are provided by what modality: mental health care management, therapy (In-person or by telehealth) and medication management. The data also tracks monthly agency outreach, contact with primary care physicians and family/caregivers and community education on healthy aging and disease prevention.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #:	6
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 (Initial data collected prior to and during 2026):	In state FY2025, there were 2,807 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 (Progress to the end of 2026):	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 from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	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 from the prior year.

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, Supportive Living, Supportive Recovery Housing, Supportive Re-Entry Housing, and Residential Re-Entry Housing 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 are 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. 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). 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. Funding for Supportive Living facilities is described in TN Code Annotated 12-4-330 directs TDMHSAS to reimburse certain supportive living facilities in 11 TN counties. Supportive Recovery Housing provides quality, safe, and affordable permanent housing with access to an array of recovery services to support the substance use recovery of adults. Supportive Reentry Housing program provides quality, safe, and affordable permanent housing with access to an array of supportive services that promote sustained community living for adults in Tennessee who re-enter the community from prisons and jails or have been previously incarcerated. Residential Re-Entry Housing Program (RRHP) supports six residential facilities to serve individuals with severe and persistent mental health challenges reentering the community from incarceration. These facilities serve individuals with severe and persistent mental health challenges re-entering the community from incarceration.

Data issues/caveats that affect outcome measures:

The Residential Re-Entry Housing Program (RRHP) is in development to create six residential facilities to serve individuals with severe and persistent mental health challenges reentering the community from incarceration. These facilities will provide quality, safe, and affordable long-term supportive housing for individuals re-entering the community from incarceration who would otherwise not be able to successfully live in the community due to the lack of available housing with the capacity to meet their specific needs. There is also one additional ILS facility that is expected to begin placing residents in FY26.

Indicator #:	7
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 (Initial data collected prior to and during 2026):	In state FY25, 629 peer specialists were certified.
First-year target/outcome measurement (Progress to the end of 2026):	Maintain or increase the number of peer specialists certified from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the number of peer specialists certified from the prior year.

Data Source:

The number of individuals that will become Certified Peer Recovery Specialists is reported by the Division of Mental Health Services, 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 Division of Children and Youth Mental Health Services.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #:	8
Indicator:	Percentage rate of employment for 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 (Initial data collected prior to and during 2026):	In state FY2025, 1,864 individuals were served through the evidence-based IPS initiative, and 42% were employed in competitive and integrated work for at least one day.

First-year target/outcome measurement (Progress to the end of 2026):	Maintain or increase the percentage of the individuals served through IPS will be employed in competitive and integrated work for at least one day from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the percentage of the individuals served through IPS will be employed in competitive and integrated work for at least one day from the prior year.

Data Source:

Data is submitted into REDCap by the IPS providers and evaluated by TDMHSAS Office of Research.

Description of Data:

The Supported Employment program assists individuals with serious mental illness and/or co-occurring disorders in working at competitive and integrated jobs of their choosing, following the IPS evidence-based model of supported employment. The total number of jobs served by the Supported Employment Initiative includes programs funded by the state, mental health block grant, VR interagency funds (SEE), FEPI, and CHR-P 2 grants.

Data issues/caveats that affect outcome measures:

The 42% placement rate for FY25 is consistent with the national average for IPS teams, which is also 42%.

Indicator #:	9
Indicator:	9. Number of individuals receiving suicide prevention and postvention 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 (Initial data collected prior to and during 2026):	In state FY2025, 125,893 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 (Progress to the end of 2026):	Maintain or increase the total number of individuals receiving suicide prevention training, and/or public awareness activities from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the total number of individuals receiving suicide prevention training, and/or public awareness activities from the prior year.

Data Source:

Number of individuals will receive suicide prevention and post-vention training as reported by Tennessee Suicide Prevention Network (TSPN) state monthly reports; number of teachers will receive suicide prevention training as reported by Jason Foundation state monthly 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 monthly reports to the Office of Crisis Services and Suicide Prevention. Number of individuals receiving suicide prevention training, suicide risk screening, or resource/referral training as reported by Centerstone (Youth and Young Adult Suicide Prevention and Mental Health Awareness Program Provider) state monthly 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. The Youth and Young Adult Suicide Prevention and Mental Health Awareness Program provides mental health awareness and suicide prevention training to Institutions of Higher Education and Pediatric Offices in establishing processes for providing suicide risk screening and referrals.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #:	10
Indicator:	Percentage of Peer Support Center survey respondents who report they are less likely to need psychiatric hospitalization.

Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, 90% of Peer Support Center survey respondents reported less likely to need psychiatric hospitalization.
First-year target/outcome measurement (Progress to the end of 2026):	Maintain the total number of individuals from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain the total number of individuals from the prior year.

Data Source:

Peer Support Center participants share their voice in an annual survey.

Description of Data:

Peer Support Centers are open to individuals throughout the state who have lived experience of mental illness or co-occurring disorders of mental illness and substance use disorder; these participants share their voice in an annual survey regarding their satisfaction with the peer support services provided and how their participation influences their own recovery journey.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #:	11
Indicator:	Percentage of completed SOAR (SSI/SSDI Outreach, Access, and Recovery) applications received from SSA that have been approved for RMHI patients discharging back to the community
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, 116 applications were completed, with 98% of completed applications receiving a decision from the Social Security Administration (SSA).
First-year target/outcome measurement (Progress to the end of 2026):	Maintain or increase the percentage of approved application for SSI/SSDI benefits.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the percentage of approved application for SSI/SSDI benefits.

Data Source:

Monthly program reports are submitted by provider agencies. SSI/SSDI applications are completed by the SOAR liaison if the referred patient has an expected discharge date within 90 days from the referral date.

Description of Data:

This program identifies patients ready for discharge who are appropriate candidates for SOAR (SSI/SSDI Outreach, Access, and Recovery) and completes the applications. Community-based mental health agencies have SOAR Liaisons supporting the state-operated Regional Mental Health Institutes to work with patients who will be discharged to complete SOAR applications. The SOAR Liaisons assist with access to SSI/SSDI benefits to help facilitate discharge and ensure access to permanent housing and services.

Data issues/caveats that affect outcome measures:

Total served information comes from a combination of fields, including the number of cases screened, the number of applications submitted, the number of applications approved, and the number of applications denied. Data is also pulled from the SAMHSA-managed SOAR Online Application Tracking (OAT) system.

Priority #:	2
Priority Area:	Expand services targeting children and youth who have or are at-risk for serious emotional disturbances (SED), behavior problems, or substance use disorders to increase opportunities for prevention and early intervention.
Priority Type:	MHS
Population(s):	SMI, SED, ESMI, BHCS

Goal of the priority area:

Expanding services that intervene earlier in treatment for mental health issues to prevent more significant problems from worsening later in life.

Strategies to attain the goal:

Program strategies supporting the objective include First Episode Psychosis; School-Based Behavioral Health Liaisons; Juvenile Justice Diversion; and the Regional Intervention Program and Child Care Consultation programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults who will receive evidence-based treatment and recovery support services through First Episode Psychosis Initiative (FEPI).

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there were 243 youth and young adults served.

First-year target/outcome measurement (Progress to the end of 2026): Maintain or increase the total number of individuals receiving evidence-based treatment and recovery support services through FEPI from the prior year.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase the total number of individuals receiving evidence-based treatment and recovery support services through FEPI from the prior year.

Data Source:

Data is collected from Community Mental Health Center providers entered into the REDCap database.

Description of Data:

Aggregate data includes information about those enrolled in the FEPI.

Data issues/caveats that affect outcome measures:

The loss of COVID-ARPA funding has affected the number of individuals served, primarily due to a reduction in the number of sites available for this population. A key caveat of this program is that the effectiveness of measurement is not determined by the number of individuals enrolled. To ensure accuracy when working with psychosis, each program site is limited to a maximum caseload of 30 participants, given the intensity of services required for each individual. Furthermore, the average length of stay for participants in our programs is 16 months. In FY25, there were 92 discharges and 93 admissions across all programs. Teams are committed to maintaining the 30 allotted slots filled in each program in accordance with evidence-based fidelity standards.

Indicator #: 2

Indicator: Reduction in the number of days hospitalized after enrolling in OnTrack TN (FEPI).

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there was an average of 1284 days of hospitalization for those enrolled in OnTrack TN (FEPI).

First-year target/outcome measurement (Progress to the end of 2026): Decrease the total number of days hospitalized for those enrolled in OnTrack TN (FEPI).

Second-year target/outcome measurement (Final to the end of 2027): Maintain or decrease the total number of days hospitalized for those enrolled in OnTrack TN (FEPI) from the prior year.

Data Source:

Data is collected from Community Mental Health Center providers entered into the REDCap database.

Description of Data:

Aggregate data includes information about those enrolled in the First Episode Psychosis Initiative (FEPI).

Data issues/caveats that affect outcome measures:

The loss of COVID-ARPA funding has affected the number of individuals served, primarily due to a reduction in the number of sites available for this population. A key caveat of this program is that the effectiveness of measurement is not determined by the number of individuals enrolled. To ensure accuracy when working with psychosis, each program site is limited to a maximum caseload of 30 participants, given the intensity of services required for each individual. Furthermore, the average length of stay for participants in our programs is 16 months. In FY25, there were 92 discharges and 93 admissions across all programs. Teams are committed to maintaining the 30 allotted slots filled in each program in accordance with evidence-based fidelity standards.

Indicator #: 3

Indicator:	Increase the number of students served by the school-based behavioral health liaisons using the Multi-Tiered System of Support interventions from Tier II and Tier III services.
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, there were 23,053 children and youth served through Tier II and III services.
First-year target/outcome measurement (Progress to the end of 2026):	Increase the number of children and youth served through Tier II and III services.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the number of children and youth served through Tier II and III services.

Data Source:

Data is collected from Community Mental Health Center providers entered into the REDCap database.

Description of Data:

The aggregate data includes unduplicated students served from tiers II and III services. Examples of Tier II and Tier III services include Psycho-Educational Groups, Individual Student Consultations, Behavioral Health Screenings, and Individual, Group, and Family Therapy.

Data issues/caveats that affect outcome measures:

Changes to consent laws in the State of Tennessee, program standardization, and changes to the data collection process have affected outcome measures.

Indicator #:	4
Indicator:	Increase the number of Tennessee teachers and school staff to receive behavioral health training and consultation from school-based behavioral health liaisons (Tier I).
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, 15,935 school personnel received Tier I services.
First-year target/outcome measurement (Progress to the end of 2026):	Increase the number of school personnel who received Tier I services.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the number of school personnel who received Tier I services.

Data Source:

Data is collected from Community Mental Health Center providers entered into the REDCap database.

Description of Data:

The aggregated data includes unduplicated teachers served from teacher trainings.

Data issues/caveats that affect outcome measures:

Issues impacting data collection include the lack of an official count of teachers and staff and changes in data collection processes.

Indicator #:	5
Indicator:	Increase the number of enrolled for the Juvenile Justice Diversion Program across all providers.
Baseline measurement (Initial data collected prior to and during 2026):	In state FY2025, there were 2,303 referrals received across all providers.
First-year target/outcome measurement (Progress to the end of 2026):	Increase the total number of referrals received from the prior year.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain or increase the total number of referrals received from the prior year.

Data Source:

Data collected from Community Mental Health Center providers.

Description of Data:

Aggregate data includes the self-reported total number of referrals collected across providers during the fiscal year.

Data issues/caveats that affect outcome measures:

None reported.

Indicator #: 6

Indicator: Increase the number of children under the age of 6 and their families who will receive prevention and early intervention services and supports through the Regional Intervention Program (RIP) to ensure that young children and their families experiencing challenging behaviors receive services and support.

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there were 329 children who received RIP services.

First-year target/outcome measurement (Progress to the end of 2026): Increase the number of children who received RIP services.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase the number of children who received RIP services.

Data Source:

Data is collected from the Nashville RIP site and Community Mental Health Center providers.

Description of Data:

Aggregate data includes the number served from RIP Nashville and the RIP expansion sites throughout Tennessee.

Data issues/caveats that affect outcome measures:

None reported.

Indicator #: 7

Indicator: Increased improvement in the child's reported behavior by parent following RIP enrollment.

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there was a 93% improvement in child behavior reported by parents.

First-year target/outcome measurement (Progress to the end of 2026): Maintain or increase % improvement in child behavior reported by parents.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase % improvement in child behavior reported by parents.

Data Source:

Data is collected from the Nashville RIP site and Community Mental Health Center providers.

Description of Data:

Aggregate data includes parent self-report of parenting skills post-enrollment.

Data issues/caveats that affect outcome measures:

None reported

Indicator #: 8

Indicator: Increased improvement in the parenting skills reported by parent following RIP enrollment.

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there was a 97% improvement in parenting skills.

First-year target/outcome measurement (Progress to the end of 2026): Maintain or increase % improvement in parenting skills.

Second-year target/outcome measurement (Final to Maintain or increase % improvement in parenting skills.

the end of 2027):

Data Source:

Data is collected from the Nashville RIP site and Community Mental Health Center providers.

Description of Data:

Aggregate data includes parent self-report of parenting skills post-enrollment.

Data issues/caveats that affect outcome measures:

None reported

Indicator #: 9

Indicator: Increase the number of children receiving direct services through Child Care Consultation (CCC).

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, there were 850 children receiving direct services through CCC.

First-year target/outcome measurement (Progress to the end of 2026): Increase the number of children receiving direct services through CCC.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase the number of children receiving direct services through CCC.

Data Source:

Data collected from the Community Mental Health Center providing CCC.

Description of Data:

Aggregate data includes the total number served by CCC.

Data issues/caveats that affect outcome measures:

In FY25, regions were clearly defined, and as the program has grown, capacity has been opened up to serve more counties.

Indicator #: 10

Indicator: Improved the level of functioning for the child in at least one life domain through Child Care Consultation (CCC).

Baseline measurement (Initial data collected prior to and during 2026): In state FY2025, 88% of completed service enrollments with pre- and post-data demonstrated an improved level of functioning for the child in at least one life domain.

First-year target/outcome measurement (Progress to the end of 2026): Increase improved level of functioning for the child in at least one life domain.

Second-year target/outcome measurement (Final to the end of 2027): Maintain or increase improved level of functioning for the child in at least one life domain.

Data Source:

Data collected from the Community Mental Health Center providing CCC.

Description of Data:

Aggregate data includes pre- and post-data from the Devereux Early Childhood Assessment (DECA) for children ages 0 - 6 and the Strengths and Difficulties Questionnaire for children 6 and older.

Data issues/caveats that affect outcome measures:

This data is representative only of families completing the program.

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Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application *Funding Agreement/Certifications and Assurances.*

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis Services								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$4,185,202.00			$652,000.00			$211,516.00
7. State Hospital			$26,682,900.00	$5,681,400.00	$360,944,200.00	$0.00	$3,519,100.00	
8. Other Psychiatric Inpatient Care			$264,136,600.00		$16,583,200.00			
9. Other 24-Hour Care (Residential Care)		$10,514,886.00	$135,293,800.00		$51,411,873.00			$0.00
10. Ambulatory/Community Non-24 Hour Care		$18,389,838.00	$547,333,100.00	$19,442,721.00	$281,131,052.00			$1,692,131.00
11. Crisis Services (5 percent Set-Aside)[c]		$2,530,402.00	$48,335,100.00	$21,200,434.00	$66,314,790.00			$105,758.00
12. Other Capacity Building/Systems Development								
13. Administration[d]		$1,874,754.00	$811,200.00	$726,800.00	$39,472,700.00	$861,600.00		$105,758.00
14. Total		**$37,495,082.00**	**$1,022,592,700.00**	**$47,051,355.00**	**$816,509,815.00**	**$861,600.00**	**$3,519,100.00**	**$2,115,163.00**

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

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	9915012.00
1b. Crisis Services for Adults	2530402.00
1c. CSC/ESMI program for Adults	
1d. Other outpatient/ambulatory services for Adults	2122927.00
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	14568341.00
3. Services for Children	
3a. EBPs for Children	5868084.00
3b. Crisis Services for Children	
3c. CSC/ESMI program for Children	2576684.00
3d. Other outpatient/ambulatory services for Children	5086030.00
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	13530798.00
5. Other Capacity Building/Systems Development[a]	7521189.00
6. Administrative Costs[b]	1874754.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**37495082.00**

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

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support	$2,530,402.00	$211,016.00
3. Partnerships, Community Outreach, and Needs Assessment		
4. Planning Council Activities	$982,800.00	
5. Quality Assurance and Improvement	$1,732,088.00	$140,882.00
6. Research and Evaluation		
7. Training and Education	$2,275,899.00	$1,142,146.00
8. Total	**$7,521,189.00**	**$1,494,044.00**

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

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

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

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

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

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

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

TDMHSAS is committed to maintaining a high-quality continuum of services while continuing to expand access to behavioral health care for all Tennesseans. Examples of programming that work to expand access to care include:

The Behavioral Health Safety Net is a state-funded program providing essential outpatient mental health services to uninsured Tennesseans ages 18 and older and uninsured/underinsured Tennessee children ages 3 to 17 who meet program eligibility criteria through a network of participating CMHPs. Essential services offered through the BHSN include assessment and evaluation, therapeutic interventions, case management, psychiatric medication management, laboratory tests related to medication management, pharmacy assistance and coordination, and transportation to BHSN services. Both in-person and telehealth services are available. With more than 140 physical BHSN sites across the state and the successful utilization of telehealth, the statewide BHSN of TN Provider Network of 15 community mental health centers can serve eligible adult Tennesseans, no matter the county where they reside. This program serves over 35,000 uninsured adults annually.

TDMHSAS's robust crisis system, which includes Crisis Call Centers, Mobile Crisis Services, Walk-in Centers, and Crisis Stabilization Units, is accessible to all adults with SMI and co-occurring intellectual and/or developmental disabilities 24/7/365. Through partnership with the TN Department of Disability and Aging, TDMHSAS is currently establishing an MOU that outlines the formal collaboration and coordination of care when an individual with intellectual and/or developmental disability presents to crisis services. Collaboration efforts with TDDA ensures that those presenting to crisis receive effective and efficient crisis assessment, service linkage, and follow-up care.

Beginning in March 2023 and expanding in FY25, in collaboration with the TDOH, the Co-located Mental Health Services at County Health Departments Pilot was implemented to have bachelor-level care managers and master level therapists from community mental health providers onsite at county health departments. The six rural county health departments were selected for this pilot based on mental health prevalence data and counties without a physical community mental health center location. Serving both adults and children, this pilot improves access to in-person care in rural areas.

The Promoting the Integration of Primary and Behavioral Healthcare grant supports integrated screening and assessment for mental health and SUD among adults with SMI through college health clinics. Students who are uninsured or uninsured receive therapeutic supports, such as care coordination, therapy, and peer support, at no additional cost. The universal behavioral health and SUD screening supports students ages 16-28 on college campuses.

The state has invested in early intervention programs such as the First Episode Psychosis (FEPI) Ontrack initiative. This program offers a multidisciplinary approach that includes psychotherapy, medication management, care coordination, peer support, and education/employment services for young adults experiencing psychosis. This comprehensive care ensures quicker access to specialized services for serious mental illness (SMI), ultimately providing intensive support and reducing the number of visits to behavioral health hospitals. Although neither the Ontrack nor the CHRP program targets individuals with intellectual and developmental disabilities (IDD) explicitly, the integrated care model of the FEPI program provides a foundation that can be adapted for adults with serious mental illness (SMI) and IDD. This model combines clinical therapy, psychiatric support, peer involvement, and care coordination, allowing for structured care management and personalized therapeutic planning. Furthermore, if a young person with IDD is referred to the program but does not meet the eligibility requirements, the team will direct them to the appropriate type of care, ensuring that they receive the most suitable support possible. Both the Ontrack TN and CHR-P programs include substance use screening as part of their standard intake assessments. When co-occurring disorders are identified, these programs offer integrated treatment along with substance use assessments every three months, following an evidence-based clinical treatment approach. This method combines therapy, psychiatry, peer engagement, and support from families or educational resources, reducing service gaps and enhancing outcomes through coordinated care.

There are multiple housing and recovery services programs to support access to care for individuals with substance use disorders who are also having justice system involvement. The Creating Homes Initiative continued its work in increasing the stock of safe, quality, and affordable permanent housing for Tennesseans across the state who experience mental illness and or substance use disorder, particularly with the completion of housing infrastructure funded by the CHI 2.0 grant that focuses on efforts for individuals in substance use disorder (SUD) recovery, and the CHI 3.0 grant that focuses on individuals with mental illness and/or SUD who are justice involved. Upon completion of these residential facilities, the corresponding Supportive Recovery Housing and Supportive Reentry Housing grant programs (respectively) provide funding to support operational costs to ensure Permanent Supportive Housing best practices can be implemented in the residences for the benefit of service recipients. Additionally, TDMHSAS' newest housing grant program, the Residential Reentry Housing Program (RRHP), selected four proposals (via competitive process) for funding to create new licensed housing with enhanced supportive services for Tennesseans experiencing Severe and Persistent Mental Illness (SPMI) who are justice involved; one of the four projects has been completed, with the remaining three set to be completed within the next 12 months. TDMHSAS intends to establish two more facilities under the RRHP grant, which would result in a total of 100 beds for this unique program.

The Clinical High Risk for Psychosis (CHR-P) program targets youth aged 12 to 25 who are at risk for psychosis and severe emotional disturbances. This program includes evidence-based screenings for mental health and substance use, ensuring early detection and prompt intervention. It offers a range of services such as therapy, medication, peer support, and care coordination to promote holistic recovery for those experiencing serious emotional disturbances or co-occurring substance use disorders. The primary goal is to identify young people who may be at risk of developing psychosis, thereby reducing the severity of their emotional disturbances through early intervention. The CHR-P model is primarily designed to support youth and young adults at risk of developing psychosis. However, it can also serve as a valuable entry point for identifying young people with overlapping developmental needs. The program provides pre-screening assessments for individuals aged 12 to 25, allowing for early identification of concerns that may extend beyond traditional mental health issues.

The TN Co-Occurring Disorder Collaborative (TNCODC) works to improve understanding, treatment, and support for individuals in Tennessee with co-occurring mental health and substance use disorders (COD). The Department is strongly committed to educating professionals about COD and the need for integrated services; informing the public about co-occurring disorders and how to access care; and developing more integrated treatment and recovery services for individuals and their families. To assist with this, the TNCODC was created to develop regional learning communities, provide technical assistance to providers, and work to enhance the behavioral health system's ability to identify and respond to COD. By engaging diverse stakeholders and maintaining updated tools and data tracking, the project fosters a coordinated, informed approach to improving outcomes for those affected by co-occurring disorders.

The Certified Peer Recovery Specialist (CPRS) program in Tennessee is a fully co-occurring program that certifies individuals with lived experience of mental health disorders and/or substance use disorders. TDMHSAS certifies CPRS to provide peer support throughout the behavioral health system, thereby increasing access to care for adults statewide.

More information about Tennessee's efforts to improve access to care for substance use disorders may be reviewed in the TDMHSAS Substance Abuse Prevention and Treatment Block Grant Application.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

Tennessee successfully passed legislation that aligns state statute with federal parity law and strengthens state enforcement efforts. 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. In 2021, the Tennessee General Assembly passed, and Governor Bill signed into law SB151/HB360/Public Chapter 244 re: behavioral health parity. This legislation requires, by January 31 annually, the Tennessee Department of Commerce and Insurance (TDCI) to issue a report to the Tennessee General Assembly and provide an educational presentation to that body. The bill requires the TDCI to request from the United States Department of Labor and the United States Department of Health and Human Services certain analyses submitted to those entities the previous year in compliance with the federal Consolidated Appropriations Act of 2021 and incorporate these analyses into the report. This bill requires that TDCI's report and presentation: (1) List health plans sold in this state and over which of these plans TDCI has jurisdiction; (2) Discuss the methodology TDCI is using to check for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and Tennessee Code Annotated (TCA) sections 56-7-2601, 56-7-2602, 56-7-2360; (3) Identify market conduct examinations and full scope examinations conducted or completed during the preceding 12-month period and summarize the results of the examinations;(4) Detail educational or corrective actions TDCI has taken to ensure health benefit plan compliance with the MHPAEA and TCA sections 56-7-2601, 56-7-2602, 56-7-2360; 5) Detail TDCI's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and (7) Describe how TDCI examines any provider or consumer complaints related to denials or restrictions for possible violations of the MHPAEA and TCA sections 56-7-2601, 56-7-2602, 56-7-2360, including complaints regarding, but not limited to: (A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary; (B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested (C) Denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication; (D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary; (E) Step therapy requirements imposed before buprenorphine or naltrexone are approved; (F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine; and (G) Denial of in-network authorization or denials of out-of-network services or claims where there is not an in-network provider within 75 miles of the insured patient's home.

Tennessee's state Medicaid authority, TennCare, currently contracts with three (3) managed care organizations (MCOs) to provide inpatient, outpatient, and emergency services to individuals enrolled in the TennCare CHOICES program. TDMHSAS partners with the Division of TennCare Long-term Services & Supports (TennCare LTSS) and the TN Department of Disability and Aging (TDDA) through an interagency contract to provide individuals of any age seeking nursing facility placement for short-term rehabilitative care, long-term care, or enrollment in TennCare CHOICES Home and Community Based Services (HCBS) with a Pre-admission Screening and Resident Review, commonly called a PASRR. This Screening results in a person-centered plan of care that is then

administered and monitored through their enrollment in CHOICES by TennCare's contracted MCOs to maintain that plan of care, whether an individual is admitted to a skilled nursing facility or lives more independently out in the community receiving Home and Community Based Services (HCBS).

The PASRR program can track and monitor mental health parity for any Tennessee resident seeking placement in a Medicaid-certified nursing facility for rehabilitative care or long-term services and supports, as well as prescribing a plan of care for physical and behavioral health specialized services. This plan of care is provided through Tennessee's CHOICES program to include nursing facility services and home and community-based services (HCBS) for adults 21 years of age and older with a physical disability and seniors (age 65 and older). A PASRR screening is federally required as part of this process of eligibility determination for everyone applying to or residing in Medicaid-certified nursing facilities, even individuals not receiving Medicaid benefits. The screening ensures prior authorization for timely and appropriate access to medically necessary covered services, and that care is delivered in accordance with generally accepted standards of medical practice, in the most appropriate setting, and to prevent inappropriate service utilization.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

TDMHSAS supports integrated care models by encouraging co-occurring competent and co-occurring friendly programs that can support individuals with both mental health and substance use disorders.

Encouraging co-occurring competent and co-occurring friendly programs is a key value present in all grant contracts administered by TDMHSAS. The purpose of the TN Co-Occurring Disorder Collaborative (TNCODC) is to improve understanding, treatment, and support for individuals in Tennessee with co-occurring mental health and substance use disorders (COD). The TDMHSAS is strongly committed to educating professionals about COD and the need for integrated services; informing the public about co-occurring disorders and how to access care; and developing more integrated treatment and recovery services for individuals and their families. To assist with this, the TNCODC was created to develop regional learning communities, provide technical assistance to providers, and work to enhance the behavioral health system's ability to identify and respond to COD. By engaging diverse stakeholders and maintaining updated tools and data tracking, the project fosters a coordinated, informed approach to improving outcomes for those affected by co-occurring disorders.

Project Rural Recovery delivers integrated mental health, substance use, and physical health services to individuals of all ages across 20 underserved rural Tennessee counties through mobile health clinics. These counties were selected by TDMHSAS due to high rates of chronic conditions, behavioral health needs, and limited healthcare infrastructure. By offering fully integrated care, the project is uniquely positioned to serve individuals with co-occurring mental health and substance use disorders. Funded by state and federal resources, four community agencies staff and operate the mobile units. Now in its fifth year, the project has provided nearly 18,000 visits to over 6,300 rural residents who might not have otherwise accessed services.

The Certified Peer Recovery Specialist (CPRS) program in Tennessee is a fully integrated, co-occurring program that certifies individuals with lived experience of mental health disorders and/or substance use disorders. CPRS provides peer support throughout the behavioral health system and serves as an emblem of hope for recovery.

Another program example of supporting integrated systems of care is through the Statewide Peer Wellness Initiative. 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 assist providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities. In the Peer Wellness Initiative, Peer Wellness Coaches act as liaisons between case managers, clients, and primary care practitioners. The Peer Wellness Coaches help individuals develop and maintain relationships with primary care practitioners and continue to provide support as needed.

Multiple programs also support integrated services for children and youth across the state. The Promoting the Integration of Primary and Behavioral Healthcare grant supports evidence-based screening models in healthcare settings, schools, and community programs to identify mental health needs and risky substance use early on. Once identified, individuals receive coordinated or fully integrated treatment, where mental health and SUD services are delivered via the same provider or network, enabling unified care planning, therapy, medication oversight, and peer support.

The state provides integrated services for individuals with co-occurring mental health and substance use disorders through initiatives like the FEPI, known as Ontrack TN, and the CHR-P programs. Both programs focus on youth and young adults and include evidence-based screenings for mental health and substance use administered every three months. This helps identify co-occurring conditions early, allowing for swift access to intervention and treatment. The Ontrack TN program offers integrated treatment through a multidisciplinary team for individuals aged 15 to 30. It provides a range of services, including individual and group therapy, medication management, care coordination, family education, peer support, and assistance with employment and education. When substance use issues are identified, they are directly addressed in the care plan, ensuring a unified treatment approach and coordination to higher levels of care if necessary. The CHR-P program adopts a stepped-care model to support

young people at risk for psychosis. It offers care coordination, peer support, therapy, medication management, and educational/employment support. Routine screenings for substance use are included to facilitate timely and integrated responses.

These programs demonstrate the state's commitment to early prevention, prompt intervention, and coordinated treatment, which help minimize service gaps and ensure that mental health and substance use concerns are addressed within a comprehensive support system.

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

Our statewide robust network of co-occurring competent and co-occurring friendly providers provide treatment services to adults and youth. In addition, our system has evidence based youth specific treatment options in multiple communities.

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

No, but other co-occurring focused EBPs are being provided.

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

N/A

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

N/A

e. Do you have a statewide COD coordinator? (●) Yes ( ) No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

A couple of programs stand out for providing integrated support for behavioral health and primary health care.

The Project Rural Recovery program provides mobile, integrated primary health care, mental health, and substance abuse services to rural Tennesseans of all ages, regardless of ability to pay. Services are delivered via mobile health units across rural counties. Services for healthcare include basic, physical health services that include management of hypertension, diabetes, lipid disorders, weight disorders, and other issues, including treatment for common colds, minor physical injuries, vaccinations, and other non-emergency issues. The units can also provide health screenings and testing. These units also provide assessment of and treatment for mental health disorders and substance use disorders, and/or provide referral to appropriate community services. The strategies include Behavioral Health Integration (BHI), Screening, Brief Intervention, and Referral to Treatment (SBIRT), Medication-Assisted Treatment (MAT), C-SSRS suicide screening, Individual Placement and Support (IPS), and Trauma-Informed Care (TIC). This program aims to serve up to 4,000 individuals per year with improved overall health outcomes.

Additionally, TDMHSAS has a partnership with the TN Department of Health to co-locate mental health services, provided through a Community Mental Health Agency (CMHA), at a health department in rural counties. The program is in six rural counties to include both a bachelor-level care manager and a master level therapist onsite at each county health department. The county health department refers patients to the CMHA, regardless of payor source. The CMHA will coordinate and/or deliver both in-person and telehealth mental health services for individuals referred.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

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

e) Children and youth with SED and I/DD

Several programs within Tennessee's behavioral health system strongly emphasize care coordination to ensure that individuals

(and their families) receive comprehensive support.

The statewide School-Based Behavioral Health Liaison (SBBHL) program operates within the Multi-Tiered System of Supports (MTSS) framework to provide coordinated layers of academic, behavioral, and social-emotional support for students. The program is designed to enhance trauma-informed learning environments by providing targeted, school-based mental health support to children and youth who are experiencing, or are at risk for, serious emotional disturbances (SED), behavioral challenges, or substance use disorders. There are 390 School-Based Behavioral Health Liaisons across the state that collaborate directly with classroom teachers to offer consultation and coaching, helping to implement effective behavioral strategies and interventions. They also deliver training and professional development focused on mental health, substance use, and trauma-informed practices. In addition to supporting classroom environments, liaisons serve as a vital link between schools and families—facilitating communication, promoting family engagement, and coordinating care. They assist with student transitions between general education and alternative educational placements, and guide both families and school staff in accessing appropriate mental health and related support services. Liaisons also conduct mental health screenings, psycho-educational groups, and, when appropriate, provide therapeutic interventions to address student needs.

Care coordination for individuals with co-occurring mental health and substance use disorders is also provided through initiatives like the FEPI, known as Ontrack TN. Ontrack TN utilizes evidence-based, recovery-oriented Coordinated Specialty Care (CSC). CSC is a comprehensive intervention model for people who have experienced a first episode of psychosis (FEP). CSC promotes shared decision making, and treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and to get their lives back on track. The CSC model helps these individuals navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, at a job, and in the social world. The CSC program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology geared to individuals with FEP, care coordination and management, peer support, and work or education support, depending on the individual's needs and preferences. The individual and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin. The Ontrack TN program offers integrated treatment through a multidisciplinary team for individuals aged 15 to 30. It provides a range of services, including individual and group therapy, medication management, care coordination, family education, peer support, and assistance with employment and education. When substance use issues are identified, they are directly addressed in the care plan, ensuring a unified treatment approach and coordination to higher levels of care if necessary.

The CHR-P program also offers care coordination, peer support, therapy, medication management, and educational/employment support via a stepped-care model to support young people at risk for psychosis. Routine screenings for substance use are included to facilitate timely and integrated responses.

The Promoting the Integration of Primary and Behavioral Healthcare grant supports evidence-based screening models in healthcare settings, schools, and community programs to identify both mental health needs and risky substance use early on. Once identified, individuals receive coordinated or fully integrated treatment, where mental health and SUD services are delivered via the same provider or network, enabling unified care planning, therapy, medication oversight, and peer support.

Just as care coordination is vital for youth and families navigating complex systems, it's equally important for older adults. Tennessee has the Older Adults Program to provide mental health care management services to people ages 50 and older who do not financially qualify for Medicaid (TennCare) or the Behavioral Health Safety Net. Care management services offered may include depression screening, assessment, referral/linkage to community resources, in-home therapy, person-centered advocacy, community outreach, and other supportive services as needed, as well as providing older adult-related behavioral health education. This education promotes healthy aging best practices, cognitive disease prevention, and older adult mental health concerns in the local community. Recipients of this education include local health councils, pharmacists, legal-aid organizations, senior centers, councils on aging, and faith-based communities, as well as clients, their families, and their caregivers. There are six community mental health provider agencies across the state contracted to provide coordinated care for older adults in direct collaboration with a client's primary care physician and nurses.

There are several residential housing support programs that include care coordination practices. The Community Supportive Housing, Intensive Long-term Support, Supportive Recovery Housing, and Supportive Reentry Housing programs each incorporates access to support services, such as peer recovery support, supported employment, SSI/SSDI, Access, Outreach, and Recovery (SOAR), community engagement, skill building for daily living and social engagement, and individualized goal planning. With a person-centered approach to service delivery within these programs, connection to specific resources and services is tailored to the unique needs of each person served. In addition, Tennessee implements the Projects for Assistance in Transition from Homelessness (PATH) program, which focuses on individuals with serious mental illness who are experiencing or at risk of homelessness. The PATH program emphasizes outreach, engagement, and intensive care coordination services, helping individuals connect to mental health treatment, substance use services, housing, medical care, and mainstream benefits. PATH providers often collaborate with local shelters, HUD Continuums of Care, health systems, and social service agencies to coordinate individualized, person-centered care. Program service providers often coordinate with various reputable community partners to increase access to support services to program service recipients.

Lastly, the Tennessee Move program supports discharging long-term patients from the Regional Mental Health Institutes (RMHI).

The state-funded Move teams provide recovery-focused, intensive, and customized care coordination services to identified individuals in long-term units of RMHIs for the purposes of transitioning those individuals to the least restrictive and most integrated setting appropriate to individual need. Each team has a full-time Care Coordinator position that coordinates recovery-focused, intensive, and customized services to support daily activities, family life, health, medication support, housing assistance (supportive housing), supportive employment (where appropriate), financial management, entitlements, and community mental health services. The 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 community.

These programs demonstrate the state's commitment to coordinated treatment to help minimize service gaps and ensure that mental health and substance use concerns are addressed within a comprehensive support system.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

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 a 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 is a concerted effort among agencies, trade organizations, associations, and advocacy groups that are committed to providing education and awareness to treatment providers, individuals, families, and communities regarding the impact of co-occurring disorders. The primary goals of TNCODC include (1) to share knowledge about the conditions and available resources, (2) to reduce stigma, and (3) to accurately direct people to timely and effective prevention, treatment, and support.

TDMHSAS supports its Certified Peer Recovery Specialist program, which currently has 1,571 CPRS trained in co-occurring peer support. The Certified Peer Recovery Specialist (CPRS) program in Tennessee is a fully integrated, co-occurring program that certifies individuals with lived experience of mental health disorders and/or substance use disorders. CPRS provides peer support throughout the behavioral health system and serves as an emblem of hope for recovery. The Statewide Peer Wellness Initiative 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 assist providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

In addition to statewide efforts, there are focused prevention, treatment, and recovery services for children and youth provided through Tennessee's network of co-occurring competent and friendly contracted providers.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Tennessee has strong partnerships at the state and local levels to provide integrated, person-centered support for individuals with behavioral health and I/DD issues.

TDMHSAS is an active member of the Employment First Task Force, a task force created to address the barriers faced by individuals with disabilities in the workforce. The focus of this task force is prioritizing integrated and competitive employment as the preferred option for individuals with disabilities, including those with an intellectual/developmental disability or mental health and/or substance use diagnosis. TDMHSAS works with multiple state departments and partner agencies on the Employment First Task Force to create solutions to improve programs for individuals with a disability living in Tennessee to ensure access to the necessary supports for participation in the workforce and community. TDMHSAS chairs the Behavioral Health Workgroup/Statewide Steering Committee subgroup of the Employment First Task Force, focusing on statewide access to an evidence-based employment program and access to mental health treatment for all individuals with a disability.

The Department also serves on the Council on Developmental Disabilities, participating in quarterly Council meetings as well as the annual retreat. The Council on Developmental Disabilities works to address the needs of individuals with developmental disabilities and advocate for change and improvement to services, as well as integration and independence for these individuals. In this role, TDMHSAS is able to promote the importance of mental health treatment and screening, help address issues related to access to treatment services, provide education on mental health, substance use, and/or co-occurring disorders and treatment, and help support the integration of mental health, substance use, and/or co-occurring services with other services. The TDMHSAS helps fund the Tennessee Disability Pathfinder, a website and call center to support all ages and all types of disabilities to provide information and referrals, education and training, and a multicultural outreach program.

TDMHSAS also maintains a Governor-Appointed seat on the TN Department of Disability & Aging (DDA)'s Statewide Interagency Coordinating Council (SICC) in support of the Tennessee Early Intervention System (TEIS). Currently, the Director of the Office of Infant & Early Childhood Initiatives fulfills this role. The State Interagency Coordinating Council for TEIS has established a guiding vision to support the department through a statewide comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families in Tennessee. This council is statutorily created

and required by law. Tennessee Early Intervention System (TEIS) is a voluntary program that offers therapy and other services to families of infants and young children with developmental delays or disabilities. Services are provided at no cost to families through IDEA Part C funding. TEIS is critically important to supporting the development of Tennessee children with disabilities and developmental delays as they prepare for school.

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

N/A

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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

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

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care (CSC)	7.00
	0.00
	0.00
	0.00

	0.00
	0.00

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

FY2026	FY2027
2,092,600.00	2,092,600.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Currently, Medicaid does have bundled case rates but other insurance companies in TN do not cover ESMI/FEP bundle rates. The FEPI program sites exhaust all billing sources including Medicaid when applicable before billing the grant. FEPI program sites can bill Medicaid and other insurance for billable service components of the coordinated specialty care model. Program sites can bill insurance for therapy, case management, medication, and peer-related services. If a program participant does not have insurance, FEPI sites will screen and enroll eligible participants in the Behavioral Health Safety Net, a TDMHSAS grant program providing essential outpatient mental health services to uninsured Tennesseans. The Behavioral Health Safety can pay for FEPI services like psychiatric medication management, individual and group therapy, peer support services, and case management.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with 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. TDMHSAS has expanded its grant contracts from four providers to six providers in total. Each program site implements the OnTrackNY coordinated specialty care (CSC) evidence-based model for structuring the program for youth and young adults experiencing their first episode of psychosis. In addition to the coordinated specialty care (CSC) evidence-based practice, each program site utilizes the Individual Placement and Support (IPS) model for supported employment and education services. Each program site also offers peer support services through the Certified Peer Recovery Specialists and Certified Young Adult Peer Support Specialists Programs. TDMHSAS has implemented programs across various regions of the state. Alliance Healthcare Services provides FEPI programming in Shelby County, and Carey Counseling Center, Inc. offers FEPI programming in rural northwest Tennessee across seven counties, providing coverage in Lake, Obion, Weakley, Henry, Benton, Carroll, and Gibson counties. Mental Health Cooperative provides services in Davidson County, and Helen Ross McNabb Center provides FEPI programming in Knox, Blount, Loudon, Monroe, and Hamilton counties. Each OnTrackTN program team is 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). The TDMHSAS collaborates with Alliance Healthcare Services to provide a Critical High Risk for Psychosis Program, aimed at assisting youth and young adults aged 12 to 24. This program serves young individuals in Shelby County who are at risk for psychosis by using a STEP Care Model Approach, which is similar to the evidence-based practice known as Coordinated Specialty Care (CSC). The program incorporates the Individual Placement and Support (IPS) model to offer supported employment and educational services. Additionally, it provides peer support services through the Certified Peer Recovery Specialists and Certified Young Adult Peer Support Specialists Programs. Other services available at the program site include medication management, case management, and individual therapy. The program also maintains a bi-directional relationship with the First Episode Psychosis program at Alliance, ensuring that young people experiencing their first episode of psychosis receive coordinated care.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

TDMHSAS contracts with Park Center to employ a statewide trainer who 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 collaborates with OnTrackUSA for ongoing training and consultation. 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 has developed a fidelity scale to determine each OnTrackTN team's adherence to the Coordinated Specialty Care model. Since the program's inception, OntrackTN has provided FEPI services to 242 Youth and Young Adults with psychosis-related concerns across 22 counties. In FY2024, clients enrolled in the FEPI program reported a 38% increase in employment among participants and a decrease in hospitalization days from 1,284 days at admission to 381 days at the most recent follow-up.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

The goal for Tennessee's First Episode Psychosis (FEP) program for FY2026-FY2027 is to expand services into a true continuum of

care for early psychosis across our existing FEPI program sites. A central component of this plan is broadening the age criteria to serve individuals ages 12–30, allowing teams to reach and potentially enroll more young people who are at clinical high risk for psychosis and provide earlier, more comprehensive support. To achieve this, we will increase evidence-based training for FEPI teams, cross-train more therapists within partner agencies in early psychosis care and train organizations with tools such as the Structured Interview for Psychosis-Risk Syndromes (SIPS) assessment, that will assess the eligibility potential of a young person at clinical high risk for psychosis. In addition, FEPI teams will participate in ongoings learning collaboratives such as the Beck Institute to implement Recovery-Oriented Cognitive Therapy (CT-R), a proven approach that fosters empowerment, resiliency, and recovery among individuals experiencing psychosis. The program will also continue to strengthen its partnerships with the first episode psychosis national leaders in evidence-based practice, including OnTrack NY, The PIER Institute, and the STARS Training Academy, to ensure program fidelity and alignment with early psychosis best practice standards. The FEPI programs will also expand TDMHSAS evaluation procedures by developing more robust data collection metrics and engaging national consultants to learn strategies to braid funding resources that support long-term sustainability. These efforts are designed to increase enrollment across the state, improve the quality of care, reduce hospitalizations, strengthen psychosis symptom reduction, and ultimately build a sustainable early psychosis continuum of care that meets the needs of young people and families throughout Tennessee.

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

Be between fifteen through thirty (15-30) years of age;
Be currently living physically present in Davidson, Shelby, Benton, Carroll, Gibson, Henry, Lake, Obion, Weakley, Knox, Anderson, Montgomery, Hamilton Blount, Loudon, and Monroe Counties
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.

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

Using the 2022 Census population totals, the estimated incidence for Tennessee is 2,115, with an estimated .0003 rate of incidence.

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

The first episode psychosis initiative will continue to outreach and engage those at clinical high risk for psychosis or experiencing psychosis by providing awareness and education to the general public and community partners. Program sites will continue monthly outreach to private mental health practitioners, school systems, primary care doctors, hospitals, and crisis units. In addition, the first episode psychosis initiative will continue its cross-collaboration and bi-directional referral system with other youth and young adult serving programs across TN.

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

N/A

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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

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

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

Over two dozen unique billable behavioral health treatment and recovery services are offered through the state's Behavioral Health Safety Net. Through person-centered planning (for the purposes of TDMHSAS, this is more commonly referred to as individualized treatment 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 for them. The Older Adults Program offers person-centered mental health care coordination and education on a case-by-case basis, customizing care plans to meet each client's and their caregivers'/family's specific needs.

The residential housing programs, including Community Supportive Housing, Supportive Recovery Housing, and Supportive Reentry Housing programs, each incorporate the use of individualized housing plans, which are centered around the service recipient's goals toward greater independence, recovery, and resiliency. Each service recipient engages with the program service provider staff to collectively formulate their person-centered plan (for the purposes of TDMHSAS, this is more commonly referred to as individualized treatment planning), which promotes client choice in care and wellness decision-making. Access to supportive services paired with the permanent housing setting provides service recipients with tools and resources to help establish achievable steps toward achievement of each identified goal.

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. State Peer Wellness Coaches offer multiple different programs in a wide variety of settings, including individual outpatient therapy and inpatient programs at behavioral health centers and agencies, mental health crisis units and centers, peer support centers, group homes, and other settings for people living with mental health and or co-occurring disorders. These workshops are backed by research demonstrating proven success among a wide range of demographic areas. These workshops are split into two different categories and focus on learning new skills such as: Healthy Eating, Decision-Making, Medication Usage, Physical Activity, Problem-Solving, Dealing with Depression, Better Sleep, Better Breathing, Working with Your Healthcare Organization, Using Your Mind, Communication Skills, and Weight Management. In addition, the statewide consumer organization, Tennessee Mental Health Consumers' Association, provides peer support throughout the state that engages consumers in managing their health. If a person has developed a Wellness Recovery Action Plan (WRAP), cross system crisis plans 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 the people identified to assist with the plan.

The State has a Certified Family Support Specialist certification program in which parents and caregivers use their lived experience to provide peer-to-peer support services to parents and/or caregivers navigating the child-serving systems on behalf of a child with a Social Emotional Disturbance (SED) or co-occurring disorder. Following training and experiential hours, individuals can

apply for certification. The State also has a Certified Peer Recovery Specialist program and a Certified Young Adult Peer Support Specialist program (CYAPSS) for young adults ages 18-30. Peers work within the CHMP programs with the Care Coordinators and Therapists to ensure person-centered planning (for the purposes of TDMHSAS, this is more commonly referred to as individualized treatment planning).

Project Rural Recovery delivers integrated mental health, substance use, and physical health services to individuals of all ages across 20 underserved rural Tennessee counties through mobile health clinics. These counties were selected by TDMHSAS due to high rates of chronic conditions, behavioral health needs, and limited healthcare infrastructure. The project serves individuals with serious mental illness (SMI) by promoting shared decision-making and enhancing communication. Mobile care teams use trauma-informed, recovery-oriented approaches to build trust, empower individuals to participate actively in their care planning, and support person-centered (for the purposes of TDMHSAS, this is more commonly referred to as individualized treatment planning), coordinated treatment. By integrating physical and behavioral health services, the project strengthens health outcomes and promotes long-term recovery.

Through coordinated care, care planning is a collaborative process in which all providers working with a child, youth, or young adult participate in the process to ensure the creation of one plan that all parties agree to and work on goals together. It is understood that with children, youth, young adults, and their families, in order to have successful, long-term outcomes, a coordinated and collaborative approach to care planning is a best practice.

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

The person-centered principle of building supports around individual goals, respecting individual autonomy, and facilitating active decision-making is present within all community program contracts.

Programs such as the Peer Wellness Initiative (PWI) emphasize individual empowerment and self-determination. Peer Wellness Coaches are Certified Peer Recovery Specialists (CPRS) with the TDMHSAS. A CPRS is a person who has lived experience of a mental illness, substance use disorder, or co-occurring disorder, who has made the journey from illness to wellness, and who has been trained and certified to help others. Using this training and relying on evidence-based information to work with participants, PWCs provide a unique and supportive resource to people who are working toward various health goals. Although PWC does not and cannot diagnose participants, many work within clinical environments and often work alongside healthcare providers as peer support resources. The workshops offered include Chronic Disease Self-Management Program, Diabetes Self-Management Program, Nutrition and Exercise for Wellness and Recovery, Whole Health Action Management, Chronic Pain Self-Management Program, Tobacco Free Program, Matter of Balance, Enhancing Immune Health, Well Body, First Aid Arts, and Mindful Recovery.

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 the purposes of TDMHSAS, this is more commonly referred to as individualized treatment planning) 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, Supportive Recovery Housing, and Supportive Reentry Housing programs, each of 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 (for the purposes of TDMHSAS, this is more commonly referred to as individualized treatment planning). 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.

PASRR is a person-centered mental health prescription of care. The Pre-Admission Screening Resident Review (PASRR) Program coordinates the federally mandated Level II person-centered evaluations for individuals seeking placement in a Medicaid-certified nursing facility (NF) in the State of Tennessee. TDMHSAS oversees the finalization of person-centered evaluations for individuals with mental illness (MI), intellectual disabilities (ID), and related conditions (RC), in accordance with the Omnibus Budget Reconciliation Act of 1987 (OBRA). This legislation requires that all applicants seeking Medicaid-certified nursing facility (NF) admission be screened for serious mental illness (SMI), intellectual disabilities (ID), or related conditions (RC). PASRR screenings are required of all persons NF admits, regardless of method of payment. The Level II person-centered assessment evaluates whether an individual's needs can best be met in a nursing home. If his/her needs can be met in a nursing home, then appropriate recommendations are made to ensure the nursing facility (NF) provides the required level of care and specialized psychosocial services. If the nursing home cannot meet the person's needs and/or provide for the person's individualized services, supports or level of care due to mental illness (MI), intellectual disability (ID) or related condition (RC), then a PASRR Level II determination is made for the arrangement of alternative types of specialized care that will meet the person's recommended Level II needs in an HCBS setting according to whatever benefit tier the person is eligible for based on their payer source or enrollment in TennCare CHOICES.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

Sharing information about the Declaration for Mental Health Treatment with Peer Support Center members is a contractual requirement. Certified Peer Recovery Specialists in Tennessee's 45 Peer Support Centers provide training and education to service recipients on Tennessee's version of a Psychiatric Advanced Directive, called the Declaration for Mental Health Treatment. A "Declaration for Mental Health Treatment" allows people receiving services to plan ahead; it may also assist service providers in giving appropriate treatment. The "Declaration for Mental Health Treatment" form describes what a service participant wants to occur when receiving mental health treatment. It describes mental health services that a service participant might consider, the conditions under which a declaration may be acted upon, and directions on how a service participant can revoke/cancel a declaration. In addition, the Peer Support Center staff make sure the Declaration for Mental Health Treatment brochure is available on site for participants to take home and fill out.

TDMHSAS also operates a toll-free Helpline staffed by peer specialists who regularly share information about the Declaration for Mental Health Treatment and send brochures to a variety of behavioral health agencies, hospitals, and clinics throughout the state.

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

N/A

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following 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?

The Office of Contracts, within the TDMHSAS, includes prohibitions within sub-recipient grant contracts related to the use of the mental health block grant funds. 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. All grant 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 TDMHSAS Grantee Manual, located on the Grants Management page, includes resources about the grant contracting process, highlights key contract provisions, reviews the programmatic and fiscal requirements for grant contracts, outlines the monitoring process, and provides resources related to grant management. Additionally, the For Providers, Grants Management section of the TDMHSAS website includes extensive information and guidance for sub-recipients around the use of federal funds, including Uniform Guidance, Allowable Vs. Non-Allowable Costs, FFATA, and more.

Grantees report on deliverables and program progress to the TDMHSAS monthly. TDMHSAS program staff work 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 with 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 is 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; and 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.

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

N/A

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

6. 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 offers multiple programs to support community-based living for those with SMI and COD.

Behavioral Health Safety Net offers outpatient services to uninsured adults to support mental health recovery in the community. The Safety Net provides essential outpatient mental health services to uninsured adults and children who are uninsured or underinsured. Services provided through the BHSN promote recovery, treatment, and resiliency and include assessment and evaluation, therapy, case management, peer support, medication management, psychosocial rehabilitation, transportation, and assistance with pharmacy coordination. The Older Adult Program provides mental health care management services to people age 50 and older who do not financially qualify for Medicaid (TennCare) or the Behavioral Health Safety Net. Services can include mental health assessment, community outreach, linkage to care supports and services, in-home therapy, and other supportive resources. In addition, community mental health education is provided to promote awareness regarding older adults and healthy aging issues. These services are provided to improve quality of life and to develop skills to enable living as independently as possible in the community or to successfully “age in place”. Telehealth is being widely leveraged to provide care coordination services in the Older Adult program, which greatly improves access for rural communities and older individuals with limited mobility.

Tennessee Crisis Services incorporates a continuum of high-quality crisis services, including 988 Telephonic Triage and Intervention, Mobile Crisis (all ages), Crisis Stabilization Units (CSUs), Crisis Respite, and Walk-In Center (WIC) services. Crisis WIC services may include mental health assessment, referral to services, and follow-up services. 988 is a vital diversionary resource that provides access to a trained counselor in the provision of risk screening, triage, consultation, and referrals to ensure appropriate and efficient access to resources. Crisis services aim to determine the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. CPRS Peer Bridger services are provided in the CSUs in partnership with the Tennessee Mental Health Consumers’ Association (TMHCA). The CSU Peer Link program is designed to reduce repeat use of crisis services, increase continuity of care, and help individuals move forward in their recovery. Also, the Tennessee Resiliency Project (TRP) is a supportive crisis intervention that includes coordinated care within the crisis system programs that are addressing keeping children and youth out of inpatient and residential services. East Tennessee is served through three specialty crisis teams serving the detention facilities, schools, and those children and youth being seen in the CSU or WIC. In middle Tennessee, there are two providers focused on crisis, one with five crisis specialists focused on hard-to-place children and the other focused on working with school social workers and school resource officers to identify children and youth in need of diversion from the youth justice system.

TDMHSAS has housing programs focused on enabling community stability. Intensive Long-term Support (ILS) program serves individuals who have been discharged from the state’s Regional Mental Health Institutes (RMHIs) after an extensive length of stay, and who would otherwise not be able to successfully live in the community due to the lack of available housing with the capacity to meet their specific needs. The ILS program provides enhanced-level support services on-site and utilizes quality residential homes that are licensed by the State of Tennessee as Mental Health Adult Supportive Residential Facilities. Effective coordination between the RMHI and the ILS provider staff to facilitate an effective and efficient flow of referrals includes collaborative meetings and calls, strategically scheduled visits, and sharing of pertinent information; these measures promote a smooth transition from long-term hospital stays to sustained community living. TDMHSAS operates 12 ILS homes statewide in FY25. There is also a new Residential Re-Entry Housing Program that started in FY24 to build six residential facilities to serve individuals with severe and persistent mental health challenges reentering the community from incarceration. Once completed, these facilities will serve individuals with severe and persistent mental health challenges re-entering the community from incarceration. Additionally, there is the Inpatient Targeted Transitional Support (ITTS) program to assist individuals discharging from the RMHIs, Crisis Stabilization Units, and State-Contracted Psychiatric Hospitals in their successful transition to community living by providing temporary

financial assistance to obtain and maintain residence and related supports in the community until their financial resources can be established, to avert homelessness or reduce the risk of homelessness. The ITTS program provides limited, temporary financial assistance for expenses such as rent deposits, rent payments, utilities, vision care, dental care, as well as fees for obtaining documents such as birth certificates, state-issued ID cards, etc. Providing a means for such costs is vital for those who lack these resources to successfully obtain housing at such a critical time of need. This program increases opportunities for individuals discharging from inpatient settings to secure safe, affordable, permanent supportive housing that promotes recovery and resiliency in the community. The Community Targeted Transitional Support (CTTS) program targets individuals who are currently living in the community and not at an inpatient facility at the time of need. Similar to ITTS, CTTS provides temporary financial assistance (for rent deposits, rent payments, utilities, vision care, dental care, as well as fees for obtaining documents such as birth certificates, state-issued ID cards, etc.) to support service recipients' ability to sustain community living, and avert homelessness or reduce the risk of homelessness.

The Tennessee Move Initiative teams work to successfully transition 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 RMHIs. The initiative's purpose is to transition the individuals to the least restrictive and most integrated setting appropriate based on their individual needs.

Individual Placement and Support (IPS) is the supported employment model promoted by the department. It is a model of supported employment for people living 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.

The First Episode Psychosis Initiative (FEPI) and Clinical High Risk for Psychosis (CHRP) programs provide a continuum of care for youth and young adults who are experiencing or at-risk of experiencing early onset psychosis in eighteen (18) counties. These programs utilize a Coordinated Specialty Care (CSC), which is a comprehensive intervention model for people who have experienced a first episode of psychosis. Treatment is provided by a team that focuses on helping people work toward personal goals and get their lives back on track. The CSC model helps these individuals navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, at a job, and in the social world. The CSC program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology, peer support, and care coordination and management. The individual and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	◉ Yes ○ No
b)	Mental Health	◉ Yes ○ No
c)	Rehabilitation services	◉ Yes ○ No
d)	Employment services	◉ Yes ○ No
e)	Housing services	◉ Yes ○ No
f)	Educational services	◉ Yes ○ No
g)	Substance use prevention and SUD treatment services	◉ Yes ○ No
h)	Medical and dental services	◉ Yes ○ No
i)	Recovery Support services	◉ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	◉ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	◉ Yes ○ No

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

The Behavioral Health Safety Net, which consists of co-occurring competent providers, delivers core, essential, outpatient, behavioral health services to an estimated 35,000 uninsured and underinsured Tennesseans annually who meet program eligibility criteria through a network of community mental health centers. This includes assessment and evaluation, individual, family, and group therapy, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination. Other BHSN services that may be available include peer support, psychosocial rehabilitation services, and transportation. Many of the services offered within the Behavioral Health Safety Net are

evidence-based practices.

Tennessee's Regional Intervention Program (RIP) Fidelity Model & founding staff were central to the initial development of The Pyramid Model for Promoting Social-Emotional Competence in Infants and Young Children (Pyramid Model). The Pyramid Model is a framework of evidence-based practices for promoting young children's healthy social and emotional development. The Pyramid Model informs implementation for TDMHSAS programming, including Child Care Consultation, RIP, and Project BASIC. Additionally, RIP Training & Technical Assistance Staff are trained to deliver Positive Solutions for Families (PSF). PSF is an evidence-based seven-part series of workgroups for parents and caregivers to learn how to use positive approaches and effective parenting techniques to improve interactions with their child(ren), which in turn will support social and emotional development and address challenging behaviors.

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. The Multi-Tiered Systems of Supports is a service delivery framework focused on prevention and problem-solving for all students. An integrated MTSS connects all of the academic and non-academic interventions, supports, and services available in schools and communities to support instruction and eliminate barriers to learning and teaching. Within an MTSS framework, multiple levels of instruction, assessment, and intervention are designed to meet the academic and non-academic needs of all students.

Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed. The Transition to Independence Process (TIP) Model was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties to: a) engage them in their own futures planning process; b) provide them with developmentally appropriate, non-stigmatizing, culturally competent, trauma-informed, and appealing services and supports; and c) involve the young people, their families (of origin or foster), and other informal key players, as relevant, in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals. Youth and young adults are guided in setting and achieving their own short-term and long-term goals across relevant Transition Domains, such as: employment/career, educational opportunities, living situation, personal effectiveness/well-being, and community -life functioning. Coordinated specialty care is a recovery-oriented, team approach to treating early psychosis that promotes easy access to care and shared decision-making among specialists, the person experiencing psychosis, and family members. Specifically, coordinated specialty care involves multiple components: Individual or group psychotherapy, Family support and education programs, Medication management, Supported employment and education services, and Case management.

TDMHSAS ensures access to co-occurring competent services by training its provider network in the COMPASS EZ (creating welcoming, recovery-oriented, co-occurring capable services for adults, children, youth, and families with complex needs). In addition, the Department funds the Co-Occurring Disorders collaborative. Since 2011, this collaborative has brought education and awareness of co-occurring disorders to the Tennessee public behavioral health network.

3. Describe your state's case management services

There is a variety of pathways for individuals to access case management. Some examples include:

Case Management is offered as a service in the Behavioral Health Safety Net. Case management is defined as outpatient 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. The Older Adults Program care management services provide community outreach, collaboration with other health care providers, healthy aging education, psycho-social screening assessments, in-home therapy via telehealth or face-to-face visits for older adults with limited mobility, person-centered advocacy, and referral/linkage to community resources such as respite care and other supportive health services for older adults, their families, and caregivers.

TDMHSAS operates a Helpline where peer advocates assist callers in understanding their rights, navigating services, handling

complaints, and linking to appropriate providers.

There is a SOAR Liaison program that works with patients ready for discharge from RMHIs who are appropriate candidates for SOAR (SSI/SSDI Outreach, Access, and Recovery). The SOAR Liaisons work with the individual to complete the application and assist those with access to SSI/SSDI benefits to help facilitate discharge and ensure access to permanent housing and services. For those who have a mental illness, substance use issues, or co-occurring disorders that impair cognition, the application process is even more difficult – yet accessing these benefits is often a critical first step in recovery. Much of the work of the SOAR Liaisons is case management, including serving as the applicant's representative, collecting medical records, arranging for assessments, and writing a medical summary report.

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

TDMHSAS has multiple programs and strategies aimed at utilizing community-based programs to reduce hospitalization and hospital stays.

Offering a full continuum of crisis services: 988 call centers, 24/7 crisis lines, mobile crisis teams, walk-in centers, and crisis stabilization units reduce reliance on inpatient hospitalization. Crisis Services are available to all consumers experiencing a mental health crisis, at no cost, 24/7/365. These services are designed to connect the consumer with services that meet their clinical needs in the least restrictive setting possible. TDMHSAS has also contracted with Mobile Crisis provider agencies to ensure these services are available state-wide. Mobile Crisis staff are able to assess the current needs of the consumer and refer to the least restrictive settings that are clinically appropriate. These referrals include Crisis Stabilization Units (CSU), which are facilities that are able to treat a consumer, on a voluntary basis, and address needs such as medication management. Respite Services are also available across the state, and these services are able to assist the consumer, offering voluntary admission, while also connecting them with community resources that are able to address clinical needs. TDMHSAS also has contracted with providers to establish Walk-In-Centers (WIC) for consumers to access crisis services. These WIC facilities offer crisis assessment services and are able to facilitate admission for levels of care such as 23-hour Observation, Crisis Stabilization Unit, or Medically Monitored Crisis Detox Services. All of these services are available at no cost to the consumer and offer treatment outside of the inpatient setting. TDMHSAS supports the Tennessee Mental Health Consumers' Association (TMHCA) in the Peer Intensive Care program, which places Certified Peer Recovery Specialists (CPRS) at the state's four Regional Mental Health Institutes and ten Crisis Stabilization Units (CSUs) to provide peer support services that include aftercare services in community to prevent recurring use of inpatient psychiatric services. 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.

Housing and peer support services help individuals with SMI maintain stable living situations and decrease the likelihood of hospitalization. The Community Supportive Housing and Supportive Recovery Housing programs have over 1,000 beds statewide to offer supported housing for adults. These programs incorporate 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. Additionally, the Intensive Long-term Support program provides supportive housing for individuals discharging from the Regional Mental Health Institutes (RMHI), 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. The Tennessee Move Initiative also supports the RMHIs by providing community-based teams to provide recovery-focused, intensive, and customized care coordination services to identified patients in long-term units of RMHIs for the purposes of transitioning to the least restrictive and most integrated community setting appropriate to individual need. The 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 community.

TN Resiliency Project provides grants to local community behavioral health providers/school districts/other health entities aiming to address children and youth mental health concerns. The TRP Grant supports evidence-based mental health services for youth ages birth through eighteen (18) years with social, emotional, or behavioral needs and their families, resulting in outcomes such as an increase in childcare/pre-school attendance, a decrease in K-12 disciplinary referrals, and children being diverted from inpatient hospitalization in emergency departments. As part of this program, there are 8 specialized crisis teams for youth added to serve East and Middle TN. These specialized crisis teams focus on placing "hard-to-place children" and diverting them from hospitalization.

Lastly, TDMHSAS has invested in the expansion of employment services over the last several years following the Individual Placement and Support (IPS) Supported Employment evidence-based model of supported employment. People who are employed experience overall improvement in physical and mental health. Employment is critically important in mental health care, while unemployment worsens mental health. Gaining employment can improve mental health, even for people with the most serious mental illnesses. Employment provides an opportunity for improved self-esteem, better symptom control, improved quality of life, increased social relationships, and better community integration, without harmful side effects.

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

N/A

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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	513,414	200,220*
2.Children with SED	97,003	109,176*

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

Tennessee uses NSDUH State-level data (upper limit) combined with Census data to estimate prevalence among adults. We use Hendall's state-level estimate for SED combined with Census data to estimate SED in children. Prevalence estimates are used to determine appropriate budget and service needs to meet the needs in Tennessee at the state level, and by region and county level when appropriate. We've moved from using NRI's data to NSDUH this year for adults with SMI, which led to an increase.

Tennessee uses the FY2024 URS tables to report the number of those receiving services with SMI and SED through the mental health block grant.

*Because this is the number of individuals treated, incidence would exceed these counts for total statewide estimates; therefore, Tennessee relies on prevalence to estimate need.

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

N/A

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

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

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

N/A

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

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 tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

With 78 of the state's 95 counties being rural, the TDMHSAS prioritizes supporting rural programs to reach all Tennesseans.

Project Rural Recovery uses four mobile clinics to deliver integrated behavioral and physical health services in twenty rural areas that are underserved and/or distressed counties by addressing transportation and infrastructure barriers for patients. The units offer exam spaces, a restroom, a small waiting area, and a lift for accessibility. Providers offer integrated behavioral and physical healthcare for free or at no cost to the patient. Project Rural Recovery began in 2020 with a $10 million, 5-year federal grant.

The Behavioral Health Safety Net of TN is available to eligible uninsured adult Tennesseans and uninsured/underinsured Tennessee children who live in rural areas of the state. Comprehensively, there are 149 physical sites across the state in 77 counties, with 62 of those counties considered rural. Transportation is a reimbursable BHSN service to help with transportation needs, especially in rural communities, to behavioral health services for individuals enrolled in BHSN. All BHSN services remain available via telehealth, which greatly improves optional access to care, as well.

Individual Placement and Support (IPS) Supported Employment is a model of supported employment, and research indicates that it is a successful model for rural communities. Currently, IPS is offered in 55 counties, 38 of which are IPS Providers in rural communities. The IPS program was able to significantly increase statewide through a partnership with the Tennessee Department of Human Services, Division of Vocational Rehabilitation.

TDMHSAS partners with the Department of Health to co-locate mental health services, provided through a Community Mental Health Agency (CMHA), at six health departments in rural counties. The county health department selected for the pilot project will refer patients to the CMHA, regardless of payor source. The CMHA will coordinate and/or deliver mental health services for individuals referred by the county health department. The CMHA will have staff on-site at the county health department, with the CMHA providing the telehealth equipment and the county health department providing the private office space.

The crisis continuum provides community-based assessments statewide in both rural and urban areas to Tennesseans. Several of Tennessee's crisis providers serve rural communities within their designated catchment areas and collaborate with community stakeholders to meet the needs of rural consumers. Crisis services are available to all age groups and to individuals, including those who present in rural county emergency departments, county jails, consumers' residences, and/or are homeless. Crisis providers often partner with local law enforcement and emergency department personnel to troubleshoot technology-assisted assessments to reduce response times, ensure timely response to community locations, reduce the average length of stay in emergency rooms, and improve the overall efficiency of limited crisis resources.

Programs for youth and families use 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. With new state funding added in recent years, TDMHSAS expanded the School-Based Behavioral Health Liaisons program to all 95 Tennessee counties and created more than one liaison position in many counties. Because 60-80% of children who receive mental health services do so in schools, the TDMHSAS continues to expand early intervention services and supports in schools to reduce barriers and increase access to care.

Tennessee's First Episode Psychosis Initiative (FEPI) in rural west Tennessee was recognized as one of the first FEPI programs 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 Juvenile Justice Reform Diversion Grant Programs (JJR) provide community-based services and training to increase treatment options for juvenile courts across the state. These services and training are evidence-based and outcomes-oriented. JJR services have been implemented in 91 of Tennessee's 95 counties, reaching every rural area in the state.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) supports a comprehensive range of targeted programs aimed at preventing and reducing homelessness among vulnerable populations, including individuals with serious mental illness (SMI), serious emotional disturbance (SED), co-occurring disorders, transition-age youth, and those with complex service needs. These services are designed to increase access to behavioral health care, promote housing stability, and support long-term recovery.

Four key programs, PATH (Projects for Assistance in Transition from Homelessness), Children and Youth Homeless Outreach Project (CYHOP), SOAR (SSI/SSDI Outreach, Access, and Recovery), and the Emerging Adults program, are central to the state's efforts. PATH conducts homeless outreach services to 7 regions within the state, while CYHOP focuses on homeless outreach to children and youth, which benefits the family. TDMHSAS has made a concerted effort to expand its reach in addressing homelessness in rural communities. In FY26, updates to the PATH program included a significant expansion into rural counties that had previously lacked access to dedicated outreach and support services. PATH and CYHOP outreach workers actively engage individuals who are homeless or at risk, build strong relationships with area shelters, collaborate with HUD Continuums of Care, partner with local and faith-based organizations, and disseminate information about available mental health services. SOAR supports the effort to complete and submit high-quality SSI/SSDI applications for a high rate of approvals. Tennessee remains a national leader in the SOAR initiative, consistently ranking among the top 10 states in terms of both the number of applications submitted and approval rates. SOAR helps eligible individuals who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or co-occurring substance use disorder access vital SSA disability benefits (SSI/SSDI). Upon SAMHSA's imminent closure of the SOAR TA Center in August 2025, the SOAR community in Tennessee will lose a valuable resource in training for SOAR certification, providing data to a national Online Application Tracking system, which has collected SOAR outcomes, and access to ongoing technical support. To help offset the dissolution of this resource, TDMHSAS is working to develop a TN SOAR Certification process to benefit the community by fortifying training, technical support, and integrity for SOAR efforts in the state. The certification model will ensure the SOAR initiative in Tennessee can endure, adapting to changes and sustaining the quality delivery of SOAR services, which have been highly effective across the state. The Emerging Adults program serves young adults who are exiting foster care or mental health residential treatment to support their transition to community living as adults; the program provides an opportunity for safe, supportive housing and/or life skills development for this vulnerable population to help prevent homelessness at a critical time in their lives. Each of these programs provides individualized support to those who are unstably housed, at risk of homelessness, or experiencing chronic homelessness; services from these programs focus on service navigation, benefits access, care coordination, housing assistance, and engagement in behavioral health treatment and recovery support services.

Many Tennesseans experiencing homelessness or who are at risk of homelessness are often 1 or 2 essential costs away from securing housing or other basic yet essential needs for the following month to support their survival and path toward independence, recovery, and resiliency. The Community Targeted Transitional Support (CTTS) program and the Inpatient Targeted Transitional Support (ITTS) program provides limited, one-time financial assistance to support immediate costs such as rent deposits or payment, utility deposits or payment, emergency food, or other essential items that are all too often a barrier between being unhoused and having a safe place to live; these programs help to convert that barrier into a gateway.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

The Older Adults Program provides mental health care management services to people ages 50 and older who do not financially qualify for Medicaid (TennCare) or the Behavioral Health Safety Net (BHSN). Services can include mental health assessment, community outreach, referral to care supports and services, in-home therapy, as well as coordination with primary care providers. In addition, community mental health education is provided to promote awareness regarding common older adult issues and healthy aging. These services are provided to improve the quality of life and to develop skills to enable living independently in the community or to "age in place". Telehealth is being widely leveraged to provide care coordination services in the Older Adult program, which greatly improves access for rural communities and individuals with limited mobility. The BHSN 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.

TDMHSAS is also responsible for fulfilling the federal mandate for reviewing and approving all Level II Preadmission Screening and Resident Reviews (PASRR) for nursing home admissions for residents/applicants of Medicaid Certified Nursing Facilities. TDMHSAS partners with the Division of TennCare Long-term Services & Supports (TennCare LTSS) and the TN Department of Disability and Aging (TDDA) through an interagency contract to provide individuals of any age seeking nursing facility placement for short-term rehabilitative care, long-term care, or enrollment in TennCare CHOICES Home and Community Based Services (HCBS) with a Pre-admission Screening and Resident Review, commonly called a PASRR. This screening process is a comprehensive mental health assessment and physical history evaluation ensuring people diagnosed with serious mental illness, intellectual, and/or developmental disabilities, or related conditions such as substance use disorders, are able to live in the most independent settings while receiving the recommended care and interventions to improve their quality of life and address their co-occurring disorders and related conditions. Finding appropriate placement and developing a plan of care is essential to preventing unnecessary hospitalization and mitigating the development of acute patient destabilization.

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

N/A

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

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

Criterion 5: Management Systems

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

Criterion 5

1. Describe your state's management systems.

TDMHSAS primarily partners with the Tennessee Association of Mental Health Organizations (TAMHO) and the Tennessee Association of Alcohol, Drug, and Other Addiction Services, Inc. (TAADAS) to support provider workforce training.

Typically, there are trainings that occur annually or semi-annually for the behavioral health workforce. TAMHO supports topics such as homeless services, supported employment, crisis services, school-based providers, and early psychosis trainings and conferences. These offerings will include continuing education for the workforce. TAADAS works with TDMHSAS annually for a peer conference, peer supervisor trainings, and facilitates Certified Peer Recovery Specialist trainings. There are also older adult virtual conferences with CEUs offered annually in collaboration with MHA.

TDMHSAS crisis services staff regularly offer Mandatory Pre-screening Agent (MPA) training to ensure adequate, qualified mental health professionals are certified to write the first “Certificate of Need” after conducting the first crisis assessment for involuntary psychiatric hospitalization.

TDMHSAS youth engagement staff offer Family Support Specialist Certification for individuals who provide direct caregiver-to-caregiver support services to families of children and youth with mental, emotional, behavioral, or co-occurring disorders and/or developmental disorders.

The TDMHSAS Regional Intervention Program offers various trainings and technical assistance, including the Evidence-based Positive Solutions for Families (PSF) series.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

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

Embracing telehealth has allowed mental health services to be offered safely, to eliminate any potential disruption in mental health treatment and recovery, and expand access to rural and vulnerable populations. In FY25, a total of 36,582 individuals were served by the Behavioral Health Safety Net. Over 700,000 units of service were delivered, with 15% delivered via telehealth. This 15% has stayed consistent for the last several years. All BHSN providers use telehealth services, and all BHSN services are allowable for telehealth service delivery. BHSN contracts and service rate sheets include language that BHSN Providers follow federal and state guidelines and clinical standards when offering services via telehealth.

All crisis providers across the state have the capability to provide crisis assessments via in-person or telehealth. All jails and emergency rooms, especially in rural areas, have the equipment they need to utilize telehealth services for those experiencing a mental health crisis. Crisis providers across the state have the capability to provide crisis assessments via telehealth, based on the preference of the individual or referral source requesting a crisis assessment to be completed.

The Mandatory Prescreening Agents (MPA) are trained and certified by TDMHSAS to write the first “Certificate of Need” after conducting the first assessment for involuntary psychiatric hospitalization. The MPA training has transitioned to a virtual setting. Offering this training virtually cuts down on time and expenses for the providers, and it also allows TDMHSAS to conduct any last-minute needs for additional training when necessary.

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

N/A

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

Tennessee has a data warehouse that includes four internal data systems:
1. State-operated psychiatric hospitals
2. Private psychiatric hospitals under contract with the State
3. Crisis Management Information System
4. Behavioral Safety Net Information System

Each system includes data for clients, programs, and providers. Tennessee also works with a contractor to collect transactional data, NOMs, and MHSIP survey data from providers at the client level. We receive aggregate Medicaid data that is combined with cleaned CLD data to complete URS reporting.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

The current data collection and reporting system is specific to mental health services. Tennessee has separate data systems for collecting mental health and substance abuse service data. Behavioral health data systems are separate from data systems in other agencies, including Medicaid and child welfare.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

Currently, data systems are not linked to other state agencies/entities, but the capacity to do so has been discussed.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

Tennessee currently reports on evidence-based practices.

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

One limitation is that we do not have access to Medicaid's client-level data. Because we are provided aggregate data, there is some duplication in the URS tables.

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

We ensure data quality by working closely with our contractors, our data warehouse, and our Office of Research for a full annual review of the federal reporting process and final reports before submission.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

No barriers to report at this time.

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

N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

TDMHSAS contracts with twelve community behavioral health providers to provide mobile crisis and crisis hotline services. Tennessee has a vast statewide crisis system, with a 24-hour crisis line and services, reaching over 112,000 individuals in the state fiscal year 2025. The statewide crisis line received approximately 9,700 calls.

Each contracted agency operates a local crisis hotline, and there is a statewide toll-free crisis line 855-CRISIS-1 (855-274-7471) telephone call routing system for individuals within the State of Tennessee who are experiencing a behavioral health crisis. A telephone call coming into the

Crisis Hotline is routed to the crisis services provider serving the area from which the telephone call originated.

Services provided via statewide Crisis Hotline, as well as the local crisis provider responder lines, include "live" answering by qualified and trained crisis triage personnel within three (3) minutes, telephonic crisis assessment, intervention, and triage until the individual can be linked to the crisis services provider serving the area from which the telephone call originated and/or the area where the individual is physically present. All crisis call centers are required to be adequately staffed to respond in "real time," whenever possible, to telephone calls transferred to their telephone line by the statewide Crisis Hotline to meet the needs of the population served.

In alignment with national efforts, the statewide crisis line transitioned to become a part of the national 988 Suicide and Crisis Lifeline on July 1, 2025. Tennessee's 988 Network is comprised of eight (8) crisis call centers across the state. Four include state-contracted crisis services providers, and the remaining providers are not crisis services providers. Funds from the MHBG 5% set-aside continue to support the TN 988 Network in efforts to improve the infrastructure needed for 988 implementation. TN 988 centers will continue to contract with TDMHSAS through this funding to maintain staffing capacity, increase call handle rates, and enhance service monitoring. All funds from the MHBG 5% crisis set aside support the TN 988 Network in efforts to continue these improvements.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

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

3. Briefly explain your stages of implementation selections here.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) directly funds, supports, and oversees the Tennessee Statewide Crisis Services System. This continuum includes the statewide toll-free crisis line, adult mobile crisis response, children and youth mobile crisis response, walk-in centers, crisis stabilization units, crisis respite, and follow-up services. Tennessee's Crisis Services Continuum comprises a comprehensive array of services designed to support eligible individuals experiencing a behavioral health crisis. These services aim to address immediate needs in the least restrictive, most appropriate setting, with the goal of alleviating or stabilizing symptoms while enhancing support systems and coping skills. This approach enables individuals to remain safely in their communities during and after a crisis. The full continuum, consisting of crisis call centers, mobile crisis response services, and crisis stabilization centers, is being implemented statewide. All three components are currently considered to be in the Program Sustainment stage.

Someone to talk to: TDMHSAS contracts with twelve community behavioral health providers who provide mobile crisis and crisis hotline services. Tennessee has a vast statewide crisis system, with a 24-hour crisis line and services, reaching over 112,897 individuals in the state fiscal year 2025. Approximately 9,700 of the calls were received by the statewide hotline. Each contracted agency operates a local crisis hotline, and there is a statewide toll-free crisis line 855-CRISIS-1 (855-274-7471) telephone call routing system for individuals within the State of Tennessee who are experiencing a behavioral health crisis. This hotline is still active, but automatically directs all calls to TN's statewide network of 988 providers.

A telephone call coming into the Crisis Hotline is routed to the crisis services provider serving the area from which the telephone call originated. Services provided via statewide Crisis Hotline, as well as the local crisis provider responder lines, include "live" answering by qualified and trained crisis triage personnel within three (3) minutes, telephonic crisis assessment, intervention, and triage until the individual can be linked to the crisis services provider serving the area from which the telephone call originated and/or the area where the individual is physically present. All crisis call centers are required to be adequately staffed to respond in "real time," whenever possible, to telephone calls transferred to their telephone line by the statewide Crisis Hotline to meet the needs of the population served.

Tennessee's 988 Network is comprised of eight (8) crisis call centers across the state. Four include state-contracted crisis services providers, and the remaining providers are not crisis services providers. Funds from the MHBG 5% set aside continue to support the TN 988 Network in improvement efforts across the state of TN. TN 988 centers will continue to contract with TDMHSAS through this funding to maintain staffing capacity to increase call answer rates, enhance service monitoring, and enhance the chat/text workforce. All funds from the MHBG 5% crisis set aside support the TN 988 Network in efforts to continue these improvements.

All twelve crisis hotline service providers, along with all eight (8) 988 service providers, have crisis follow-up protocols in place. At present, we are unable to gather data on the total percentage of mental health-related calls made to the 911 system.

Someone to respond: TDMHSAS contracts with twelve (12) community behavioral health providers to operate adult and youth mobile crisis services. These services are non-hospital, community-based interventions available twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) for behavioral health illnesses, crisis situations, or perceptions of crisis situations. Services can be accessed by calling 988.

Adult Mobile Crisis Services are provided to adults who are eighteen (18) years of age and older, while Children and Youth Mobile Crisis Services serve individuals ages 17 years of age and younger. Four (4) regional Children and Youth Mobile Crisis Response Teams provide statewide coverage across 95 Tennessee counties. The scope of services and deliverables in the department's grant contracts with the community providers is a response time of two (2) hours or less for at least 90% of the crisis calls that necessitate a mobile crisis team response. For calls originating from local schools, the state standard for response time is one (1) hour.

Children's Mobile Crisis Services are fully implemented and currently in the Program Sustainment stage. These services are supported through a combination of state appropriations and TennCare (Tennessee's Medicaid authority) funding. All Mobile Crisis teams incorporate peer support specialists in various roles to enhance the delivery and effectiveness of crisis services.

Place to go: Tennessee crisis services providers operate ten (10) Crisis Walk-In Centers (WIC), which are non-hospital, facility-based programs affiliated with each of the State-licensed Crisis Stabilization Units (CSU). The WIC/CSUs operate twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365) and serve as accessible entry points for individuals experiencing symptoms of a behavioral health condition or crisis.

Crisis Walk-in Triage Services include assessment and evaluation; early intervention; prevention; stabilization; referral(s) to appropriate behavioral health services; and follow-up care. Individuals may be maintained in the WIC pending final disposition to the recommended level of care. All ten (10) Walk-In Centers also provide 23-hour observation services as appropriate. CSUs are licensed by the State to offer (24/7/365) intensive, short-term stabilization and behavioral health treatment for those persons whose behavioral health condition does not meet the criteria for involuntary commitment to a psychiatric hospital or other treatment resource and who cannot be appropriately and/or safely managed in a less restrictive environment. Currently, there are ten (10) CSUs across the state, offering a total of one hundred and eighty-one (181) beds for adults and twelve (12) beds for children and youth. To expand access to these critical services, TDMHSAS will be adding four (4) new WIC/CSUs to further strengthen the statewide availability of community stabilization services.

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

TDMHSAS initiated the development of the state's crisis system in 1991 with the implementation of crisis call lines and mobile crisis services, providing statewide coverage across all 95 counties for children, youth, and adults. In 2008, the continuum of crisis services was expanded to include Walk-In Centers, Crisis Stabilization Units, and Respite services.

In Fiscal Year 2022, TDMHSAS began formally supporting the national 988 Suicide & Crisis Lifeline system through recurring funding from the Mental Health Block Grant. As of June 1, 2022, this support was further bolstered by funding from the SAMHSA.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network: 8

ii. Not in the suicide lifeline network: 4

b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: 8

ii. Not in the suicide lifeline network: 4

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 0

b. Integrated with public safety first responder structures (police, paramedic, fire): 0

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 0

b. Number of Emergency Departments that operate a specialized behavioral health component: 0

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 10

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The crisis set aside is used to enhance Tennessee's 988 Network. Funds from the MHBG 5% crisis set aside support the TN 988 Network in efforts to improve and increase infrastructure, while allowing for ongoing data capture to identify service gaps and continued needs. TDMHSAS helps support funding for the eight Tennessee National Suicide Prevention Lifeline Center Network providers. Funding is primarily for supporting staffing needs at these agencies. Each call center has identified counties of service where they are designated as the "primary" call center. If the primary call center does not answer the call within a certain amount of time, then it shifts to a "backup" 988 center in Tennessee. There has been emphasis in the improvement grants on maintaining a 90% in-state answer rate, and grants have supported additional staffing to answer the increased capacity of calls. If a call is not answered by the state primary or back-up center, then the call goes to a national backup center.

Through the 988 Improvement Grants, Tennessee has prioritized strengthening the state's 988 chat and text response. Currently, the state has four chat/text centers. One center is 24/7, two centers are funded for 3 FTEs, and one center has 1 FTE to manage 988 chat/text across Tennessee. If one of the four chat/text centers does not have the capacity to answer a chat/text message, then it is sent to a 988 national backup center.

There are currently two funding sources that support the 988 programming with a focus on support for the 988 centers. The first is a recurring set-aside from the Community Mental Health Services Block grant. Additionally, Tennessee received a new federal SAMHSA Cooperative Agreement that is expected to provide recurring funds to support the same 988 centers. This new federal agreement also includes funds for statewide evaluation. Funds from these two sources are focused on supporting the enhanced infrastructure, data collection and service evaluation for the 988 centers in Tennessee.

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

N/A

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Footnotes:

Please see additional program implementation data that characterizes crisis services system development.

Someone to contact:
There are 12 locally based crisis call centers in Tennessee. Tennessee has 12 crisis call centers with follow up protocols in place. Tennessee does not have data to estimate the percent of 911 calls that are coded out as BH related.

Someone to respond:
Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities) All
Independent of public safety first responder structures (police, paramedic, fire): Data not available
Integrated with public safety first responder structures (police, paramedic, fire): Data not available
Number that utilizes peer recovery services as a core component of the model: Data not available

Safe place to be
Number of Emergency Departments: Data not available
Number of Emergency Departments that operate a specialized behavioral health component: Data not available
Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 10

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

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

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

In addition, there are 10 identified guiding principles of recovery:

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

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

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

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, Crisis Stabilization Units, Regional Mental Health Institutes (state psychiatric hospitals), peer wellness programs, a Peer Recovery Call Center, and training and advocacy programs, among other places.

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 has a Transition-Age Designation of the Certified Peer Recovery Specialist, the Certified Young Adult Peer Support Specialist program (CYAPSS) for individuals ages 18-30 with lived experience of mental illness or substance use disorder.

Fully co-occurring since 2013, Tennessee's Certified Peer Recovery Specialist program trains and certifies individuals with lived experience of mental illness and/or substance use disorder. Currently, 1,577 CPRS serve as a role model for recovery and hope every day in Tennessee.

The CADRE (Career Development for Peer Recovery Specialists) portal contains everything peers in Tennessee need for certification—applications, personal dashboards where they can upload continuing education, certification handbooks, etc. In addition, it provides providers the opportunity to confirm certification credentials for the peers that they employ.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

The Creating Homes Initiative 2.0 (CHI 2.0) and the Supportive Recovery Housing programs are major contributors to addressing identified needs for safe and affordable recovery housing for Tennesseans experiencing substance use disorders (SUD), many of whom also have a co-occurring or undiagnosed mental health illness. TDMHSAS has also established the Creating Homes Initiative 3.0 (CHI 3.0) and Supportive Reentry Housing programs to focus efforts on permanent supportive housing for Tennesseans who are justice-involved, many of whom experience both SUD and mental illness. Best practices in both mental health and SUD recovery are implemented in these programs to ensure a comprehensive approach in service delivery to each person served, which equips them as they navigate their path toward greater recovery, resiliency, and independence.

More information about Tennessee's recovery and recovery support services for individuals with substance use disorders may be reviewed in the TDMHSAS Substance Abuse Prevention and Treatment Block Grant Application.

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

N/A

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

N/A

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] 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.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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

[2]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.

[3]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.

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

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

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The resilience of children and youth with SUD? ◉ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ◉ Yes ○ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

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

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, four times annually, for child-serving agencies to discuss current trends within the state as well as potential barriers to service. 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, Young Child Wellness Council, Association for Infant Mental Health in Tennessee, Infant and Early Childhood Mental Health Financing Policy Team, TN Start Advisory Council, and the Tennessee Council on Autism Spectrum Disorder. In July 2025, the system of care in Tennessee achieved sustainability through transitioning high-fidelity wraparound to a Medicaid billable service, 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, faith-based organizations, law enforcement, the juvenile justice system, and child welfare services.

In 2025, TDMHSAS continues to partner with the Tennessee Department of Education through a Comprehensive School-Based Mental Health Policy Academy. The policy academy led to an updated version of the Comprehensive School Mental Health Implementation Guide for Districts, as well as a pilot working with 22 school districts on embedded mental health services and supports into the fabric and culture of the school community. In addition, TDMHSAS and TDOE continue to partner on the SAMHSA Project AWARE-SEA (Advancing Wellness and Resiliency in Education-State Education Agency) grant, which expanded school-based mental health services to students in high-need school districts in Tennessee. Project AWARE staff continue partnering with Shelby County AWARE, which was awarded a county-level grant. The collaboration with the Department of Education allows for additional partners and community engagement, which translates into sustainability for grant-funded projects.

The Behavioral Health Safety Net (BHSN) for Children provides essential outpatient mental health services to uninsured and underinsured Tennessee children, with an emphasis on connecting children to more robust mental health payors like TennCare or CoverKids.

The Tennessee Resiliency Project (TRP) has several projects partnering with various other child-serving systems. In northeast Tennessee, aside from partnering with schools for SBBHL and Project AWARE, the provider is partnering with a pediatric office to integrate mental health care. In East TN, the provider is collaborating with crisis teams with the school, courts, and the children's hospital. In Middle TN, providers are working with schools to divert from the youth justice system and hospitals. In West TN, the provider is looking to provide prevention services within the Obstetrics Unit to educate new mothers about children's mental health, and they have co-located a clinic with a primary care office. Across Tennessee, one provider is providing high-intensity crisis care for the hard-to-place population. The success of the co-location of a therapist led to the use of BSCA dollars to expand the co-location to other regions throughout the state.

Significant funding from the initial Tennessee Resiliency Project (TRP), funded in February 2023 following a statewide RFP process, has been designated to develop a model and implementation vehicle for Infant & Early Childhood Mental Health Consultation (IECMH-C) in Tennessee, in collaboration with several related agencies including the Association for Infant Mental Health in TN, the State Centers of Excellence, and Child Care Resource & Referral. This effort is also supported by Technical Assistance provided by Zero to Three and the Center for Early Childhood Mental Health Consultation (Georgetown University). The IECMH-C Coordinating Council & IECMHFPT both support the systemic work necessary towards developing a model framework to best serve Tennessee's youngest citizens.

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

N/A

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

N/A

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

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

The Tennessee Suicide Prevention Network (TSPN) is a public-private network to address suicide prevention and postvention in the state. The TN State Suicide Prevention Plan, which is a collaborative effort between TDMHSAS and the Tennessee Suicide Prevention Network Advisory Council, provides a focus on interventions and ensures that these interventions are readily available statewide. The TSPN Advisory Council is a TDMHSAS Commissioner-appointed council and provides oversight for TSPN. TSPN provides gatekeeper suicide prevention trainings, in addition to postvention services, across the entire state. TDMHSAS also contracts with Mental Health America, in both East and Middle Tennessee Regions, to ensure individuals have access to suicide risk online screenings, but also a connection to services and resources that assist with current needs. The Mental Health 101 program, which is a part of Mental Health America of East Tennessee, provides suicide prevention training to middle and high school students and staff. The Youth and Young Adult Suicide Prevention Program, which is through Centerstone of Tennessee, ensures that providers at pediatric primary care offices, as well as higher education institutions in the Middle and West TN regions, have access to training, resources, and support for suicide prevention. The Jason Foundation, through its Project Tennessee program, provides a wide array of 2-hour suicide prevention trainings for educators, students, parents, coaches, and mentors. The curricula have a wide range of focuses, including foster care, bullying, depression, non-suicidal self-injury, and many other topics.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

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

If yes, please describe how barriers are eliminated.

All Mobile Crisis service providers, who are contracted with TDMHSAS, ensure that all individuals who are assessed by mobile crisis receive a comprehensive Crisis Management Plan. This plan includes assisting the individual, as well as their support system, with education on how to identify the onset of a mental health crisis, how to ensure that the home environment is safe and secure, as well as how to connect with services, both emergent and routine provider appointments. Mobile Crisis service providers also ensure that individuals who are assessed receive follow-up services. These follow-up services can ensure that the individual was admitted to a facility, review the Crisis Management Plan, and serve as a reminder of how to access both outpatient services and emergency mental health services.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

TDMHSAS has a Promise to Call initiative and continues to promote it state-wide. The initiative encourages individuals to create a plan to reach out to an identified contact if they experience suicidal ideation. This initiative has a website, which includes electronic access to this individualized plan, available resources to assist, and a connection to 988 if that level of response is required.

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

N/A

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

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

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

TDMHSAS has expanded on many partnerships, including:
• Partnership with the Tennessee Department of Correction for the Certified Peer Recovery Specialist program inside its facilities. Individuals on the inside who are doing well in their recovery and who meet TDOC's criteria and CPRS eligibility requirements can take the CRPS training, become certified, and provide peer support as their employment while incarcerated.
• Development of an advanced endorsement on the Certified Peer Recovery Specialist credential for CPRS who have lived experience of having served our country with the Tennessee Department of Veteran Services. The CPRS-V endorsement will include advanced training and continuing education requirements.
• Expansion of the Co-located Mental Health Services at County Health Departments program to more rural counties with the Department of Health. This program places a community mental health provider at a county health department to coordinate and/or deliver mental health services.

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.

Tennessee works to have a customer-focused, efficient, and effective state government. The Customer Focused Government (CFG) provides business optimization and strategy development consulting services to the Governor's Office and 23+ state departments and agencies. Each State Department creates annual performance plans that align with the Governor's Operational Priorities. These annual plans are informed by departments' 4-Year Strategic Plans. Part of these plans is to include relationships with other State agencies needed to ensure the success of the work. The Office of Evidence & Impact (OEI) maintains a Program Inventory Dashboard and has a role in the budget request process with the emphasis on evidence-based budgeting. Part of this effort, known as evidence-based budgeting, facilitates the use of research and evidence to inform programmatic funding decisions in a way that improves outcomes for Tennessee citizens.

An example of these in action is with the TDMHSAS and the Tennessee Department of Human Services, Division of Vocational Rehabilitation (TDHS). These agencies continue to work together to expand the Individual Placement and Support (IPS) model of supported employment across the state. 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 IPS program. This helps to outline responsibilities between the two agencies.

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

N/A

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

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.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

The Department 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.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

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

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.

Membership includes: service recipients, representatives of recipients and their families; advocates for children, adults, and the elderly; service providers; veterans; 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 the Governor on the service system, including the Department's programs, services, supports, and facilities.

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

N/A

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Footnotes:

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES PLANNING AND POLICY COUNCIL

c/o 500 DEADERICK STREET
ANDREW JACKSON BUILDING, 5th FLOOR
NASHVILLE, TENNESSEE 37243

PAUL FUCHCAR
CHAIR

AMBER HAMPTON
VICE-CHAIR

August 22, 2025

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

RE: FY2026 Mental Health Block Grant Application

Dear Commissioner Williams:

The Tennessee Department of Mental Health and Substance Abuse Services 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 FY2026 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 the 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 ensure 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,

Paul Fuchcar
TDMHSAS Planning and Policy 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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Sarah Adams	State Employees	Tennessee Bureau of TennCare	310 Great Circle Road Nashville TN, 37243 PH: 615-952-2192	sarah.e.adams@tn.gov
Richard Barber	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		153 Willow Branch Jackson TN, 38305 PH: 731-694-0252	barberrichard07@gmail.com
Melissa Birdwell	Providers	Frontier Health	2001 Stonebrook Place Kingsport TN, 37660 PH: 423-224-1000	mbirdwel@frontierhealth.org
Amy Blackwell	Parents of children with SED		1830 Clydesdale Street Maryville TN, 37801 PH: 865-724-2325	director@cccmaryville.org
Renee Bouchillon	State Employees	Tennessee Department of Human Services District Office	1400 College Park Drive Columbia TN, 38401 PH: 931-380-4636	renee.bouchillon@tn.gov
Jim Casey	State Employees	Tennessee Department of Correction	320 6th Avenue North Nashville TN, 37243 PH: 615-253-8163	jim.casey@tn.gov
Regina Clark	Providers	Frontier Health	128 Oak Drive Unicoi TN, 37692 PH: 423-956-2426	rclark@frontierhealth.org
Amy Coleman	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		38 Thornfield Drive Bells TN, 38006 PH: 731-513-4145	Amy.coleman2@uhsinc.com
Courtney Collier	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		648 Bowman Road Medon TN, 38356 PH: 731-426-5688	firstclass1906@outlook.com
Lindsey Crowder	Providers	Aspell Recovery Center	PO Box 2412 Jackson TN, 38305 PH: 731-499-3929	lindsey@aspellrecovery.com

Ben Dickey	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		2390 West Monica Drive Bartlett TN, 38134 PH: 901-517-0681	bendickey7@gmail.com
Paul Fuchcar	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		207 Spears Avenue Chattanooga TN, 37405 PH: 423-667-3311	paul.fuchcar@cadas.org
Melvin Gatewood	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	United States Department of Veterans Affairs	1310 24th Avenue South Nashville TN, 37212 PH: 615-983-7833	melvin.gatewood@va.gov
Katrina Gay	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		131 Sanders Ferry Road Hendersonville TN, 37075 PH: 615-545-2548	kgay@namitn.org
Amber Hampton	Advocates/representatives who are not state employees or providers	Mental Health America of the MidSouth	446 Metroplex Drive Nashville TN, 37211 PH: 615-312-3113	ahampton@mhamidsouth.org
Ben Harrington	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		P.O. Box 37231 Knoxville TN, 37930 PH: 865-584-9125	ben@mhaet.com
Rikki Harris	Parents of children with SED		500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	rharris@tnvoices.org
Debbie Hillin	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		5465 Village Way Nashville TN, 37211 PH: 615-975-0196	debbiehillin@buffalovalley.org
Robert Humphreys	Providers		5600 Brainerd Road Chattanooga TN, 37411 PH: 423-266-4588	robert.humphreys@cherokeehealth.com
Amy Irvin	Providers	The Omni Family of Services	1401 Williams Street Chattanooga TN, 37408 PH: 423-544-4815	amyirvin@theomnifamily.com
Jennifer Jones	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		1321 Murfreesboro Pike Nashville TN, 37217 PH: 615-780-5901	jennifer@taadas.org
Melinda Jones	Parents of children with SED		3235 Royal Knight Drive Memphis TN, 38118 PH: 901-428-6494	mlindaj73@yahoo.com
Susan Langenus	Providers	Centerstone	2400 White Avenue Nashville TN, 37204 PH: 615-460-4451	susan.langenus@centerstone.org
Brock Martin	State Employees	Tennessee House of representatives	425 Rep John Lewis Way N Nashville TN, 37243 PH: 615-741-7478	rep.brock.martin@capitol.tn.gov

Elton Maupins	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		1428 Goodnight Court Nashville TN, 37207 PH: 615-707-9852	elton@giduniversity.org
Dawn Mitchell	Parents of children with SED		1010 Drummond Drive Nashville TN, 37211 PH: 615-293-0676	dawn.mitchell@lifecarefs.org
Morenike Murphy	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		909 Meadow Lark Lane Goodlettsville TN, 37072 PH: 615-756-4898	mmurphy@centerofhopebh.org
Tomill Newsom	Providers	Metro Health Department	5510 Country Drive Nashville TN, 37207 PH: 615-713-8429	tomill.newsom@nashville.gov
Lori Paisley	State Employees	Tennessee Department of Education	710 Robertson Parkway Nashville TN, 37243 PH: 615-253-0065	lori.paisley@tn.gov
Kim Parker	Providers	Pathways	238 Summar Drive Jackson TN, 38301 PH: 731-541-8988	kim.parker@wth.org
Jennifer Phillips	Providers	Helen Ross McNabb Center	205 West Springdale Avenue Knoxville TN, 37917 PH: 865-315-6155	jennifer.phillips@mcnabb.org
Erin Read	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		140 Dameron Avenue Knoxville TN, 38118 PH: 615-585-4066	erin.read@knoxtnhousing.org
Albert Richardson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		4041 Knight Arnold Road Memphis TN, 38118 PH: 901-360-0442	arichardson@caapincorporated.com
Mary Linden Salter	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		6649 Sugar Valley Drive Nashville TN, 37211 PH: 615-579-8808	marylinden@taadas.org
Pamela Sessions	Providers	Renewal House	3600 Clarksville Pike Nashville TN, 37218 PH: 615-255-5222	psessions@renewalhouse.org
Toni Shaw	State Employees	Tennessee Housing Development Agency	502 Deadrick Street Nashville , 37243 PH: 615-815-2034	tshaw@thda.org
Alysia Smith Knight	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		102 Bridle Court Hendersonville TN, 37075 PH: 615-519-3985	asmithknight@tamho.org
Patrick Starnes	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		607 Neil Avenue Nashville TN, 37206 PH: 615-330-1832	trucare10@yahoo.com
Angel Townsend	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		5751 Uptain Road Chattanooga TN, 37411 PH: 423-290-3269	atownsend@homelesscoalition.org

Emily Waitt	Advocates/representatives who are not state employees or providers	Tennessee Primary Care Association	710 Spence Lane Nashville TN, 37217 PH: 317-605-5259	emily.waitt@tnpca.org
Allison White	Providers	Methodist Le Bonheur Healthcare	5050 Poplar Avenue Memphis TN, 38157 PH: 901-826-9720	allison.white@mlh.org
Eula Whittaker	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		3323 Foxwood Drive Memphis TN, 38115 PH: 901-949-0661	eleewhit0611@gmail.com
Marie Williams	State Employees	Tennessee Department of Mental Health and Substance Abuse Services	500 Deaderick Street Nashville , 37243 PH: 615-532-6500	Marie.Williams@tn.gov
Kevin Wright	State Employees	State Vocational Rehabilitation Agency	710 James Robertson Parkway Nashville TN, 37243 PH: 615-741-3599	kevin.r.wright@tn.gov
Evelyn Yeargin	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		375 Cumberland Bend Nashville TN, 37228 PH: 615-743-1467	eyeargin@mhc-tn.org

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

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	12	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	8	
3. Parents of children with SED	4	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**24**	**53.33%**
6. State Employees	8	
7. Providers	11	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**19**	**42.22%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	2	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**2**	**4.44%**
16. Total membership (all members of the council)	**45**	

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15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

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 at the following link: https://www.tn.gov/behavioral-health/planning1/mental-health-block-grant.html

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

The final version was posted for the previous year at this link: https://www.tn.gov/behavioral-health/planning1/mental-health-block-grant.html

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

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

N/A

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Footnotes: